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AHW RHA Efficiency Review
East Central Health

Governance and Accountability Overview

Final Report

June 18, 2007

Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

Governance and Accountability Overview

Key Components of Governance and Accountability

- The province of Alberta uses a four part accountability framework that includes: 1) a three year Health Plan; 2) Annual Business Plans; 3)Quarterly Performance Reports; and 4) Annual Reports. This framework is to promote:
  - Governance and management of the health region
  - Accountability to the Minister
  - Keeping the public informed
- For this assessment, Deloitte has focused on the Three-Year Health Plan to assess the degree to which there is demonstrable evidence that the direction is cascading to the operational level.
- In addition, Deloitte has applied a high level assessment of the Board's role related to:
  - Responsibilities and mandate
  - Structure and organization
  - Processes and information
  - Performance assessment and accountability
  - Organizational culture

ECH Three-Year Plan

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goals 1	Legislated Responsibility 1
• Albertans Choose Healthier Lifestyles	• Promote and protect the health of the population in the health region and work towards the prevention of disease and injury

Deloitte Observations at the Operational Level	• Four corresponding strategies identified: • **1.1 – Support individuals and communities in healthy choices and healthy behaviours** • **1.2 – Improve utilization of HealthLink services** • **1.3 – Improve utilization of Telehealth** • **1.4 – Support individuals and families through Young Family Wellness Initiative** • The region's 3-Year Plan has identified several performance measures to support these strategies, but the level of detail across measures are mixed: some provide annual targets across the three years, while others set only an end-goal for March 2009. Limited information provided as to rationale provided for some targets, or why more aggressive targets not chosen (e.g. # of fruits eaten per day by ECH residents). • The plan identifies performance measures to increase use of telehealth in the geriatric and pediatric populations, but several indicators do not have baselines established from which to compare progress to targets. Consultation findings support good traction in the use of telehealth for geriatric psychiatry, but there is a suggested need for improved mapping of services relative to waiting lists. • Increased utilization of HealthLink services are targeted to reduce dependence on regional ERs for triage level 4 and 5 patients, which will help to ease ER workload. However, no corresponding targets on facility ER staffing or resources are noted, and stakeholders did not identify this as a key strategy for the ERs across the facilities visited. A broader regional tracking tool of HealthLink use would benefit to the region, which could inform both ER human resources and siting strategies, as well as PCN planning.

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 2	Legislated Responsibility 2
• Albertans Health is Protected	• Assess on an ongoing basis the health needs of the region.

Deloitte Observations at the Operational Level	• Four corresponding strategies identified: • **2.1 – Strengthen capacity to vaccinate against preventable diseases, identify emerging threats, and prevent increases of sexually transmitted infections.** • **2.2 – Reduce adverse health effects from environmental health hazards** • **2.3 – Reduce suicide and risk of serious injury** • **2.4 – Improve access to disease screening and prevention services** • The performance measures related to environmental health relate only to the incidence of disease (e.g. food-borne illness), but do not address operational performance metrics to support strategy (e.g. % of restaurants inspected according to standards). In support of this strategy, consultations identified an increase in public health inspection staff to improve surveillance of environmental health risks. However, stakeholders report the need for additional staffing to meet current demand, and an anticipation of increased demand given regional construction, oil and mining industries. • The new Population Health Leader is undertaking a review of programming across the region with the intent of ensuring an appropriate use of resources. Consultation findings indicated that there is only 1.6 FTE of dedicated resource for Sexual Health across the region, and no regularly scheduled SH or STD clinics. Additional resources are also required for pandemic planning. • To support these strategies, the region would benefit from a comprehensive community health needs assessment that would help to set the baseline for planning.

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 3	Legislated Responsibility 3
• Improve Access to Health Services	• Reasonable access to quality health services is provided in and through the health region.

Deloitte Observations at the Operational Level	• Three corresponding strategies identified: • **3.1 – Provide continuing care services that allow individuals to "age in place" in their homes and communities** • **3.2 – Improve access to health services for all residents** • **3.3 – Improve access to primary care** • The Region has a policy to facilitate choice in placement for LTC instead of first-available bed, which supports its 'age in place' strategy. • Further supporting this strategy, the region is setting a number of baselines related to home care services, from which it will target future service levels (e.g. home respite). • As part of the region's continuing care plan, a shift to the Eden model of care is being embraced, and facility redevelopment is shifting the delivery model to an increased proportion of DAL setting in the region. • The region is starting to explore the need for more dedicated palliative care resources, including a hospice, a chronic pain clinic, and support for increased palliative and pain management education to better integrate best practice into clinical practice. • While there is a integrated mental health plan for the region, it is high level with limited information on mental health needs of ECH residents and specific strategies to meet those needs.

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 3 (cont'd)	Legislated Responsibility 3 (cont'd)
• Improve Access to Health Services	• Reasonable access to quality health services is provided in and through the health region.

Deloitte Observations at the Operational Level (continued)	• For surgical and obstetrics services, the region has identified a measure of service consolidation, however the identified targets are not related to this measure. This should be considered in relation to a community health needs assessment and the region's health services plan to help guide the appropriateness and sustainability of local service delivery. • Strategy 3.2 identifies a number of access measures, but does not directly measure whether the service provided is the right service, or provided in a cost effective manner. Further consideration by the region on this balance would benefit planning. • Stakeholder consultations on primary care indicate a challenge to implementing PCNs in the region. Although progress has been made through the Camrose and Provost PCNs, the continued high level of triage level 4 and 5 patient volumes in regional ERs is a sign of continued challenges in accessing primary care. Further education on the benefits of PCN as part of a broader clinical service and facility role review may better support this initiative.

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 4	Legislated Responsibility 4
• Improve Health Services Outcomes	• Activities and strategies to improve program and facility quality.

Deloitte Observations at the Operational Level	• Five corresponding strategies identified: • **4.1 – Implement a health workforce plan** • **4.2 – Provide education and training programs to develop the health workforce** • **4.3 – Implement innovative initiatives to recruit and retain health workers** • **4.4 – Promote effective and efficient utilization of the health workforce** • **4.5 – Increase rural access to healthcare practitioners and multidisciplinary teams** • Consultations revealed established linkages with local training programs for healthcare roles (LPN, RN, lab) to support identified strategies. • Regional use of supernumerary approach for new RN graduates is reported by stakeholders as supporting nursing recruitment and retention across rural sites. This and other regional initiatives are offered to but not well-adopted by the Associate Partners, however, which is an ongoing challenge for the region. The related identified performance measures do not link Associate Partners as part of the strategies supporting this goal, which is an area for consideration by ECH to help better understand overall success toward the goal across ECH and the Associate Partners. • Consultations with board and senior management identify challenges in the sustainability of current facility configuration relative to health human resources challenges, however the three year plan does not identify this issue as part of strategy 4.4. – It is suggested that the region re-examine the question of health human resource sustainability, measured as a function of resources to deliver services to the right person, in the right place, at the right time – and this should be balanced relative to the service access strategies identified for Goal #3.

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 5	Legislated Responsibility 5
• Health System Sustainability	• Determine priorities in the provision of health services in the health region and allocate resources accordingly.

Deloitte Observations at the Operational Level	• Four corresponding strategies identified: • **5.1 – Promote quality standards for health services** • **5.2 – Improve quality of continuing care services** • **5.3 – Strengthen capacity to manage hospital and community acquired infections, adverse events, and medical errors** • **5.4 – Chronic Disease is prevented, delayed, and managed** • Stakeholders report success in a 90% response rate to resident complaints within 24 hours, as part of the targets associated with these strategies. • Rehabilitation is a regional program, and the new Manager is in the process of bringing service levels and programming to appropriate and consistent levels/processes, which will support Strategy 5.1. • Consultation findings indicate several other initiatives underway to support improved quality management and team coordination in the region, although in many cases, limited coordination with Associate Partners was identified. – Improved collaboration, communication and transparency between regional and Associate Partner senior management and boards are needed as critical success factors to improve quality standards of health services across ECH. • The Region is moving towards implementation of the new continuing care standards in support of Strategy 5.2, including implementation of MDS, which must be achieved by March '07. The Continuing Care Plan and long-term Capital Plan both reflect these goals.

Three Year Plan

ECH Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of East Central Health's strategies (2006–2009) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 6	Legislated Responsibility 6
• Create Organizational Excellence	• Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Deloitte Observations at the Operational Level	• Three corresponding strategies identified: • **6.1 – Maintain quality and public confidence in the regional health system** • **6.2 – Implement technology to support clinical and management decision-making** • **6.3 – Support research activities that enhance rural health service delivery** • Public confidence is reported to be a critical priority within the region with Board members being represented from a number of communities across the region. • Regional implementation of Meditech is in progress, with current three-year planning in place to drive achievement of the EHR. Stakeholders report confidence in future state, but resource challenges in maintaining operational service delivery during implementation. • Consultation findings also identify good coordination with the Associate Partners in the Meditech implementation, which has also improved operational collaboration. • Region reports process in place to support research initiatives, and good coordination with universities to support rural research. • The Region also has supported Grant MacEwan College to deliver a rural nursing program. This program is offered through a combination of telehealth and traditional programming, with classroom education and placements provided in regional facilities. All graduates are reported to have taken jobs with the Region.

Three Year Plan

ECH Challenges and Opportunities Section

- Deloitte's review of East Central Health's Three Year Plan (2006-2009) provides the following observations.
  - The plan identifies regional strategies and priorities in alignment to AHW's Health System Goals and legislated responsibilities. The performance measures and targets associated with each goal are clustered, however, with no clear alignment of measures to the specific strategies supporting each Health System Goal. This is especially a challenge where a large number of performance measures and targets are identified for a given Health System Goal (e.g. >115 for Goal 3).
  - Some performance measures across strategies are not well-aligned for the purpose of regional tracking and association with target achievement. For example, there are several measures related to Health Link, but with different purposes, which will make tracking of these measures to targets and strategies difficult.
  - There are also several 'performance measures' that are truly action items – e.g. Surgical services are reviewed and consolidated where appropriate and inpatient surgery cases repatriated as appropriate.
  - The data supporting regional initiatives is dated in some cases, suggesting the need for more recent data that supports leading trends and health service target setting (e.g. % of palliative home care and % ideal continuing care admissions are both based on 2002-03 data).

Three Year Plan

ECH Challenges and Opportunities Section (continued)

- There is a need for an overall clearly articulated implementation plan that supports the Three Year Plan, and which identifies:
  - Key leaders responsible for each initiative.
  - Targets on a year-over-year basis.
  - Key activities to support goal achievement.
  - This level of planning exists at an operational service or departmental level, but stakeholder feedback identified challenges in achieving operational plans in the face of budget constraints. It is suggested that an overall plan that presents an integrated understanding of resource requirements, timing and key activities would benefit the region.
- The planning parameter of 'No Closures' is a limitation to the region's ability to effectively address the question of health service sustainability in the face of current health human resource challenges.
  - While this parameter is understandable relative to the impact of health services on local economies in the region's communities, it is unlikely that this approach will be feasible in the future.
- An Annual Plan is not separately developed in ECH as it is in some of the other regions, and so commentary is incorporated into three-year plan observations.

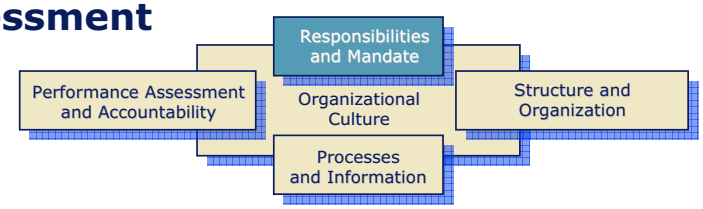
ECH Governance Assessment

ECH Governance Assessment
Assessment Areas and Indicators

- The high level assessment of the five areas of governance responsibility included:
  - Responsibilities and mandate
  - Structure and organization
  - Processes and information
  - Performance assessment and accountability
  - Organizational culture

ECH Governance Assessment

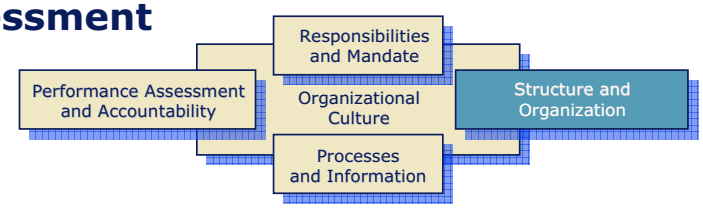
Responsibilities and Mandate



Areas of Assessment	• Understanding of scope, authority and responsibilities (the difference between stewardship and management and setting policy vs. implementing policy) • Involvement in multi-year strategic planning • Involvement in annual planning and budgeting • Involvement in establishing risk management process and aware of procedures to mitigate risk • Ensuring management effectiveness and succession • Communication with key stakeholders
Deloitte Observations	• Board self reports to have good level of involvement in key areas of responsibility, with a focus on policy. Management is given a clear mandate to respond to operational issues. • Board Chair reports that while members are familiar with their responsibilities and personal liabilities associated with their regional governance role, especially related to physicians, this is an area for renewed focus. This suggests an opportunity for further board development and education. This opportunity was echoed as a need by some of the Associate Partners for their own boards. • Board has regular involvement with community stakeholders and uses informal networking to gauge community needs. A public-component is held for all board meetings, and community is invited to attend. • Although ECH reports collaboration and engagement with the Associate Partner Boards, there are few documented processes supporting these linkages, and consultations indicated challenges in the effectiveness of these linkages. These challenges in achieving strong collaboration and engagement have also been identified by the Associate Partners, and is an opportunity that would provide value to the region at a board and senior management level.

ECH Governance Assessment

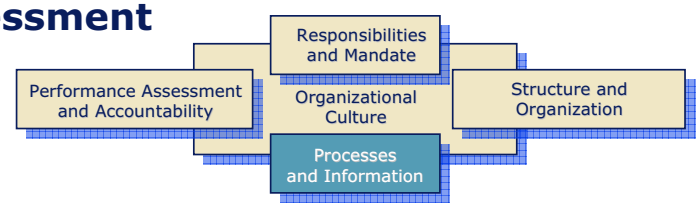
Structure and Organization



Areas of Assessment	• Appropriate number of members and meetings • Appropriate representation of communities • Committee structure • Self assessment
Deloitte Observations	• The Board currently has 12 members, 8 of whom have been with the region since 1995. The Board Chair reports a good mix of community representation. There are no Associate Partner representatives on the board, which presents an opportunity for consideration by the region. – The board currently considers the Associate Partners primarily a management relationship and responsibility, however it does invite the Associate Partner Boards to specific planning sessions. • Board self reports effective working structure for board, with twice monthly meetings to address regular Board work and ongoing needs. • The Board relies largely on the "committee of the whole" (Board and management group) for regular decision making and business of the region. It was reported that the Executive Committee of the Board meets on rare occasions. The Board has moved away from separate finance and human resource committees, such that these items are addressed by the 'committee of the whole', however ad-hoc committees are used as needed (e.g. Policy Review Committee). • Although the board structure and frequency of meetings is reported as working effectively by the Board Chair, both result in a significantly higher level of involvement of the board than has been observed in other regions. This suggests opportunity for a review of board processes and meetings to better understand how the structure and role of board may be re-aligned to support a more streamlined approach to governance in the region.

ECH Governance Assessment

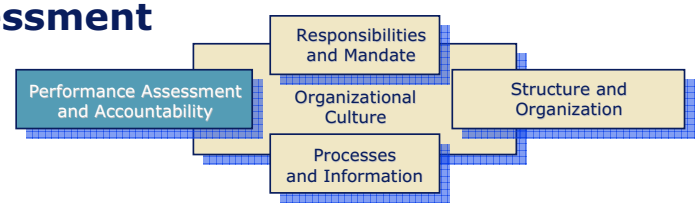
Processes and Information



Areas of Assessment	• Board identification of information needs and receives required reporting • Board meetings considered to be appropriate structured (length, frequency, advance circulation of materials, attendance, management ability to respond to enquiry) • Documentation of meetings • Identification of required skill sets / competencies for board members • Formal orientation; ongoing education / development • Board related policies (roles/responsibility; code of conduct; conflict of interest; …)
Deloitte Observations	• Board self reports good information flow between management and Board. All of senior management attends board meetings, and each provides a written or verbal report. • Board meetings are structured into two components: a morning session of the board and management team, in which only decisions are minuted, and a public afternoon session that is minuted. Meetings rotate through communities. Board Chair reports high level of satisfaction with structure of meetings. Although this has worked well for the region in the past, documenting the full board meeting may enable improved record keeping and decision reference points. • Formal orientation process for new Board Members in place with the Board Chair and CEO, and includes ECH site visits. Ongoing development opportunities exist for Board Members, such as annual conferences hosted by AHW and HBA, and through annual regional board retreats. • The Board Chair reports that there is a good mix of required skills and competencies across the board, with no identified gaps. • Terms of reference for the Committee of the Whole is in place. Other guidelines and policies are also reported to be in place including code of conduct conflict of interest, roles and responsibilities, etc.

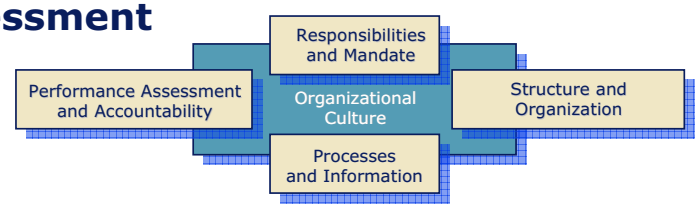
ECH Governance Assessment

Performance Assessment and Accountability



Areas of Assessment	• Process to assess and monitor organization performance related to financial management, operations, people management, risk and safety • Process to monitor achievement of strategic directions • Self assessment of board performance • Board understanding of liability issues • Process to routinely assess performance of CEO/President
Deloitte Observations	• The Board is compliant with required reporting. Board self reports that its ability to assess organizational performance is very strong, and that it regularly monitors the region's achievement of the strategic directions outlined in its 3-Year Health Plan. • The Board has a structured process in place for annual self-evaluation of the Board, which is conducted and reviewed at its annual retreat. • A separate Board evaluation of the CEO is also conducted annually, into which the Operations Committee of the management team is invited to provide input. • The Board reports some risk management reporting at a Board level. An annual briefing of liability insurance is in place, and regular discussions occur on liability issues as they arise. • Given the challenges in knowing about and governing risk across the Associate Partners, this is an area of potential improvement for the region, with potential opportunities including: – An alignment of regional and Associate Partners board policies; – Clear governance accountabilities between the region and Associate Partners – Improved involvement and reporting by Associate Partners at regional board meetings – Common physician credentialing, medical by-laws and MAC terms of reference.

ECH Governance Assessment
Organization Culture



Areas of Assessment	• Board involvement in setting organization's values and philosophies • Diverse representation from communities within Region • Board serving role as policy advocates with government and key stakeholders • Fosters effective board / management relations
Deloitte Observations	• Board self reports significant involvement in value setting and strong relationship with management • The region has one Community Health Council, but it is reported as not being very active or engaged. • The Board reports good community representation in its own membership, however, and leverages its membership to attain community representation. As well, regular rotation of Board meetings through the region allows for improved community interaction, although community members are reported to rarely attend open board meetings. • Although the board reports a strong regional focus in its discussions and decision-making, the prospect of service rationalization and site consolidation is expected to generate a return to behaviour rooted in local community-focus among some members. This process will need careful management and leadership by Board executive. • Strong linkages are reported between the Board and key political and government stakeholders, which is reported to facilitate regional governance and decision-making.

Concluding Comments
ECH

Strengths to build on include…

- **Strong community representation across the Board**
- **Continued revitalization of the organization's information systems**
- **Identification of need for new focus on Health Human Resources as a strategic priority**
- **Development of a Health Services Plan for the ECH region to provide a future road map for development and service planning**

Areas for further development and assessment…

- **Augmentation of Regional and Associate Partner board education**
- **Further development of linkages with Associate Partners to improve seamless governance, management and delivery of services throughout the region**
- **Review of board processes to streamline regional governance and further engage community (e.g. CHC)**
- **Adjustments in programming anticipated with release of Health Services Plan under development. This will provide a template for change and stewardship in the region**
- **Human Resources leadership and planning to support strategic directions**
- **Completion of a regional community health needs assessment to ensure alignment of priorities**

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Project Overview

Project Overview

Scope, Objectives and Business Drivers

Scope:

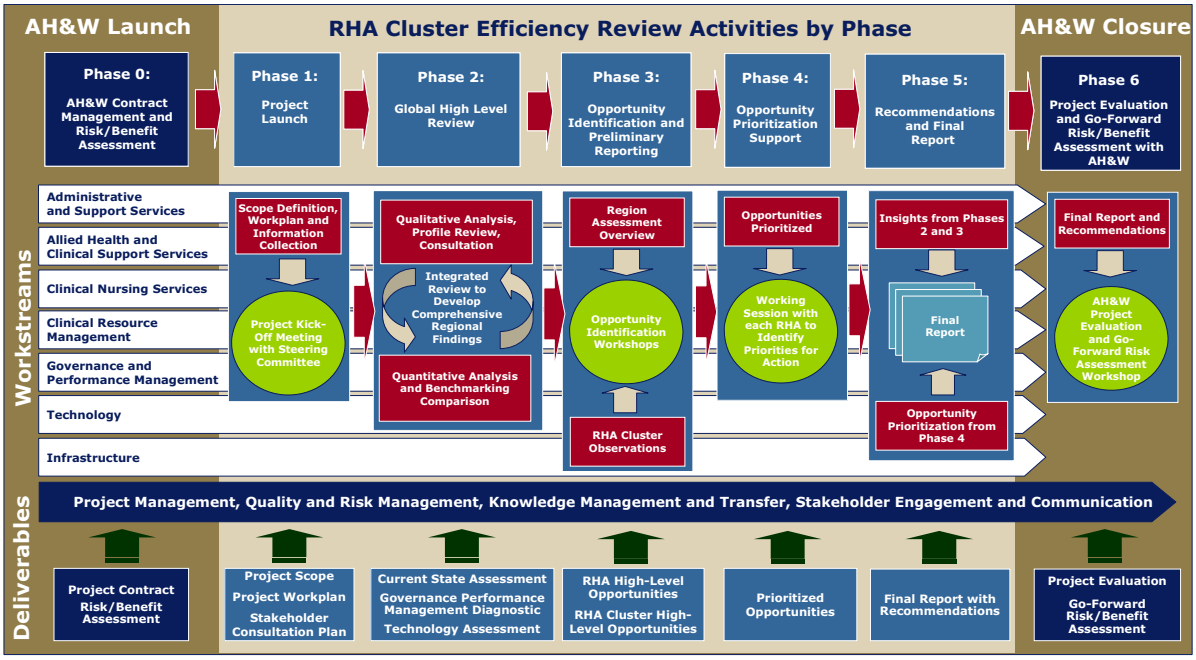
- Alberta Health and Wellness is undertaking an RHA Efficiency Review to identify potential efficiencies and opportunities for improvement within each of the RHAs in the province.
- To achieve this purpose, this Review is focusing its scope on improvements to deployment across five key dimensions:
  - Increases to productivity
  - Improvements to patient flow
  - Improvements to patient outcomes
  - Improvements to financial stewardship
  - Exploration of province-wide opportunities
- The review does include voluntary organizations, but will not be reporting to the voluntary boards.

Project Objectives

- There are three primary objectives that direct the activities of this Review:
  - Identify performance improvement issues and opportunities.
  - Identify productivity and performance improvement strategies and solutions.
  - Provide recommendations to optimize: available resources, operational efficiency, service delivery, safety and quality.

Project Overview
Approach and Timelines

- The diagram below outlines the project approach, and key activities of the review.
- The review started in June 2006, and was completed in June 2007.



Project Overview
Reporting

- This report presents the findings and opportunities identified through the region's review.
- Findings and opportunities are organized into 10 categories of reporting:
  1. Clinical Resource Management
  2. Acute Care
  3. Continuing Care
  4. Community Health Services
  5. Physician Findings and Opportunities
  6. Clinical Support and Allied Health
  7. Corporate and Support Services
  8. Operational Trending and Key Metrics
  9. Human Resources
  10. Infrastructure
- Following the identification and validation of findings and opportunities for each region, two additional activities were completed for this review, which are summarized in the final two sections of the report:
  - Identification of opportunities at a cluster / provincial level.
  - An opportunity prioritization and mapping exercise to support regional planning and go-forward monitoring.

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Clinical Resource Management

Clinical Resource Management
Overview

- Clinical resource management analysis includes CIHI analysis (internal trending of complexity and utilization data and external comparison of utilization data for each program) and the results of the MCAP ® review.
- In conducting an internal review of the complexity and utilization data, a drill-down approach is used to understand changes in utilization efficiency (volume, complexity and utilization efficiency).
  - Analysis is based on 2003-04, 2004-05, and 2005-06 (Q3 YTD) data.
  - 2005-06 Q3 YTD data was straight-line projected to a full year.
  - 2005-06 full year (preliminary and not coded/grouped) data is in line with projected volumes.
- In conducting an external comparison of utilization data, the goal is to identify potential opportunities to improve utilization in relation to CIHI ELOS and peer performance.
  - A drill-down approach is utilized, which begins with a "gross" assessment of utilization and potentially "conservable days" opportunities by comparing CH's acute ALOS by CMG to the CIHI acute ELOS.
  - Although this analysis examines trends across three years of data, it is focused on 2004-05 data due to availability of peer reported data for comparison.
  - This analysis is then fine tuned to determine the more realistic opportunities related to improved utilization management. A filter is applied that specifies the number of cases required and the minimum variance in ALOS required before an opportunity can be considered realistic. For example, if there were fewer than 10 cases or the conservable days for the CMG are less than .5, it is not considered to be a realistic opportunity.
- Lloydminster Regional Hospital was excluded from the trending analysis as data was not reported for 2005-06. Lloydminster Regional Hospital was, however, included in the days savable analyses – for which 2004-05 data was available.

Top 10 Patient Services (2003-04 to 2005-06p)

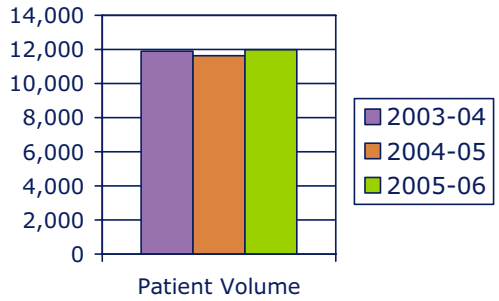
CIHI Abstract Data (Region)

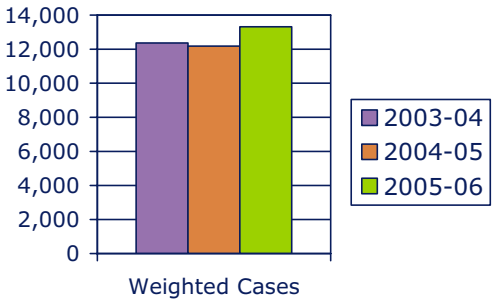
- The Top 10 Patient Services account for the 96% of the region's total caseload in 2005-06.
- The overall increase in patient volume between 2003-04 and 2005-06 is driven primarily by increases for General Surgery, Newborn, and Obstetrics.
- At a site level (not shown here), St. Mary's volume increase of 16% for the same period has also been a large driver of the overall increase in volume for ECH.

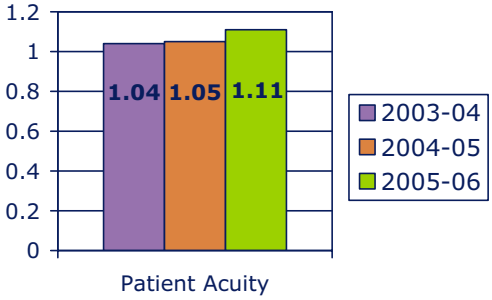
Patient Service	2003-04	2004-05	2005-06p	Variance
General Medicine	7,763	7,361	7,472	-4%
General Surgery	772	881	1,007	30%
Newborn	554	612	629	14%
Obstetrics Delivered	557	613	628	13%
Orthopedics	393	354	409	4%
Paediatric Medicine	517	409	375	-28%
Psychiatry	330	306	344	4%
Palliative Care	175	167	219	25%
Cardiology	237	241	199	-16%
Gynecology	43	158	191	343%
Top 10 Patient Services Total	11,341	11,102	11,472	1%
Other Patient Services Total	558	530	511	-8%
Region Patient Services Total	**11,899**	**11,632**	**11,983**	**1%**

NOTE: Excludes Lloydminster Regional Hospital as data for 2005-06 was not available.

Patient Volume, Weighted Cases and Patient Acuity (Region)





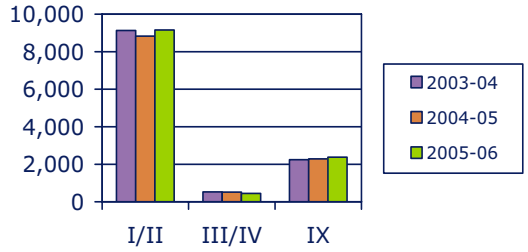


- Inpatient volume across the ECH and Associate Partner sites increased marginally by 1% between 2003-04 and 2005-06.
- However, overall patient acuity has increased by 7% for the same period, resulting in an 8% increase in weighted cases.
  - This increase in acuity was observed across a number of regional and Associate Partner sites in ECH.

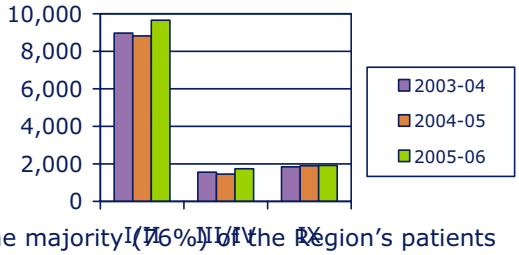
NOTE: Excludes Lloydminster Regional Hospital as data for 2005-06 was not available. 2005-06 Data is Q3 YTD Projected.

Patient Volume, Weighted Cases and Patient Acuity by Plx (Region)

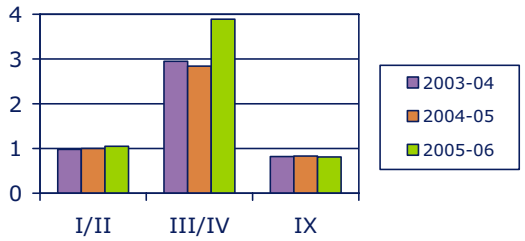
Cases by Plx



Weighted Cases by Plx



Acuity by Plx



Note: Plx further refines case mix groups to reflect additional diagnoses that influence a patient's overall medical condition. Cases are assigned to one of four Plx Levels. Level 1 denotes the absence of co-morbid conditions, while Level 4 denotes the presence of co-morbid conditions that may be potentially life threatening.

- The majority (76%) of the Region's patients are Plx level I/II, case volumes for which have remained stable since 2003-04.
  - Plx I/II acuity has increased by 7%, driving a corresponding 8% increase in weighted case volume.
- Plx III/IV volumes represent only 4% of total region caseload, but have shown the greatest change since 2003-04.
  - Plx III/IV weighted cases have increased by 12%, due to a 32% increase in acuity since 2003-04.
- Although acuity has remained stable for Plx IX, weighted case volumes have increased by 4% due to a 6% increase in case volume.

NOTE: Excludes Lloydminster Regional Hospital as data for 2005-06 was not available. 2005-06 Data is Q3 YTD Projected.

Import/Export Inpatient Volumes for ECH

By Complexity for 2004-05

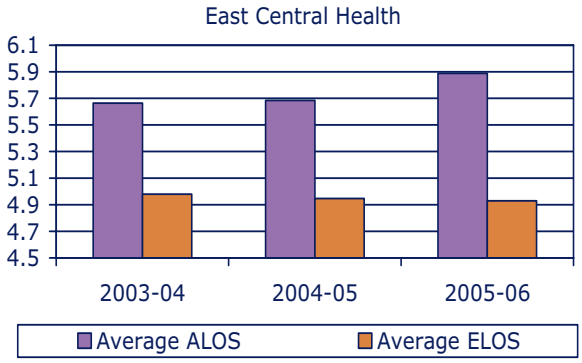
As a % of Total Cases for each Plx	2004-05			
	Plx I/II	Plx III/IV	Plx IV	Total
% Imports	9%	8%	7%	8%
% Exports	27%	42%	31%	29%

- In examining the impact of import/export on inpatient volumes for 2004-05, an overall average of 8% of patients were imported into ECH in 2004-05:
  - Further examination suggests that imported patients are from a number of regions, with the largest % of imports coming from Aspen Regional Health Authority (29%) and Capital Health (25%).
- Overall, 29% of inpatient volumes were exported from ECH in 2004-05:
  - Plx III/IV patients demonstrated the highest proportion of exports, at 42%.
  - Further examination suggests that 83% of exported patients are sent to Capital Health.
  - While this level of export is higher than observed in some of the other non-metro regions, ECH's lack of a regional centre and ICU, lack of repatriation drive for services, and proximity to Capital Health are anticipated to be the primary drivers.
- Although not demonstrated here, analysis suggests that imports and exports as a % of total cases has not changed significantly for ECH over 2003-04 and 2004-05, and preliminary data suggests a continued trend for 2005-06.
  - Further the proportion of imports and exports by Plx level has also been comparable over the two-year period.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05

Average Length of Stay vs. Expected Length of Stay

As a Region



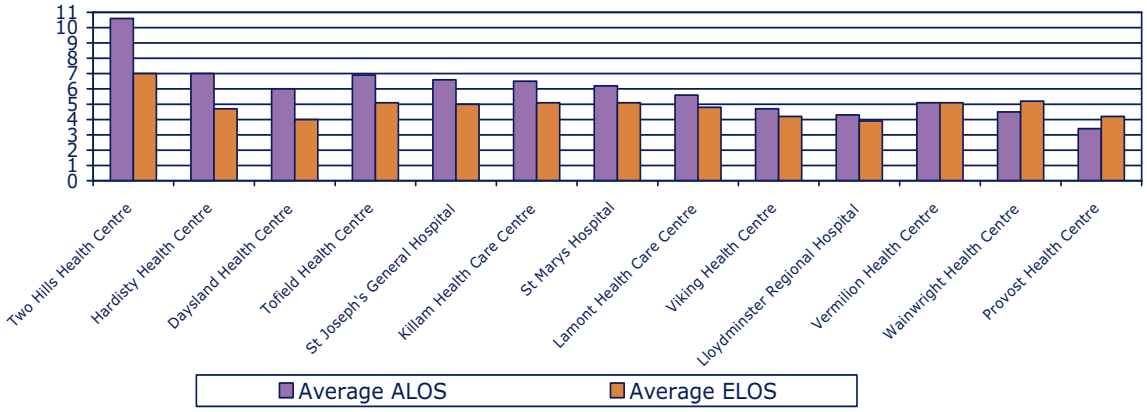
- Length of Stay analysis shows ECH's average length of stay (ALOS) is consistently higher than the CIHI expected length of stay (ELOS), and this gap has increased over three years.
- The chart below shows that the patients in Plx I/II and III/IV are driving the increased ALOS to ELOS gap between 2003-04 and 2005-06.
  - For Plx I/II, ALOS has increased, while ELOS has remained stable.
  - For Plx III/IV, there is significant rise in both ELOS and ALOS, and corresponding gap, for this group.
  - ALOS has been in line or less than ELOS gap for Plx IX.
  - Challenges noted in discharge planning may be contributing to this increasing gap across the sites.

Fiscal Year	PLx Level I/II		Plx Level III/IV		Plx Level IX	
	ALOS	ELOS	ALOS	ELOS	ALOS	ELOS
2003-04	5.5	4.5	12.8	13.1	4.6	4.9
2004-05	5.6	4.5	12.1	13.0	4.7	4.7
2005-06	5.7	4.5	17.1	14.6	4.6	4.7

NOTE: Excludes Lloydminster Regional Hospital as data for 2005-06 was not available.

Average Length of Stay vs. Expected Length of Stay

By Site



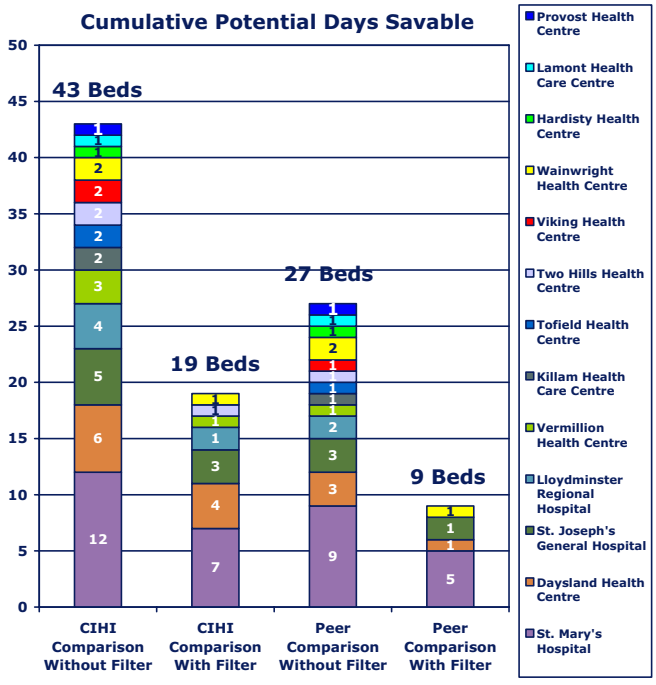
- The data represented in the graph above is for 2005-06 Q3 YTD, with the exception of Lloydminster Regional Hospital, for which only 2004-05 data was available.
- Two Hills Health Centre, Hardisty Health Centre, and Daysland Health Centre demonstrated the greatest gap between overall ALOS and ELOS.
  - For Two Hills, this gap appears to be driven primarily by SAGE program rehabilitation patients.
- Vermillion HC, Wainwright HC, and Provost HC each had overall ALOS that was less than or in line with ELOS, however, there may be opportunities for improvement at a CMG level.
- The regional gap in ALOS to ELOS was driven primarily by larger sites such as St. Mary's Hospital, St. Joseph's Hospital, and Daysland HC due to higher overall volume at these sites.

Top 10 CMGs by Potential Days Savable in 2004-05
As a Region

CMG	CMG Description	Total Cases	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	OTH FACTORS CAUSE HOSPITALIZ	567	10.9	6.9	3.9	1,810
847	OTHER SPECIFIED AFTERCARE	208	15.4	9.6	5.8	710
143	SIMPLE PNEUMONIA & PLEURISY	439	6.4	5.3	1.1	517
222	HEART FAILURE	315	7.5	6.6	0.9	502
142	CHRONIC BRONCHITIS	252	7.3	6.2	1.2	314
483	DIABETES	246	6.5	5.7	0.8	275
783	PSYCHOACTIVE SUBSTANCE DEPEND	75	6.7	4.7	1.9	215
772	DEMENTIA W OR W/O DEL W AXIS3	65	11.4	15.4	(4.0)	210
237	ARRHYTHMIA	310	4.3	3.7	0.6	209
842	SIGNS & SYMPTOMS	93	5.5	5.7	(0.1)	201
Top 10 Region CMGs Total Cases		2,570				4,963
Other 291 Region CMGs Total Cases		10,740				2,401
Total Region CMG Cases (includes Lloydminster)		13,310				7,364

- Leading CMGs for savable days are "Other Factors Causing Hospitalization" and "Other Specified Aftercare", which suggests an opportunity to improve coding and/or documentation, to support improved management of existing acute care beds.
  - Although analysis indicates a high potential days savable for CMG 841 "Rehabilitation", we have excluded this from analysis as it is driven primarily by the SAGE program at Two Hills, which has a purposefully longer ALOS than the CIHI ELOS.
- Opportunity for days savable related to CMG 222 Heart Failure is in part due to the lack of Internist resources in the region to support better management of this patient group in an outpatient setting.
  - Opportunities across CMGs 222, 142 and 483 also suggest the need to further build capacity in O/P chronic disease management.
- The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Beds Savable in 2004-05
As a Region



- Comparison of ECH ALOS to CIHI ELOS suggests that the Region could save as many as 43 beds across regional and Associate Partner sites.
  - This sums the ALOS-ELOS gap across all CMGS for all sites.
  - When a filter of a minimum ALOS-ELOS gap of 0.5 days, and a minimum of 10 cases per CMG is used, the ECH ALOS to ELOS comparison suggests a potential opportunity to save 19 beds across all sites.
- When compared to peers using the filter process, however, the opportunity across all sites is further reduced to close to 9 potential beds savable for 2004-05:
  - St. Mary's Hospital: 5 of 9 beds
  - St. Joseph's General Hospital: 2 of 9 beds
  - Daysland and Wainwright each: 1 of 9 beds
- Given this distribution of potential beds savable relative to peers, the focus for continued review should be on St. Mary's Hospital, with consideration of the coding and discharge planning challenges identified by the site.

- Note: The filter excludes cases where the gap between actual length of stay was less than 0.5 of a day, and the number of cases per CMG was less than 10. Estimated bed savings are based on 100% occupancy.

Top 10 CMGs by Peer Potential Days Savable in 2004-05
At St. Mary's Hospital

CMG	CMG Description	Total Cases	Average Length of Stay	Peer Potential Days Savable
766	DEPRESS MOOD DIS NO ECT/AX3	70	16.5	486
783	PSYCHOACTIVE SUBSTANCE DEPEND	30	11.7	188
777	SCHIZOPHREN/PSY NO ECT/AXIS3	31	13.6	156
842	SIGNS & SYMPTOMS	22	14.6	146
143	SIMPLE PNEUMONIA & PLEURISY	78	7.8	128
784	PSYCHOACTIVE SUBSTANCE ABUSE	22	7.2	104
791	ANXIETY DISORDERS (MNRH)	13	11.7	102
142	CHRONIC BRONCHITIS	44	9.1	97
325	PANCREAS DISEASES (EX MALIG)	16	9.8	79
485	NUTRIT/MISC METABOLIC DISORD	24	8.5	73
Top 10 Region CMGs Total Cases		350		1,559
Other 225 Region CMGs Total Cases		2,732		360
Total Region CMG Cases		3,082		1,919

- Several CMGs across the mental health continuum (CMGs 766, 783, 777, 784, 791) drive 54% of the potential days savable for St. Mary's hospital, equivalent to approximately 3 of the total 5 beds savable.
- These CMGs represent opportunity for examining broader community mental health service availability to facilitate patient care and ALOS management, and improved partnerships with AADAC and other community resources.
- Note: These days savable do not reflect those patients designated as ALC by the organization.
- The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

MCAP Review

MCAP Overview

Process

- An MCAP® review was conducted to:
  - Gain a better understanding of patients' required levels of care and their specific care needs and the impact these needs have on inpatient bed utilization
  - Identify system issues why patients are not at appropriate level of care.
- MCAP® is a utilization management tool that uses rigorous scientifically researched and validated criteria to review the intensity of services required for any given patient and determine the appropriate level of care required.
- The tool uses a "service-driven methodology" and focuses on the treatment plan/services ordered for that day.
- By avoiding the placement of patients at too high or low of a care level, health care managers can be assured that patients will receive the highest possible care quality and will move through the health care system in the shortest possible time.
- The review was conducted by Registered Nurses certified in MCAP. They reviewed the charts of all admitted inpatients in the Acute Care settings of selected health care centres between July 17 – 21, 2006.
- Using the MCAP criteria, the following three key questions were answered for each admitted patient:
  - Does the patient require the level of care (i.e. Long Term Care, Acute Care, Intensive Care, etc.) they are receiving?
  - If not, what level of care does the patient require?
  - Why is the patient not at the level of care they require?

Patient Profile

East Central Health Acute Care

- 141 patients were reviewed at the acute care sites within East Central Health that were visited by the consultation team. This represents 64% of the total number of acute care bed capacity (222) within these sites.
  - Occupancy rates were lowest for Lamont (43%), Vermillion (48%), and Daysland Acute (50%).
  - At St. Mary's, 76% of beds were reviewed.
- The average age of patients was 73 years, which was fairly consistent across sites.
- 53% of patients were female and 47% were male.

East Central Health Acute Sites Visited

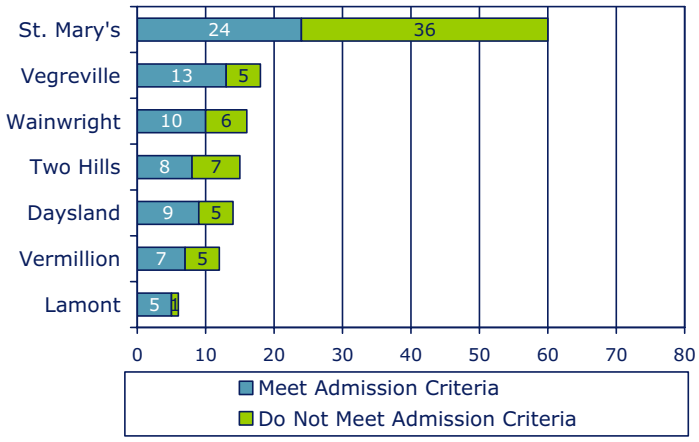
Sites	Number of Beds Reviewed	Total Number of Beds
Camrose (St. Mary's)	60	79
Daysland	22	16
Lamont	6	14
Two Hills	15	27
Vegreville	18	30
Vermillion	12	25
Wainwright	16	25
Grand Total	**141**	**222**

St. Mary's Hospital Inpatient Units

St. Mary's Inpatient Units	Number of Beds Reviewed	Total Number of Beds
Medicine	23	25
Psychiatry	9	10
LRD/Surgery	18	20
Surgery	10	12*
Grand Total	**60**	**67**

*Note: The Total Number of Surgery Beds at St. Mary's represents the total number of beds open in the summer.

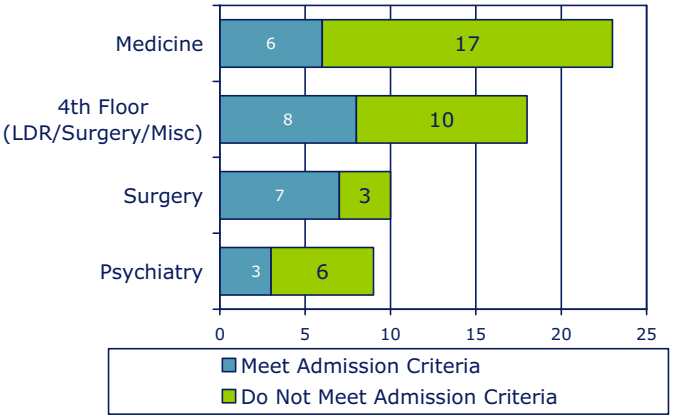
Patients Who Meet Clinical Criteria for Admission
East Central Health Acute Care



Site	Percent at Appropriate Level
Lamont	83%
Vegreville	72%
Daysland	64%
Wainwright	63%
Vermillion	58%
Two Hills	53%
St. Mary's	40%
Total	**54%**

- Of the 141 patient charts reviewed, 76 patients (or 54%) reviewed met clinical criteria for admission.
- St. Mary's is observed to be the primary driver of this result, given the larger number of patients reviewed at St. Mary's, and the higher proportion of patients who did not meet the clinical criteria for admission.
- In comparison to our experience with other regions and hospitals in Canada, this is lower than the typically observed average for other Canadian sites, which have approximately 65-75% of patients meeting criteria for the care setting to which they are admitted.

Patients Who Meet Clinical Criteria for Admission
St. Mary's Health Centre

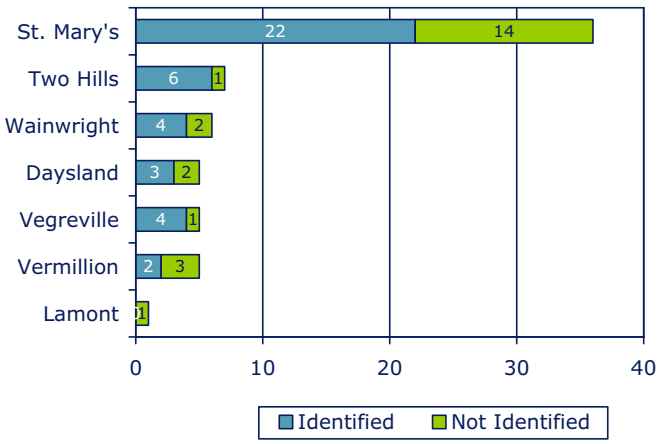


Service	Percent Meeting Clinical Criteria for Admission
Surgery	70%
4th Floor (LDR/Surgery/Misc)	44%
Psychiatry	33%
Medicine	26%
Total	**40%**

- Overall, 24 out of the 60 patients (40%) reviewed at St. Mary's met the clinical criteria for admission to the unit to which they were admitted.
- The 4th Floor, Medicine and Psychiatry units were all found to have a low percentage of patients meeting the clinical criteria for admission.
  - This finding for the Psychiatry unit correlates with the CMG Potential Days Savable analysis for St. Mary's, which found a high proportion of Mental Health inpatient cases with potential to reduce ALOS.

Patients Identified as Requiring a Different Level of Care

East Central Health Acute Care



Site	Percent Identified as Requiring a Different Level of Care
Two Hills	86%
Vegreville	80%
Wainwright	67%
St. Mary's	61%
Daysland	60%
Vermillion	40%
Lamont	0%
Total	**63%**

- Of the 65 patients who did ***not*** meet clinical criteria, 41 (63%) of this group were already identified by the facilities as requiring a different level of care.
- The 24 patients requiring a different level of care ***but not identified as*** such were located across all of the sites reviewed. This suggests a regional opportunity to improve the early identification of when patients require a different level of care to support improved patient management.

Required Level of Care for Patients

East Central Health Acute Care

- Across the ECH acute care sites visited, the required level of care for the 65 patients who did not meet clinical criteria for admission was identified.
  - The majority of ECH patients in the review (58%) required access to long term care or other alternative levels of care (e.g. supportive living, enhanced lodge)
- A focused review on the required levels of care for patients at St. Mary's that did not meet the clinical criteria for acute admission found a similar trend.
  - The majority of St. Mary's patients in the review (61%) also required access to long-term care or other alternative level of care (e.g. supporting living, enhanced lodge).
  - Further, the review identified the need for increased access to outpatient/community psychiatric services, which is in line with the CMG potential days savable analysis findings for Mental Health ALOS.

East Central Health Acute Sites Visited

Required Level of Care	Number of Patients
Sub-Acute	2
Palliative Care	1
Long Term Care	20
Alternative Level of Care	20
Outpatient Psychiatry	8
Home Care	5
Home	9
Total for Region	**65**

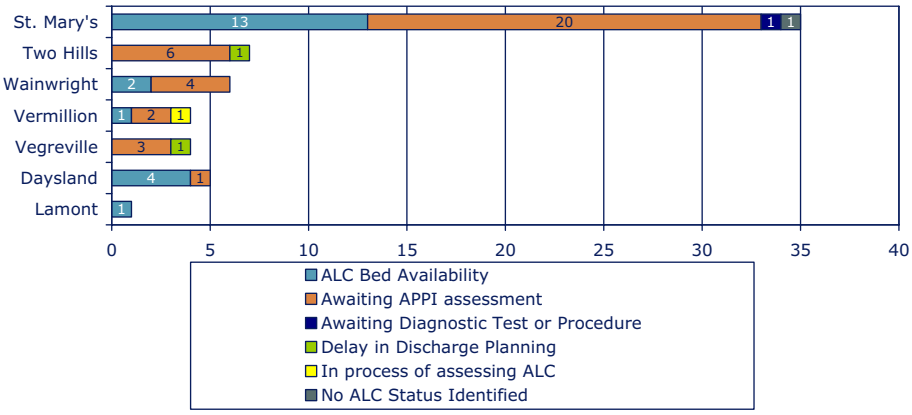
St. Mary's Hospital

Required Level of Care	Number of Patients
Palliative Care	1
Long Term Care	11
Alternative Level of Care	11
Outpatient Psychiatry	6
Home Care	1
Home	6
Total for St. Mary's	**36**

Reasons Patients Did Not Meet Clinical Criteria

East Central Health Acute Care

- Of the 65 patients who did ***not*** meet clinical criteria, the majority were for reasons related to the facility of care:
  - 58% of patients who did not meet clinical criteria were Awaiting APPI Assessment, which relates in part to consultation findings on the level of discharge planning support in the region.
    - St. Mary's is shown to have a significant volume of patients in this category, which was echoed in consultation findings through reports of minimal regional discharge planning and LTC placement support available to patients in Camrose.
  - 33% of patients who did not meet clinical criteria were related to ALC Bed Availability, primarily related to continuing care.
- Other drivers for patients not meeting their required level of care include physician-related reasons such as inappropriate delay in discharge.
- Although not shown through this MCAP analysis, consultation findings suggest other challenges in managing patients to their required level of care, including reports that some physicians delay ALC designation due to the associated fees charged to patients designated ALC.



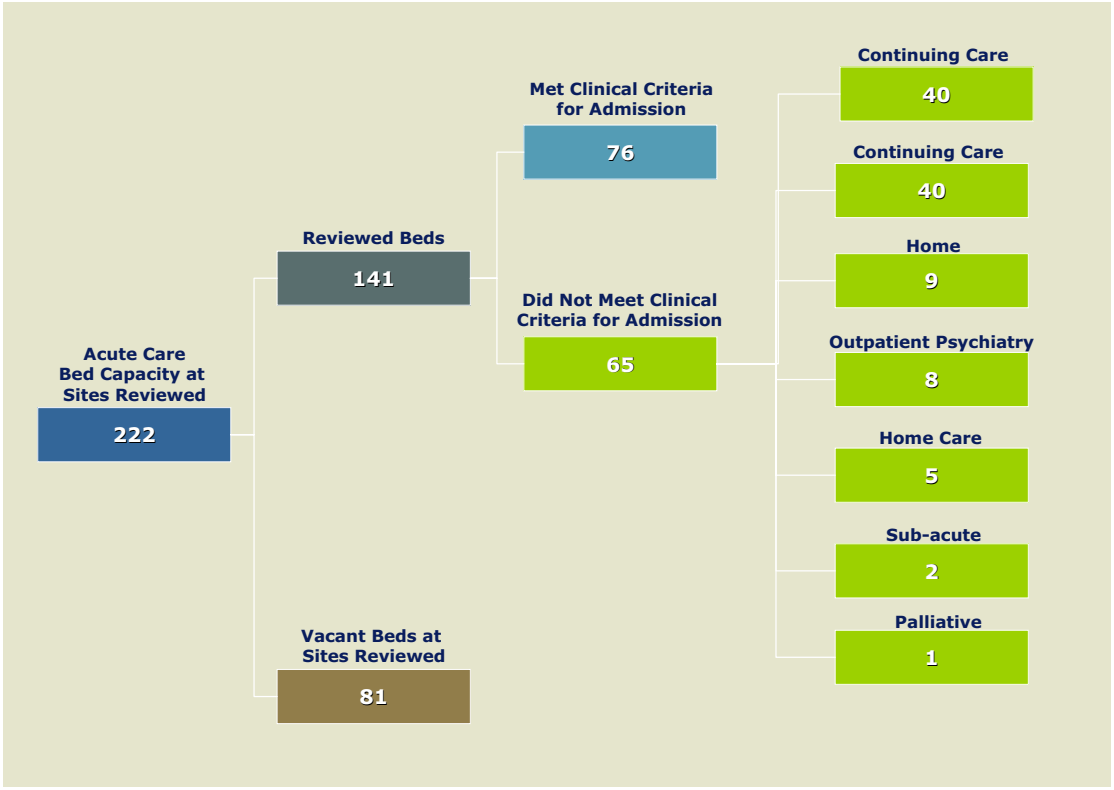
Insufficient Documentation

East Central Health Acute Care

- A final analysis for our MCAP review focused on the availability of documentation to support the review process.
- Our findings indicate that insufficient physician documentation was evident in 15 of the charts reviewed (12%), however additional consultation with hospital staff and management enabled a determination of the required levels of care for patients with poor documentation.
- The table below provides a summary of where physician documentation was found to be insufficient for the review purposes.
- Although verbal communication may be considered sufficient to enable good patient care across the clinical team, this finding (12% insufficient physician documentation) highlights a potential risk in patient care management.

Sites	# of Charts with Insufficient Documentation	Total Beds reviewed	Insufficient Documentation Rate
St. Mary's	8 (4 in Psych.)	60	13%
Vermillion	3	12	25%
Wainwright	2	16	13%
Daysland	1	22	5%
Two Hills	1	15	7%
Grand Total	**15**	**125**	**12%**

ECH Acute Care Profile Summary: July 17 - 21, 2006



Clinical Resource Management Opportunities

Opportunities	Findings
1. Review and redesign the utilization management processes and functions to establish consistency across the region. Review should include the following components: a) Admission/discharge criteria. b) Improve education and awareness of leading practices. c) Consider adoption of a regional utilization management tool. d) Current processes and timing of the AAPI assessment, with a focus on minimizing related delays.	• Analysis identified that only 54% of patients across the ECH sites reviewed met clinical criteria for admission. – Further, of those patients requiring a different level of care, only 63% were identified as such. • While St. Mary's, Two Hills and Vermillion had the greatest opportunities for improvement, a regional approach will improve consistency. • Improved awareness of, and education on admission best practices to staff will support the realization of this opportunity. • Consultation findings identified the need for increased discharge planning and utilization management support across several sites in the region, suggesting the need for a more consistent approach across ECH. • The MCAP review and consultation findings highlighted specific challenges in delayed completion of the AAPI assessment to support LTC and ALC bed placement, and gaps in time between: LTC order and approval, approval date and ALC date, and ALC date and billing date.

Clinical Resource Management Opportunities (continued)

Opportunities	Findings
2. Improvements to Regional Documentation, Coding and Abstracting	• Analysis identified CMG 851 (Other Factors Causing Hospitalization) and CMG 847 (Other Specified Aftercare) as having the highest potential days savable for ECH relative to ELOS. • The high presence of these CMGs, and MCAP findings of insufficient MD documentation in 12% of charts reviewed suggest additional documentation, coding and abstracting focus is required to help the region more discreetly identify and manage this patient volume.
3. Continue current planning to increase continuing care capacity across the region. 4. Explore the development of a first-available bed policy or other alternative settings of care for early continuing care placement.	• The MCAP review found a large number of patients in ECH that required continuing care services, which would include a mix of long-term care, supportive living and enhanced lodge settings. • This finding supports ECH's current initiative to increase overall continuing care capacity in the region. • Further, the MCAP review identified that 21 patients were delayed from discharge due to a lack of alternative level of care bed availability, the majority of which was related to continuing care. Consultation findings indicate that part of this challenge in patient flow is due to the commitment of the region to place patients only into the community of their choice. – Stakeholders report that up to 44 patients are currently awaiting placement in LTC in acute care beds across the region.

Clinical Resource Management Opportunities (continued)

Opportunities	Findings
5. Continue mental health planning focus on broader continuum of care. 6. Increase efforts to build community partnerships with key agencies such as AADAC.	• Both the CMG and MCAP analyses identified opportunity for improved inpatient psychiatry resource management in the region, with specific focus on the psychiatry services at St. Mary's. • Consultation findings found that one of the key challenges to moving patients from an inpatient to an outpatient or community setting is the reported lack of community resources and partnerships (e.g. AADAC, community detox centres, etc.), which impacts both Camrose and other ECH communities. • Although ECH does have a regional mental health plan that identifies similar challenges, these findings suggest the need for a continued regional drive for mental health programming, which should further consider non-bedded services as viable alternatives service delivery models.

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Clinical Service Delivery Review

Clinical Service Delivery Review
Introduction

- Our review of the clinical programs and facility-based care across ECH has focused on identifying key findings and opportunities related to service delivery and staffing.
- The clinical service delivery findings and opportunities will be reported on in the following order:
  - Regional Clinical Service Delivery Findings and Opportunities
  - Clinical Program Findings and Opportunities
  - Clinical Sites Findings and Opportunities
- This filter approach to reporting is intended to streamline findings and opportunities, such that where a given opportunity exists across all three levels of reporting, it will only be highlighted in the most appropriate section.
- As a result, the Clinical Sites Findings and Opportunities will report only on those items related to local staffing resource, and other key locally-specific opportunities.

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Regional Clinical Service Delivery Findings and Opportunities

Regional Clinical Service Delivery
Findings and Opportunities

Opportunities	Findings
1. Conduct a community health needs assessment to inform health service planning, future programming and organization priorities for ECH. 2. In alignment with the above community health needs assessment, re-assess the ongoing sustainability of the facilities' current clinical roles and configuration in the region. 3. Align ECH Health Services Plan to community health needs assessment and clinical facility role review.	• Consultation findings identified: – The region is currently in the process of developing an ECH Health Service Plan to identify go-forward clinical programming priorities for the region. – A community health needs assessment has not been completed for the region in several years, which suggests an information gap for health planning. – Many of the 13 acute care centres are without critical mass to provide efficient acute and emergency service, which will be worsened by the increasing health human resources shortages. – The region previously had a more robust process to align site-based operational plans to the region's strategic planning, but that this has since stopped, which makes it difficult for the region to monitor and validate site operations alignment and sustainability. – Some of the current health services provided appear opportunistic in response to physician staffing/availability versus as a coordinated regional strategy, which, in turn, has an impact on associated staffing and other resources. Improvements to this occurrence may come through the pending regional health services plan.

Regional Clinical Service Delivery
Findings and Opportunities

Opportunities	Findings
4. Re-align clinical service delivery and organization structure to have common region-wide clinical programming, planning and leadership - achieved through collaboration between the region and Associate Partners. 5. Continue the shift to a Service Level Agreement model that supports improved clinical service delivery, programming, management, and accountability with Associate Partners. 6. Continue plan to create St. Mary's as a secondary referral centre for the region, with clearly defined roles and responsibilities for its part in regional programming, planning and care delivery.	• Consultation findings identified: – A gap in regional (ECH) vs. Associate Partner clinical program planning and coordination. – Although some coordination and planning does exist (e.g. the involvement of the Associate Partners in the ECH Service Plan development), specific examples of where gaps exist include: a lack of common clinical services, protocols and programming leadership. – Improved collaboration and planning between the region and its Associate Partners is a critical success factor - given the plan identified by stakeholders for St. Mary's and Lloydminster to become secondary referral centres for the region. – Challenges in the current contractual agreements between ECH and the Associate Partners, which were characterized by stakeholders as: 'high-level', 'not service-driven', and contributing to challenges in clinical service delivery coordination and planning. • ECH has identified a shift to a service level agreement model with the Associate Partners, to be in place by 2007-08.

Regional Clinical Service Delivery
Findings and Opportunities

Opportunities	Findings
7. Re-align clinical organization structure of Director of Acute, HCCs and NCCs to create clinical program leadership that extends across ECH and Associate Partners. 8. Establish regional clinical programs and service delivery strategy that integrate ECH and Associate Partner, with defined strategic and operational plans. 9. Explore creating common Medical Leads across the ECH and Associate Partner sites, with consideration of the role of St. Mary's as a secondary referral centre. 10. Establish a regional health human resource and recruitment strategy, coordinated centrally (regionally), to support the shift to region-wide clinical program delivery and site-based resource management.	• Acute care organization structure appears duplicative. The region currently has the following roles in acute care: Director of Acute, Health Centre Coordinators and Nursing Care Coordinators. • Clinical organization structure is supported by Program Leads, but programs are not organized across ECH and regional sites. • Consultation findings indicate: – Clinical leadership is generally provided by Program Leads, with no, or limited, overall vision/strategic plan for nursing in ECH. – Medical program leads are not yet in place in the region, which could provide beneficial leadership in a regional-hub driven model of care. – Resource alignment to clinical programs, or a focused recruitment and retention plan that extends across both ECH and Associate Partner sites is not currently in place. • Several sites (ECH and Associate Partners) report challenges in clinical recruitment and retention.

Regional Clinical Service Delivery
Findings and Opportunities

Opportunities	Findings
11. Re-examine Program Lead roles with consideration of dedicating these roles (full FTE) to education, practice and quality management for respective areas. 12. Undertake a comprehensive staff education review that includes: • Clarifying role of Program Leads and Staff Development in clinical education. • Conducting a formal needs assessment to ensure that educational programs are aligned with staff needs across region and regional service priorities. • Re-examining clinical education resources to determine alignment to program vs. regional needs. • Developing common programming and planning for clinical education across ECH and Associate Partner sites.	• ECH is currently developing a clinical program focus vs. isolated facility-based care. To date, ECH has identified Program Leads for Emergency, Surgical Services and Obstetrics. Clinical leadership has between 0.4 - 0.8 dedicated FTE. Reported scope includes: ECH-managed sites, education and training, and facilitation of local quality committees. – Development of these clinical programs has been extended to the Associate Partner sites, however not all have adopted the program model. • Consultation findings indicate: – Improved coordination and role clarity required for Program Leads in clinical education relative to the Staff Development function. – ECH and the Associate Partners stakeholders report limited engagement of the Associate Partners staff/management in ECH clinical education sessions, which limits dissemination of new or changing practice, and facilitation of common clinical standards. – While numerous educational programs are planned, staff development is not consistently perceived as useful or effective. Programs are reported as often cancelled due to lack of staffing or location.

Regional Clinical Service Delivery
Findings and Opportunities

Opportunities	Findings
13. Establish an interdisciplinary professional practice model that includes roles, responsibilities, policies and practices governed by an interdisciplinary committee.	• The model of nursing care varied across the region, with not all LPNs functioning to full scope of practice. • Currently there is no regional committee devoted to nursing or interdisciplinary professional practice.
14. Continue to develop consistent region-wide infection control policies and procedures, supported by required resources to proactively manage risks and meet APIC staffing standards.	• A region-wide infection control program has been recently established that is responsible for surveillance across the health continuum for ECH and the Associate Partners. • Infection control also provides education to group homes, and performs home care site audits. • Although improvements have been observed in infection outbreak rates and in the development of policies and procedures since additional infection control resources have been added, consultation findings suggest continued challenges in meeting infection control standards as defined by APIC. – Current resources are reported as 2.0 FTEs, but APIC standards would require at least 6 FTEs: • 1.0 FTE per 150 Acute Beds • 1.0 FTE per 250 Continuing Care Beds – Specific risk areas have been identified by infection control (e.g. MRSA at Vegreville). – Vacancies also exist in the Wound and Skin Care Coordinator position.

Regional Clinical Service Delivery
Findings and Opportunities

Opportunities	Findings
15. Review and align the role of quality initiatives within the region to needs and priorities, with the consideration of establishing reliable funding and processes for moving forward. 16. Re-focus regional quality teams on a program basis that extend across all ECH and Associate Partner sites. 17. Re-examine the local quality team structures, with consideration of establishing one local quality improvement team at each site that consolidates the teams and activity across programs, and links into regional program quality initiatives.	• The region is in the process of establishing quality improvement and measurement initiatives, however, quality initiatives are reported as funded on an ad-hoc basis, which creates sustainability challenges. • Local quality improvement committees are in place for ER, Med/Surg and Obstetrics at each of the five full service ECH sites, which are facilitated by Program Leads. • MoreOB program implementation is progressing and supporting the move to evidenced-based obstetrical care. • Regional quality improvement teams also exist, but they are reported as meeting irregularly – and stakeholders report a preference for the local teams' ability to respond to local issues and initiatives. • Current regional plans to expand the quality initiatives to the other sites is anticipated to necessitate consolidation across programs, given the smaller size of some regional sites. • In addition to the ECH initiatives, St. Mary's has a number of quality teams established to support patient care, and is involved in the region's quality initiatives.

Deloitte.

Clinical Program
Findings and Opportunities

Clinical Program Findings and Opportunities
Introduction

- Our review of the clinical programs across ECH has focused on identifying key findings and opportunities related to service delivery and programming.
- The clinical programs will be reported on in the following order:

Clinical Programs
Acute Care
Emergency Services
Obstetrics
Rehabilitation Services
Palliative Care
Mental Health
Continuing Care
Home Care
Population Health
Environmental Health

Clinical Program Findings and Opportunities
Acute Care

Opportunities	Findings
1. Strengthen acute care by developing a strategic nursing plan including examining roles, responsibilities and model of care across the region.	• There is limited strategic clinical leadership and direction across regional and affiliate centres. – While one Director has overall responsibility for acute care, she also has administrative responsibility for 7 sites which consumes much of her time. – Clinical leadership is largely left to the part time Program Leads – There is no overall vision or strategic plan for Nursing in the Region . – Model of nursing care varied across the region, with not all LPNs functioning to full scope of practice – There is no region-wide interdisciplinary or nursing practice committee

Clinical Program Findings and Opportunities

ECH Emergency Department Volumes by Triage Level

Triage Level		2003-04 ECH Emergency Visits	2005-06 ECH Emergency Visits	% of Total ECH Emergency Visits Volume (2005-06)	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	241	251	0%	0.4%	0.2%
II	Emergency	1,696	1,408	1%	9.9%	8.5%
III	Urgent	8,712	9,811	9%	37.9%	38.9%
IV	Semi-Urgent	30,877	33,968	32%	41.9%	45.3%
V	Non-Urgent	55,426	55,844	53%	9.5%	6.7%
IX	Unavailable	8,094	4,880	5%	0.0%	0.0%

Source: Alberta Health & Wellness ACCS Database; ECH Triage Data

- Sites included in the information above (due to information availability) are: Daysland Health Centre, Hardisty Health Center, Killam Health Center, Lamont Health Centre, Provost Health Center, St Joseph's General Hospital, St. Mary's Hospital, Tofield Health Center, Two Hills Health Center, Vermilion Health Center, Viking Health Centre, and Wainwright Health Center – which illustrates a high degree of CTAS usage throughout ECH.
- A decrease in the number of visits with an "Unavailable" triage level suggests improved compliance with CTAS since 2003-04, or may indicate an outpatient coding change, however the 2005-06 volumes in this category suggest opportunity for continued improvement.
  - Consultation findings also suggest that challenges in maintaining consistency in CTAS coding across the region, which may also be impacting reported triage volumes.
  - Many sites report a high number of ambulatory patients are seen in the ER – which impacts the number of non-urgent cases.
- A review of 2005-06 triage levels suggests that 85% of ECH's emergency department visits are distributed across the lower acuity levels of Semi-Urgent and Non-Urgent, which is significantly out of line with national averages.
- The proportion of triage level II and III volumes is also out of line with what is nationally observed - which might be expected given the proximity to Capital Health.

Clinical Program Findings and Opportunities

St. Mary's Hospital Emergency Department Volumes by Triage Level

Triage Level		2005-06 Proj. ECH Emergency Visits	% of Total ECH Emergency Visits Volume (2005-06)	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	39	0.3%	0.4%	0.2%
II	Emergency	473	3.1%	9.9%	8.5%
III	Urgent	4,543	29.6%	37.9%	38.9%
IV	Semi-Urgent	7,637	49.7%	41.9%	45.3%
V	Non-Urgent	2,656	17.3%	9.5%	6.7%
IX	Unavailable	3	0.0%	0.0%	0.0%

Source: Alberta Health & Wellness ACCS Database; ECH Triage Data

- St. Mary's emergency visit volume across the respective triage levels is more closely aligned to the national averages than the total ECH cohort, although there is still opportunity for improvement.
  - A review of 2005-06 triage levels suggests that 67% of ECH's emergency department visits are distributed across the lower acuity levels of Semi-Urgent and Non-Urgent.
  - Although not shown here, three-year trending analysis suggests a minor shift of patient triage levels to those that are less acute – with a decline in the proportion at Level II, and an increase in the proportion at Levels III, IV and V.
  - Consultation findings indicate that St. Mary's still has some challenges in maintaining consistency in accurate CTAS coding.
  - A low proportion of visits with a classification of "Unavailable" indicates good compliance with CTAS coding.

Clinical Program Findings and Opportunities
Emergency Services

Opportunities	Findings
1. Develop a strategic plan for Emergency Services that reviews: appropriate model for sites (EDs vs. UCCs across the region), links with pre-hospital care programming, and alignment with a community health needs assessment. 2. Develop a CTAS implementation plan to formalize the patient triage function at all non-compliant sites in the region, with consideration of both staffing and infrastructure resources required. 3. Develop formalized ER clinical protocols that identify roles and responsibilities for MDs and RNs covering the ER, after-hours ER access, enabled by supporting education for staff and community. 4. Collaborate with community EMS providers to align staffing requirements to availability of hospital-based ER services.	• Emergency departments at all sites are challenged to achieve compliance to CTAS: – Sites report challenges in maintaining consistent CTAS coding. – At many sites, patients are registered before being triaged, which is a risk to patient care and to the region. – Facilities infrastructure design is a challenge at many sites, where the ER triage desk does not have line-of-site visibility to the waiting room. – Physician coverage challenges have resulted in some patients being triaged after-hours without physicians seeing patients (e.g. Lamont). This is a significant risk to the region. • Many sites do not have defined and dedicated triage roles in the emergency departments, which can be difficult to achieve where dedicated staffing resources are not available. • Due to staffing resource availability, many sites with emergency departments are only able to have after hours access via buzzer, with varied process and protocols for after-hours access, which is a risk issue for the region. • Several sites report that physicians are often not on-site due to low ER volumes, which suggests the need for formalized protocols when MDs come to treat ER patients – it appears that RNs are currently bearing significant triage and risk requirements as a result. • Consultation findings also suggest the need for improved linkages with pre-hospital care providers, to improve consistency across which EMS services have paramedics staffed, service level requirements, etc.

Clinical Program Findings and Opportunities
Obstetrics

Opportunities	Findings
1. Continue to examine alignment of obstetrics services to community needs, with consideration of site consolidation vs. building additional support for sites currently providing obstetrics services. 2. Develop common policies, strategy, and minimum MD and competency maintenance thresholds for obstetrics. 3. Consider a partnership with Public Health and community health providers to provide regional prenatal education classes.	• Obstetrics services are provided in several sites across the region. The bulk of deliveries are performed at Lloydminster, with the second highest volume at St Mary's in Camrose. – 5 Regional sites continue to provide obstetrics services, but with low volumes. – The region has relative low volumes overall, suggesting the need for a focused review and programming plan for the siting for obstetrical services that can be sufficiently supported by adequate health human resources, quality controls, and other regional mechanisms. • Policies and procedures are standardized across sites (with the exception of Lloydminster). The introduction of the MoreOB program has facilitated this consistency, as have the local OB quality committees. • Quality is also monitored through the Alberta Perinatal Program which has allowed benchmarking between regions, although it was reported that this program had been less active recently. • Prenatal care is mostly all delivered by physicians. There is one prenatal clinic at St. Mary's Hospital. An attempt to have regional childbirth education classes several years ago was unsuccessful, as patients were apparently not willing to travel. • Acute services are standalone. While there are some services provided by public health, these are focused on well baby. • Two full-time pediatricians exist in the region – at St. Mary's and Lloydminster – supported by 3 itinerant clinics in the region. A community health needs assessment would inform improved physician human resource planning for this discipline.

Clinical Program Findings and Opportunities
Rehabilitation Services

Opportunities	Findings
1. Continue Rehabilitation Services initiatives, with increased focus on integrating services across all of the Associate Partners. 2. Investigate the cost and benefit of providing access to real time databases of electronic journals for all clinical staff.	• During 2005-06, the region initiated a new investment in rehabilitation services, under the leadership of a new Rehabilitation Manager. • A number of key changes are in place, or are currently in development: – The region has moved to a regional model with Rehabilitation Coordinators located in 5 sites. Each Coordinator has responsibility for front line supervision and direction of all the rehab professionals in the particular site(s), with the ability to flex staff time between acute, community and continuing care, as required. – The region is currently implementing accountability structures and processes, clarifying expectations for service provision. This includes defining primary services for each service stream, plus secondary services as required as well as developing and clarifying referral processes, documentation standards, desired outcomes, etc. – Two part-time Clinical Practice Leaders have been appointed to assist in building best practices, support new therapists, provide peer resourcing, etc. • Despite the service offered by Staff Development, the Manager reports challenges in ensuring that therapists have quick access to electronic databases and journals – Renewed focus is being placed on tightening up relationship with contracted private clinics. Previously there was automatic payment and little accountability, They are now implementing an invoice system with clear expectations. – Have established target benchmarks for service provision for each therapy and service stream. The region reports service levels below peers, and is monitoring whether service deficits are due to recruitment issues or due to funding. • While these initiatives appear to be promoting positive change across the region and the majority of the Associate Partners, increased coordination of rehabilitation services to include all Associate Partners would further benefit patient care.

Clinical Program Findings and Opportunities
Palliative Care

Opportunities	Findings
1. Continue development of palliative care program that aligns to community health needs assessment and provides a focus on designated palliative infrastructure in community, balanced with hospital-based palliative services. 2. Continue to build education resources for staff and physicians to support ongoing palliative care program development.	• ECH has had a palliative care program in place for over six years, and it has evolved from primarily an education service to more of a consultative basis that provides secondary support to physicians, nurses, pharmacists, etc. • Currently there is both a palliative care team as well as a number of champions across the region. The Palliative Team consists of 3 physicians and 5 partial FTE nurses with advanced training who provide service across the sectors. The Champions network consists of volunteers, nursing attendants, nurses, clergy, social workers, physicians, pharmacists across the region – with 85 members in total. • As part of the ongoing development of the palliative care program, the region is starting to explore the need for more dedicated resources, including a hospice, a chronic pain clinic, and support for increased palliative and pain management education to better integrate best practice into clinical practice.

Regional Mental Health Services

Mental Health Outpatient Activity

Top 10 Diagnoses Driving Enrolments Year over Year

Diagnoses	2002-03	2003-04	2004-05	3-Year Variance
Major Depression	598	567	591	-1%
Adjustment Disorder	194	196	251	29%
Anxiety Disorder	108	153	166	54%
Vascular Dementia	56	86	102	82%
Dementia of the Alzheimer's Type	102	97	98	-4%
Attention-Deficit Hyperactivity Disorder	47	69	97	106%
Dysthymic Disorder	61	67	97	59%
Parent-Child Relational Problem	64	72	91	42%
Bipolar Disorder	73	99	91	25%
Schizophrenia	64	70	73	14%
Top 10 Diagnoses Total	1,367	1,476	1,657	21%
Grand Total	2,247	2,341	2,541	13%

- The top 10 diagnoses driving enrolments have increased by approximately 21% between 2002-03 and 2004-05, and represent approximately 65% of total enrolments in 2004-05.
- Notable increases are observed for ADHD (106%), Vascular Dementia (82%), and Dysthymic Disorder (59%)
  - On a volume basis Adjustment and Anxiety Disorders have contributed the most to the overall increase in enrolment activity.
- 9% of Enrolments in 2004-05 had no diagnosis assigned. This is down from 14% in 2002-03 indicating an improvement in information capture.

Source: ARMHIS Database 2002-3 to 2004-05

Mental Health Outpatient Activity
ECH Overview

- As presented below, ECH Enrolments increased by 13% between 2002-03 and 2004-05, while Events remained relatively flat for the same period.
- Enrolments and Events have increased most significantly at Tofield and Vegreville Mental Health Clinics for the same period, while declines in Enrolments were most significant for Provost and Wainwright, and declines in Events were highest for Wainwright and Vermillion.
- Where variances between Event and Enrollment changes across sites exist (e.g. Vegreville and Killam), this may be due, in part, to information capture capacity, but may also speak to changes in programming.
- Excluded here was Lloydminster's Mental Health Clinic information due to inconsistent reporting.

Clinics	Enrolments			Events		
	2002-03	2004-05	3-Year Variance	2002-03	2004-05	3-Year Variance
Camrose Mental Health Clinic	741	813	10%	6,476	7,316	13%
Vegreville Mental Health Clinic	409	610	49%	3,784	4,413	17%
Wainwright Mental Health Clinic	378	329	-13%	4,424	3,499	-21%
Vermilion Mental Health Clinic	316	305	-3%	3,024	2,388	-21%
Tofield Mental Health Clinic	51	133	161%	854	1,561	83%
Hardisty Mental Health Clinic	79	85	8%	1,361	1,434	5%
Killam Mental Health Clinic	178	194	9%	1,551	1,275	-18%
Provost Mental Health Clinic	95	72	-24%	576	578	0%
Grand Total	2,247	2,541	13%	22,050	22,464	2%

Mental Health Outpatient Activity
Events by Type

Type of Event	Type of Activity	2002-03	2003-04	2004-05	3-Year Variance
Face-to-Face	Assessment	1,881	2,033	2,105	12%
	Consultation	1,871	1,454	1,900	2%
	Group Work	25	122	113	352%
	Therapeutic Intervention	10,288	10,410	10,853	5%
Face-to-Face Total		14,065	14,019	14,971	6%
Telephone		2,838	3,127	3,777	33%
Videoconference		0	17	34	N/A
Other		5,257	5,224	3,682	-30%
Grand Total		22,160	22,387	22,464	1%

Source: ARMHIS Database 2002-3 to 2004-05

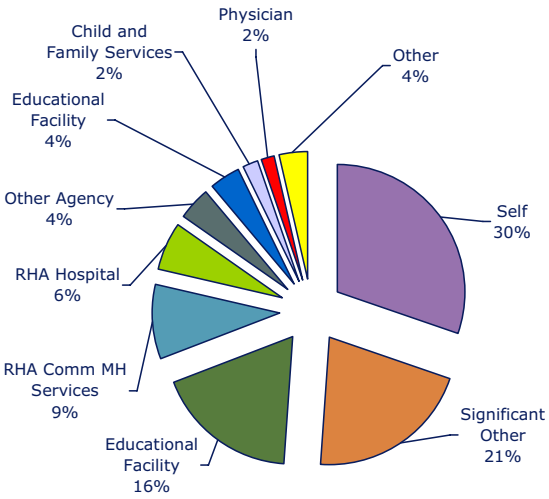
- As demonstrated above, outpatient mental health activity in ECH has been relatively flat between 2002-03 and 2004-05.
- Increases in volume for the same period are most notable Group Work and Telephone event types, however group work is still shown to have relatively low overall volumes.
- The "Other" category includes client support activity, collateral consultation, documentation, supervision/consultation, and travel.
  - The decline in this category is driven by a 79% decrease in activity related to "Documentation".
- Examining Event volumes with the exclusion of the "Other" category, results in an observed increase in mental health event volume between 2002-03 and 2004-05 of 11%.

Mental Health Outpatient Activity

MH Referral Sources

- The top 3 referral sources for mental health enrolments in ECH represent almost two thirds of the total enrolments for 2004-05. From these sources, the main referral source for Mental Health enrolments in ECH was Self-Referral, at 30% in 2004-05
- Overall regional average time between referral and intake call for ECH in 2004-05 was 12.1 days, which is an improvement from 2002-03. Illustrated in the table is the intake time sorted from lowest to highest for 2004-05. The time between intake call and initiation of services is not available.

NLHR Top 10 Enrolment Referral Sources



Source: ARMHIS Database 2003-04 and 2004-05

Mental Health Clinics	Average Days Between Referral & Intake Call		
	2002-03	2003-04	2004-05
Killam Mental Health Clinic	4.8	5.9	9.4
Vegreville Mental Health Clinic	15.3	10.8	10.9
Camrose Mental Health Clinic	13.4	15.6	10.9
Wainwright Mental Health Clinic	13.6	12.3	11.7
Hardisty Mental Health Clinic	10.2	13.5	13.2
Tofield Mental Health Clinic	13.5	11.2	14.0
Provost Mental Health Clinic	15.1	12.7	14.1
Vermilion Mental Health Clinic	14.1	20.7	18.3
ECH Average	13.2	13.7	12.1

Clinical Program Findings and Opportunities

Mental Health

Opportunities	Findings
1. Integrate Mental Health services across community and acute care. 2. Examine service delivery model, with consideration of expanded use of group work. 3. Institute a quality improvement program with specific targets and indicators for Mental Health, as part of identified regional quality initiative.	• While there is a integrated mental health plan for the region it is fairly high level with limited information on mental health needs of ECH residents and specific strategies to meet those needs. – The Region has little or no access to psychiatric beds at St Mary's. Consultations suggested that the St. Mary's psychiatry beds were frequently not accessible and were perceived as primarily a local versus a regional resource. – If a mental health client attends one of the regional ERs they are triaged– depending on score, they are usually either admitted to a psychiatric tertiary facility in another region, admitted locally, or referred to an outpatient program or clinic. – After hours service is available only through the ERs, although the region has recently received funding for a community crisis response service. – Limited psychiatrist support is available from resident psychiatrists in Camrose and Lloydminster. – Client Case conferences are held approximately every two weeks, although there is no psychiatrist in attendance. • Consultation findings indicated that quality of care indicators or outcomes are limited to client satisfaction results. • Most services consist of 1:1 therapy, with some group work, although regional statistics indicate a lower level of group therapy than other regions. • ECH reports that St. Mary's will become a designated psychiatric site for the region, as a result of a recent AHW Mental Health Bed Review.

Regional Continuing Care

Continuing Care Activity Analysis

ECH Weighted Cases by Classification

Facility Name	Spring 2006 Weighted Cases	3yr Variance (%)
Lamont Health Care Centre	8,768	-13%
Bethany Meadows	7,793	-22%
Vegreville Long Term Care	7,789	-9%
Louise Jensen Centre*	7,221	25%
Wainwright Health Centre	6,339	-10%
Two Hills Health Centre	5,178	-6%
Extendicare – Viking	4,521	-30%
Tofield Health Centre	4,481	-8%
Vermilion Health Care	4,019	-42%
Killam Health Care Centre	3,982	-10%
Provost Health Care	3,715	55%
Mary Immaculate Auxiliary	2,764	1%
Bashaw Health Centre	2,213	-3%
Mannville Community HC	1,997	4%
Galahad Health Care	1,618	-14%
Hardisty Health Centre	1,127	5%
Islay Health Centre	876	-10%
Total**	**74,401**	**-21%**

- As depicted in the table to the left, ECH had 74,401 continuing care weighted cases in Spring 2006.
- This represents an overall decrease in weighted cases by 21% from Spring 2003.
  - Although not shown here, this decrease is primarily driven by a 41% decrease in overall LTC cases since Spring 2003, which fits the region's overall shift to a DSH model of care.
  - Over the same period, the ECH average CMM increased by 34%, from 73 to 98.
- Notes:
  - *Louise Jensen's data was only available for 2005 and 2006 – trending variance is for these 2 years only.
  - **Total 3yr variance excludes Louise Jensen.

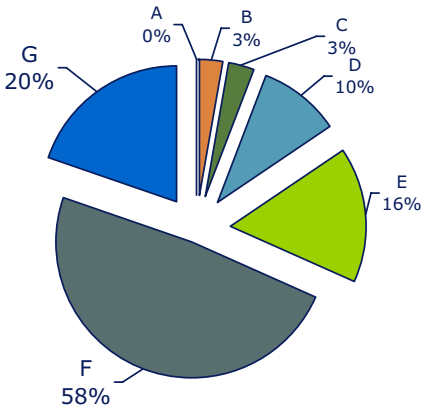
Source: Alberta Health & Wellness LTC Database

Continuing Care Activity Analysis

ECH Weighted Cases by Classification

Classification	Spring 2006 Continuing Care Weighted Cases	Spring 2006 Proportion of Total Weighted Cases	Proportion Variance Spring 2003 to Spring 2006
A	93	0%	211%
B	1,944	3%	26%
C	2,268	3%	-23%
D	7,337	10%	-4%
E	11,913	16%	29%
F	36,266	49%	18%
G	14,579	20%	-34%
ECH Total	74,401	100%	

Proportion of Weighted Cases by Classification



Source: Alberta Health & Wellness LTC Database

- 85% of ECH's continuing care weighted cases are distributed across classifications E, F and G as of Spring 2006.
  - The overall proportion of G weighted cases has decreased by 34% between Spring 2003 and Spring 2006, while the proportion of A and B weighted cases have increased - supporting the overall trend of decreases in weighted cases.
  - Increases in the proportion of E and F patients are also observed, while the proportion of C and D residents has declined for the same period.
- Note: **Dr. Cooke Extended Care Centre's 2006 data was not reported in the information received from Alberta Health and Wellness.

Clinical Program Findings and Opportunities

Continuing Care

Opportunities	Findings
1. Consider expansion of day support programs and early identification of clients who could benefit from such programs with the goal of avoiding acute care admissions. 2. Develop a targeted HR strategy for PCAs to support increased DSH and Home Care in the region. 3. Consider identified staffing efficiencies relative to 2006-07 funding, and regional shift to Eden and DSH service models.	• The continuing care portfolio consists of 11 regional centers providing LTC, some respite and limited day support programs (Provost, Wainwright, Two Hills and Vegreville). The region has a number of continuing care initiatives underway, including the development of new LTC sites in Lloydminster, Vegreville and Vermillion; and an increased shift from LTC to DAL beds. • The region's planned increased shift from the LTC to DSH setting will result in an increased dependency on PCAs. Consultation findings indicate challenges in recruiting and retaining PCAs across the continuing care and home care services in the region, suggesting the need for a targeted HR strategy for PCAs to support this shift. Caution should be taken in ensuring that only those clients appropriate for DSH are accepted. The use of unregulated care providers in caring for patients with complex care needs is not recommended. • During our consultation, a large number of patients were waiting for LTC – an increase of 15% from the previous year, however current continuing care planning appears to address this need. • New Continuing Care Health Service and Accommodation Standards established by the province are creating momentum for positive change, as well as ability to monitor quality indicators – The region is currently conducting a gap analysis of staffing and infrastructure. As part of analysis, the region is introducing multi-skilled workers in staffing mix. – Implementing MDS 2.0, beginning fall 2006, will support quality monitoring. • Staffing comparison analysis suggests staff savings opportunity across the majority of standalone long term care sites, which need to be considered by regional management for their applicability to each site's service delivery model, minimum staffing requirements, and the 2006-07 staffing levels of 3.6 HPRD funded by AHW. See next page for detail.

Clinical Program Findings and Opportunities

Continuing Care Staffing Analysis

- Continuing Care staffing levels for the remaining long term care facilities that we are able to report on are compared to the 2005-06 AHW recommendation that residents receive 3.4 Hours per Resident Day (HPRD) of combined Nursing and Personal Care, for facilities with an average CMI of 100.
- There are several notes for consideration in reviewing this staffing comparison for ECH Continuing Care:
  - This comparison does not include staffing related to rehabilitation and recreation therapy.
  - Because the consulting team did not visit all these sites, these opportunities need to be considered by regional management for their applicability to each site's service delivery model, minimum staffing requirements, and the 2006-07 staffing levels of 3.6 HPRD funded by AHW.

Site	Actual FTEs 2005-06	Actual Total Paid HPRD 2005-06	AHW Recom'd 3.4 HPRD @ 100 CMI	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Bashaw Health Centre	17.8	3.8	3.3	(2.5)
Galahad Care Centre	13.0	3.7	3.2	(1.6)
Islay Care Centre	10.8	5.1	3.0	(4.5)
Mannville Care Centre	14.5	3.5	3.1	(1.6)
Vegreville Care Center	52.7	3.3	3.2	(1.3)
Bethany - Louise Jensen Centre	47.9	4.1	3.8	(3.6)
Bethany - Meadows	53.1	4.5	4.1	(3.7)
Mary Immaculate Health Centre	16.8	3.2	3.6	2.2

Regional Community Care Services

Clinical Program Findings and Opportunities
Regional Community Care Services

Opportunities	Findings
1. Investigate alternatives to patients waiting in acute care for placement through such options as expanded home care, interim LTC beds, and a first available bed policy. 2. Investigate increased availability of home care services in the region, with consideration of expanded evening and weekend availability.	• Community care services are provided out of 12 sites across the region, consisting of discharge planning, placement coordinators and home care case coordination of nursing, therapist, personal care, respite, and other resources. – Discharge planners assigned to each acute site facilitate transition back to community. Stakeholders report that coordination with Associate Partners is more limited, however. – All sites provide 7 day per week scheduled services although there is no intake for new referrals on the weekends. There is some evening service provided in Camrose and Vegreville – There is currently no waitlist for home care, however consultation findings identified challenges in accessing home care across several communities. • Regional placement coordination for clients approved for LTC or DSH. Currently have 130 people waiting for LTC, which is an increase of 15% from the previous year. Of these, 64 (50%) are waiting in community with services, 44 (34%) are currently in an acute bed. • Consultation findings indicate recruitment and retention challenges, especially with Home Support Aides (PCAs), which supports the previously identified opportunity to create a targeted PCH HR strategy. • The region will be implementing the MDS Home Care in 2007 to support clinical and management decision making – Currently use tools such as the Regina Risk Indicator Tool and the Caregiver Risk Screen to assess need for placement and in home respite

Regional Population Health

Clinical Program Findings and Opportunities
Regional Population Health Services

Opportunities	Findings
1. Continue to review Population Health service and staffing levels across sites and clinics. 2. Consider reallocating resources and offering regularly scheduled sexual health and STD clinics on a drop in basis.	• ECH Population Health services are operating under a Manager who is new to the role since November 05. • The program includes numerous immunization clinics offered across the region (well child, flu, etc.), however there are limited resources for Sexual Health Counselling and Screening (1.6 FTEs, 1 in Vermillion and 0.6 in Camrose), with few regularly scheduled sexual health or STD clinics • Provincial traveling well-women clinics do provide breast screening and cervical screening services in the region. • Consultation findings suggest that opportunities exist to reallocate resources within the program and the new Manager is in the process of reviewing service and staffing levels (For example, travel vaccines are offered out of 9 sites).

Regional Environmental Health Services

Clinical Program Findings and Opportunities
Regional Environmental Health Services

Opportunities	Findings
1. Conduct a regional review of Environmental Health services to align service programming and resources to increasing community health inspections needs and to meet minimum provincial standards. 2. Consider a formalized approach to build service specialization expertise as an overlay on current geographic PHI staffing model. 3. Review OT approach in region and consider contracting for special events. 4. Review paper-based inspections processes with consideration of TMS functionality improvement and clerical support to reduce PHI administrative workload. 5. Improve formalized mechanisms with local communities to identify new inspections entities as part of business licensing.	• PHIs are aligned geographically across the region. Although some PHIs have expertise in select areas, there is no formal approach to building expertise across inspections specialties in the region. • The increasing number of establishments and industry is beginning in the area and starting to put a strain on the ability of the program staff to conduct routine inspections. • Currently it is estimated 50% of inspectors time is spent responding to inquires (e.g. demand workload), not on proactive inspections. • Environmental Health reports being unable to meet AHW blue book standards for routine inspections, due to current staffing levels, and has identified several related risk areas to the region. • A recent 1 FTE increase has been improved to bring total complement of PHIs to 7.5 FTEs to support increased workload and manage routine inspections. - Because workload and activity are only just starting to be tracked for all inspections, however, alignment of resources to workload is difficult to determine. • Stakeholders report that overtime is not paid to PHIs, so PHIs take time owing at double time, thus further affecting PHI availability for region. • Although the region uses Capital Health's TMS information system, limited functionality is noted. Further, current process for completing on-site inspections are paper-based, resulting in duplicated data recording into the TMS system at the office by PHIs. • There is no notification system to flag new facilities that need to be inspected. A lot of info comes informally throughout the community.

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Clinical Sites
Findings and Opportunities

Clinical Site Findings and Opportunities
Introduction

- Our review of the facility-based clinical care across ECH has focused on identifying key findings and opportunities related to service delivery and staffing.
- Clinical sites and services will be reported on in the following order:

Clinical Facilities and Services
St. Mary's Hospital – Medical Services
St. Mary's Hospital – Surgical Services
St. Mary's Hospital – L&D Services
St. Mary's Hospital – Psychiatric Services
Lamont Health Centre
St. Joseph's – Vegreville Health Centre
Daysland Health Centre
Two Hills Health Centre
Vermillion Health Centre
Wainwright Health Centre

Clinical Site Findings and Opportunities
Nursing Staffing Process Overview

- The relative efficiency of patient/resident care services was assessed based on a comparative analysis of staffing levels and skill mix for each inpatient care unit using three key inputs:
  - GRASP Systems International Database
  - Deloitte Peer Database
  - Unit Staffing Schedule/Pattern
- As an indicator of variance from the benchmark, the difference in hours per patient day (HPPD) is reflected using an FTE estimate for illustrative purposes.
- To gain an understanding of the clinical requirements and environment on each unit, profiles were completed and consultation was conducted with clinical leadership.
- For each patient care unit, the following analysis was then conducted:
  - Total nursing unit producing personnel (UPP) worked hours per patient day/visit (HPPD).
  - Nursing UPP Worked Hours include direct patient care hours provided by RNs, RPNs, and certain percentage of Health Care Aides. UPP hours include regular worked, relief, and overtime, and exclude benefit hours (i.e., vacation and absenteeism).
  - HPPD were calculated for 2004-05 and 2005-06 then compared to the comparable peer units based on the profiles completed by each program/unit.
  - All units are shown at the 50th percentile. In some units, adjustments have been made to better reflect patient mix/care requirements.
  - The skill mix profile based on 2005-06 actual was identified compared to peer units.

ECH – St. Mary's Hospital

Clinical Site Findings and Opportunities

St. Mary's Hospital

Opportunities	Findings
1. Review St. Mary's HR plan for current needs (nursing, medical staff, medical leadership), as well as to meet future role and planning needs.	• The region's vision is to have St. Mary's as a regional secondary referral site. Consultation findings suggest that there is currently a mixed level of joint planning between St. Mary's and ECH to support this vision, however. – Informal weekly meetings with regional and St. Mary's senior management have been initiated. – Formal joint operations meetings are held quarterly with leadership from St. Mary's and ECH. • As part of its secondary referral role, the region is currently working with St. Mary's to review opportunities stemming from a recent operations review, as well as proceeding with functional planning. It is anticipated that these efforts will result in an increased requirement for staffing. • This suggests support for the previously identified need for ECH to increase its collaboration with its Associate Partners for clinical programming, planning and leadership.

Clinical Site Findings and Opportunities

St. Mary's Hospital (continued)

Opportunities	Findings
2. Explore the development of on-site infection control support at St. Mary's, in coordination with regional programs. 3. Explore the development of on-site clinical education support for St. Mary's staff, in coordination with regional programs.	• Consultation findings indicate a lack of infection control and clinical staff education on site at St. Mary's. • No resources dedicated to on site clinical education –Access some nursing education (e.g.) ACLS through Region Clinical Leads and Staff Development, but there is nothing available for other staff –It is important to differentiate between assisting and educating nurses. Lack of formal education process including drug calculations and ongoing certifications is a risk.
4. Explore the development of a central staffing office, supported by staffing float pool at St. Mary's.	• Consultation findings identify that Unit managers spend a great deal of time coordinating staffing. • St. Mary's reports that the float pool is in the process of expansion, which suggests the need for increased coordination of this resource.
5. Support the plan to cohort ALC patients on one unit and develop a model of care which is population appropriate at St. Mary's.	• MCAP findings and consultation further supported high level of ALC's in hospital spread throughout facility. • Consultation findings report a significant number of patients waiting for placement which impacts efficiency and quality of care of all inpatient units.

Clinical Site Findings and Opportunities

St. Mary's Hospital – Medicine (Unit 2)

Opportunities	Findings
1. Conduct a review of Medicine unit telemetry practices and develop evidence based indications for the initiation and discontinuation of telemetry.	• MCAP findings supported by consultation suggest inappropriate use of telemetry (i.e. patient leaving site for pass and then placed back on telemetry when returning.) • Consultation findings suggested underutilized monitored room, with 2 full stocked crash carts.
2. Invest staffing in Unit 2 to bring staffing to peer levels and skill mix.	• Staffing comparison suggests that the unit is below peer staffing for 2005-06. Staffing should be targeted at an average 5.4 HPPD. • Skill mix in the unit is 45%, which is significantly below peers, so suggests a focus for staffing investment.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix
Medicine (Unit 2)	22.5	26.7	4.6	5.0	5.4	2.5	45%

Source: ECH 2004-05, 2005-06 Sept Payroll, Deloitte Database, Grasp Database

Clinical Site Findings and Opportunities

St. Mary's Hospital – L&D, Surgery, Palliative (Unit 4)

Opportunities	Findings
1. Explore options to cohort ALC and Palliative patients for improved care management. 2. Explore implementation of LDRP model at St. Mary's, as part of functional programming. 3. Improve connection with regional obstetrics lead to improve consistency across region.	• Unit consists of a mix of obstetric (L&D, Postpartum), medical, surgical and patients waiting for placement. Consultation findings indicate that the patient mix on the unit makes patient care delivery challenging, and impacts staff morale. • Palliative and ALC patients not appropriately cohorted with surgery and L&D. • There is no LDRP model in place for obstetrics patients. • The new Manager has instituted standardized obstetrical education and orientation, however there is limited connection with the regional clinical lead for Obstetrics.
4. Focus efforts on reducing the number of services and patient populations on this unit, and align staffing model (staff mix) to support new service delivery model.	• Staffing comparison suggests that the unit is above peer staffing for 2005-06. However, the mix of patient programs and physicians, combined with a number of new graduate nurses would make this target difficult to achieve at this time. There is no staffing opportunity at this time. • In addition, skill mix is 63%, which is substantially below peer levels.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix
L&D, Surgery, Palliative (Unit 4)	18.3	22.1	5.9	6.5	5.5	(3.4) See Above	63%

Source: ECH 2004-05, 2005-06 Sept Payroll, Deloitte Database, Grasp Database

Clinical Site Findings and Opportunities

St. Mary's Hospital – Surgical Services (OR, Day Surg, Endo, Pre-Admit)

Opportunities	Findings
1. Reorganize all St. Mary's surgical services to be under one Manager, to enable streamlined care delivery, policies and planning. 2. Develop and implement consistent policies and procedures to address in Pre-Admission Clinic and OR booking. 3. Consider options to increase service throughput across the surgical services within existing staffing complement.	• Responsibility for surgical services are spread across the organization – Surgical inpatient beds located on Unit 4 (7 beds) and Unit 5 (24 beds) (2 Managers) – Day Surgery/Same Day and OR/CSR both operate under Manager Liaisons • Consultation findings suggest pre-admission screening is inconsistent: – Surgeons are reported as non-compliant – Nurses determine who requires assessment based on anaesthesia guidelines • OR booking performed by clerk according to surgeon request, with limited coordination across perioperative services. • Physical plant of Day Surgery does not support quality patient care delivery, and is being examined through the current functional planning. • Staffing comparison suggests small efficiency opportunities across perioperative services. Given the shift of St. Mary's to a secondary referral centre for the region, these opportunities should be considered as capacity for increased throughput, instead of staff savings.

Unit/Area Description	Actual FTEs 2004-05	Actual FTE 2005-06	Actual HPPC/V 2004-05	Actual HPPC/V 2005-06	Recom'd HPPC/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Operating Room	9.0	10.6	5.7	6.2	6.1	(0.2)
Day Surgery	1.8	3.1	2.0	3.0	2.1	(0.9)
Endoscopy	0.6	0.9	1.3	2.0	1.3	(0.3)
Pre-Admit Clinic	2.2	1.3	3.2	1.7	0.9	(0.6)

Source: ECH 2004-05, 2005-06 Sept Payroll, Deloitte Database, Grasp Database

Clinical Site Findings and Opportunities

St. Mary's Hospital – Surgery (Unit 5)

Opportunities	Findings
1. Focus efforts improving interdisciplinary relationships on Unit 5. 2. Target identified staffing reductions for Unit 5 after interdisciplinary relationships are improved, with a focus on improving nursing skill mix.	• Staffing comparison suggests that the unit is above peer staffing for 2005-06. However, skill mix is at 45%, which is substantially below peer levels. • Inter-professional relationships on the Surgical Unit are reported as a challenge between one of the surgeons and the nursing staff and anaesthetists, which impact care delivery and staff morale.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix
Surgery (Unit 5)	20.1	25.1	4.7	5.7	5.4	(1.5)	45%

Source: ECH 2004-05, 2005-06 Sept Payroll, Deloitte Database, Grasp Database

Clinical Site Findings and Opportunities

St. Mary's Hospital – Mental Health (Unit 3)

Opportunities	Findings
1. Continue collaboration with St. Mary's as part of regional mental health planning, to ensure alignment of inpatient mental health services to regional priorities and community health needs. 2. Continue to explore business case for creating a Short Stay Crisis Unit. 3. Consider development of discharge charting guidelines.	• Consultation findings indicate that the mental health patient population is increasing. • Consultation and MCAP findings support a lack of discharge documentation. Booklet given to patient, but details not documented on legal record. • MCAP review identified a number of inpatients that required outpatient treatment, supporting the need for further alignment of community mental health services. • The unit is hoping to open a 72 hour short term assessment unit, pending government approval. This could assist in shortening length of stay, as well as preventing the high readmission rate of between 35 & 43%
4. Target staffing reduction for Unit 3 to align to recommended HPPD.	• Staffing comparison suggests that the unit is slightly above peer staffing for 2005-06.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix
Mental Health (Unit 3)	10.5	11.2	5.7	5.7	5.1	(1.1)	70%

Source: ECH 2004-05, 2005-06 Sept Payroll, Deloitte Database, Grasp Database

Clinical Site Findings and Opportunities

St. Mary's Hospital – Emergency

Opportunities	Findings
1. Assign staff to CTAS triage RN during peak periods to improve consistency, etc. 2. Move to having MD in ER during peak periods for patient safety. 3. Invest in ER staffing and skill mix enhancement to bring to peer levels.	• Consultation findings indicated a number of significant quality and risk issues at the St. Mary's ER, including: • Roles and responsibilities are not clearly defined or appropriate – Staffing levels on nights include only 1 RN with support from Supervisor – No patient assignments in place, patients taken by nurses as they arrive. All nurses register and triage, including LPN. – No clerical coverage or central registration – all departments do their own including emergency • Compliance to CTAS Standards is inconsistent – Stakeholders report that there are times when no staff are at triage desk. – Physicians not consistently located in ER, and receive triage information over telephone. They are reported to give orders over the phone at times, and may not arrive in a timely fashion. • Physical plant does not support quality patient care delivery • Relationships between medical staff are reported as poor and this impacts care delivery. • Further, physicians are reported to use the ER, in part, to see office patients and to do booked minor procedures – which supports observed skew of triage data relative to national averages. • These challenges support the previously identified opportunity for the need for a regional emergency services strategic and operational plan that includes CTAS adherence. • Peer comparison indicates an opportunity to invest 1.4 FTEs, which should be allocated to the night shift. Skill mix at 76% is also lower than peer practice.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix
Emergency	11	10.5	1.1	1.0	1.1	1.4	76%

Source: ECH 2004-05, 2005-06 Sept Payroll, Deloitte Database, Grasp Database

ECH – Lamont Health Centre

Clinical Site Findings and Opportunities
Lamont Health Centre

Opportunities	Findings
1. As part of regional ER Strategy opportunity, determine role of Lamont in providing ER vs. UCC services, with clear communication and education to local community.	• Lamont serves a community of 8500 – 10,000. Services include 14 acute care beds, emergency, OPD/ambulatory care, surgical services as well as 105 continuing care beds. – No formal obstetrics program but do occasionally perform emergency deliveries – All day surgery patients are screened via telephone prior to surgery • ER volumes approx 5,600 per year (includes scheduled visits) – The ER is staffed from 0800 until 2000 hrs, however between 2000 and 2200 hours nurses will triage patients and refer if urgent to the physician on call for the acute beds. – The practice of providing service after the facility is officially closed may confuse the public and presents a risk issue to the organization, physician and nursing staff.

Clinical Site Findings and Opportunities
Lamont Health Centre (continued)

Opportunities	Findings
2. Invest in staffing across the acute care areas to align to peer areas, with a focus on improving acute care unit skill mix. 3. Examine 2006-07 staffing LTC staffing levels to ensure alignment to funded levels.	• The organization is finding it challenging to recruit staff, and staffing comparison shows an opportunity for investment across its acute, emergency and OR/Day Surgery areas to align to peer levels. The skill mix of the acute care unit was also significantly lower than peers, at 40% in 2005-06, suggesting a focus for re-investment. • Although the long-term care unit shows an opportunity for staffing efficiency in comparison to 2005-06 funded levels, 2006-07 funded levels will result in required increase in staffing in this area.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Acute Care Unit	10.8	9.7	4.0	3.5	5.2	4.6
Long Term Care Unit	64.3	72.0	2.8	3.2	3.0	(4.6)
Emergency	2.0	1.7	0.6	0.5	0.9	1.5
OR and Day Surgery Combined	4.9	5.3	3.3	3.3	3.7	0.6

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

ECH – Vegreville Health Centre

Clinical Site Findings and Opportunities

St. Joseph's – Vegreville Health Centre

Opportunities	Findings
• Please refer to regional and clinical program opportunities identified.	• St. Joseph's has a 30 bed inpatient unit, which is reducing to 25 beds in August by improving utilization – This reduction in acute care beds aligns to MCAP findings. – A lack of designated ALC beds impacts utilization of inpatient unit – Opportunity exists to increase home care services, particularly on the evenings and weekends. • ER volumes approx 17,000 per year – Staffed 24/7 although on nights the RN goes to the inpatient unit and returns with a colleague if patients present. – Management has made efforts to decrease the number of clinic patients who present in ER • ER Physical space is well laid out, although patients must register in admitting first unless he/she is in urgent need of care. – The nursing station has visibility of the registration area (although the RN might not be at the desk). – The waiting room is across to the right of the nursing station and is largely but not completely visible. • Programs operate largely in isolation from regional programs and sites (e.g. pharmacy, clinical education), suggesting the potential benefit of greater regional program alignment. • Consultation findings suggest significant physician conflict is impacting service delivery and sustainability.

Clinical Site Findings and Opportunities

St. Joseph's – Vegreville Health Centre (continued)

Opportunities	Findings
1. Target alignment of acute care unit and ER staffing levels to peer HPPDs as part of the organization's shift to a 25-bed configuration. 2. Consider development of service attendant position to reduce nursing workload.	• Staffing comparison suggests an opportunity for staffing efficiency in the acute care unit, compared to peers for 2005-06. This staffing comparison is based on the current 30-bed configuration for St. Joseph's, so does not factor in the planned move to 25 beds. • Staffing comparison also identifies an opportunity for investment in the ER, relative to peers. • Consultation findings suggested many non-nursing functions are currently performed by RN. – e.g. delivering trays, laundry, stocking supplies etc.

Unit/Area Description	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Combined Medical/Surgical Nursing Unit	32.5	5.7	5.4	(1.8)
Emergency Unit	6.7	0.6	0.9	2.7

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database. Note: 2004-05 Payroll Data for St. Joseph's not available.

ECH Daysland Health Centre

Clinical Site Findings and Opportunities
ECH – Daysland Health Centre

Opportunities	Findings
1. Consider redefining ALC beds for increased and improved utilization – develop clear criteria for admission/discharge, and generate buy-in across region to no impact on appropriate ALC use. 2. Conduct a review of discharge and APPI process to improve alignment of care practices to care needs. 3. Examine Daysland community needs as part of broader regional health needs assessment to determine services that are lacking in facility.	• Daysland has 12 acute beds and 10 ALC designated beds. ALC beds are designated as: respite, convalescence, sub-acute, and palliative. • Consultation further identified that ALC beds were being shifted around to accommodate patients for longer periods of time. For example, a patient whose sub-acute time (5-7 days) has expired is then designated convalescence. • Utilization analysis and MCAP findings suggested opportunities to reduce length of stay, shift patients into alternative level of care, and increase consistent discharge process. • Nursing Care Coordinator is 0.6 FTE facility dedication and 0.4 FTE to Regional Program Lead for OR/CSR. • 40% of 0.6 FTE of Nursing Care Coordinator time is dedicated to patient care on the units, due to staff shortages, which results in limited management time available. • Stakeholders report a large transient and lower socioeconomic population, contributes to challenges with discharge and arranging services. No social worker available to site is also reported as a related challenge in supporting this population. • Consultation findings also indicate that no Speech Language Pathologist is available, which impacts stroke rehabilitation.

Clinical Site Findings and Opportunities
ECH – Daysland Health Centre (continued)

Opportunities	Findings
4. Target identified staffing investment for Daysland acute care, with a focus on improving nursing skill mix.	• Staffing comparison for the combined acute care unit and ER suggests an opportunity for investment, to align to peer levels. • A review of the acute care unit skill mix identifies that Daysland is significantly below peer levels, at only 51% RNs, and so suggests a focus for re-investment. • OR staffing comparison indicates that Daysland is in line with peer staffing levels.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Combined Acute Care Unit and ER	21.7	22.4	5.2	5.3	5.6	1.4
Operating Room	1.4	1.3	5.1	4.6	4.6	0.0

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

ECH – Two Hills Health Centre

Clinical Site Findings and Opportunities

ECH – Two Hills Health Centre

Opportunities	Findings
1. Examine admission criteria for SAGE to ensure optimal regional utilization, and support with related education to referring providers. 2. Examine SAGE patient discharge management and placement to minimize fragmentation of patient care.	• Stakeholder consultation suggests admission criteria are too restrictive for the Stroke and Geriatric Empowerment (SAGE) program. • Consultation findings indicate that once SAGE patients are ready to discharge, they are sent back to referring hospital for placement, so that there is no impact on SAGE program. • Although this facilitates SAGE patient management, it may create a challenge to regional patient transport and patient care/flow. • The SAGE unit staffing comparison suggests an efficiency opportunity, but this needs to be considered in the context of the need to re-examine SAGE programming to improve utilization and throughput.

Clinical Site Findings and Opportunities

ECH – Two Hills Health Centre (continued)

Opportunities	Findings
3. As part of examination of SAGE programming, align SAGE staffing to peer HPPD with consideration of increased unit utilization. 4. Invest in long term care staffing, with consideration of 2006-07 funding level alignment.	• Staffing comparison indicates an opportunity for efficiency across the acute care unit at Two Hills, however minimum staffing levels would make it difficult to achieve this opportunity. • The SAGE unit staffing comparison also suggests an efficiency opportunity, but this needs to be considered in the context of the need to re-examine SAGE programming to improve utilization and throughput. • Staffing comparison for the long-term care unit to 2005-06 funded levels suggests a need for re-investment.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Acute Care Unit	16.2	15.7	7.5	7.2	6.5	(1.6)
SAGE Rehabilitation Unit	11.3	10.0	6.2	6.9	4.8	(3.1)
Long-Term Care Unit	38.7	38.2	3.0	3.1	3.4	3.4

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

ECH – Vermillion Health Centre

Clinical Site Findings and Opportunities

ECH – Vermillion Health Centre

Opportunities	Findings
1. Consider program focus or ALC bed model (like Daysland) at Vermillion for increased utilization of beds for the region. 2. Explore and implement models of daily multidisciplinary discharge planning meetings at Vermillion.	• MCAP review and related consultation identified that there is current under-utilization of acute beds at Vermillion. – Further, the MCAP analysis identified several patients who did not require the level of acute care being provided. • Consultation findings also identified that interdisciplinary discharge planning meetings do occur, but only weekly, which may be impacting patient flow and utilization management.
3. See Regional ER and CTAS opportunities. 4. Explore feasibility of expanding evening/weekend clinic availability to reduce community dependence on ER. 5. Explore feasibility of expanding home care hours to accommodate evening and weekend client care. 6. Collaborate with community partners to explore expansion of social services available to Vermillion residents after-hours.	• Vermillion has approximately 13,000 ER visits per year (includes scheduled visits). The ER is staffed 24/7, however on nights the RN goes to the inpatient unit and returns if a patient presents. Physicians are on-call vs. in house. • Consultation identified that although there is good confidence in current triage data, the percentage of patients missed in CTAS coding has increased to over 8% - primarily during busy periods. • High level of Triage 4 and 5 due to lack of community clinic availability in evenings and weekends, as well as a lack of regular after-hours home care and social services.

Clinical Site Findings and Opportunities

ECH – Vermillion Health Centre (continued)

Opportunities	Findings
7. Target staffing efficiency in the acute care unit, with consideration of removing the medication nurse role. 8. Consider increased OR/Endoscopy utilization to optimize staffing resources, in alignment to regional health services planning. 9. Continue to examine long term care staffing levels relative to 2006-07 funding levels. 10. Target staffing investment in ER, in alignment with regional ER strategy.	• Staffing comparison suggests an opportunity for efficiency in the acute care unit relative to peer levels for 2005-06. Consultation also identified that the use of a medication nurse role prevents nurses from functioning at full scope. • The staffing comparison for the OR and Endoscopy areas also identified opportunity for efficiency. Given the minimum staffing in these areas however, this opportunity is suggested as a focus for increased service capacity. • A potential staffing efficiency was also found for the long-term care unit relative to 2005-06 funded levels, however the increase in 2006-07 funding suggests a potential opportunity for investment. • ER staffing was found to be below peers for 2005-06, and represents an opportunity for investment.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Acute Care Unit	21.8	23.2	5.2	5.8	5.3	(2.2)
Operating Room and Endoscopy	2.0	2.4	11.4	10.2	7.2	(0.7)
Long Term Care Unit	43.4	34.7	3.2	3.5	3.4	(0.6)
Emergency Department	5.7	5.6	0.7	0.7	0.9	1.7

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

ECH – Wainwright Health Centre

Clinical Site Findings and Opportunities

ECH – Wainwright Health Centre

Opportunities	Findings
1. As part of regional ER Strategy, consider infrastructure improvements to align Wainwright ER department to CTAS standards. 2. Continue focus on improved PAC policies and procedures, in alignment with broader regional programming. 3. Continue MORE^{OB} training for nursing staff without training, in alignment with regional obstetrics programming.	• Wainwright Health Centre is a full service site offering acute care, emergency, ambulatory care, surgical services, obstetrics, and continuing care. The town's population is reported as increasing due to oil and military industries. • The Wainwright ER has annual volumes of approximately 13,000 (includes scheduled visits). The physical layout of the ER is very poor with a small nursing station, arrival and waiting area not visible from the triage station, both which create challenges to patient care and risk management. • For surgical patients, there is no formal pre-op assessment. – Stakeholders report that it is up to individual surgeons to provide information to anaesthesists who will see patient before OR. – OR nurse does call all patients but some information has been missing. – The site is now working with region to include a stronger nursing assessment. • Wainwright has approximately 110 deliveries per year. All nursing staff working in acute care have 4 days obstetrical training, and 16 nurses have completed the initial MORE^{OB} Module. – Despite this, it is not always possible to have nurses competent in obstetrics on every shift. • The site also reports that its affiliation with Grant McEwan College rural nursing program is very positive for ongoing staff recruitment and retention.

Clinical Site Findings and Opportunities
ECH – Wainwright Health Centre (continued)

Opportunities	Findings
4. Consider expansion of outpatient cardiac rehabilitation programming from a regional perspective, in alignment with a community health needs assessment.	• Consultation findings identified a need in region for increased cardiac care. This was further supported by the CMG analysis, which suggested that limited outpatient cardiac care availability was impacting length of stay. • It was reported that a Cardiologist visits this site to provide outpatient cardiac rehabilitation and consultations, suggesting that opportunity may exist to expand this program.
5. Continue with plans to conduct Wainwright functional planning, in alignment with regional health services plan and a community health needs assessment.	• Consultation findings and stakeholder reports suggest challenges in the physical facilities of patient care areas at Wainwright (e.g. nursing unit layout, patient room bathrooms and bathroom doors are small, etc.). • Current regional plans are to complete functional planning for the facility during 2006-07.

Clinical Site Findings and Opportunities
ECH – Wainwright Health Centre (continued)

Opportunities	Findings
6. Target staffing efficiency in the acute care unit. 7. Consider increased OR utilization to optimize staffing resources, in alignment to regional health services planning. 8. Continue to examine long term care staffing levels relative to 2006-07 funding levels. 9. Target staffing investment in ER, in alignment with regional ER strategy.	• Staffing comparison suggests an opportunity for efficiency in the acute care unit relative to peer levels for 2005-06. • The staffing comparison for the OR also identified opportunity for efficiency. Given the minimum staffing in the OR, however, this opportunity is suggested as a focus for increased service capacity. • A potential staffing efficiency was also found for the long-term care unit relative to 2005-06 funded levels, however the increase in 2006-07 funding suggests a potential opportunity for investment. • ER staffing was found to be below peers for 2005-06, and represents an opportunity for investment.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2004-05	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Acute Care Unit	24.2	23.8	5.8	5.8	5.6	(0.9)
Operating Room	1.0	1.4	6.2	7.2	4.1	(0.6)
Long Term Care Unit	50.3	52.1	3.4	3.5	3.2	(3.6)
Emergency Department	3.6	3.6	0.5	0.4	0.9	3.7

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

ECH –
Other Acute Sites Not Visited

Clinical Site Findings and Opportunities

ECH – Other Sites Not Visited

- Although the consulting team did not visit the remaining rural sites in the region, a comparative peer staffing analysis was conducted.
- As outlined in the table below, there are several opportunities for resource realignment across the rural sites available for consideration. **These opportunities should be explored further in the context of broader regional community health needs, before action is taken.**
- Before acting on potential staffing opportunities, consideration of various factors is required, where:
  - Acute and long term care nursing staff cross-cover these respective areas within facilities,
  - Minimum staffing requirements exist, and
  - There is expected staffing impact given the increase in 2006-07 funding levels for long term care.

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Hardisty Health Centre	Acute Care Unit	5.7	5.7	5.8	5.1	(0.8)
	Long Term Care Unit	15.7	15.6	5.0	2.7	(7.1)
	Emergency Department	0.6	0.6	0.4	0.9	0.7

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

Clinical Site Findings and Opportunities
ECH – Other Sites Not Visited (continued)

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD 2005-06	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Killam Health Centre	Acute Care/Emergency	14.4	16.3	13.6	7.6	(7.2)
	Long Term Care Unit	28.2	29.2	3.0	3.2	1.2
Provost Health Centre	Acute Care Unit	19.4	20.4	6.9	7.2	0.8
	Long Term Care Unit	0.7	1.2	16.4	4.1	(0.9)
	Emergency Department	25.3	25.9	3.2	3.5	2.3
Tofield Health Centre	Acute Care/Emergency	17.7	17.2	7.3	6.4	(2.2)
	Long Term Care Unit	35.2	36.7	3.5	3.1	(3.6)
Viking Health Centre	Acute Care/Emergency	22.4	22.1	8.3	7.4	(2.5)
	Operating Room	2.2	1.6	14.5	6.3	(0.9)

Source: ECH 2004-05, and 2005-06 Payroll, Deloitte Database, Grasp Database

Physician Findings and Opportunities
Introduction

- The review process incorporated several direct consultations with physicians, which have yielded a number of findings and opportunities.
- Physician-related findings and opportunities have been clustered into the following four key areas, which also have linkage to opportunities identified across other areas of the region:

Physician Findings & Opportunities
Governance and Leadership

Findings

- Consultation confirmed MAC is comprised of site chiefs, chiefs of departments, and the VP of Medical Services. Meetings are well attended and considered effective. MAC is not involved with the credentialing process.
- VP Medical Services reported as having no jurisdiction over development and operation of clinical programs at Associate Partner sites, which contributes to a fragmented clinical programming, common standards and protocols.
- Consultation findings suggest that the Chief of Staff role at St. Mary's is not supported administratively by the organization, and is focused primarily on complaint management and physician scheduling. This is a limited role compared to common practice, and likely contributes to challenges in physician management and coverage in select areas (e.g. ER).
- Regional compensation for medical leadership roles are observed as below that of other regions, which may contribute to an observed lower level of medical leadership engagement.

Opportunities

1. Review medical leadership structure across regional and Associate Partner sites, with the goals of:
   - Implementing defined roles, relationships, and accountabilities to support a regional approach to medical leadership.
   - Standardize roles and responsibilities for Chiefs of Staff across region and associate sites.
   - Consider the potential to create medical program leads.
2. Review MAC terms of reference and membership to assess fit with medical leadership needs of the region. Consider functions of recruitment, retention, quality, and credentialing as part of this process.
3. Actively collaborate with St. Mary's Hospital administrative and medical leadership to create clear roles, relationships and accountabilities of medical staff that are centred on improving patient care and management.

Physician Findings & Opportunities

Physician Human Resources

Findings

- Consultation findings suggested that the region does not have a clearly delineated medical human resource plan with defined recruitment and retention strategies, or a comprehensive regional physician impact assessment process that considers clinical and support service impacts.
- Similarly, the region does not currently have a medical succession plan that projects physician needs with linkage to recruitment and retention. This is compounded by an identified immediate need for 12 physicians throughout the region by the VP Medical.
- A large portion of the physicians throughout the region are IMGs (85%), which provides a needed resource-base to the region, but creates some cultural and practice challenges in select areas.
- Consultations also identified that the fee-for-service structure is a potential barrier to physician recruitment in the region – promoting single-source services and discouraging AFPs.
  - Although the region paid close to $3.75M in physician on-call fees, less than $150,000 was paid in site chief stipends.
  - Limited other direct income support for physicians (paid by the region), which is in contrast to other regions in Alberta.

Opportunities

1. Engage physicians and regional leadership to develop a regional Physician Human Resource Strategy, that is linked to the broader regional HR strategy, to address Physician resource gaps, skills management and education, alignment/realignment of current resources to core service delivery needs, remuneration and recruitment/retention.
   - As part of physician human resource strategies and planning, generate initiatives to engage physicians in creating a common physician culture across the region and Associate Partners.
2. Develop a consistent regional Physician Impact Assessment process for physician recruitment needs planning, and in assessment when new physicians are being considered.
3. Explore alternative payment models for physicians in the region, with an objective to improve resources and linkage to care/service delivery model.
   - Related to this opportunity, explore alternate staffing models to consider physician AFP options – e.g. APN/NP model in ER and community health clinics.
   - Consider medical compensation strategies that link to a regional medical HR plan.

Physician Findings & Opportunities

Quality, Risk, & Performance Management

Findings

- Significant concern regarding the medical credentialing process, which is not currently aligned across the region and Associate Partners. The lack of consistency creates duplication in process, and presents a liability risk to the region and Associate Partners (where processes and standards are not common).
- Similarly, quality assurance across the region and Associate Partner sites is fragmented. Quality programs are separate, and the VP Medical does not have an ability to effectively monitor quality in the Associate Partner sites (e.g. VP cannot gain access to medical records)
- There are no specific CME requirements for the region, which limits the ability of the region to manage quality and risk – although each physicians' CME complement is assessed by the VP with recommendations offered.
- There appears to be limited traction in achieving physician engagement on standards of practice.
- Consultations in several sites indicated that the region needs to take a more active role in supporting sustainable "on-call". Many sites are struggling to secure locums, some of which may not meet the needs of the community. The region needs a more central and coordinated effort to support on-call in each of the sites- it is at risk if this process is left entirely to the site chiefs.

Opportunities

1. Create a standardized accountability framework for regional and Associate Partner sites with evaluation and quality/risk/performance management tools for Physicians, which is integrated into the broader regional framework.
2. Develop a regional approach and support for CME for both Canadian-trained and foreign-trained medical graduates, based on a sustainable business model, and integrated with the physician recruitment and retention strategy and broader regional education function.
3. Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management).
4. Engage physician and administrative leadership from across the region and Associate Partners to create a common physician credentialing process.

Physician Findings & Opportunities
Clinical Program Frameworks and Review

Findings

- Consultation findings suggest that the region's facilities and many respective services operate in silos, that there is a lack of regional programs, and that there is significant variability in services by site. In part, this is driven by many services in the region being single resourced, thereby creating solo physician practices.
- Communication and coordination of services across the region continues to be a challenge for select areas – suggesting a need for greater integration region-wide.
- Observed challenges across the region suggest a need for a greater regional focus to:
  - –Define scope of service for current and future community/regional needs.
  - –Ensure congruence of site/regional services with functional planning exercises.
  - –Assess and determine current/future capacity requirements/constraints.
- Discussions with the region on PCN suggest limited penetration of primary care across ECH. This may in part be due to a lack of a physician champion for this initiative.

Opportunities

1. Conduct external reviews of Emergency, Obstetrics and Surgery services as regional programs, with focus on developing a coordinated and sustainable strategy for each programs to address the respective needs of communities served.
2. Review delivery of specialty programs across the region to align programming to community health needs assessment, supported by contingency plans where services are single sourced.
3. Enhance communication across facilities by leveraging Telehealth technology in a structured approach to coordinate service, share leading practice information, CME and professional support.
4. Review strategic opportunities for PCN throughout the region and establish a physician lead for the initiative.

Physician Findings & Opportunities
Summary of Key Issues

- The following five key issues summarize the physician findings and opportunities for the region:
  1. Risk Management (e.g. single resource specialty, coverage, IMGs)
  2. Human Resources (e.g. quantity, quality, critical mass, comprehensive planning)
  3. Physician Leadership (e.g. roles, responsibilities, and accountabilities)
  4. Quality Program (e.g. clinical protocols, formal processes, common credentialing)
  5. Vision-Mission Alignment with Community Health Needs Assessment (including PCN)

Clinical Support and Allied Health Services

Clinical Support and Allied Health Services

Peer Staffing Comparison Process Overview

- To understand the relative efficiency of the Clinical Support and Allied Health services, we conducted a comparative analysis with a number of comparable health regions from Alberta, British Columbia, Manitoba, and Saskatchewan.
- Fiscal 2005-06 data for ECH and the Associate Partners was used for peer comparison, as this represents a full year of staffing, but reference to budgeted 2006-07 staffing levels are also provided.
- The efficiency analysis assessed peer staffing based on a comparison of actual total paid hours per adjusted patient day (HAPD) for each "discipline" within the organization (based on MIS functional centre alignment).
  - Although many of the allied health disciplines in the region are aligned to clinical program, an MIS-based alignment for comparison was used to ensure an 'apples-to-apples' comparison to peers.
- The adjustment factor increases the base of inpatient clinical activity to better reflect the span of inpatient, outpatient, continuing care and community clinical activity.
- The results across the comparator group were considered with the following "rules" applied at the departmental level:
  - Values among the comparator group that were well outside the range (e.g. outliers) were eliminated from the analysis.
  - For Clinical Support and Allied Health Services, the FTE efficiency opportunity was identified compared to the 50th percentile to reflect a more realistic level of clinical resourcing to support patient care needs.
- Staffing opportunities are identified based on comparative analysis and the team's understanding of minimum staffing requirements. Staffing opportunities are not stand alone, however, and need to be considered in the context of other opportunities identified for each area.
- The benchmarking information should be used as input to management decision-making, rather than as a decision in and of itself.

Clinical Support and Allied Health Services
Peer Staffing Comparative Analysis Areas Reviewed

MIS Primary Account	Departments and Disciplines
71410	Clinical Laboratory
71415	Diagnostic Imaging
71440	Pharmacy
71445	Clinical Nutrition
71435, 71450, 71455, 71460	Rehabilitation Services: Respiratory Therapy, Physiotherapy, Occupational Therapy, Audiology and Speech/Language Pathology
71470	Social Work
71485	Recreation

Clinical Support and Allied Health Services
Clinical Laboratory

Opportunities	Findings
1. Review the current organization and distribution of lab services in the region, with a focus on streamlining services to increase coordination across the region and Associate Partners, and to align lab services with the facility role review. (Relates to region-wide opportunity.) 2. Improve lab specimen transportation (as part of regional distribution system) to support and enable a regional lab model. 3. Develop a targeted lab human resources and workforce plan to address current and future recruitment needs.	• ECH recently separated the management of lab and DI services, in response to increasing workload related to the implementation of Meditech and PACS. • Staffing across many sites is still coordinated, however, with many sites employing CXLTs that work across both areas. The region is facing current staff shortages, high overtime, and a staff retirement wave is anticipated in 5-10 yrs. • Wainwright represents the primary hub for ECH labs, although St. Mary's, Vermillion and Vegreville all provide a higher volume of service in the region. The St. Mary's lab reports extra capacity. Three LTC sites also perform some lab testing, while other LTC sites are collection sites only. • The region contracts Pathologist services from Aspen RHA. • Stakeholder consultations suggest a high degree of duplication in testing capability exists across these hubs, and across other regional acute sites. While there appears to be good management coordination across the regional and Associate Partners for labs, a lack of dedicated transportation system has limited service delivery coordination.

Clinical Support and Allied Health Services
Clinical Laboratory

Opportunities	Findings
4. Establish a regional Lab Utilization Committee to improve lab utilization, explore new testing models, and standardize lab policies, procedures and practice across the region and Associate Partners. 5. Review the use of lab order sets, with consideration of establishing pre-set order sets for select clinical protocols. 6. Develop a business case to explore the costs and benefits of expanding the use of point-of-care testing.	• ECH labs do not use lab panels/order-sets, primarily as a control mechanism to ensure that physicians are purposefully requesting each test individually. – Consultation across regions suggests that this may be a challenge to maintain, given new Meditech functionality. – Pre-set lab order sets may prove beneficial in achieving efficiencies related to select clinical protocols (e.g. MI) • Further, there is no regional lab utilization committee to help guide lab test and order set use in clinical practice, or drive standardization across the region and Associate Partners. • Reports also suggest minimal point-of-care testing is in place.
7. Target reductions in lab costs/procedure to align cost structure to Alberta peers, as part of lab service rationalization across ECH and Associate Partner sites.	• Varied models of lab services across the RHAs, required a comparison based on lab costs/procedure. – This comparison found that ECH had the highest lab cost per procedure among the Alberta non-metro regions.

Area Description	Lab Cost/Procedure 2004-05	Alberta Peer Lab Cost/Procedure MIN	Alberta Peer Lab Cost/Procedure MAX
Clinical Laboratory	$19.90	$6.34	$19.90

Source: AHW MIS for 2004-05, RHA-Provided GL Data for 2005-06

Clinical Support and Allied Health Services
Diagnostic Imaging

Opportunities	Findings
1. Review DI modality utilization and siting within region to determine an optimal and sustainable configuration that aligns with community health needs assessment and regional health services plan. (Relates to region-wide opportunity.) 2. Develop a DI human resource plan for staff and radiologists to align resource needs to DI service model. 3. Explore the business case for centralized exam scheduling across the region and Associate Partners, as part of broader wait list strategies.	• Majority of regional sites with DI services have general x-ray, and Wainwright and Vermillion also have ultrasound services. Camrose and Vegreville act as regional DI hubs, with x-ray, ultrasound, fluoroscopy and CT (at St. Mary's). Mammography and BMD services are also provided at the Smith Clinic. • Consultation findings suggest that utilization of DI services throughout the region is variable and is quite low at some sites. The region identifies challenges in sustaining DI services in select sites due to low utilization, aged equipment, and human resource constraints (e.g. Mundare, Mannville and Myrnam). • DI equipment at the majority of sites is otherwise well supported, with many CR conversions planned in conjunction with PACS implementation by March 2007. This will enable improved equipment and protocol standardization. • Camrose and Vegreville each have 1 radiologist, which are the only resources in the region. To support radiologist workload, the region has an arrangement with a group in Capital Health, and reports good turnaround on reports and films. • Under the direction of a new DI manager, the region is starting to consider additional DI opportunities such as centralized exam scheduling, however currently limited coordination with the Associate Partners is a challenge. This could benefit access to services that currently have longer waitlists (e.g. ultrasound)

Clinical Support and Allied Health Services
Diagnostic Imaging

Opportunities	Findings
1. Determine staffing requirements for DI once service utilization and siting planning is complete for ECH and Associate Partner sites.	• High overtime was observed in 2005-06, but this has improved since 2004-05 through extended operational hours. • DI also had 1.1 FTE CXLT vacancy shared with labs. • Although the region is moving to PACS, there is no FTE savings anticipated through the implementation. Although there will be film cost savings, there are no film library staff savings projected as this work is currently performed by the DI techs/CXLTs. • Staffing comparison found that ECH has an opportunity for staffing investment, relative to peers at the 50th percentile. This opportunity may, in part, be driven by the wider range of DI modalities available in other regions. – This opportunity should be considered within context of a the broader DI service model alignment.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Diagnostic Imaging	42.0	0.23	0.23	0.42	0.30	12.8 (See Above)

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Clinical Support and Allied Health Services
Pharmacy

Opportunities	Findings
1. Explore models to create a single regional pharmacy service and distribution model that includes ECH and the Associate Partners, and aligns delivery and logistics to the ECH health services plan and facility role review. (Relates to region-wide opportunity.) 2. Establish a common Pharmacy and Therapeutics committee for all ECH and Associate Partner Sites, and re-visit the need for a parallel Pharmacy Advisory Committee. 3. Develop a single common regional formulary for ECH and Associate Partners to minimize drug costs and improve quality controls. 4. Develop a business case for automated unit dose packaging, as part of a regionalized distribution model which uses St. Mary's as the hub.	• Pharmacy is considered a regional service across the ECH sites, but minimal operational coordination with the Associate Partners is in place. • A regional Pharmacy and Therapeutics committee exists that does includes St. Joseph's, however. A region-wide Pharmacy Advisory Committee also exists that includes the Associate Partners. • Stakeholders report both region and site formularies. Region formulary is about 80% of drugs used, sites are about 20%. • Drug packaging models vary across the region, although the region plans to increase centralized service delivery: – Manual unit dose exists at Daysland, which provides drug packaging for the other ECH sites; plan is to automate this process. – LTC sites use blister cards, but are shifting to pouch-packaging – Associate Partners are on their own separate systems • Given the intent to establish St. Mary's and Lloydminster as secondary referral centres for the region, alignment of regionalized pharmacy services with these sites will support broader clinical service delivery. This should also be a consideration for capital equipment investment as the region moves to automated unit dose.

Clinical Support and Allied Health Services
Pharmacy

Opportunities	Findings
5. Establish clear policies and procedures for the payment of home care medications, and communicate to key stakeholders.	• Home care medication (e.g. HPT) are charged to the patient but the region often does not collect if this is not paid. This was reported to cause challenges where some MDs do not discharge patients due to this requirement to pay, while the region will also cover the costs in some cases.
6. Continue to increase partnerships with community pharmacists to expand clinical pharmacy support to patient care. 7. Develop a targeted recruitment and retention strategy and workforce plan for Pharmacy.	• Given the shortage of pharmacists, competition with community pharmacies, and recruitment challenges, the region relies on pharmacy techs with remote supervision by a Pharmacist for several sites. • Due to reported pharmacist shortages, the level of clinical pharmacy work performed across the sites varies. • Where on-site regional pharmacists exist, stakeholders report a good working relationship with other providers in clinical pharmacy work and medication order reviews. • The region is currently operating with vacancies equivalent to 1.6 FTEs of Pharmacists, and 1.2 FTEs of Pharm. Techs. • Further, an estimated 20% of current Pharmacists are expected to retire within the next 3 years. • An initial attempt to recruit foreign grads in Pharmacy was unsuccessful, but the region is still considering this option. • Staffing comparison found ECH to be in line with peers.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Pharmacy	30.3	0.17	0.13	0.25	0.17	-

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Clinical Support and Allied Health Services
Clinical Nutrition

Opportunities	Findings
1. Improve integration of Clinical Nutrition resources across the continuum, to facilitate coordination in care delivery and increase flexibility in staffing recruitment, retention and deployment. 2. Explore further integration with the Associate Partners for Clinical Nutrition service delivery and staffing.	• Clinical Nutrition provides service to the acute care, long-term care and community care settings as three separate services under common regional management. • Consultation suggests that there is minimal cross-coverage of Clinical Nutrition roles across these separate components of the health continuum. • Community resources have budget/line responsibility into regional Food and Nutrition Services, but align service delivery with the community program lead. • Although some job-sharing is planned for part-time resources with the Associate Partners, broader clinical service delivery and staffing coordination is not in place. • Stakeholders report historical challenges in recruitment and retention, however the region has recently filled the majority of its Clinical Nutrition vacancies (2.6 of 2.9 FTEs). • Staffing comparison found ECH to be in line with peers.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Clinical Nutrition	8.3	0.05	0.04	0.12	0.05	-

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Clinical Support and Allied Health Services
Rehabilitation Services

Opportunities	Findings
• Please refer to Rehabilitation Services in Clinical Programs.	• Rehabilitation services includes Physiotherapy, Occupational Therapy, Respiratory Therapy, Speech Language Pathology (SLP) and Audiology. • Please refer to the Rehabilitation Services findings in the Clinical Programs section for a broader set of opportunities.
1. Consider staffing investments in Occupational Therapy and SLP/Audiology, as part of regional Rehabilitation Services Planning.	• Analysis indicates a high level of high sick time across the rehabilitation disciplines in 2005-06. • Staffing comparison indicates that ECH is in line with peers for Physiotherapy, but has a staffing investment opportunity for the other rehabilitation disciplines. • Opportunity for Respiratory Therapy is likely driven by the fact that other regions have a regional ICU, whereas ECH does not. • SLP/Audiology initiatives to increase availability of services to residents (e.g. newborn screening, student initiatives, etc.) would align to peers.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Respiratory Therapy	4.2	0.02	0.02	0.19	0.10	12.9 (See Above)
Physiotherapy	45.6	0.26	0.10	0.31	0.26	-
Occupational Therapy	24.6	0.14	0.11	0.20	0.16	3.5
SLP/Audiology	12.8	0.07	0.07	0.18	0.16	14.9

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Clinical Support and Allied Health Services
Social Work

Opportunities	Findings
1. Create common roles and responsibilities for Social Work related to discharge planning across the ECH and Associate Partners, which will require a staffing investment.	• Consultation findings indicated a lack of dedicated social work resources to consistently support discharge planning, and facilitate transition across the continuum of care. • Staffing comparison finds an opportunity for staffing investment to align ECH to peers at the 50th percentile, supporting consultation findings above.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Social Work	3.9	0.02	0.01	0.07	0.05	5.3

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Clinical Support and Allied Health Services
Recreation Therapy

Opportunities	Findings
1. As part of regional planning to transition LTC to the Eden and DAL models, consider Recreation Therapy staffing efficiency opportunities.	• Recreation Therapy provides services primarily to the long term care units and centres in the region. • A comparison of regional staffing in Recreation Therapy finds that ECH has an efficiency opportunity relative to peers at the 50th percentile. • This comparison does not include staff or activity in the Bethany Group, as information was not available to include in the analysis. • This efficiency opportunity should be considered in alignment with the increased funding for Continuing Care, and the need to examine role of Recreation as the region shifts to an Eden Model and DAL setting.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Recreation	35.8	0.20	0.06	0.21	0.15	(9.1)

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services

Peer Staffing Comparison Process Overview

- To understand the relative efficiency of the Corporate and Support Services, we conducted a comparative analysis with a number of comparable health regions from Alberta, British Columbia, Manitoba, and Saskatchewan.
- Fiscal 2005-06 data for ECH and the Associate Partners was used for peer comparison, as this represents a full year of staffing, but reference to budgeted 2006-07 staffing levels are also provided.
- The efficiency analysis assessed peer staffing based on a comparison of actual total paid hours per adjusted patient day (HAPD) for each "department" within the organization (based on MIS functional centre alignment).
- The adjustment factor increases the base of inpatient clinical activity to better reflect the span of inpatient, outpatient, continuing care and community clinical activity.
- The results across the comparator group were considered with the following "rules" applied at the departmental level:
  - Values among the comparator group that were well outside the range (e.g. outliers) were eliminated from the analysis.
  - Given the northern geographic challenges faced by the region, the FTE efficiency opportunity for all Corporate, Support, Clinical Support and Allied Health Services was identified compared to the peer 50th percentile level of staffing performance.
- Staffing opportunities are identified based on comparative analysis and the team's understanding of minimum staffing requirements. Staffing opportunities are not stand alone, however, and need to be considered in the context of other opportunities identified for each area.
- The benchmarking information should be used as input to management decision-making, rather than as a decision in and of itself.

Corporate and Support Services

Peer Staffing Comparative Analysis Areas Reviewed

MIS Primary Account	Departments
71105, 71110, 71205, 71305, 71405, 71505	General Administration and Nursing Administration Combined (Combined to ensure comparability to peer reported data)
71115	Finance
71120	Human Resources/Personnel and Occupational Health & Safety
71840	Education
71125	Systems Support – Regional IT
71135	Materiel Management (includes all CSR for the region)
71145	Housekeeping
71150	Laundry and Linen
71153, 71155, 71165, 71175	Plant Operations, Maintenance and Biomedical Engineering Combined (Combined to ensure comparability to peer reported data)
71190, 71180, 71130	Health Records, Registration and Telecommunications Combined (Combined to ensure comparability to peer reported data)
71195, 71910	Patient/Resident and Non-Patient Food Services Combined (Combined to ensure comparability to peer reported data)

Corporate and Support Services

Corporate Services (General and Nursing Administration Combined)

Opportunities	Findings
1. Review senior management organization structure and portfolios, to re-align skill sets with regional priorities and operations, and do so in consideration of Associate Partner linkages.	• The region has had a clinical senior manager vacancy for the past year. • The recent recruitment of a CNO/VP Health Services suggests the need to review senior portfolios. This is especially relevant for the linkage of this role to the Associate Partner clinical service delivery.
2. Continue efforts to standardize key policies and procedures across the region and Associate Partners, which are linked to the Associate Partner service level agreements. 3. Formalize asset management processes and tools in coordination with Materiel Management, to better inform capital planning.	• Corporate Services is currently re-focusing efforts on standardizing policies and procedures across ECH and the Associate Partners, as part of broader approach to region-wide risk management. • The region currently manages capital through an informal approach to asset management, which is not supported by technology.
4. Examine opportunities for further corporate service integration across ECH and the Associate Partners to contribute to staffing efficiency target.	• Staffing comparison finds that ECH has a significant efficiency opportunity relative to peers. This is largely driven by the duplication in administrative functions across ECH and the Associate Partners.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Corporate Services	108.5	0.61	0.42	0.61	0.49	(21.3)

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services

Finance

Opportunities	Findings
1. Review the current budgeting process in the region: • to align budgeting to regional priorities, • to focus on fiscal accountability, and • to improve funding timing to Associate Partners. 2. Explore development of common Finance functions across ECH and the Associate Partners, with a focus on transactional activities that will not negate current governance or autonomy.	• Finance is a regionalized service that is centralized at the ECH regional office in Camrose. Re-regionalization in 2003-04 resulted in further centralization of new Finance resources. • The Finance function is currently not integrated across ECH and the Associate Partners, although ECH does provide all financial services to Killam. • Annual budgeting focuses primarily on previous year plus inflation. Finance reports that it is the responsibility of program managers and site managers to work with their VPs to locate funds for new priorities within their portfolios - this function is not formally led through a centralized process. – Although Finance reports that this process works well, several stakeholders reported challenges in achieving change in their portfolios. – The region also runs new priorities in addition to base budgeting, for which an accumulated deficit of $5.6M existed as of March 2006. – The budgeting process was further echoed as a challenge by the Associate Partners, who also report challenges in the timeliness of their funding from the region. From a regional perspective, Associate Partners are funded globally. Unused budget is not pulled back from the Associate Partners, but because there is no service level agreement in place, this is difficult to track or examine for impact on service delivery. • Stakeholders report that the Meditech implementation has necessitated additional staff for the payroll function and role changes. Responsibilities of site staff and ECH finance staff are in transition. • With all ECH and Associate Partner sites now on the Meditech platform for financials, and QHR for payroll, however, there may be opportunity to consolidate some transactional activities.

Corporate and Support Services
Finance

Opportunities	Findings
3. Improve integration of financial and statistical data for reporting and analysis with the Associate Partners, supported by defined reporting requirements that align to service level agreements between ECH and the Partners. 4. Given staffing investment opportunity, explore the development of a common Decision Support function for the region and Associate Partners, supported by technology, with a focus on improving site-level management analysis support.	• The region has identified the need for decision support for the sites to have improved analysis and management capabilities. – This has been reduced over the past year due to the staffing support required for the Meditech implementation. – Further, the region relies primarily on Excel-based analyses, as it is still working on refinements to the Meditech implementation for reporting and analysis. – The region's Finance function has a low skill mix, with the CFO as the only CA to provide professional direction. • Consultation findings indicate that the region struggles with the integration of information from the Associate Partners into regional systems, that it must rely on several assumptions on how to allocation information, and that it may be missing some statistical data. • Staffing comparison finds that ECH has an investment opportunity in Finance.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Finance	21.7	0.12	0.12	0.22	0.14	3.0

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services
Human Resources

Opportunities	Findings
1. Integrate ECH and Associate Partner HR and OH&S functions, supported by identified staffing investment, and aligned to broader regional re-focus on HR strategy and management. • Please refer to Human Resources section for additional opportunities.	• Staffing comparison finds that ECH has a staffing investment opportunity relative to peers at the 50th percentile. This reflects, in part, the existing vacancies within the department. • Consultation findings across the Associate Partners identified limited HR and OH&S support in those organizations, which may be contributing to this investment opportunity. • Please refer to Human Resources section for additional findings.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Human Resources / Personnel and OH&S	13.1	0.07	0.07	0.18	0.12	8.2

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services
Education

Opportunities	Findings
1. Further integrate ECH and Associate Partner Education functions, supported by identified staffing investment. • Please refer to Human Resources section for additional opportunities.	• Staffing comparison finds that ECH has an opportunity for staffing investment relative to peers at the 50th percentile. • This supports consultation findings of challenges in disseminating education on-site across the rural sites, the balance of Program Leads vs. Educators, and the lack of education resources available to the Associate Partners. • Please refer to Human Resources section for additional findings.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Education	3.9	0.02	0.02	0.10	0.08	10.4

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services
Systems Support

Opportunities	Findings
1. Consider staffing investment opportunity in IT, as part of broader regional resource planning for RSHIP and other IT initiatives. • Please refer to Technology section for additional opportunities.	• Staffing comparison finds that ECH has an opportunity for staffing investment relative to peers at the 50th percentile. • This is supported by consultation findings about resource challenges in recent Meditech implementation. • Please refer to Technology section for additional findings.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Systems Support	12.8	0.07	0.07	0.16	0.10	5.0

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services
Materiel Management

Opportunities	Findings
1. Collaborate with Associate Partners to create a single region-wide Materiel Management function. 2. Re-examine the business case for a regional transportation system, with broader consideration of support to Materiel Management, Laundry, Labs, Pharmacy and Food Services distribution, in alignment with facility role review and other identified opportunities for service regionalization. (Relates to region-wide opportunity.)	• Materiel Management is a centralized regional function for ECH that is responsible for purchasing (including capital), supply contracts, receiving. The function also supports purchasing for St. Mary's, and inventory distribution and non-stock purchases for Mundare and Killam. • The region maintains inventory at each of the ECH sites and St. Mary's using a top-up model, with some out-of-region storage for pandemic planning. Considerations are underway for development of off-site storage in Camrose to support service delivery. • Although service delivery integration with the other Associate Partners is limited, contracts, capital, and minor equipment are region-wide. • Further, the region reports a high level of product standardization across ECH and the Associate Partner sites, which is facilitated by an integrated product standardization committee. • Transportation of supplies is mostly completed via drop-ships directly to sites in most cases. There is no regional transportation fleet in place, so the region relies on couriers for ad-hoc shipments.

Corporate and Support Services
Materiel Management (continued)

Opportunities	Findings
3. Re-align CSR into one function with identified clinical leadership, to improve practice standardization and risk management, in alignment with facility role review. (Relates to region-wide opportunity.)	• CSR services are provided at all surgical sites by dedicated staff. Other centres clean dirty equipment on site and send to CSR site for sterilization (equipment sent via courier). • In the majority of sites, CSR is aligned with Materiel Management. At St. Mary's, CSR is aligned with the OR. • Stakeholders report limited cross-site collaboration to ensure consistent standards and practices are maintained. • Consultation also suggests challenges to the service due to a lack of clinical leadership for CSR.
4. Consider staffing investment opportunity in Materiel Management to align with increased ECH and Associate Partner integration, with consideration of CSR re-alignment, and in support of identified regional transportation opportunity.	• Staffing comparison finds that ECH has a staffing investment opportunity in Materiel Management relative to peers at the 50th percentile.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE Effic.)/ Re-Invest.
Materiel Management	35.3	0.20	0.20	0.53	0.25	9.4

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services
Environmental Services

Opportunities	Findings
1. Build on regional progress and collaborate with the Associate Partners to create common region-wide policies and procedures for all areas of Environmental Services. 2. Explore the business case for creating a centralized laundry and linen service for ECH and the Associate Partners, with consideration of the identified regional transportation and distribution system, and aligned to the facility role review.	• Environmental Services includes Housekeeping, Laundry and Plant Operations. These services are managed regionally for ECH sites, with site-based working leaders coordinating with HCCs for daily operations. • The region also provides capital construction project coordination and leadership to all Associate Partners with the exception of Lloydminster and Viking Extendicare. No other Environmental Services are provided to the Associate Partners by the region. • The region reports a good focus on preventative maintenance across the regional sites, but limited similar focus in some Associate Partners (e.g. Lloydminster), which is a capital risk. – Once the new Meditech Environmental Services module is introduced, all sites will be using a common preventative maintenance program, except Lloydminster. • Stakeholders report a good degree of standardization in policies and procedures across Environmental Services in the regional sites. A finalized set of standard policies and procedures are in development, but service standardization is reported to already be in place. • Laundry and Housekeeping staff are cross-trained to provide flexibility in staffing on-site. • For Laundry services, all regional sites do their own separate laundry. There is no regional laundry service, and minimal automation across sites. – Bethany does however provide laundry service to St. Mary's, Killam and Daysland, as a revenue-generating service. – Lamont does laundry processing for other sites outside of ECH, and reports additional capacity to increase production

Corporate and Support Services
Environmental Services

Opportunities	Findings
3. Develop a business case to examine benefits of investment in energy management plan, with consideration of identified facility role review.	• The region has developed an energy management plan across sites, but has faced challenges in funding the plan. • Improved energy management across regional and Associate Partner sites could result in potential savings, as observed in other organizations.
4. Continue to develop policies and procedures for isolation room cleaning communication, with a focus on addressing potential privacy issues.	• Stakeholder consultations report that communication between Housekeeping and Nursing is improving about isolation room cleaning. • However, continued challenges persist when Housekeeping is not informed of what they are cleaning due to privacy concerns for patients and staff living in smaller communities.
5. Explore options to implement technology-based solutions to provide added security to regional acute care sites, in alignment with regional ER strategy.	• Consultation findings across the regional acute care sites identified concerns about the lack of on-site security, and a reported growing number of incidents. • Although on-site security may not be feasible in many sites, alternative technology-based security solutions exist that may provide the identified need for support to staff for facilities with active Emergency Departments providing 24/7 service.

Corporate and Support Services
Environmental Services

Opportunities	Findings
6. As part of regional HR planning, develop a targeted Environmental Services recruitment and retention plan, with consideration of identified staffing investments.	• Consultation findings identified concern on the ability of the region to compete with the oil and construction industries for the retention of Environmental Services staff. • This is especially a concern for skilled plant operations trade staff. • Analysis of salary premium drivers found high over time in Plant Operations, although this improved since 2004-05, and high sick time was found in Laundry and Housekeeping, which increased since 2004-05. –These challenges were echoed in consultation, which raised a concern about potential staff burnout across Environmental Services. • Staffing comparison finds that ECH has opportunity for investment across Environmental Services. This may, in part, reflect the purposeful reduction in staff by the region as part of the shift from a traditional LTC model to DSH-based service delivery.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Housekeeping	108.0	0.60	0.55	0.75	0.64	6.9
Laundry	32.1	0.18	0.15	0.27	0.20	4.1
Plant Ops/Maintenance and Biomedical Engineering Combined	57.7	0.32	0.29	0.41	0.33	0.9

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services
Health Records, Patient Registration and Telecommunications Combined

Opportunities	Findings
1. Build on regional progress and collaborate with the Associate Partners to create common region-wide policies and procedures for Health Information, Privacy and Patient Registration. 2. Lever implementation of Vianetta digital transcription system to create a region-wide transcription service for ECH and the Associate Partners.	• Health Information and Patient Registration are aligned with IT and are managed as a regional service for the ECH sites, which is reported as an effective model by stakeholders. – There is limited service coordination with the Associate Partners, some of whom have these two functions operated separately. – This is a challenge in areas such as privacy, where the fragmentation of privacy policy and procedures is a risk to the region. • The region has established common policies, procedures and standards, which are reviewed through monthly cross-site meetings. These standards are communicated to the Associate Partners, and are adopted in-part, but there is no formal mechanism to consistently drive common practice. The Associate Partners do, however, participate in regional audits. • Some sites experience backlog of coding, but the region has established a process to distribute backlogged charts to other sites for completion, which is reported as effective. • Delays in MD sign-off of up to 2 months are reported as a challenge, but this is managed at a site level where HCCs have the ability to suspend privileges when required. • The region is currently in the process of implementing regional transcription, in alignment with Vianetta implementation, which is targeted for completion by Spring 2007. – Potential savings are anticipated by consolidating transcription, as this will shift workload from technicians to more cost efficient records clerks. – This will also enable improved collaboration and coordination of transcription resources to shift workload across sites.

Corporate and Support Services

Health Records, Patient Registration and Telecommunications Combined

Opportunities	Findings
3. Consider Health Records staffing investment to increase records purging, to alleviate storage space constraints.	• All chart storage is currently on site, and no off-site has yet been required. Older charts are purged periodically, in alignment with standards. However, stakeholders report that staffing challenges have resulted in minimal recent purging, which is causing some space challenges. • HIM staff are cross-trained to perform privacy and patient registration functions across the regional sites, to provide flexibility in staffing coverage. • Staffing comparison finds that ECH has a small staffing investment opportunity in Health Records, relative to peers at the 50th percentile.

Area Description	Actual FTEs 2005-06	Actual HAPD 2005-06	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Health Rec., Pt. Reg. and Telecom. Combined	79.4	0.44	0.36	0.58	0.45	0.6

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Corporate and Support Services

Patient & Non-Patient Food Services Combined

Opportunities	Findings
1. Develop a business case to explore a regionalized food preparation and distribution model that includes the ECH and Associate Partner sites, with consideration of identified staffing efficiencies. 2. Improve consistency in roles for food service delivery and tray pick-up across the rural sites, where feasible.	• Food Services is a regionally managed service across the ECH sites, where each site has separate primarily non-selective menus and raw food production with limited automation supporting food preparation. • Consultation findings suggest that the region works together with the Associate Partners to achieve common standards and practices. • Regionalized food preparation and distribution has not been explored, in part due to current facilities' ability to support regional food production and transportation costs. Given the region's current capital re-development plans, this could be considered in facility design. • Tray distribution and pick-up are done by both food services staff and nursing – a mix of roles across the region. Although improvements would improve the consistency of service delivery, this can be a challenge to standardize depending on available staffing. • As the region shifts to a DSH model, further mixing of roles with Environmental Services is expected through a multi-skilled role. • Analysis indicates that Food Services had a high rate of sick time in 2005-06, although improvements were observed since 2004-05. • Staffing comparison suggests that ECH has a staffing efficiency opportunity in Food Services, relative to peers at the 50th percentile.

Area Description	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Patient & Non-Pt. Food Services Combined	143.8	0.80	0.48	0.86	0.79	(3.2)

Source: Alberta H&W MIS 2004-05 & 2005-06, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, ECH Payroll Data 2005-06

Operational Trending and Analysis

Operational Trending and Analysis
Introduction

- Through the peer staffing comparison, this review has already explored opportunities for efficiency and effectiveness across approximately 70% of the organization's operational spending.
- Other key drivers of cost to consider include:
  - Sick and Overtime Premium Costs
  - Non-Salary Discretionary Supplies and Sundries
  - Medical/Surgical Supply Costs
  - Drugs and Medical Gas Supply Costs
  - Food Supply Costs
- Further examination of each of these costs will be presented over the following slides.
- In addition, an overall review of where the region is investing its operating dollars across the continuum of care will be presented relative to peers.

Sick Time and Overtime Summary

Service Area	Total FTEs 2005-06	Sick Time % of Total Paid 2004-05	Sick Time % of Total Paid 2005-06	Potential FTE Savings 2005-06
Administration & Support Services	343	3.1%	3.3%	1.7
Nursing	491	3.4%	3.5%	1.3
Allied Health	163	2.6%	2.3%	0.9
Community & Social Services	427	3.2%	3.4%	2.1

Service Area	Total FTEs 2005-06	Overtime % of Total Paid 2004-05	Overtime % of Total Paid 2005-06	Potential $ Savings 2005-06
Administration & Support Services	343	1.0%	0.9%	$22,281
Nursing	491	1.9%	2.1%	$49,084
Allied Health	163	1.2%	1.1%	$9,238
Community & Social Services	427	0.6%	0.5%	$8,603

Source: ECH Payroll 2004-05, 2005-06.

- Sick time rates increased across most areas in ECH from 2004-05 to 2005-06, while overtime decreased across most areas.
- By examining the region's internal sick and overtime averages by service area, opportunities for improvement can be realized by shifting departments to perform at the area-specific sick and overtime averages.
- Analysis suggests a potential for up to 6.0 FTEs in sick time improvement, and slightly over $89,000 in overtime premium cost savings, which would need to be explored within a broader HR framework for change, with consideration of resource availability across the region's sites.

***Note:** Due to information availability, this analysis does not include the Associate Partners.

Non-Salary Discretionary Supplies and Sundries

- An analysis of non-salary discretionary accounts was conducted to identify spending variations as well as to understand the large increase in sundry expenses.
  - Discretionary accounts are identified as those non-salary costs that are not directly related to patient care, and over which management is able to exert a degree of control.
- Overall, non-salary discretionary costs increased by over $1.25 million, or 16%, between 2003-04 and 2005-06.
  - The main drivers of the increase include Professional Fees, Staff Travel, and Human Resources Fees.
- Although not shown here, it also important to note several other non-salary cost drivers in the region:
  - The cost for patient ambulance transport has increased by over $380,000 (29%) since 2003-04.
  - The cost of physician travel has increased by over $245,000 since 2003-04.
  - The region has achieved over $488,000 in savings related to utility costs, primarily through electricity costs reduction.

Account	2003-04	2004-05	2005-06	Variance 2003-04 to 2005-06
Professional Fees	$277,533	$362,222	$430,502	55%
Staff Travel and Vehicle Allowance	$1,238,174	$1,562,494	$1,790,436	45%
Data Line Private Access	$130,577	$138,242	$274,858	110%
Human Resources Fees (Recruiting, Staff Development & Memberships)	$270,492	$374,836	$505,582	87%
Sub-Total	$1,916,776	$2,437,794	$3,001,378	57%
Other Accounts	$6,016,181	$5,818,825	$6,189,710	3%
Total	$7,932,957	$8,256,619	$9,191,088	16%

Source: ECH General Ledger 2003-04, 2004-05, 2005-06. Note – due to information availability, this does not include the Associate Partners.

Med/Surg, Drugs and Food Supply Costs

- Medical/Surgical, Drugs and Food Supply expenses were examined relative to adjusted patient days for ECH and other rural RHAs in Alberta.
- In comparison to Alberta peers, ECH was found to have the lowest Medical/Surgical Supplies and Drugs and Medical Gases Expenses per APD, respectively, in 2004-05.
- For Food and Dietary Supplies, ECH was found to have the second lowest cost/APD among the rural Alberta RHAs.

Supply Costs as a % of Total Expenses	2004-05 Actual Expenses	2004-05 Expense/APD	Alberta Peers Expense/APD MIN	Alberta Peers Expense/APD MAX
Medical/Surgical Supplies	$1,424,057	$3.94	$3.94	$25.14
Drugs and Medical Gases	$1,588,552	$4.40	$4.40	$19.80
Food and Dietary Supplies	$1,824,090	$5.05	$4.53	$12.76

Source: AHW MIS for 2004-05, RHA-Provided GL Data for 2005-06

Financial Profile Across the Care Continuum

- A financial profile of ECH relative to other regions in Alberta is presented below, which examines the % of total expenses currently being allocated across different dimensions of the organization.
- As observed through this analysis, ECH has the highest % of total operating expenses in its Residential Nursing Services and Community Health Services.
  - This is likely reflective of the fact that ECH does not have a regional hospital, as do many of the other Alberta RHAs.
  - This finding is further supported by the observation that ECH has the highest proportion of long term care days relative to acute care days.
- Conversely, ECH is currently spending the lowest % of total operating expenses on Emergency, Day and Ambulatory Services, and is the second lowest among peers with respect to Acute Nursing spending as a % of total expenses. These findings are also likely reflective of the fact that ECH does not have a regional hospital, as do the majority of other RHAs compared in this analysis.
- Findings that ECH has the lowest % of total operating expenses in Allied Health, are also supported by the staffing comparison analysis, which identified several opportunities for investment in these areas.

Components of Regional Operational Expenses	2005-06 % of Total Expenses	Alberta Peers % of Total Operating Expenses MIN	Alberta Peers % of Total Operating Expenses MAX
Corporate Services	7.5%	6.3%	12.4%
Support Services	19.5%	12.6%	22.2%
Acute Nursing	17.8%	14.9%	26.4%
Residential Nursing	18.2%	4.6%	18.2%
Emergency, Day and Ambulatory Services	4.4%	4.4%	8.2%
Telehealth	0.0%	0.0%	0.3%
Clinical Support and Allied Health	13.8%	13.8%	17.9%
Community Health Services	15.9%	10.1%	15.9%
Marketed Services	0.2%	-0.1%	13.7%
Undistributed	2.6%	0.0%	5.6%

Source: AHW MIS for 2004-05, RHA-Provided GL Data for 2005-06

Deloitte.

Human Resources Strategy and Management

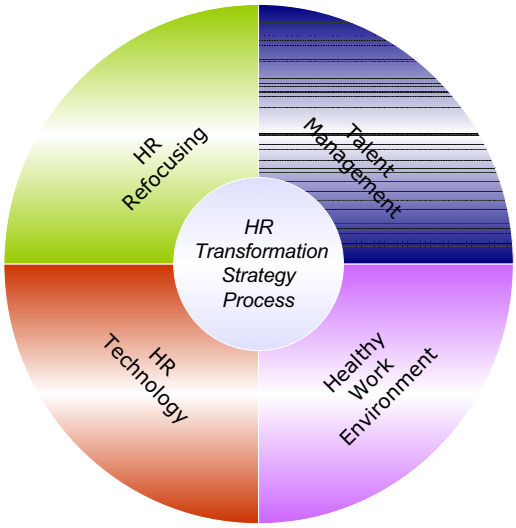
Human Resources Strategy and Management
Overview

- Talented people – or shortage of talented people – can make or break any organization's strategy. In the past, the health care service sector has not provided sufficient focus on people and talent issues. Our people plans – including hire strategy and / or workforce deployment were tactical issues to be addressed once the business strategy was finalized.
- This approach can no longer stand up to the growing and increasingly complex demands of the health care workforce. In light of huge resource scarcity, what was tactical is now strategic,
- In undertaking this review, Deloitte expected that the Health Regions would share the following common healthcare workforce challenges:
  - Critical shortage of numerous professional and non-professional roles
  - Retention issues as staff leave health care industry for other better paying opportunities
  - Retention issues as staff go to other healthcare organizations for better pay or perceived better role
  - Aging workforce
  - Increased casualization of the workforce
  - Reliance on foreign graduates and the corresponding need for higher level of organizational support for these individuals
  - Need for incentives to recruit and retain
  - Restrictive labour contracts and requirements
- Our goal was to assess the extent to which the Region understands these issues and has developed strategy to respond. Specifically, we are looking to see the degree to which the Human Resource Strategy and roles are well positioned to support the growing complex world of people management.

Human Resources Strategy and Management
Overview

- Our findings are based on a review of relevant documentation and consultation, and have been used to identify broader people management opportunities for consideration. Our reporting and opportunity identification follows a four part framework:

- ***Human Resources Re-focus*** – efforts to enhance HR capacity and capability to support and align to service and management priorities of the Region.
- ***Talent Management*** – the integration of processes, programs, technologies and staff to Develop, Deploy and Connect the workforce.
  - Develop – builds individuals' capabilities as required by organization – either currently or for the future.
  - Deploy – ensures candidates are attracted, and recruited to roles and that recruitment is well aligned to strategic and operational needs.
  - Connect – cultivates high quality work relationships and culture that fosters engagement, productivity and innovation.
- ***Human Resources Technology –*** focuses on the extent to which technology supports the HR capacity and consistency in practice across Region.
- ***Healthy Work Environment*** – encompasses the physical and psychosocial work environment. Healthy work environment practices exist where culture and practices converge to create improvements for staff that cascade to the patient and community level.



Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
HR Refocusing	
1. Develop a single health human resources plan for ECH and the Associate Partners that aligns health human resources needs and priorities to regional strategic objectives, and which addresses ongoing site sustainability. 2. Explore the creation of a single Human Resources function for ECH and the Associate Partners to integrate service delivery and lever increased capacity required to establish HR as a strategic partner.	• Human Resources functions and services are separate across the region and Associate Partners, except for Killam. Although some coordination occurs on an ad-hoc basis, this has resulted in a fragmented region-wide perspective on health human resources. • Due to reported staff shortage, Human Resources has focused primarily on maintaining transactional workload in the past year, and has not been able to drive strategic initiatives. • The region is lacking a dedicated HR plan that aligns health human resource needs and priorities to the strategic objectives and health services planning. • Physician human resources are currently managed under the VP Medical, with limited support or focus. • The region has not yet developed a health human resources plan that addresses the shortages of key resources (e.g. MDs, RNs, Pharmacists, etc.) relative to the sustainability of the current regional site and service delivery configuration.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
Talent Management	
1. Consolidate HHR recruitment and retention across the region and Associate Partners, to achieve common practice, build capacity, and ensure consistent alignment to HHR priorities. 2. Build on existing education planning to integrate Associate Partners, which aligns to regional priorities. (Relates to earlier region-wide opportunity.)	• The region reports a strong recruitment and retention focus on nursing resources through the use of a supernumerary program for new RN grads. This program is in place only at the regional sites. • Consultation findings suggest that Unit/Site managers are often engaged in recruitment activities in isolation of regional supports, however. • Although there is some collaboration across the region and Associate Partners across services at the operational level, this has in part been driven through the recent Meditech implementation or other ad-hoc needs vs. a concerted effort to create common culture across the region. – Further, although the region has invested in clinical education and internship programs, these have not been fully extended to or embraced by the Associate Partners, which impacts the ability to share best practice, deliver consistent standards of care, and support region-wide recruitment and retention initiatives. – Stakeholders report additional risk to the region through management burnout and a lack of attractiveness of management roles for staff.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
HR Technology	
1. Increase use of telehealth technology to expand clinical education availability and frequency across the sites. 2. Examine technology options to support education delivery and coordination to improve potential for staff attendance.	• Consultation findings indicated challenges in organizing and delivering clinical education sessions, due to geographic challenges. • Although telehealth is used in some capacity for education, stakeholders report several cancellations due to last-minute travel/geography and staff shortage related challenges.
3. Implement management training on QHR functionality to leverage HR management at the regional and site levels.	• The region has implemented QHR for payroll and staff scheduling across ECH and the Associate Partners. • Currently, the staff scheduling functionality is not in use, and so the potential benefits of technology to support staff scheduling and contract management for premium technology in support hours have not been achieved.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
Healthy Work Environment	
1. As part of regional HR planning, develop a strategy to achieve a common regional culture that connects management, staff and physicians across the region and Associate Partners.	• The region has implemented a Health Living initiative supported through federal funding that is reported to be successfully building on corporate culture of pride in work in the region. • Stakeholder consultation suggests that although there is some collaboration, much of the management, staff and physician cultures are also divided across ECH and the Associate Partners.
2. Develop a coordinated OH&S function across the region and Associate Partners, to create common standards, share best practices, and improve regional risk management.	• OH&S is reported as being well supported by the region, and regional stakeholders report good satisfaction with initiatives. • Although some coordination exists with the Associate Partners, a consistent coordinated approach to creating a healthy work environment and mitigating workplace safety risks across the region is not in place, which is a potential risk to the region and HHR.

Regional Infrastructure Alignment
Introduction

- Our review of regional infrastructure is intended as a high level assessment of how well infrastructure is aligned to support operations.
- Where there are opportunities for improvement to infrastructure, these opportunities will be identified for the region's consideration.
- The review has focused on the key high level opportunities across two dimensions of regional infrastructure, with findings and opportunities based on consultation, document review and related analysis:

Facilities and Equipment

Facilities and Equipment
Regional Acute Facilities

- High-level consultation findings, on-site observations, and analysis of available Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
1. Re-evaluate regional capital planning for facilities to align to identified facility role review.	• The region's long-term capital plan identifies a number of planned renovations and redevelopments across its acute care facilities. • Many of these suggested plans are well-founded based on the current operating conditions of the sites. For example, there is a need for facilities redevelopment at Wainwright that has resulted in the region starting to pursue master functional planning, due to: – Old site with design layout issues – Very poorly configured ER → no triage or waiting space • Given the challenges that have been identified in the potential sustainability of the current facility role configuration in the region, capital planning should be re-aligned to a community health needs assessment and the region's health services plan.

Facilities and Equipment
Regional Emergency Departments

- High-level consultation findings, on-site observations, and analysis of available Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
2. As part of regional ER strategy, assess the need for regional ER facilities/space redevelopment across sites.	• ER facilities infrastructure design is a challenge, and space across several sites (e.g. Two Hills) do not meet CTAS standards, for example: – Patient registers before being triaged across several sites. – Poor visibility between ER triage and waiting room • Examples of sites that require a review and decision on ER space re-configuration include Wainwright, however this should be conducted in alignment with the previously identified regional ER strategy. – As noted previously, the region is currently conducting a master functional planning exercise at Wainwright that will examine the ER facilities needs.

Facilities and Equipment
Regional Labs

- High-level consultation findings, on-site observations, and analysis of available Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
3. Examine lab space and utilization as part of regional facility role review, with consideration of lab service consolidation.	• Lab space across several sites is limited, and impacts workflow and efficiency. • Key sites where challenges exist include: – Wainwright – Vermillion – Viking (lab renovations planned). • Other labs in the region have additional capacity (e.g. St. Mary's), which could be used to leverage broader regional lab service coordination.

Facilities and Equipment
Regional Diagnostic Imaging

- High-level consultation findings, on-site observations, and analysis of available Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
4. Explore consolidation of DI services to support ongoing service sustainability and avoid future capital costs, in alignment with facility role review.	• The region has made significant investment over the past few years into DI capital infrastructure, and is in the process of converting several sites from analog X-Ray to CR. • Stakeholders report that DI will continue to face a level of high capital investment over the next 5 years, and that it will also face challenges in DI HHR sustainability. This suggests the need to develop a plan to consolidate DI services in alignment with the previously identified facility role review.

Facilities and Equipment
Regional Pharmacy

- High-level consultation findings, on-site observations, and analysis of available Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
5. Re-examine the optimal placement of Pharmacy technology investments based on clinical service delivery, in alignment with the facility role review.	• The region is currently investigating the acquisition of a PAC-MED machine to supported the use of automated unit dose in regional pharmacy services. • The current manual unit dose service established at Daysland, and stakeholders indicate a continued focus on this site for the new equipment. • Given the regional focus on St. Mary's as a secondary referral centre, however, further consideration on the location of pharmacy technology investments should be made in alignment with the identified facility role review.

Facilities and Equipment
Regional Materiel Management

- High-level consultation findings, on-site observations, and analysis of available Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
6. Continue planning for the new off-site inventory storage to play a broader regional inventory role.	• The region reports that inventory storage space in St. Mary's is at capacity, and insufficient to support the shift of St. Mary's into a regional secondary referral centre role • The region is currently considering the development of increased off-site inventory space within the region. The purpose of this space is currently planned to provide service to regional facilities, as well as storing regional pandemic planning supplies.

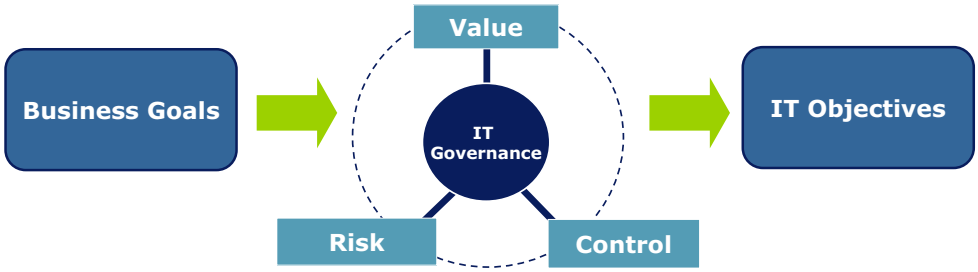
Technology

Leveraging the Value of Information Technology through IT Governance

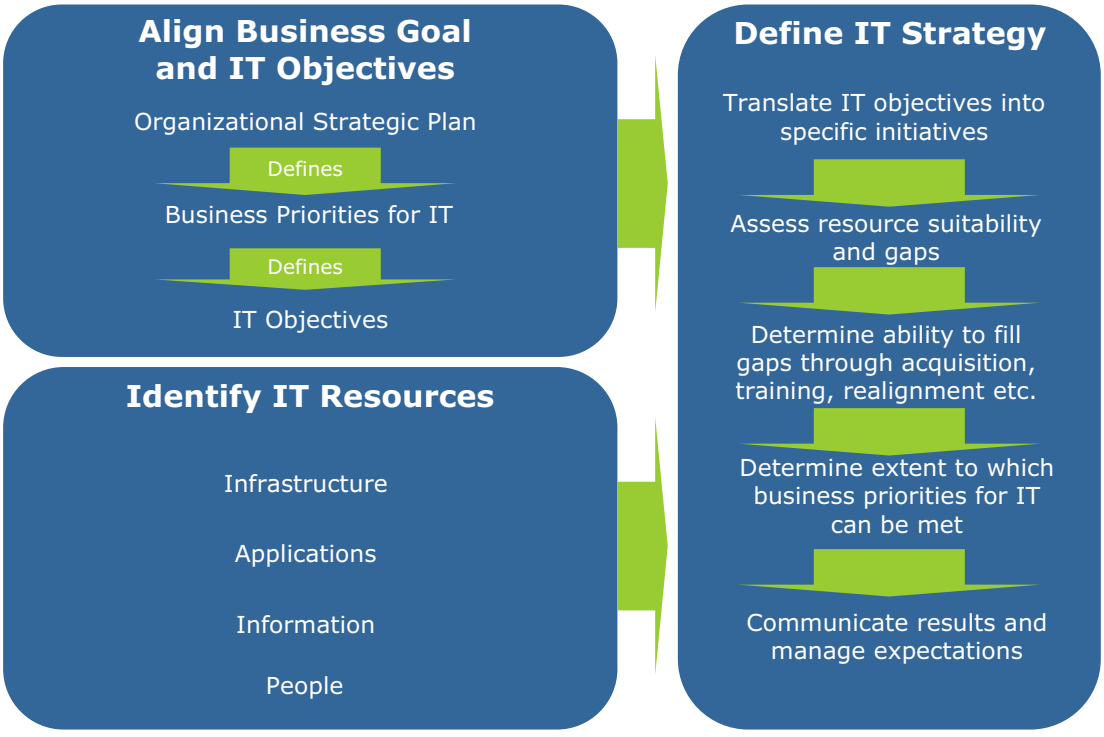
- Information and the Technology that supports it often represent the most valuable but least understood asset in an organization.
- The essential elements of IT governance are to ensure that value is received from spending on technology and then to control and safeguard information.
- The purpose of an IT governance framework is to institutionalize good practices that ensure an organization's IT investment supports business objectives - and involves:
  - ensuring senior management and frontline providers are involved in determining the direction and goals of the IT department
  - evaluation of service delivery from two perspectives, the total cost of technology operations and monitoring of project outcomes
  - ongoing support and maintenance intended to safeguard the value of existing assets and knowledge in the regional facilities.
- Available IT resources, including infrastructure, applications, information and people, should be optimized to support goals.
- Organizations need to satisfy the quality, fiduciary and security requirements of IT information and infrastructure as for all other assets.
- To discharge these responsibilities, as well as to achieve objectives, the status of evolving enterprise architecture must be known.

What is IT Governance?

- IT governance consists of leadership, organizational structures and processes that are designed to support an organization's strategies and objectives to increase stakeholder value.
- Clear responsibility for the direction of IT requirements is necessary to successfully deliver services that support the enterprise's strategy.
- Monitoring success in delivering against business requirements, requires that management put a framework in place to measure achievements against goals.
- IT governance transforms business goals into IT objectives through consideration of value, risk and control.



Determination of IT Activities



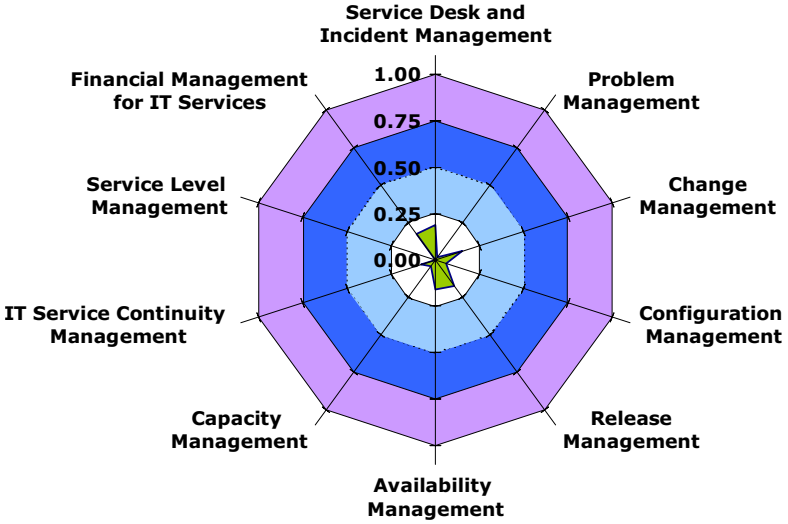
Technology Assessment Overview

- Findings and observations for the technology workstream are intended to identify the degree to which IT investments and resulting initiatives support the goals of the region, and the degree to which they are executed efficiently and effectively.
- The following key documents were reviewed in support of the Technology review for ECH:
  - Profiles – East Central Health Facilities, Programs and Departments
  - IT Surveys – IS Director, IS Staff, IS End Users
  - Consultation Findings
  - Supplementary Documents from IS Department
  - IT Organization Chart
- Information has been summarized in five key focus areas, which are also supported by an overall assessment of IT Service Management:

Technology Categories	Key Questions
Strategic Alignment	• Is the IT strategy aligned to support the business? • Is there a clear understanding of how IT is supporting the RHA's business objectives?
Resource Alignment	• Is the RHA achieving optimum use of its IT resources? • Is the RHA investing in the appropriate IT resources?
Value Delivery	• Does the RHA perceive value from their IT investments? • Is IT delivering the promised benefits?
Risk Management	• Are IT risks understood and being managed?
Quality Management	• Is the quality of IT systems appropriate for business needs? • Is there a framework within which to measure the achievement of IT goals?

Technology Service Management Assessment

- As part of the Technology workstream, regional IT service management was evaluated relative to a 10-part ITIL framework.
- Information for this assessment was based primarily on self-reported data from the region, as well as additional data identified through consultation.
- The diagram below provides a summary of the region's IT service management assessment (highlighted in green). The assessment evaluates the region's performance across 10 key dimensions using a five-point service scale:
  - 0.00: No Service Present
  - 0.25: Reactive
  - 0.50: Proactive
  - 0.75:Service Driven
  - 1.00: Business Driven
- As shown, there are opportunities for the region to improve its approach across all 10 dimensions of IT service management.
- Additional opportunities are identified along the five key areas of focus, on the following slides.



Key Focus Area 1: Strategic Alignment

Leading Practice Attributes	• The organization focuses on ensuring the linkage of business and IT plans; on defining, maintaining and validating the IT value proposition; and on aligning IT operations with enterprise operations.
Deloitte Findings and Observations	• East Central currently does not have an regional IT Strategic Plan in place that aligns IT to business objectives. • The region does however have an RSHIP business plan that incorporates both RSHIP and non-RSHIP IS initiatives, which guides decision-making. • ECH has supported the implementation of Meditech at the Associate Partner sites, which has enabled improved coordination at an operations level, and a common IT system for service delivery. • RSHIP has contracted J.J. Wild to assist the region in developing a 36-month tactical plan which will include implementation of RSHIP phase II, and its integration with other regional and provincial initiatives. The region is awaiting the completion of this plan to build into its own planning. • The region has several IS steering committees to review and recommend appropriate IS proposals from different areas of the region.
Potential Opportunities	1. Development of a targeted regional IT Strategic Plan is suggested to help guide regional IT initiatives and balance RSHIP vs. non-RSHIP priorities in regional resourcing. 2. Ensure the 36-month tactical plan is finished in time for Phase II and that region-specific lessons learned from Phase 1 are incorporated. 3. The new regional 36-month tactical plan should take into account resource allocation, change management, and training concerns raised during Phase I, to ensure a smooth execution of Phase II.

Key Focus Area 2: Resource Alignment

Leading Practice Attributes	• The organization is focused on the optimal investment in, and the proper management of critical IT resources: applications, information, infrastructure and people including the optimization of knowledge and infrastructure.
Deloitte Findings and Observations	• IS resources are centralized in Camrose, and travel to sites as needed. • The IS department provides a tier 1 help desk service for non-RSHIP requests to ECH staff and Associate Partner staff. Change request processes are in place and documented. A partially ITIL-compliant tool is being used to facilitate help desk operations and management. • The region finds it hard to recruit talents, especially those who have Meditech experience. IS talent shortage at both junior and senior levels is reported as a major concern in the region. • The region is specifically concerned about the lack of advanced level resources for Phase II of the RSHIP implementation. • End-users report good satisfaction with the IS department.
Potential Opportunities	1. Continue to expand compliance with ITIL to optimize service delivery and service support. 2. Develop an ECH-specific HR strategy to attract, recruit and retain skilled Meditech IT resources for ongoing implementation. 3. Work with RSHIP and the other non-metro regions to develop a broader resource strategy to support Meditech implementation.

Key Focus Area 2: Resource Alignment (continued)

Leading Practice Attributes	• The organization is focused on the optimal investment in, and the proper management of critical IT resources: applications, information, infrastructure and people including the optimization of knowledge and infrastructure.
Deloitte Findings and Observations	• End-users report challenges in maintaining operations throughout the Meditech implementation. • Some stakeholders reported concern about moving to Phase II too fast, before the impacts of Phase I implementation have been fully integrated. Other stakeholders indicated the need to push forward quickly with Phase II, suggesting a divide in regional planning across the operational areas. • The standardization process of RSHIP is time consuming: all 7 regions have to agree on every add-in or change request raised by one or more of the regions. Some requests are unique to the region that raised them, consequently other regions have difficulties to understand the changes. While this is expected in this type of collaboration, consultations suggest the need to streamline these processes.
Potential Opportunities	4. Conduct a region-wide current state assessment of Phase 1 implementation to determine areas for further improvement and support, before initiating Phase II of the RSHIP implementation. 5. Develop a targeted resource allocation strategy that aligns appropriate IT and operational resources to the 36-month tactical plan for RSHIP Phase II. 6. Collaborate with RSHIP and the other non-metro regions to review, standardize and streamline processes to implement changes to the Meditech modules currently implemented.

Key Focus Area 3: Value Delivery

Leading Practice Attributes	• The organization executes the value proposition throughout the delivery cycle, ensuring that IT delivers the promised benefits against the strategy, concentrating on optimising costs and proving the intrinsic value of IT.
Deloitte Findings and Observations (continued on next page)	• Business users report good involvement in the Meditech implementation, and are seeing value from their involvement. This involvement has increased confidence in achieving value upon full roll-out, and has increased partnering with the Associate Partners. • Although a good level of satisfaction was reported by end-users on the training support through the Meditech implementation, some concern was raised that the trainers had limited Meditech experience. • Several operational areas reported challenges in how Meditech is able to support their areas (e.g. reporting functionality, clinical decision support, inventory management), however, which suggests opportunities for improvement. • Stakeholders focus was primarily on Meditech, with limited focus on other systems or IT initiatives. • An overall benefits framework is lacking for the RSHIP implementation in East Central. • Although business users are engaged in the implementation, and are involved to ensure that the system meets business needs and promotes standardization across regions, where possible, this activity has not resulted in the identification of specific benefits that are expected post-implementation.

Key Focus Area 3: Value Delivery (continued)

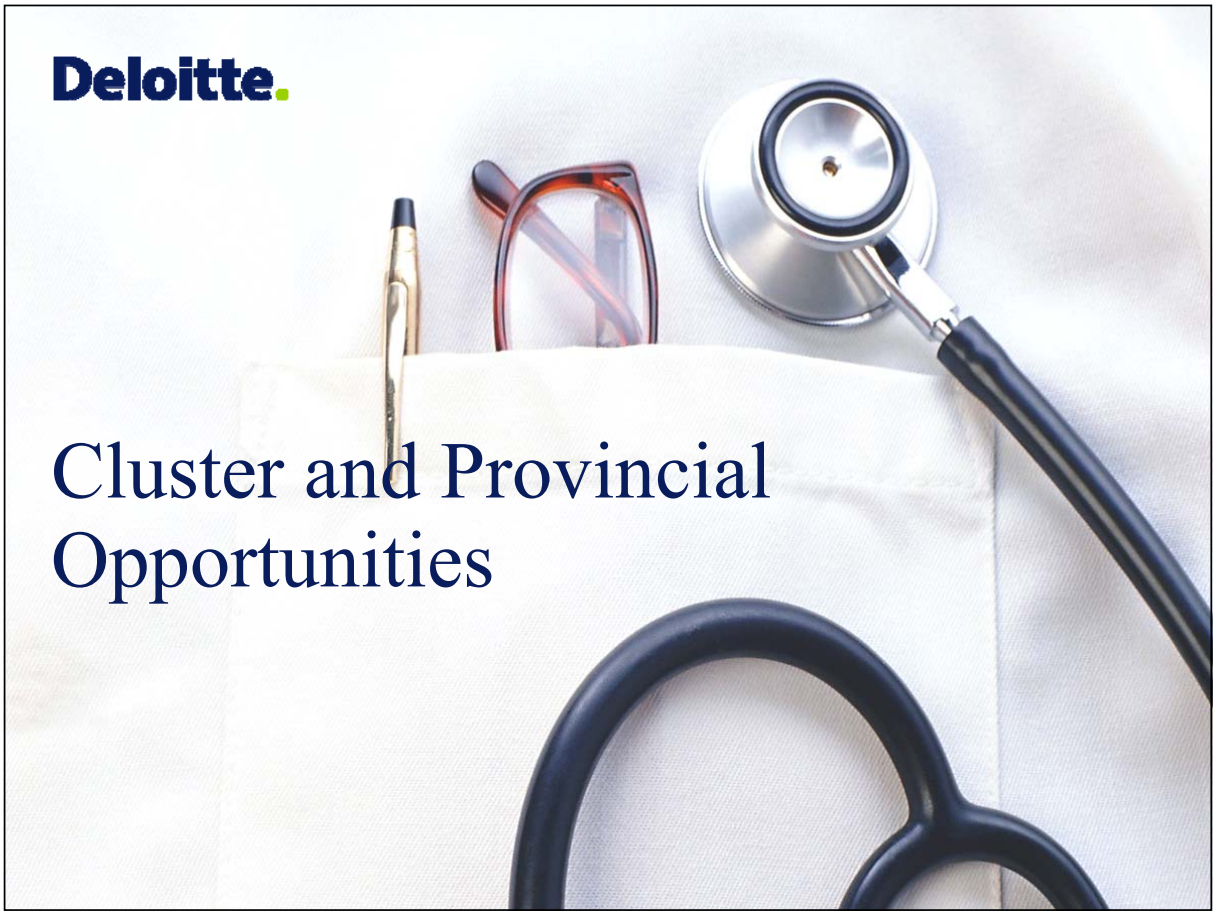
Leading Practice Attributes	• The organization executes the value proposition throughout the delivery cycle, ensuring that IT delivers the promised benefits against the strategy, concentrating on optimising costs and proving the intrinsic value of IT.
Deloitte Findings and Observations	• Consultation with end-users supports this observation, where the majority of business users did not identify specific expectations with regards to improved efficiency or effectiveness to department operations post-implementation. • As such the region has opportunity to identify expected qualitative and quantitative benefits for each key department with respect to expected efficiency and effectiveness, and then monitor expected benefits for realization.
Potential Opportunities	1. Explore options to increase communication and stakeholder awareness of non-RSHIP IT initiatives, in alignment with regional priorities. 2. Establish a benefits realization framework that identifies, promotes, monitors and assesses benefits realization for each key department as the new Meditech system is implemented, rather than focusing on future functionality. 3. Pilot and refine the benefits realization framework by using it to assess the impact of Phase I implementation, before Phase II implementation begins.

Key Focus Area 4: Risk Management

Leading Practice Attributes	• The organization requires risk awareness by senior corporate officers, a clear understanding of the enterprise's appetite for risk, understanding of compliance requirements, transparency about the significant risks to the enterprise, and embedding of risk management responsibilities into the organization.
Deloitte Findings and Observations	• Processes to control user access, and policies about security and privacy are in place. • The region also has some infrastructure in place to support risk management – such as off-site tape backup capacity – but does not have a disaster recovery strategy • Further, the region has a tactical business continuity plan for the Meditech system, but does not have a broader regional business continuity strategy. • There is a noted risk of IS knowledge gap for the Region, especially the recent departure of the IS Director and recent arrival of new IS management staff, which is impacting both IT operations and development activities. • Stakeholders report challenges in IT resourcing to support initiatives. This is a risk to continuing the current pace of implementation while also maintaining operations and clinical service delivery. • Further, the challenges reported by end-users related to Meditech implementation workload suggest a potential risk to the organization's ability to balance implementation with ongoing operations. • The organization is refreshing its corporate risk management framework, which may address some of these risk areas.
Potential Opportunities	1. Develop and implement operational resource requirements aligned to an IT risk management framework for both IT and end-users in the Region. 2. Develop a regional disaster recovery strategy. 3. Develop a regional business continuity strategy.

Key Focus Area 5: Quality Management

Leading Practice Attributes	• The organization utilizes a system of performance measurement to track and monitor strategy implementation, project completion, resource usage, process performance and service delivery, using, for example, balanced scorecards that translate strategy into action to achieve goals measurable beyond conventional accounting.
Deloitte Findings and Observations	• IS department maintains a User Acceptance Test strategy that contains detailed instructions and workflows. • SLAs exist in the contracts signed between the Region and RSHIP, and between the Region and Associate Partners. • Although other quality management mechanisms are in place, consultations suggest that quality controls are not routinely followed. • Help desk is monitoring user satisfaction by user surveys. Consultation findings suggest that users tend to go around help desk and contact RSHIP directly for some Meditech requests, and so may not understand the tiered-level of support across the region, RSHIP and Meditech.
Potential Opportunities	1. Continue to standardize quality management mechanisms, with increased focus on ongoing quality control monitoring. 2. Consider consolidating the help desk contact point for end-users, to facilitate quality control and management of help desk service, supported by clear communication to stakeholders about help desk contact processes.



Cluster/Provincial Opportunities
Introduction

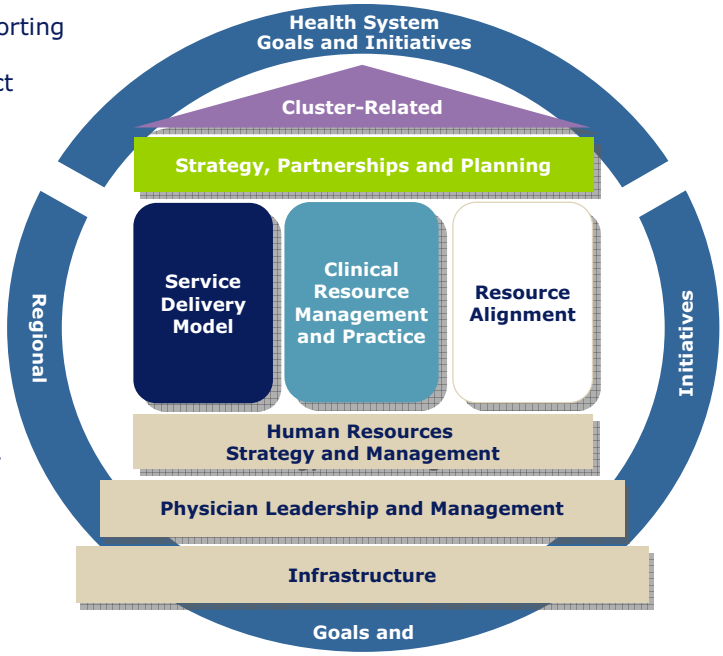
- Having reviewed the seven non-metro regional health authorities, we have identified opportunities that are common across the seven regions.
- We have identified common opportunities as 'Cluster/Provincial Opportunities', and they are based on of the following three criteria:

  - Where the opportunity requires a *solution larger than 1 Region's capacity* (as it may require cross-region collaboration, provincial collaboration or investment).
  - Where a *cross region collaboration* and solution development will *deliver greater value (either qualitative or quantitative)* than if pursued by 1 Region independently.
  - Where individual regions are *without the current resources or talent* and/or will have challenge attracting and recruiting individuals or securing resources independently.

- Opportunities identified in the Cluster 1 Review that we feel are specific to the first three regional reviews (Cluster 1), and not common across Cluster 2, are not included in this report.

Cluster/Provincial Opportunities
Reporting Framework

- Cluster/Provincial Opportunities are presented across seven key areas of reporting, which fit within the broader context of health system and regional goals and initiatives.
- This builds on the previous reporting framework, and separately highlights two additional distinct areas of reporting, given their importance in health service planning and delivery:
  - Health Human Resources Strategy and Management
  - Physician Leadership and Management
- It should be noted that AHW has not yet decided which of the Cluster/Provincial opportunities identified in this report will be acted on, or their related timing.



Cluster/Provincial Opportunities
Strategy, Partnerships and Planning

I. Establish a mandated regular community health needs assessment process for RHAs, which is aligned to health service planning, budgeting and reporting with AHW.

II. Develop a transparent and reproducible process for determining service delivery models, care requirements, facility roles, etc., for rural sites, with consideration of community health needs assessments.
    a. Supporting this, conduct a community economic impact review to determine feasibility and strategies around facility-based health services contraction in the non-metro RHAs.

III. Develop a provincial health services plan that is linked to the regional community health needs assessments and community economic impact review.
    a. As part of this plan, establish clinical utilization guidelines that use population based planning principles, are aligned to a clinical program model, and which are linked to health and system outcomes to determine appropriateness and feasibility of specialty service deployment across the province.

IV. Review RHA accountability model and planning frameworks to align to the provincial health services plan and regional community health needs assessments, supported by a validation process that matches planning and accountability to targeted system outcomes.

V. Re-examine the governance structure and relationships between regional boards and faith-based institutions with the view to improve transparency, strengthen accountability and ultimately ensure service rationalization and efficiency.

Cluster/Provincial Opportunities
Strategy, Partnerships and Planning (continued)

VI. Increase collaboration between AHW and FNIHB to define health service planning and delivery roles and responsibilities for First Nations within Alberta.
    a. A provincial task force made up of representatives from FNIHB, AHW, RHA and the First Nations Band Councils should be established.
    b. A provincial assessment of First Nations health care needs and expected impact on RHAs should be conducted.

VII. Develop and implement education and awareness strategies on risk, quality, rural health service delivery, and efficiency/site rationalization that is targeted to:
    a. MLA's
    b. Local communities and broad public

VIII. Increase attention and effort to creating board awareness and education on regional and individual responsibilities and liabilities.

Cluster/Provincial Opportunities

Service Delivery Model

I. Standardize trauma management, First Responders and EMS protocols as priority areas for provincial focus, given that pre-hospital care is varied across the province and represents significant area of risk.

II. Develop a province-wide formal rural triage strategy to implement CTAS standards, with consideration of related investments in capital, staffing and training required.

III. Standardize regional approaches to self vs. regional pay for service related to Home Parenteral Therapy – as this is one of the drivers of increased non-urgent volumes in regional Emergency Departments.

IV. Re-evaluate the provincial Mental Health strategy with the view to examining the roles of AMHB, the provincial mental health facilities, AADAC, Social and Housing Services, and their regional role in service delivery.

V. Develop provincial standardized criteria and processes to determine resident qualification for DAL, DSL and Long Term Care. Establish funding guidelines and develop a strategy around sustainable resourcing of community living and outcome measurement.

VI. Establish a provincial public health mechanism and/or agency with the view to developing/expanding common standards, programs and resources to support service delivery across regions.

VII. Establish provincial standards for Environmental Health to manage growing risks related to population growth, with consideration of the Blue Book and Green Book as key inputs.

   a. Develop a technology strategy for common system to support inspections.

   b. Develop and implement workload measurement and reporting for Environmental Health to enable management decision-making and cross-regional comparisons.

   c. Increase collaboration and partnership with industry to address increasing environmental health workload and associated risks.

Cluster/Provincial Opportunities

Clinical Resource Management and Practice

I. Leverage the Health Canada initiatives targeted at strengthening Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), by establishing an interdisciplinary forum that includes physician, nursing, pharmacy and allied health leadership from across the regions, as a new entity or within existing forums, to enhance the development, awareness, education, implementation of clinical leading practices.

II. Develop strategy to promote expanded clinical application and adoption of Telehealth to respond to growing clinical needs (strategy to include sourcing clinical expertise external to regions to support Telehealth delivery).

III. Adopt a stronger standardized approach to Chronic Disease Management, supported by clinical expertise and links to Telehealth, which can be customized within Regions.

IV. Expand opportunities for interdisciplinary teams of medical and other health professionals in the small centres to train and practice.

V. Establish documentation and coding standards, training and mechanisms to improve health record documentation through regional process and policy changes in order to improve quality of care and coding accuracy, and to decrease risks to patient safety.

Cluster/Provincial Opportunities
Resource Alignment

I. Explore a shared service model for core corporate services as a strategy to enhance effectiveness, avoid cost, and achieve efficiency:
   a. Finance
   b. Decision Support (clinical and administrative)
   c. Human Resources (includes physician issues)
   d. Information Systems and Support
   e. Supply Chain Services

II. Leverage the MDS implementation by developing and implementing systems to measure and manage home care caseload to enable management decision-making and cross-regional comparisons.

III. Develop and implement systems to measure and manage Public Health program and service delivery to enable management decision-making and cross-regional comparisons.

Cluster/Provincial Opportunities
Human Resources Strategy and Management

I. Develop a comprehensive approach to Health Human Resources (HHR) strategy, management and implementation that includes physicians and is focused on:
   a. Workforce/resource gaps, skills management and education;
   b. Alignment/realignment of current resources to core service delivery needs;
   c. Attraction/recruitment/retention of a talent workforce;
   d. Strategies to address casualization of workforces and manage influx of novice staff;
   e. Enhanced business case approach to cost impact analysis related to physician recruitment and service repatriation; and,
   f. Define talent strategy to ensure effective leadership in place (from governance to front line delivery) to support change in complex environment.

II. Collaborate in the development or procurement of leadership and management development and training based on identified need or gaps.

III. Review current agreement language and requirements in the AHW-AMA-RHA Agreement and staffing union labour agreements, which limit the Regions' ability to provide service in an increasingly challenged environment.

Cluster/Provincial Opportunities
Physician Leadership and Management

Our observations and identified opportunities reflect common and emerging physician practice across the country. Where these opportunities are seen as desirable by AHW, the province will have to explore different remuneration models that support and lever physician behaviour and desired change.

I. Review MAC governance structure and mechanisms with specific attention to by-law adherence and alignment to legislative requirements for patient safety, quality and risk.

II. Develop a medical leadership accountability framework and leadership requirements (which includes examining current organizational and reporting structures, and current /potential roles and responsibilities for Chiefs in the management and decision-making process at the site and regional levels).

III. Create a Physician accountability framework with evaluation and quality/risk/performance management tools for Physicians which is integrated into the broader regional performance management framework.

IV. Explore alternative payment models for physicians with the objective to improve resourcing and linkage to care/service delivery model. (As part of this opportunity, explore alternate staffing models in consideration of physician AFP options – e.g., APN/NP model in ER and other primary care models.)

V. Develop a comprehensive Physician Impact Assessment process for physician recruitment related to needs planning and service expansion, linked to HHR strategy.

VI. Conduct a review of the availability and deployment of specialists with rural medicine skills across the non-metro locum pools.

Cluster/Provincial Opportunities
Infrastructure

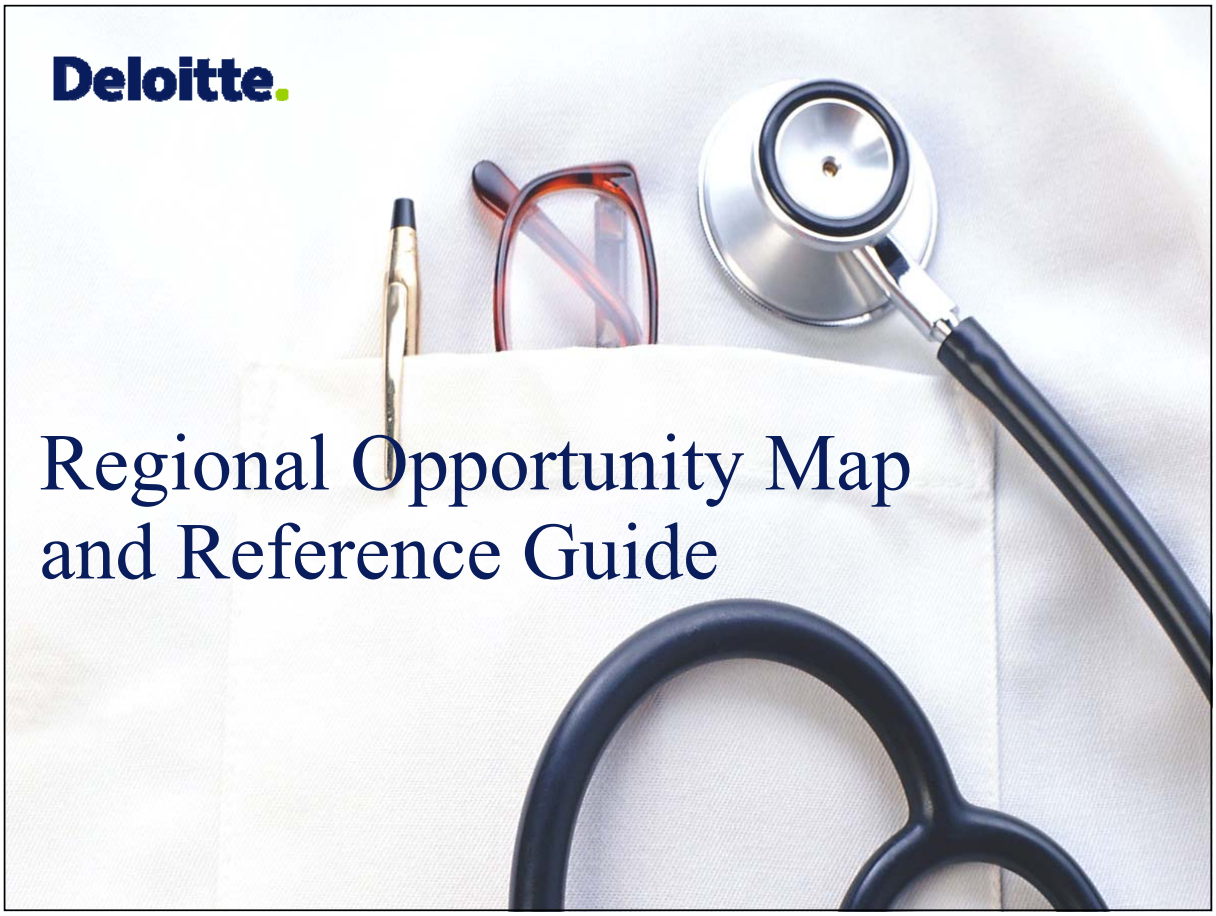
I. Conduct a comprehensive review of the RSHIP Meditech implementation to ensure success and sustainability, with consideration of:
   - Planning
   - Investments
   - Staffing
   - Training
   - Benefits
   - Module Functionality (e.g. Pharmacy, Materiel Management, Clinical Nutrition)
   - Service Levels
   - Ongoing Maintenance and Operations
   - Integration with Physician EMRs and Alignment with Physician Business Plans

II. Develop a benefits realization approach for the RSHIP Meditech implementation to ensure investments are aligned to intended outcomes, at the RSHIP and RHA levels.

III. Enhance broad regional reporting requirements to include ongoing monitoring of IT strategic initiatives, to ensure ongoing alignment of IT to business priorities and objectives.

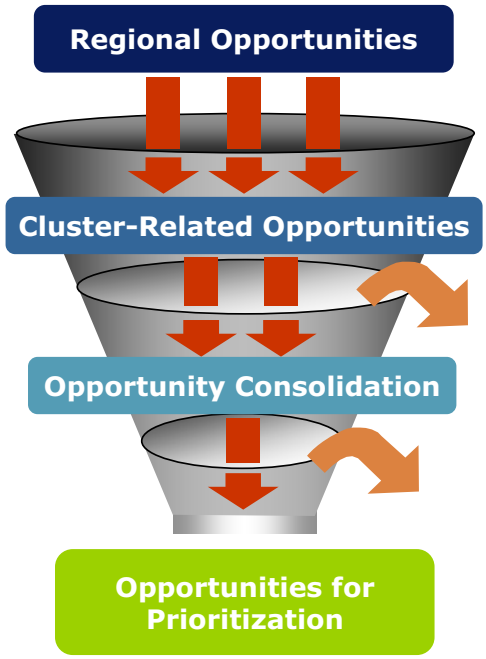
IV. Improve coordination of Alberta Infrastructure, AHW and the RHAs to align facilities capital funding to provincial and regional health services plans and community health needs assessments.

Deloitte.



Regional Opportunity Map and Reference Guide

Regional Opportunity Map and Reference Guide
Introduction

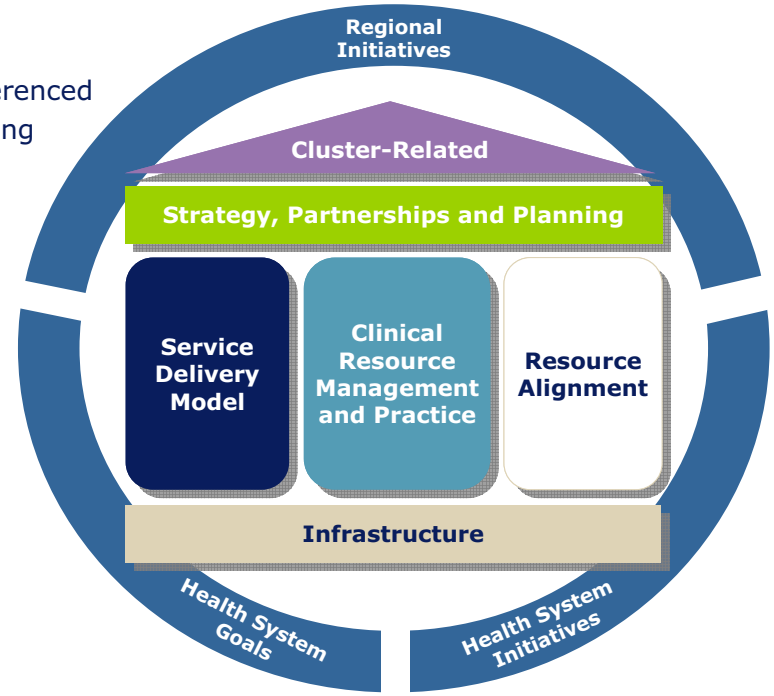


- A reference guide has been developed for the opportunities identified in the region's report.
- Opportunities have been filtered to facilitate discussion.
- **Filter 1:** The overlap of cluster and regional opportunities is one filter.
  - Cluster Opportunities will be driven by a separate process through a collaboration of AHW and the Cluster 2 regions, and so have not been prioritized in the region's opportunity map.
  - Where Cluster and regional opportunities overlap, the cluster-related regional opportunities have been identified in this reference guide, but not included in this prioritization and sequencing process.
- **Filter 2:** Like / related opportunities have been consolidated to facilitate planning and action.
  - Opportunity consolidation is based on inter-dependencies and linkages, which are highlighted in the reference guide.

Regional Opportunity Map and Reference Guide

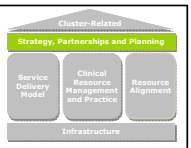
Opportunity Alignment

- To facilitate prioritization, opportunities are aligned across five areas, shown in framework below.
- This framework will be referenced to facilitate an understanding of the different types of opportunities for prioritization.
- Also important will be an understanding of how broader system goals and initiatives, and other regional initiatives impact opportunity prioritization.



Regional Opportunity Map and Reference Guide

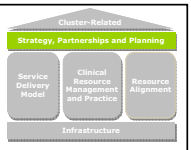
Strategy, Partnerships and Planning



Key Opportunities	Description
Community Health Needs Assessment	• Conduct a community health needs assessment to inform health service planning, future programming and organization priorities for ECH.
Senior Management Team Realignment	• Review senior management organization structure and portfolios, to re-align skill sets with regional priorities and operations, and do so in consideration of Associate Partner linkages.
Associate Partner Service Level Agreements	• Continue the shift to a Service Level Agreement model that supports improved clinical service delivery, programming, management, and accountability with Associate Partners.
Associate Partner Service Level Agreements	• Continue the shift to a Service Level Agreement model that supports improved clinical service delivery, programming, management, and accountability with Associate Partners.
Emergency Services Strategic Plan	• Develop a strategic plan for Emergency Services that reviews: appropriate model for sites (EDs vs. UCCs across the region), links with pre-hospital care programming, and alignment with a community health needs assessment.
CTAS Implementation Plan	• Develop a CTAS implementation plan to formalize the patient triage function at all non-compliant sites in the region, with consideration of both staffing and infrastructure resources required.
Emergency Services Coordination	• Collaborate with community EMS providers to align staffing requirements to availability of hospital-based ER services.

Regional Opportunity Map and Reference Guide

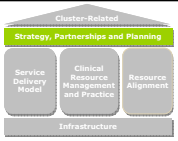
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional Facility Roles, Configuration and Capital Planning	• In alignment with the above community health needs assessment, re-assess the ongoing sustainability of the facilities' current clinical roles and configuration in the region. • Continue plan to create St. Mary's as a secondary referral centre for the region, with clearly defined roles and responsibilities for its part in regional programming, planning and care delivery. • Re-evaluate regional capital planning for facilities to align to facility role review.
Region-Wide Programming, Planning, and Leadership	• Re-align clinical service delivery and organization structure to have common region-wide clinical programming, planning and leadership - achieved through collaboration between the region and Associate Partners. • Re-align clinical organization structure of Director of Acute, HCCs and NCCs to create clinical program leadership that extends across ECH and Associate Partners.
Regional Clinical Service Delivery Strategy	• Establish regional clinical programs and service delivery strategy that integrate ECH and Associate Partner, with defined strategic and operational plans. Align ECH Health Services Plan to community health needs assessment and clinical facility role review.
Primary Care Network (PCN) Review	• Review strategic opportunities for PCN throughout the region and establish a physician lead for the initiative.

Regional Opportunity Map and Reference Guide

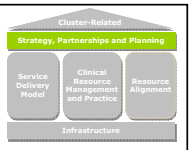
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Interdisciplinary Professional Practice Model and Planning	• Establish an interdisciplinary professional practice model that includes roles, responsibilities, policies and practices governed by an interdisciplinary committee. This should include the development of a strategic nursing plan.
Quality Improvement Management	• Review and align the role of quality initiatives within the region to needs and priorities, with the consideration of establishing reliable funding and processes for moving forward. – Re-focus regional quality teams on a program basis that extend across all ECH and Associate Partner sites. – Re-examine the local quality team structures, with consideration of establishing one local quality improvement team at each site that consolidates the teams and activity across programs, and links into regional program quality initiatives.
Health Human Resources Strategy	• Develop a single health human resources plan for ECH and the Associate Partners that aligns health human resources needs and priorities to regional strategic objectives, and which addresses ongoing site sustainability. Key considerations include: – The shift to region-wide clinical program delivery and site-based resource management. – Engagement and inclusion of physicians in resource planning. – Target key areas, including: DI, Labs, Pharmacy, Personal Care Aides

Regional Opportunity Map and Reference Guide

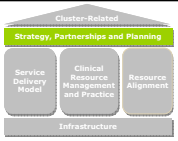
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Integrated Human Resources Function for ECH	• Explore the creation of a single Human Resources function for ECH and the Associate Partners to integrate service delivery and lever increased capacity required to establish HR as a strategic partner.
Consolidated HHR Recruitment and Retention	• Consolidate HHR recruitment and retention across the region and Associate Partners, to achieve common practice, build capacity, and ensure consistent alignment to HHR priorities.
Regional Culture	• As part of regional HR planning, develop a strategy to achieve a common regional culture that connects management, staff and physicians across the region and Associate Partners.
Integrated Education Planning Region-Wide	• Build on existing education planning to integrate Associate Partners, which aligns to regional priorities. • Explore the development of on-site clinical education support for St. Mary's staff, in coordination with regional programs. • Enhance communication across facilities by leveraging Telehealth technology in a structured approach to coordinate service, share leading practice information, CME and professional support.
QHR Training	• Implement management training on QHR functionality to leverage HR management at the regional and site levels.

Regional Opportunity Map and Reference Guide

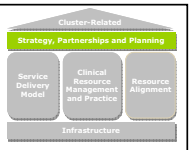
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional CME Approach	• Develop a regional approach and support for CME for both Canadian-trained and foreign-trained medical graduates, based on a sustainable business model, and integrated with the physician recruitment and retention strategy and broader regional education function.
Physician Leadership Structure	• Review medical leadership structure across regional and Associate Partner sites, with the goals of: – Implementing defined roles, relationships, and accountabilities to support a regional approach to medical leadership. – Standardize roles and responsibilities for Chiefs of Staff across region and associate sites. – Consider the potential to create medical program leads.
MAC Terms of Reference and Membership	• Review MAC terms of reference and membership to assess fit with medical leadership needs of the region. Consider functions of recruitment, retention, quality, and credentialing as part of this process.
Physician Leadership Roles and Accountability	• Actively collaborate with St. Mary's Hospital administrative and medical leadership to create clear roles, relationships and accountabilities of medical staff that are centred on improving patient care and management.

Regional Opportunity Map and Reference Guide

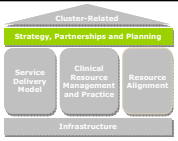
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional Physician Impact Assessment Process	• Develop a consistent regional Physician Impact Assessment process for physician recruitment needs planning, and in assessment when new physicians are being considered.
Physician Accountability Framework	• Create a standardized accountability framework for regional and Associate Partner sites with evaluation and quality/risk/performance management tools for Physicians, which is integrated into the broader regional framework.
Region-Wide Physician Credentialing Process	• Engage physician and administrative leadership from across the region and Associate Partners to create a common physician credentialing process.
Common Regional Medical Leads	• Explore creating common Medical Leads across the ECH and Associate Partner sites, with consideration of the role of St. Mary's as a secondary referral centre.
Review Program Lead Roles	• Re-examine Program Lead roles with consideration of dedicating these roles (full FTE) to education, practice and quality management for respective areas.

Regional Opportunity Map and Reference Guide

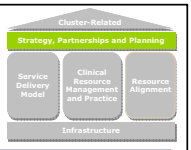
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Staff Education Review	• Undertake a comprehensive staff education review that includes: – Clarifying role of Program Leads and Staff Development in clinical education. – Conducting a formal needs assessment to ensure that educational programs are aligned with staff needs across region and regional service priorities. – Re-examining clinical education resources to determine alignment to program vs. regional needs. – Developing common programming and planning for clinical education across ECH and Associate Partner sites.
Common Regional Finance Functions	• Explore development of common Finance functions across ECH and the Associate Partners, with a focus on transactional activities that will not negate current governance or autonomy.
Budgeting Process	• Review the current budgeting process in the region: – To align budgeting to regional priorities. – To focus on fiscal accountability – To improve funding timing to Associate Partners.
Associate Partner Reporting	• Improve integration of financial and statistical data for reporting and analysis with the Associate Partners, supported by defined reporting requirements that align to service level agreements between ECH and the Partners.
Regional Asset Management	• Formalize asset management processes and tools in coordination with Materiel Management, to better inform capital planning.

Regional Opportunity Map and Reference Guide

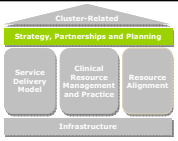
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Health Information, Privacy and Patient Registration Policies	• Build on regional progress and collaborate with the Associate Partners to create common region-wide policies and procedures for Health Information, Privacy and Patient Registration.
Region-Wide Environmental Services Policies and Procedures	• Build on regional progress and collaborate with the Associate Partners to create common region-wide policies and procedures for all areas of Environmental Services.
IT Strategy, Planning, Assessment and Resource Management	• There are several points of IT focus for the region, related to RSHIP (current state assessment, benefits realization, planning and resources), development of a regional IT Strategy, and improvements to IT service management.
Mental Health Strategies and Service Delivery	• Continue mental health planning focus on broader continuum of care, including: – Increase efforts to build community partnerships with key agencies such as AADAC. – Continue collaboration with St. Mary's as part of regional mental health planning, to ensure alignment of inpatient mental health services to regional priorities and community health needs. – Institute a quality improvement program with specific targets and indicators for Mental Health, as part of identified regional quality initiative. – Examine service delivery model, considering expanded use of group work.

Regional Opportunity Map and Reference Guide

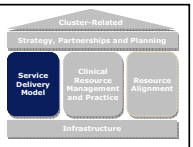
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Short Stay Unit Business Case	• Continue to explore business case for creating a Short Stay Crisis Unit.
Regional Pharmacy and Therapeutics Committee	• Establish a common Pharmacy and Therapeutics committee for all ECH and Associate Partner Sites, and re-visit the need for a parallel Pharmacy Advisory Committee.
Lab Utilization Committee	• Establish a regional Lab Utilization Committee to improve lab utilization, explore new testing models, and standardize lab policies, procedures and practice across the region and Associate Partners.
Outpatient Cardiac Rehab Programming	• Consider expansion of outpatient cardiac rehabilitation programming from a regional perspective, in alignment with a community health needs assessment.
Regional Food Preparation and Distribution	• Develop a business case to explore a regionalized food preparation and distribution model that includes the ECH and Associate Partner sites, with consideration of identified staffing efficiencies.

Regional Opportunity Map and Reference Guide

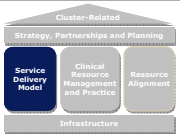
Service Delivery Model



Key Opportunities	Description
CSR Realignment	• Re-align CSR into one function with identified clinical leadership, to improve practice standardization and risk management, in alignment with facility role review.
Specialty Program Alignment to CHNA	• Review delivery of specialty programs across the region to align programming to community health needs assessment, supported by contingency plans where services are single sourced.
Obstetrics Service Delivery and Staffing	• Continue to examine alignment of obstetrics services to community needs, with consideration of site consolidation vs. building additional support for sites currently providing obstetrics services. • Develop common policies, strategy, and minimum MD and volume thresholds for obstetrics. • Explore implementation of LDRP model at St. Mary's, as part of functional programming. • Improve connection with regional obstetrics lead to improve consistency across region.
Prenatal Education Partnerships	• Consider a partnership with Public Health and community health providers to provide regional prenatal education classes.
Well-Women Clinics	• Consider establishing nurse-led well women clinics, where nurses performing pap tests under medical directives or guidelines.

Regional Opportunity Map and Reference Guide

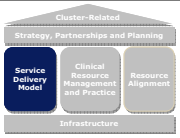
Service Delivery Model (continued)



Key Opportunities	Description
St. Mary's Central Staffing Office	• Explore the development of a central staffing office, supported by staffing float pool at St. Mary's.
Camrose ALC and Palliative Patient Care Management	• Explore options to cohort ALC and Palliative patients for improved care management. • Focus efforts on reducing the number of services and patient populations on the St. Mary's Unit 4, and align staffing model (staff mix) to support new service delivery model.
St. Mary's Surgical Services Management	• Reorganize all St. Mary's surgical services to be under one Manager, to enable streamlined care delivery, policies and planning.
Post-Acute Care Services	• Investigate alternatives to patients waiting in acute care for placement through such options as expanded home care, interim LTC beds, and a first available bed policy.
First Available Bed Policy	• Explore the development of a first-available bed policy or other alternative settings of care for early continuing care placement.
Day Support Program Expansion	• Consider expansion of day support programs and early identification of clients who could benefit from such programs with the goal of avoiding acute care admissions.
Vermillion HC ALC Bed Model	• Consider program focus or ALC bed model (like Daysland) at Vermillion for increased utilization of beds for the region.

Regional Opportunity Map and Reference Guide

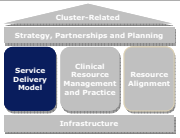
Service Delivery Model (continued)



Key Opportunities	Description
Environmental Health Services Regional Review	• Conduct a regional review of Environmental Health services to align service programming and resources to increasing community health inspections needs and to meet minimum provincial standards.
Environmental Health Special Event Contracting	• Review OT approach in region and consider contracting for special events.
New Inspection Identification Process	• Improve formalized mechanisms with local communities to identify new inspections entities as part of business licensing.
PHI Service Specialization	• Consider a formalized approach to build service specialization expertise as an overlay on current geographic PHI staffing model.
Region-Wide Transcription Service	• Lever implementation of Vianetta digital transcription system to create a region-wide transcription service for ECH and the Associate Partners.

Regional Opportunity Map and Reference Guide

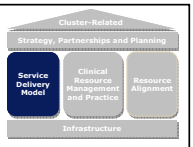
Service Delivery Model (continued)



Key Opportunities	Description
Regional Lab Services Review	• Review the current organization and distribution of lab services in the region, with a focus on streamlining services and space requirements to increase coordination across the region and Associate Partners, and to align lab services with the facility role review.
Point-of-Care Testing Business Case	• Develop a business case to explore the costs and benefits of expanding the use of point-of-care testing.
Lab Cost Analysis and Reductions	• Target reductions in lab costs/procedure to align cost structure to Alberta peers, as part of lab service rationalization across ECH and Associate Partner sites.
Lab Specimen Transportation	• Improve lab specimen transportation (as part of regional distribution system) to support and enable a regional lab model.
DI Modality Utilization Review	• Review DI modality utilization and siting within region to determine an optimal and sustainable configuration that aligns with community health needs assessment and regional health services plan.
Centralized DI Exam Scheduling Business Case	• Explore the business case for centralized exam scheduling across the region and Associate Partners, as part of broader wait list strategies.

Regional Opportunity Map and Reference Guide

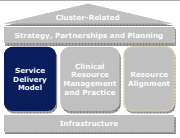
Service Delivery Model (continued)



Key Opportunities	Description
Pharmacy Service Model Review	• Explore models to create a single regional pharmacy service and distribution model that includes ECH and the Associate Partners, and aligns delivery and logistics to the ECH health services plan and facility role review.
Clinical Nutrition Service Integration and Coordination	• Explore further integration with the Associate Partners for Clinical Nutrition service delivery and staffing. • Improve integration of Clinical Nutrition resources across the continuum, to facilitate coordination in care delivery and increase flexibility in staffing recruitment, retention and deployment.
Rural Site Role Consistency in Food Services	• Improve consistency in roles for food service delivery and tray pick-up across the rural sites, where feasible.
Region-Wide Materiel Management Function	• Collaborate with Associate Partners to create a single region-wide Materiel Management function.
Regional Transportation System	• Re-examine the business case for a regional transportation system, with broader consideration of support to Materiel Management, Laundry, Labs, Pharmacy and Food Services distribution, in alignment with facility role review and other identified opportunities for service regionalization.

Regional Opportunity Map and Reference Guide

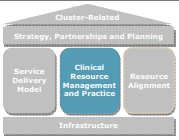
Service Delivery Model (continued)



Key Opportunities	Description
Centralized Laundry and Linen Business Case	• Explore the business case for creating a centralized laundry and linen service for ECH and the Associate Partners, with consideration of the identified regional transportation and distribution system, and aligned to the facility role review.

Regional Opportunity Map and Reference Guide

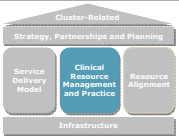
Clinical Resource Management and Practice



Key Opportunities	Description
Region-Wide Infection Control Policies, Procedures and Resourcing	• Continue to develop consistent region-wide infection control policies and procedures, supported by required resources to proactively manage risks and meet APIC staffing standards. • Explore the development of on-site infection control support at St. Mary's, in coordination with regional programs.
Isolation Room Cleaning Policies and Procedures	• Continue to develop policies and procedures for isolation room cleaning communication, with a focus on addressing potential privacy issues.
Length of Stay Management	• Review and redesign the utilization management processes and functions to establish consistency across the region. Review should include the following components: – Admission/discharge criteria – Improve education and awareness of leading practices – Consider adoption of a regional utilization management tool – Current processes and timing of the AAPI assessment, with a focus on minimizing related delays.
Documentation, Coding, and Abstracting Improvements	• Achieve improvements to Regional Documentation, Coding and Abstracting

Regional Opportunity Map and Reference Guide

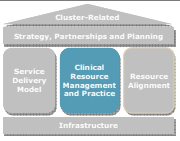
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
Vermillion Discharge Planning	• Explore and implement models of daily multidisciplinary discharge planning meetings at Vermillion.
Medicine Telemetry Practices Review	• Conduct a review of Medicine unit telemetry practices and develop evidence based indications for the initiation and discontinuation of telemetry.
Daysland Admission/ Discharge Criteria and Process	• Consider redefining ALC beds for increased and improved utilization – develop clear criteria for admission/discharge, and generate buy-in across region to no impact on appropriate ALC use. – This should also include a review of discharge and APPI process to improve alignment of care practices to care needs.
Review SAGE Admission/Discharge Process	• Examine admission criteria, discharge management and placement for SAGE to ensure optimal regional utilization, minimize fragmentation of patient care, and support with related education to referring providers.
PAC Policies and Procedures at Wainwright HC	• Continue focus on improved PAC policies and procedures, in alignment with broader regional programming.
MORE OB Training at Wainwright HC	• Continue MOREOB training for nursing staff without training, in alignment with regional obstetrics programming.

Regional Opportunity Map and Reference Guide

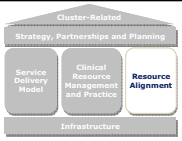
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
St. Mary's PAC and OR Booking Policies	• Develop and implement consistent policies and procedures to address in Pre-Admission Clinic and OR booking.
SMH Unit 5 Interdisciplinary Relationships	• Focus efforts improving interdisciplinary relationships on Unit 5.
Clinical Protocols	• Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management). • Additional focus should be on developing formalized ER clinical protocols that identify roles and responsibilities for MDs and RNs covering the ER, after-hours ER access, enabled by supporting education for staff and community.
Lab Order Set Review	• Review the use of lab order sets, with consideration of establishing pre-set order sets for select clinical protocols.
Region-Wide Formulary	• Develop a single common regional formulary for ECH and Associate Partners to minimize drug costs and improve quality controls.

Regional Opportunity Map and Reference Guide

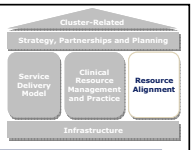
Resource Alignment



Key Opportunities	Description
St. Mary's Medicine Nurse Staffing	• Invest staffing in Unit 2 to bring staffing to peer levels and skill mix.
St. Mary's ER MD and Nurse Staffing	• Invest in ER staffing (1.4 FTEs) and skill mix enhancement to bring to peer levels. • Assign staff to CTAS triage RN during peak periods to improve consistency, etc. • Move to having MD in ER during peak periods for patient safety.
SMH Unit 5 Nurse Staffing	• Target identified staffing reductions for Unit 5 after interdisciplinary relationships are improved, with a focus on improving nursing skill mix.
St. Mary's Surgical Services Throughput	• Consider options to increase service throughput across the surgical services within existing staffing complement.
St. Mary's Mental Health Staffing	• Target staffing reduction (1.1 FTEs) for Unit 3 to align to recommended HPPD.
Rural Site Resource Alignment	• There are several opportunities for resource realignment across the rural sites available for consideration. These opportunities should be explored further in the context of broader regional community health needs, before action is taken.
Sexual Health Clinics	• Consider reallocating resources and offering regularly scheduled sexual health and STD clinics on a drop in basis.

Regional Opportunity Map and Reference Guide

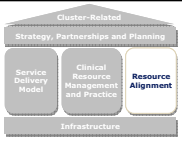
Resource Alignment (continued)



Key Opportunities	Description
DI Staffing Requirements	• Determine staffing requirements for DI once service utilization and siting planning is complete for ECH and Associate Partner sites.
OT/SLP/Audiology Staffing	• Consider staffing investments in Occupational Therapy and SLP/Audiology, as part of regional Rehabilitation Services Planning.
Social Work Discharge Planning Role	• Create common roles and responsibilities for Social Work related to discharge planning across the ECH and Associate Partners, which will require a staffing investment.
Recreation Therapy Staffing	• As part of regional planning to transition LTC to the Eden and DAL models, consider Recreation Therapy staffing efficiency opportunities.
Corporate Service Integration and Staffing	• Examine opportunities for further corporate service integration across ECH and the Associate Partners to contribute to staffing efficiency target.
Regional Decision Support Function	• Given staffing investment opportunity, explore the development of a common Decision Support function for the region and Associate Partners, supported by technology, with a focus on improving site-level management analysis support.

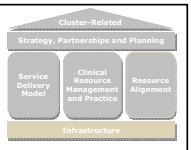
Regional Opportunity Map and Reference Guide

Resource Alignment (continued)



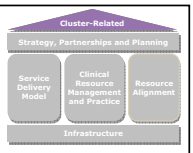
Key Opportunities	Description
Human Resources Staffing	• Integrate ECH and Associate Partner HR and OH&S functions, supported by identified staffing investment, and aligned to broader regional re-focus on HR strategy and management.
IT Staffing	• Consider staffing investment opportunity in IT, as part of broader regional resource planning for RSHIP and other IT initiatives.
Materiel Management Staffing	• Consider staffing investment opportunity in Materiel Management to align with increased ECH and Associate Partner integration, and in support of identified regional transportation opportunity.
Health Records Staffing	• Consider Health Records staffing investment to increase records purging, to alleviate storage space constraints.

Regional Opportunity Map and Reference Guide
Infrastructure



Key Opportunities	Description
ER Facilities Redevelopment Assessment	• As part of regional ER Strategy, consider infrastructure improvements to align Wainwright ER department to CTAS standards.
Technology-Based Security Solutions	• Explore options to implement technology-based solutions to provide added security to regional acute care sites, in alignment with regional ER strategy.
Automated Unit Dose Packaging Business Case	• Develop a business case for automated unit dose packaging, as part of a regionalized distribution model which uses St. Mary's as the hub.
TMS Functionality Improvement	• Review paper-based inspections processes with consideration of TMS functionality improvement and clerical support to reduce PHI administrative workload.
Regional Inventory Storage	• Consider expanding the planning for the new off-site inventory storage to play a broader regional inventory role.
Energy Management Plan and Business Case	• Develop a business case to examine benefits of investment in energy management plan, with consideration of identified facility role review.

Regional Opportunity Map and Reference Guide
Cluster/Provincial-Related



Key Opportunities	Description
Physician Alternative Payment Models	• Explore alternative payment models for physicians in the region, with an objective to improve resources and linkage to care/service delivery model. – Related to this opportunity, explore alternate staffing models to consider physician AFP options – e.g. APN/NP model in ER and community health clinics. – Consider medical compensation strategies that link to a regional medical HR plan.
Home Care Medication Payment Policies/ Procedures	• Establish clear policies and procedures for the payment of home care medications, and communicate to key stakeholders.

Regional Opportunity Prioritization

Regional Opportunity Prioritization
Introduction

- Based on a facilitated working session with the Region's Senior Management Team, the Project Team have developed an Opportunity Prioritization Map.

- Opportunity prioritization focused on sequencing, based on five key factors:
  - Opportunity Inter-Dependencies
  - Resource Requirements (Leadership, People, Financial, External Support)
  - Identified Risks
  - Timeline Feasibility
  - Priority Level to the Region

- The opportunity mapping (timeline) has six phases of effort:
  - Phase 1: 0-6 months
  - Phase 2: 6-12 months
  - Phase 3: 12-24 months
  - Phase 4: 24-30 months
  - Phase 5: 30-46 months
  - Phase 6: 36-42 months

Regional Opportunity Prioritization
Introduction (continued)

- During the working session with the region's Executive Team, opportunities were reviewed by phase of effort to discuss the appropriateness and feasibility of the preliminary prioritization.
- Throughout the discussion, a "go-forward determination" was also assigned to each opportunity to establish if phasing needs to be changed, deferred and / or not pursued:

  - ***Priority*** – Opportunities that are considered priorities for achievement by the region over the 42-month planning period.

  - ***Deferred*** – Opportunities which must be deferred at this stage, but which will be re-considered for pursuit in the future.

  - ***Not Pursued*** – Opportunities which are not considered as regional priorities, and so will not be pursued.

Regional Opportunity Prioritization
Introduction (continued)

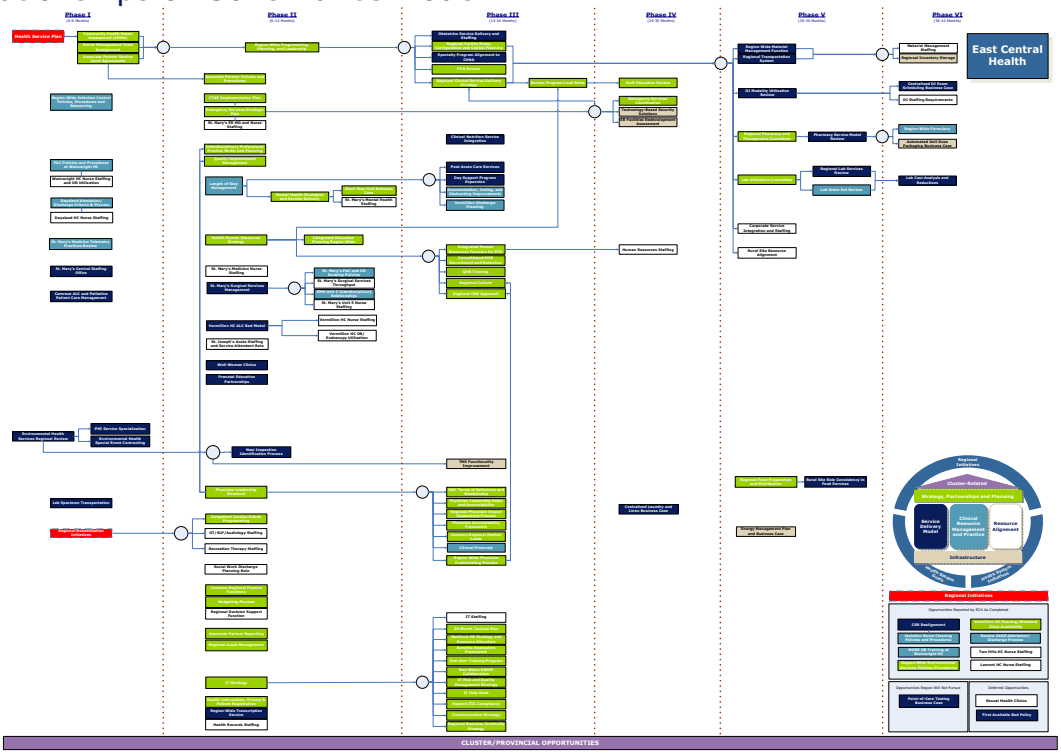
- The final opportunity map has been developed in collaboration with the region, based on those opportunities identified as priorities by the region.

- For ECH specifically, two versions of the opportunity map are presented, to demonstrate the significant impact of the existing Associate Partner governance model on regional service delivery, and what ECH is able to do with or without those Partners in their current governance model:
  - The **full set** of opportunities that are 'Achievable by ECH **through** Improved Associate Partner Service Relationships or Governance Model'
  - The **subset** of opportunities that are 'Achievable by ECH **without** Improved Associate Partner Service Relationships or Governance Model'

- Following these two versions of ECH's Opportunity Prioritization Map, a summary of the ECH Senior Leaders responsible for opportunity achievement is presented, which assumes that the full set of opportunities are targeted.

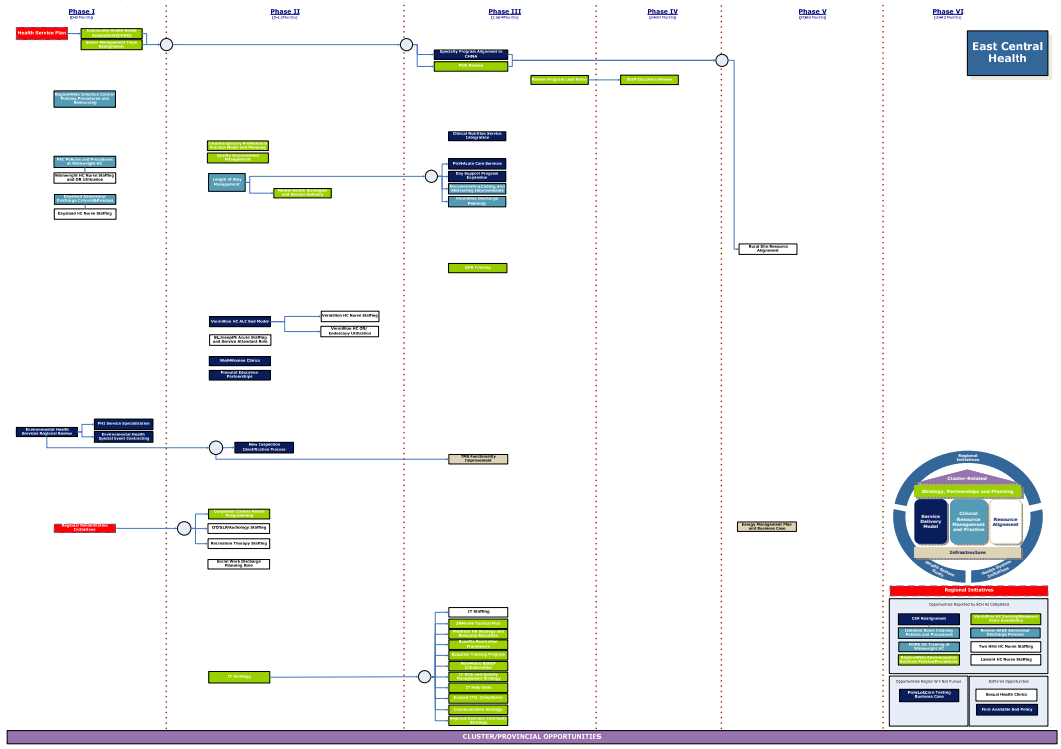
Regional Opportunity Prioritization Map – With Associates

Achievable by ECH **through** Improved Associate Partner Service Relationships or Governance Model



Regional Opportunity Prioritization Map – No Associates

Achievable by ECH **without** Improved Associate Partner Service Relationships or Governance Model



Regional Opportunity Prioritization
Regional Leads – Phase 1

Opportunity Name	Responsible Senior Lead
Community Health Needs Assessment	Steve Petz
Senior Management Team Realignment	Steve Petz
Associate Partner Service Level Agreements	Steve Petz
Region-Wide Infection Control Policies, Procedures and Resourcing	Dr. Odell Olson Phyllis Hempel
PAC Policies and Procedures at Wainwright HC	Phyllis Hempel
Wainwright HC Nurse Staffing	Phyllis Hempel
Daysland Admission/ Discharge Criteria and Process	Phyllis Hempel
Daysland HC Nurse Staff Mix	Phyllis Hempel
St. Mary's Medicine Telemetry Practices Review	Phyllis Hempel
St. Mary's Central Staffing Office	Phyllis Hempel
Camrose ALC and Palliative Patient Care Management	Phyllis Hempel
Environmental Health Services Regional Review	Brian Stevenson
PHI Service Specialization	Malcolm Kirkland
Environmental Health Special Event Contracting	Malcolm Kirkland
Lab Specimen Transportation	Dr. Odell Olson

Regional Opportunity Prioritization
Regional Leads – Phase 2

Opportunity Name	Responsible Senior Lead
Region-Wide Programming, Planning, and Leadership	Malcolm Kirkland Phyllis Hempel
Associate Partner Policies and Procedures	Steve Petz
CTAS Implementation Plan	Phyllis Hempel
Emergency Services Strategic Plan	Malcolm Kirkland Phyllis Hempel
St. Mary's ER MD and Nurse Staffing	Phyllis Hempel
Interdisciplinary Professional Practice Model and Planning	Phyllis Hempel Dr. Odell Olson
Quality Improvement Management	Phyllis Hempel Dr. Odell Olson
Length of Stay Management	Phyllis Hempel Dr. Odell Olson
Mental Health Strategies and Service Delivery	Phyllis Hempel Dr. Odell Olson
Short Stay Unit Business Case	Phyllis Hempel Dr. Odell Olson
St. Mary's Mental Health Staffing	Phyllis Hempel

Regional Opportunity Prioritization

Regional Leads – Phase 2 (continued)

Opportunity Name	Responsible Senior Lead
Health Human Resources Strategy	Malcolm Kirkland
Integrated Education Planning Region-Wide	Malcolm Kirkland
St. Mary's Medicine Nurse Staffing	Phyllis Hempel
St. Mary's Surgical Services Management	Phyllis Hempel
St. Mary's PAC and OR Booking Policies	Phyllis Hempel
St. Mary's Surgical Services Throughput	Phyllis Hempel
SMH Unit 5 Interdisciplinary Relationships	Dr. Odell Olson Phyllis Hempel
St. Mary's Unit 5 Nurse Staffing	Phyllis Hempel
Vermillion HC ALC Bed Model	Phyllis Hempel
Vermillion HC Nurse Staffing	Phyllis Hempel
Vermillion HC OR/ Endoscopy Utilization	Phyllis Hempel
St. Joseph's Acute Staffing and Service Attendant Role	Phyllis Hempel
Prenatal Education Partnerships	Phyllis Hempel
Well-Women Clinics	Phyllis Hempel

Regional Opportunity Prioritization

Regional Leads – Phase 2 (continued)

Opportunity Name	Responsible Senior Lead
New Inspection Identification Process	Malcolm Kirkland
Physician Leadership Structure	Dr. Odell Olson Malcolm Kirkland
Outpatient Cardiac Rehab Programming	Malcolm Kirkland
OT/SLP/Audiology Staffing	Malcolm Kirkland
Recreation Therapy Staffing	Malcolm Kirkland
Social Work Discharge Planning Role	Malcolm Kirkland
Common Regional Finance Functions	Norm Petherbridge
Budgeting Process	Norm Petherbridge
Regional Decision Support	Norm Petherbridge
Associate Partner Reporting	Norm Petherbridge
Regional Asset Management	Brian Stevenson
IT Strategy	Norm Petherbridge
Health Information, Privacy & Patient Registration	Norm Petherbridge
Region-Wide Transcription Service	Norm Petherbridge
Health Records Staffing	Norm Petherbridge

Regional Opportunity Prioritization
Regional Leads – Phase 3

Opportunity Name	Responsible Senior Lead
Obstetrics Service Delivery and Staffing	Phyllis Hempel
Regional Facility Roles, Configuration and Capital Planning	Steve Petz
Specialty Program Alignment to CHNA	Phyllis Hempel
Primary Care Network Review	Dr. Odell Olson Malcolm Kirkland
Regional Clinical Service Delivery Strategy	Phyllis Hempel Dr. Odell Olson
Review Program Lead Roles	Malcolm Kirkland Phyllis Hempel
Clinical Nutrition Service Integration	Brian Stevenson
Post-Acute Care Services	Phyllis Hempel
Day Support Program Expansion	Phyllis Hempel
Documentation, Coding and Abstracting Improvements	Norm Petherbridge Phyllis Hempel Dr. Odell Olson
Vermillion Discharge Planning	Phyllis Hempel

Regional Opportunity Prioritization
Regional Leads – Phase 3 (continued)

Opportunity Name	Responsible Senior Lead
Integrated Human Resources Function for ECH	Malcolm Kirkland
Consolidated HHR Recruitment and Retention	Malcolm Kirkland
QHR Training	Malcolm Kirkland
Regional Culture	Malcolm Kirkland
Regional CME Approach	Malcolm Kirkland Dr. Odell Olson
TMS Functionality Improvement	Malcolm Kirkland Norm Petherbridge
MAC Terms of Reference and Membership	Dr. Odell Olson
Physician Leadership Roles and Accountability	Dr. Odell Olson
Regional Physician Impact Assessment Process	Dr. Odell Olson Norm Petherbridge
Physician Accountability Framework	Dr. Odell Olson
Common Regional Medical Leads	Dr. Odell Olson
Clinical Protocols	Dr. Odell Olson Phyllis Hempel
Regional-Wide Physician Credentialing Process	Dr. Odell Olson

Regional Opportunity Prioritization
Regional Leads – Phase 3 (continued)

Opportunity Name	Responsible Senior Lead
IT Staffing	Norm Petherbridge
36-Month Tactical Plan	Norm Petherbridge
Meditech HR Strategy and Resource Allocation	Norm Petherbridge
Benefits Realization Framework	Norm Petherbridge
End-User Training Program	Norm Petherbridge
Non-Metro RSHIP Collaboration	Norm Petherbridge
IT Risk and Quality Management Strategy	Norm Petherbridge
IT Help Desk	Norm Petherbridge
Expand ITIL Compliance	Norm Petherbridge
Communication Strategy	Norm Petherbridge
Regional Business Continuity Strategy	Norm Petherbridge

Regional Opportunity Prioritization
Regional Leads – Phase 4

Opportunity Name	Responsible Senior Lead
Staff Education Review	Malcolm Kirkland
Emergency Services Coordination	Phyllis Hempel Dr. Odell Olson
Technology-Based Security Solutions	Phyllis Hempel Norm Petherbridge
ER Facilities Redevelopment Assessment	Brian Stevenson
Human Resources Staffing	Malcolm Kirkland
Centralized Laundry and Linen Business Case	Brian Stevenson

Regional Opportunity Prioritization
Regional Leads – Phase 5

Opportunity Name	Responsible Senior Lead
Region-Wide Material Management Function	Brian Stevenson
Regional Transcription System	Norm Petherbridge
DI Modality Utilization Review	Dr. Odell Olson
Regional Pharmacy and Therapeutics Committee	Dr. Odell Olson
Pharmacy Service Model Review	Dr. Odell Olson
Lab Utilization Committee	Dr. Odell Olson
Regional Lab Services Review	Dr. Odell Olson
Lab Order Set Review	Dr. Odell Olson
Corporate Services Integration and Staffing	Steve Petz Norm Petherbridge Malcolm Kirkland Brian Stevenson
Rural Site Resource Alignment	Phyllis Hempel
Regional Food Preparation and Distribution	Brian Stevenson
Rural Site Role Consistency in Food Services	Brian Stevenson
Energy Management Plan and Business Case	Brian Stevenson

Regional Opportunity Prioritization
Regional Leads – Phase 6

Opportunity Name	Responsible Senior Lead
Material Management Staffing	Brian Stevenson
Regional Inventory Storage	Brian Stevenson
Centralized DI Exam Scheduling Business Case	Dr. Odell Olson
DI Staffing Requirements	Dr. Odell Olson
Region-Wide Formulary	Dr. Odell Olson
Automated Unit Dose Packaging Business Case	Dr. Odell Olson
Lab Cost Analysis and Reductions	Dr. Odell Olson

Regional Opportunity Prioritization

Opportunities Deferred or Not Pursued

- The following opportunities were identified by the region as being either 'Deferred' or 'Not Pursued'. Regional commentary for these decisions is also provided.

Opportunity Name	Status	Commentary
Sexual Health Clinics	Deferred	• ECH has deferred decision on this opportunity until the completion of the Community Health Needs Assessment.
First Available Bed Policy	Deferred	• ECH has deferred decision on this opportunity, due to the existence of a voluntary first available bed policy in the region, and in consideration of ongoing work in their Long Term Care plan and model transition.
Point-of-Care Testing Business Case	Not Pursued	• ECH reports earlier consideration of Point-of-Care Testing, and that there is limited perceived benefit from this opportunity.

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AHW RHA Efficiency Review East Central Health Region

Performance Management Overview

Final Report

June 18, 2007

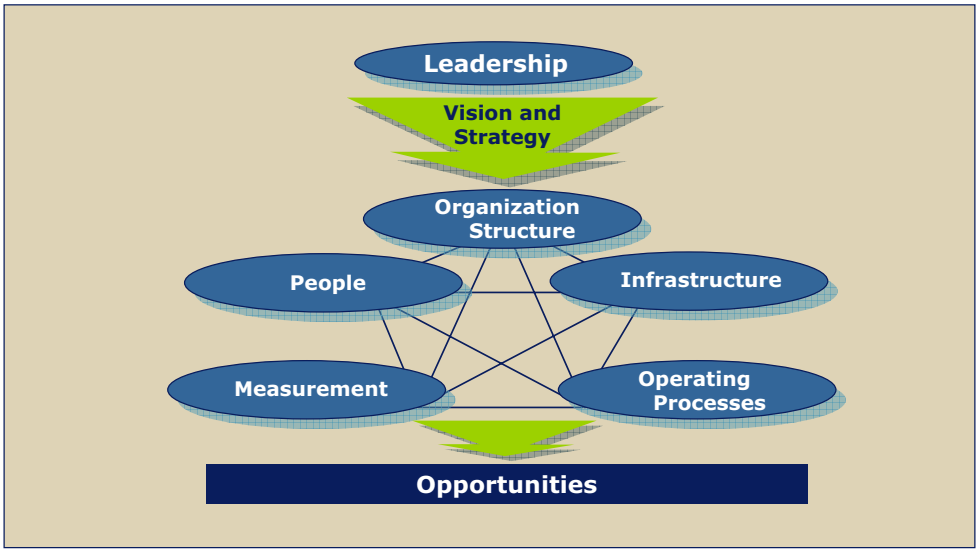
Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

Performance Management Overview

Key Components of Performance Management

- The framework below is used to assess performance management alignment. There are seven components used in this assessment.
- For each of these seven components, Leading Practice Attributes from industry have been identified to guide discussion.



1. Leadership

Leading Practice Attributes	• Visible leadership; vision and strategy focused; systems thinking and planning; • Transparent and timely management processes related to decision-making; • Demonstrated commitment to standardization; • Role mentorship and succession planning; • Multi-stakeholder relationships management

Findings

Documentation Review	Stakeholder Feedback
• 3 Year Health Plan • Organization Charts • Health Services Plan • Program Planning Documents	• Board Chair and CEO are well established in roles and report an effective working relationship; however relationships at these levels with the Associate Partners are reported by both region and Partners as fragmented and challenged. • Vacancy in Chief Nursing Officer (CNO) has led to a temporary realignment of portfolios for the past year, although the region has recently confirmed a replacement for this role to start in October 2006. • Stakeholders provided mixed feedback on the success and timeliness of decision-making through the decision document process. • Leadership is focused on maintaining status quo across regional facilities, due in part to challenges and community impacts felt in the 1995-96 facility closures.

Deloitte Observations	• Governance and operational leadership and decision-making across the region and Associate Partners is fragmented. This will continue to limit the region's ability to act and operate as a full region. A paradigm shift among all players is required to facilitate a more actively collaborative model that will be needed to shift to a stronger regional enterprise. • Vacancy in CNO portfolio has impacted clinical leadership representation at the senior leadership level. This should improve with the pending replacement. • Focus on maintaining current health facilities by the region, coupled with the region's lack of a current community health needs assessment is a limiting factor in terms of health service planning. The risk is future planning defaults to current service delivery model and site configurations. Without improved community health needs information, realignment of services to more effective configurations is limited. • Some succession planning appears to be underway at the senior level, however a clear succession plan across levels and Associate Partners was not observed.

2. Vision and Strategy

Leading Practice Attributes	• Clearly articulated Mission, Vision, and Value Statements (or Guiding Principles) • Current Strategic Plan with supportive structure and processes to cascade to operational level; prioritization process to focus organizational initiatives and decision-making • Performance management processes and structure aligned to support strategy; • Focused on direction; • Cross RHA collaboration; integration mindset.

Findings

Documentation Review	Stakeholder Feedback
• 3 Year Health Plan • Health Services Plan • Program Planning Documents	• The region's mission, vision health philosophy, and health planning parameters are clearly articulated. • A health service plan is in development for the region, and strategies are in place for all program areas to support the region's health plan. • The region and Associate Partners report challenges in bridging regional strategic planning to the Partners' planning and operations. • The region does not support a community health needs assessment approach to inform health services planning; the last assessment was conducted in 1995-96.

Deloitte Observations	• The region has a clearly articulated mission, vision and principles, which are supported by the three-year health plan; however there appears to be limited two-way alignment of these elements across the region and Associate Partners. • Although the Associate Partners are accountable to the region through budget processes, there is no two-way accountability model present related to leadership, service planning or service delivery. This is needed to support a more collaborative and accountable model in the region. • As per earlier comments, a formal community health needs assessment is required to inform health services planning, clinical facility role development and configuration; and it can serve as a baseline from which to create service delivery accountability agreements for regional and Associate Partner sites.

3. Organization Structure

Leading Practice Attributes	• Organizational structure reflects unique requirements of organization, service delivery; supports changing service and people requirements; • Supports timely decision-making and efficient work flow; role accountability and communication • Minimizes role duplication and confusion • Strategic portfolios instead of service management ones

Findings

Documentation Review	Stakeholder Feedback
• Organization Structure / Charts	• Decision making throughout the region is described as 'top-down', with limited stakeholder involvement. • Region uses a hybrid program management/site management approach, but this is still an evolving model – where changes are to reduce duplication (e.g. program lead and education) • Linkages with Associate Partners are informal and participation in regional initiatives is voluntary; there is no formal relationship at the senior or middle management levels. • Current vacancy of CNO role has led to large portfolios for remainder of the senior team for the past year, and a heavier dependence on the new VP Medical. • Medical leadership is site-based with a regional MAC, however other than palliative care, there is no program medical leadership across the region and Associate Partners.

Deloitte Observations

- Given the significant role of the Associate Partners in clinical service delivery, particularly St. Mary's Hospital, there is a need for a more formal relationship and accountability model as part of the regional organization structure.
  - To support the region's plan for St. Mary's Hospital to become the secondary referral centre and ensure effective working relationships, it is suggested that St. Mary's leadership be dual-appointed to the regional senior team (e.g. the St. Mary's CEO could be dual-appointed as the region's COO for St. Mary's).
- Review of senior management portfolios is suggested now that the CNO role has been filled, to realign responsibilities and lever strategic directions of the region. It is suggested that CNO should report directly to the CEO, given its strategic importance in the region.
- As part of health service planning and organization, further clarity and role design is needed to determine the appropriate balance of the Program Lead, HCC and NCC roles.
- In the Allied Health, Corporate and Support areas, further consideration should be given to regionalizing services and roles across regional and Associate Partner sites.

4. People

Leading Practice Attributes	• Current Human Resources Strategic Plan; HR planning and management from a regional perspective (move from local to central) • Standardized performance review process with regular application • Identified competencies for roles – particularly at leadership level • Sufficient HR staffing support across organization to support management and staff • Supportive staff development and education program / process in place / career paths / laddering opportunities

Findings

Documentation Review	Stakeholder Feedback
• Organization Structure • Program Planning Documents • 3 Year Health Plan	• A human resources plan in place for the region, but it does not fully address regional needs and stakeholders (e.g. physicians are not included). • Formal performance reviews are in place for staff and middle management, however are not used for the senior leadership team of the region. Senior leadership performance feedback is ad hoc and unstructured. • HR staffing functions are centralized for regional sites, but does include the Associate Partner sites. Formal programs support nursing recruitment (e.g. supernumerary) • Staff development programs are in place and delivered across the region, primarily focused on clinical education.

Deloitte Observations

- A comprehensive HR strategic plan is needed for the region to address staffing needs and challenges for medical staff, allied health professionals, nursing and support services staff. This plan should include strategies and resources for staff recruiting, development, and retention, and should be integrated across the region and Associate Partners.
- HR planning should be aligned to the 3-Year Health Plan, Health Services Plan and a facility role review, to help inform the sustainability of current operations and determine future workforce planning requirements.
- A process to align role competencies against performance outcomes at the senior level is needed to ensure that the strategies and priorities of the region are being effectively executed. This process should be aligned to the 3-Year Health Plan and other strategic planning documents, and should cascade throughout the organization.
- The region should investigate programs to support rural physician recruitment, skill development, and retention, in collaboration with AHW and the other rural regions.

5. Infrastructure

Leading Practice Attributes	• Current and integrated information management, technology and facility plans • Sufficient and appropriate technology to support efficient and effective operations • Capital replacement plan (current and integrated); Facility development processes and plans to support care requirements and efficient operations • Metrics to assess value of investment (economic and social value, linking service to infrastructure) • Assessment of new business models to enable infrastructure investment

Findings

Documentation Review	Stakeholder Feedback
• ECH Long Term Capital Plan • Program Planning Documents • 3 Year Health Plan	• The region uses an annual capital planning process, and regional stakeholders report a generally good level of funding, in part due to Federal funds. Associate Partners submit to this process, but report that they are not a part of capital decision-making. • The region's IT initiatives (Meditech and PACS) are resource-intensive but are expected to provide a good information foundation for care delivery and operations. • In consultations through the region, a number of sites were noted to have inappropriate or out-dated facilities with significant redevelopment needs anticipated. • The region has telehealth in all of its sites, but stakeholders report mixed use.

Deloitte Observations	• A long-term capital plan is in place that clearly identifies regional priorities, but it is not linked to a community health needs assessment and does not fully address the sustainability of the current facility configuration. This is a risk to the region. • A plan should be developed that considers the future roles of each facility and priorities of investment across the region, which is aligned to a community health needs assessment and sustainability review across the region. This should be completed as a pre-cursor to current capital development plans. – As part of this planning, it is suggested that the region re-examine its ability to integrate the PCN and other care delivery models into existing infrastructure, to help meet future service delivery challenges. • The region has committed a significant investment of capital and staffing resources into the Meditech implementation. There is a need for metrics to assess the value and benefits of this investment, to ensure alignment to regional priorities and inform planning. • Consider options to expand clinical, administrative and educational use of telehealth.

6. Measurement

Leading Practice Attributes	• Existence of a comprehensive performance management system in place (people, financial, operations, satisfaction, and other key processes) • Development of performance metrics and targets to manage care and service; linkage of measurement to action and communication; • Consistent, standardized measures • Performance measurement linked to quality and risk management

Findings

Documentation Review	Stakeholder Feedback
• 3 Year Health Plan • Program planning documents	• Performance goals and indicators are established in planning, and program-level actions are evident. This process at Associate Partners is voluntary and may not link back to the region. • Individual performance management processes are in place below senior management level, but stakeholders report variable application and compliance. There is no formal performance management approach is in place for senior management. • Performance management process for physicians is unclear and not standardized. • Quality management processes in the region exist, but improved balance between regional and site-based quality teams is needed. Associate Partners have separate quality processes, not clearly linked to the regional approach.

Deloitte Observations	• A more comprehensive performance and quality management framework is suggested that uses a scorecard approach to focus the cascading of regional goals to all levels of the organization (including senior management and physicians), and which enables regular monitoring and evaluation to defined accountabilities. This should extend across management, staff and physicians for the region and Associate Partners. • There is a need to establish clear performance reporting and accountability expectations between the Associate Partners and the region, which links performance to service level agreements. • Quality management is in place, but fragmented. Improved quality management could be achieved through a re-definition of the regional and site-based quality initiatives, and an integration of quality, performance and outcome measures across the region and Partners.

7. Operational Processes

Leading Practice Attributes	• A formal, organization-wide risk identification and management process is in place; • Established processes in place to support standardization and development of practice • Established processes, initiatives to support standardization of care and service • Established resources to support initiative implementation and monitoring • Assessment of new or different business models to support service delivery and integration • Management processes that support accountability

Findings

Documentation Review	Stakeholder Feedback
• 3 Year Health Plan • Health Services Plan • Program Planning Documents • Organization Charts • Program Planning, Design and Evaluation Guides	• The region has implemented standardized program planning and evaluation guides, and processes that link operational service plans to regional priorities. Stakeholders suggest challenges with existing planning process, however, as operational plans are often inhibited by funding constraints. Further some stakeholders report limited clarity in processes to prioritize operational plans relative to funding capacity. • Risk management is coordinated through corporate services with link to medical services through a formal risk management framework, which is in the process of being rolled-out. Linkages with Associate Partners are not clearly established. • The region works to implement standardized policies across sites. Although Associate Partners are encouraged to participate, there is no way of ensuring this occurs. • The region has limited access to the Associate Partner sites, and so has limited ability to identify or manage clinical risks in these sites. • Some regionalization of service delivery has occurred, but many clinical and support services are still site driven. Regional service delivery models are further fragmented by the lack of integration across the region and Associate Partners.

Deloitte Observations	• The program planning and evaluation guides are useful tools to support ongoing regional planning that is linked to priorities. Consideration of how to further link budget constraints into processes, and how to standardizes policies and procedures across Associate Partners, may help to improve planning at a service/departmental level. • The lack of integration between the region and Associate Partners is a challenge to risk management, service integration, service sustainability and clinical practice standardization. Collaboration with the Associate Partners should be undertaken to explore the development of regionalized clinical and support services, with consideration of: service and quality improvement; cost reduction; service sustainability and workforce planning.

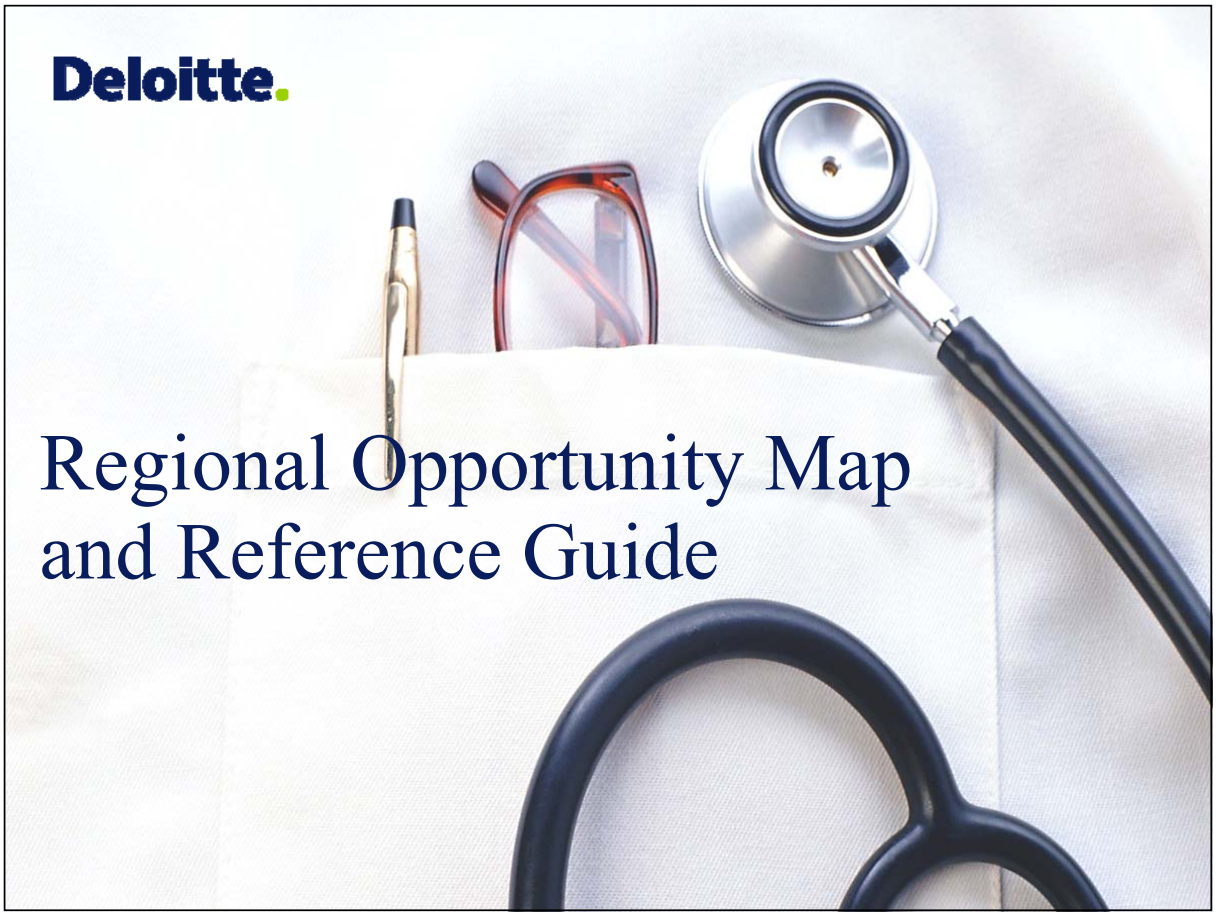
Summary Remarks

Strengths to build on include:

- **Good alignment between the three-year plan and annual program planning process**
- **A clear planning process that links operational service plans to regional priorities**
- **Recent hiring of a CNO to support regional clinical leadership**
- **Supernumerary program to support nursing recruitment and retention**
- **Progress in Meditech implementation**
- **Strong informal linkages with community**

Areas for further consideration:

- **Conduct a community health needs assessment to inform health service alignment and sustainability.**
- **Increase regional programming focus and initiatives.**
- **Formalize roles, responsibilities, and accountabilities with Associate Partners to fully engage and align the region.**
- **Develop a human resource plan for the region that is aligned with current and future regional priorities and service delivery.**
- **Implement formal performance review process for all levels of the organization and link to strategic priorities and accountabilities.**
- **Build on quality processes for the region to increase robustness.**

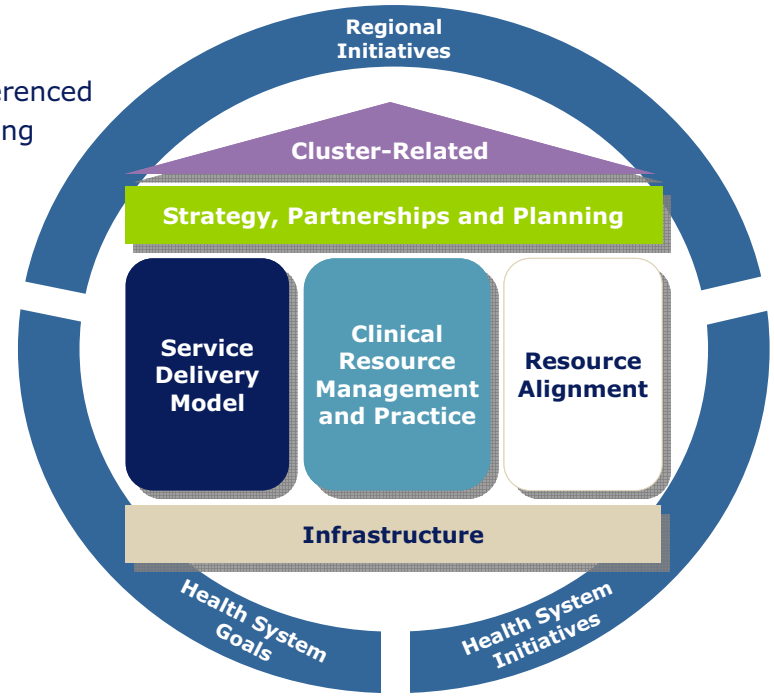


Regional Opportunity Map and Reference Guide

Regional Opportunity Map and Reference Guide

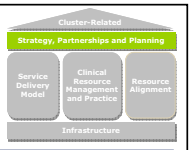
Opportunity Alignment

- To facilitate prioritization, opportunities are aligned across five areas, shown in framework below.
- This framework will be referenced to facilitate an understanding of the different types of opportunities for prioritization.
- Also important will be an understanding of how broader system goals and initiatives, and other regional initiatives impact opportunity prioritization.



Regional Opportunity Map and Reference Guide

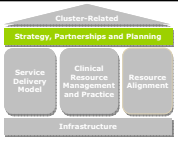
Strategy, Partnerships and Planning



Key Opportunities	Description
Community Health Needs Assessment	• Conduct a community health needs assessment to inform health service planning, future programming and organization priorities for ECH.
Senior Management Team Realignment	• Review senior management organization structure and portfolios, to re-align skill sets with regional priorities and operations, and do so in consideration of Associate Partner linkages.
Associate Partner Service Level Agreements	• Continue the shift to a Service Level Agreement model that supports improved clinical service delivery, programming, management, and accountability with Associate Partners.
Associate Partner Service Level Agreements	• Continue the shift to a Service Level Agreement model that supports improved clinical service delivery, programming, management, and accountability with Associate Partners.
Emergency Services Strategic Plan	• Develop a strategic plan for Emergency Services that reviews: appropriate model for sites (EDs vs. UCCs across the region), links with pre-hospital care programming, and alignment with a community health needs assessment.
CTAS Implementation Plan	• Develop a CTAS implementation plan to formalize the patient triage function at all non-compliant sites in the region, with consideration of both staffing and infrastructure resources required.
Emergency Services Coordination	• Collaborate with community EMS providers to align staffing requirements to availability of hospital-based ER services.

Regional Opportunity Map and Reference Guide

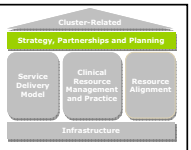
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional Facility Roles, Configuration and Capital Planning	• In alignment with the above community health needs assessment, re-assess the ongoing sustainability of the facilities' current clinical roles and configuration in the region. • Continue plan to create St. Mary's as a secondary referral centre for the region, with clearly defined roles and responsibilities for its part in regional programming, planning and care delivery. • Re-evaluate regional capital planning for facilities to align to facility role review.
Region-Wide Programming, Planning, and Leadership	• Re-align clinical service delivery and organization structure to have common region-wide clinical programming, planning and leadership - achieved through collaboration between the region and Associate Partners. • Re-align clinical organization structure of Director of Acute, HCCs and NCCs to create clinical program leadership that extends across ECH and Associate Partners.
Regional Clinical Service Delivery Strategy	• Establish regional clinical programs and service delivery strategy that integrate ECH and Associate Partner, with defined strategic and operational plans. Align ECH Health Services Plan to community health needs assessment and clinical facility role review.
Primary Care Network (PCN) Review	• Review strategic opportunities for PCN throughout the region and establish a physician lead for the initiative.

Regional Opportunity Map and Reference Guide

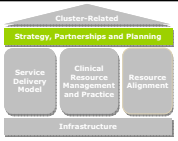
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Interdisciplinary Professional Practice Model and Planning	• Establish an interdisciplinary professional practice model that includes roles, responsibilities, policies and practices governed by an interdisciplinary committee. This should include the development of a strategic nursing plan.
Quality Improvement Management	• Review and align the role of quality initiatives within the region to needs and priorities, with the consideration of establishing reliable funding and processes for moving forward. – Re-focus regional quality teams on a program basis that extend across all ECH and Associate Partner sites. – Re-examine the local quality team structures, with consideration of establishing one local quality improvement team at each site that consolidates the teams and activity across programs, and links into regional program quality initiatives.
Health Human Resources Strategy	• Develop a single health human resources plan for ECH and the Associate Partners that aligns health human resources needs and priorities to regional strategic objectives, and which addresses ongoing site sustainability. Key considerations include: – The shift to region-wide clinical program delivery and site-based resource management. – Engagement and inclusion of physicians in resource planning. – Target key areas, including: DI, Labs, Pharmacy, Personal Care Aides

Regional Opportunity Map and Reference Guide

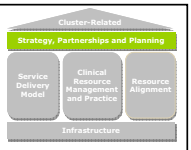
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Integrated Human Resources Function for ECH	• Explore the creation of a single Human Resources function for ECH and the Associate Partners to integrate service delivery and lever increased capacity required to establish HR as a strategic partner.
Consolidated HHR Recruitment and Retention	• Consolidate HHR recruitment and retention across the region and Associate Partners, to achieve common practice, build capacity, and ensure consistent alignment to HHR priorities.
Regional Culture	• As part of regional HR planning, develop a strategy to achieve a common regional culture that connects management, staff and physicians across the region and Associate Partners.
Integrated Education Planning Region-Wide	• Build on existing education planning to integrate Associate Partners, which aligns to regional priorities. • Explore the development of on-site clinical education support for St. Mary's staff, in coordination with regional programs. • Enhance communication across facilities by leveraging Telehealth technology in a structured approach to coordinate service, share leading practice information, CME and professional support.
QHR Training	• Implement management training on QHR functionality to leverage HR management at the regional and site levels.

Regional Opportunity Map and Reference Guide

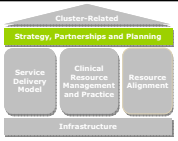
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional CME Approach	• Develop a regional approach and support for CME for both Canadian-trained and foreign-trained medical graduates, based on a sustainable business model, and integrated with the physician recruitment and retention strategy and broader regional education function.
Physician Leadership Structure	• Review medical leadership structure across regional and Associate Partner sites, with the goals of: – Implementing defined roles, relationships, and accountabilities to support a regional approach to medical leadership. – Standardize roles and responsibilities for Chiefs of Staff across region and associate sites. – Consider the potential to create medical program leads.
MAC Terms of Reference and Membership	• Review MAC terms of reference and membership to assess fit with medical leadership needs of the region. Consider functions of recruitment, retention, quality, and credentialing as part of this process.
Physician Leadership Roles and Accountability	• Actively collaborate with St. Mary's Hospital administrative and medical leadership to create clear roles, relationships and accountabilities of medical staff that are centred on improving patient care and management.

Regional Opportunity Map and Reference Guide

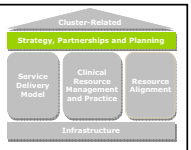
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Regional Physician Impact Assessment Process	• Develop a consistent regional Physician Impact Assessment process for physician recruitment needs planning, and in assessment when new physicians are being considered.
Physician Accountability Framework	• Create a standardized accountability framework for regional and Associate Partner sites with evaluation and quality/risk/performance management tools for Physicians, which is integrated into the broader regional framework.
Region-Wide Physician Credentialing Process	• Engage physician and administrative leadership from across the region and Associate Partners to create a common physician credentialing process.
Common Regional Medical Leads	• Explore creating common Medical Leads across the ECH and Associate Partner sites, with consideration of the role of St. Mary's as a secondary referral centre.
Review Program Lead Roles	• Re-examine Program Lead roles with consideration of dedicating these roles (full FTE) to education, practice and quality management for respective areas.

Regional Opportunity Map and Reference Guide

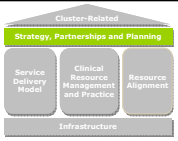
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Staff Education Review	• Undertake a comprehensive staff education review that includes: – Clarifying role of Program Leads and Staff Development in clinical education. – Conducting a formal needs assessment to ensure that educational programs are aligned with staff needs across region and regional service priorities. – Re-examining clinical education resources to determine alignment to program vs. regional needs. – Developing common programming and planning for clinical education across ECH and Associate Partner sites.
Common Regional Finance Functions	• Explore development of common Finance functions across ECH and the Associate Partners, with a focus on transactional activities that will not negate current governance or autonomy.
Budgeting Process	• Review the current budgeting process in the region: – To align budgeting to regional priorities. – To focus on fiscal accountability – To improve funding timing to Associate Partners.
Associate Partner Reporting	• Improve integration of financial and statistical data for reporting and analysis with the Associate Partners, supported by defined reporting requirements that align to service level agreements between ECH and the Partners.
Regional Asset Management	• Formalize asset management processes and tools in coordination with Materiel Management, to better inform capital planning.

Regional Opportunity Map and Reference Guide

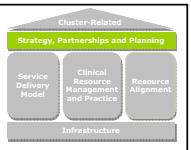
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Health Information, Privacy and Patient Registration Policies	• Build on regional progress and collaborate with the Associate Partners to create common region-wide policies and procedures for Health Information, Privacy and Patient Registration.
Region-Wide Environmental Services Policies and Procedures	• Build on regional progress and collaborate with the Associate Partners to create common region-wide policies and procedures for all areas of Environmental Services.
IT Strategy, Planning, Assessment and Resource Management	• There are several points of IT focus for the region, related to RSHIP (current state assessment, benefits realization, planning and resources), development of a regional IT Strategy, and improvements to IT service management.
Mental Health Strategies and Service Delivery	• Continue mental health planning focus on broader continuum of care, including: – Increase efforts to build community partnerships with key agencies such as AADAC. – Continue collaboration with St. Mary's as part of regional mental health planning, to ensure alignment of inpatient mental health services to regional priorities and community health needs. – Institute a quality improvement program with specific targets and indicators for Mental Health, as part of identified regional quality initiative. – Examine service delivery model, considering expanded use of group work.

Regional Opportunity Map and Reference Guide

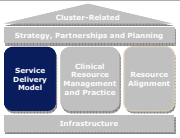
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Short Stay Unit Business Case	• Continue to explore business case for creating a Short Stay Crisis Unit.
Regional Pharmacy and Therapeutics Committee	• Establish a common Pharmacy and Therapeutics committee for all ECH and Associate Partner Sites, and re-visit the need for a parallel Pharmacy Advisory Committee.
Lab Utilization Committee	• Establish a regional Lab Utilization Committee to improve lab utilization, explore new testing models, and standardize lab policies, procedures and practice across the region and Associate Partners.
Outpatient Cardiac Rehab Programming	• Consider expansion of outpatient cardiac rehabilitation programming from a regional perspective, in alignment with a community health needs assessment.
Regional Food Preparation and Distribution	• Develop a business case to explore a regionalized food preparation and distribution model that includes the ECH and Associate Partner sites, with consideration of identified staffing efficiencies.

Regional Opportunity Map and Reference Guide

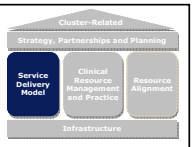
Service Delivery Model



Key Opportunities	Description
CSR Realignment	• Re-align CSR into one function with identified clinical leadership, to improve practice standardization and risk management, in alignment with facility role review.
Specialty Program Alignment to CHNA	• Review delivery of specialty programs across the region to align programming to community health needs assessment, supported by contingency plans where services are single sourced.
Obstetrics Service Delivery and Staffing	• Continue to examine alignment of obstetrics services to community needs, with consideration of site consolidation vs. building additional support for sites currently providing obstetrics services. • Develop common policies, strategy, and minimum MD and volume thresholds for obstetrics. • Explore implementation of LDRP model at St. Mary's, as part of functional programming. • Improve connection with regional obstetrics lead to improve consistency across region.
Prenatal Education Partnerships	• Consider a partnership with Public Health and community health providers to provide regional prenatal education classes.
Well-Women Clinics	• Consider establishing nurse-led well women clinics, where nurses performing pap tests under medical directives or guidelines.

Regional Opportunity Map and Reference Guide

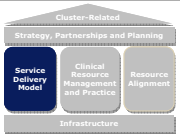
Service Delivery Model (continued)



Key Opportunities	Description
St. Mary's Central Staffing Office	• Explore the development of a central staffing office, supported by staffing float pool at St. Mary's.
Camrose ALC and Palliative Patient Care Management	• Explore options to cohort ALC and Palliative patients for improved care management. • Focus efforts on reducing the number of services and patient populations on the St. Mary's Unit 4, and align staffing model (staff mix) to support new service delivery model.
St. Mary's Surgical Services Management	• Reorganize all St. Mary's surgical services to be under one Manager, to enable streamlined care delivery, policies and planning.
Post-Acute Care Services	• Investigate alternatives to patients waiting in acute care for placement through such options as expanded home care, interim LTC beds, and a first available bed policy.
First Available Bed Policy	• Explore the development of a first-available bed policy or other alternative settings of care for early continuing care placement.
Day Support Program Expansion	• Consider expansion of day support programs and early identification of clients who could benefit from such programs with the goal of avoiding acute care admissions.
Vermillion HC ALC Bed Model	• Consider program focus or ALC bed model (like Daysland) at Vermillion for increased utilization of beds for the region.

Regional Opportunity Map and Reference Guide

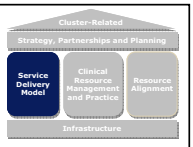
Service Delivery Model (continued)



Key Opportunities	Description
Environmental Health Services Regional Review	• Conduct a regional review of Environmental Health services to align service programming and resources to increasing community health inspections needs and to meet minimum provincial standards.
Environmental Health Special Event Contracting	• Review OT approach in region and consider contracting for special events.
New Inspection Identification Process	• Improve formalized mechanisms with local communities to identify new inspections entities as part of business licensing.
PHI Service Specialization	• Consider a formalized approach to build service specialization expertise as an overlay on current geographic PHI staffing model.
Region-Wide Transcription Service	• Lever implementation of Vianetta digital transcription system to create a region-wide transcription service for ECH and the Associate Partners.

Regional Opportunity Map and Reference Guide

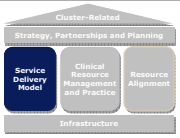
Service Delivery Model (continued)



Key Opportunities	Description
Regional Lab Services Review	• Review the current organization and distribution of lab services in the region, with a focus on streamlining services and space requirements to increase coordination across the region and Associate Partners, and to align lab services with the facility role review.
Point-of-Care Testing Business Case	• Develop a business case to explore the costs and benefits of expanding the use of point-of-care testing.
Lab Cost Analysis and Reductions	• Target reductions in lab costs/procedure to align cost structure to Alberta peers, as part of lab service rationalization across ECH and Associate Partner sites.
Lab Specimen Transportation	• Improve lab specimen transportation (as part of regional distribution system) to support and enable a regional lab model.
DI Modality Utilization Review	• Review DI modality utilization and siting within region to determine an optimal and sustainable configuration that aligns with community health needs assessment and regional health services plan.
Centralized DI Exam Scheduling Business Case	• Explore the business case for centralized exam scheduling across the region and Associate Partners, as part of broader wait list strategies.

Regional Opportunity Map and Reference Guide

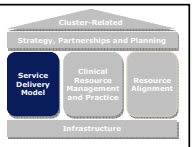
Service Delivery Model (continued)



Key Opportunities	Description
Pharmacy Service Model Review	• Explore models to create a single regional pharmacy service and distribution model that includes ECH and the Associate Partners, and aligns delivery and logistics to the ECH health services plan and facility role review.
Clinical Nutrition Service Integration and Coordination	• Explore further integration with the Associate Partners for Clinical Nutrition service delivery and staffing. • Improve integration of Clinical Nutrition resources across the continuum, to facilitate coordination in care delivery and increase flexibility in staffing recruitment, retention and deployment.
Rural Site Role Consistency in Food Services	• Improve consistency in roles for food service delivery and tray pick-up across the rural sites, where feasible.
Region-Wide Materiel Management Function	• Collaborate with Associate Partners to create a single region-wide Materiel Management function.
Regional Transportation System	• Re-examine the business case for a regional transportation system, with broader consideration of support to Materiel Management, Laundry, Labs, Pharmacy and Food Services distribution, in alignment with facility role review and other identified opportunities for service regionalization.

Regional Opportunity Map and Reference Guide

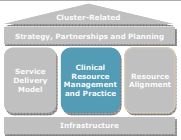
Service Delivery Model (continued)



Key Opportunities	Description
Centralized Laundry and Linen Business Case	• Explore the business case for creating a centralized laundry and linen service for ECH and the Associate Partners, with consideration of the identified regional transportation and distribution system, and aligned to the facility role review.

Regional Opportunity Map and Reference Guide

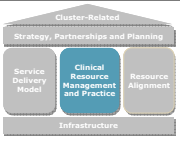
Clinical Resource Management and Practice



Key Opportunities	Description
Region-Wide Infection Control Policies, Procedures and Resourcing	• Continue to develop consistent region-wide infection control policies and procedures, supported by required resources to proactively manage risks and meet APIC staffing standards. • Explore the development of on-site infection control support at St. Mary's, in coordination with regional programs.
Isolation Room Cleaning Policies and Procedures	• Continue to develop policies and procedures for isolation room cleaning communication, with a focus on addressing potential privacy issues.
Length of Stay Management	• Review and redesign the utilization management processes and functions to establish consistency across the region. Review should include the following components: – Admission/discharge criteria – Improve education and awareness of leading practices – Consider adoption of a regional utilization management tool – Current processes and timing of the AAPI assessment, with a focus on minimizing related delays.
Documentation, Coding, and Abstracting Improvements	• Achieve improvements to Regional Documentation, Coding and Abstracting

Regional Opportunity Map and Reference Guide

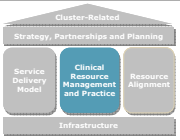
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
Vermillion Discharge Planning	• Explore and implement models of daily multidisciplinary discharge planning meetings at Vermillion.
Medicine Telemetry Practices Review	• Conduct a review of Medicine unit telemetry practices and develop evidence based indications for the initiation and discontinuation of telemetry.
Daysland Admission/ Discharge Criteria and Process	• Consider redefining ALC beds for increased and improved utilization – develop clear criteria for admission/discharge, and generate buy-in across region to no impact on appropriate ALC use. – This should also include a review of discharge and APPI process to improve alignment of care practices to care needs.
Review SAGE Admission/Discharge Process	• Examine admission criteria, discharge management and placement for SAGE to ensure optimal regional utilization, minimize fragmentation of patient care, and support with related education to referring providers.
PAC Policies and Procedures at Wainwright HC	• Continue focus on improved PAC policies and procedures, in alignment with broader regional programming.
MORE OB Training at Wainwright HC	• Continue MOREOB training for nursing staff without training, in alignment with regional obstetrics programming.

Regional Opportunity Map and Reference Guide

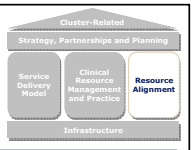
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
St. Mary's PAC and OR Booking Policies	• Develop and implement consistent policies and procedures to address in Pre-Admission Clinic and OR booking.
SMH Unit 5 Interdisciplinary Relationships	• Focus efforts improving interdisciplinary relationships on Unit 5.
Clinical Protocols	• Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management). • Additional focus should be on developing formalized ER clinical protocols that identify roles and responsibilities for MDs and RNs covering the ER, after-hours ER access, enabled by supporting education for staff and community.
Lab Order Set Review	• Review the use of lab order sets, with consideration of establishing pre-set order sets for select clinical protocols.
Region-Wide Formulary	• Develop a single common regional formulary for ECH and Associate Partners to minimize drug costs and improve quality controls.

Regional Opportunity Map and Reference Guide

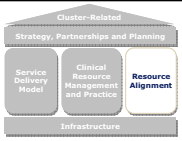
Resource Alignment



Key Opportunities	Description
St. Mary's Medicine Nurse Staffing	• Invest staffing in Unit 2 to bring staffing to peer levels and skill mix.
St. Mary's ER MD and Nurse Staffing	• Invest in ER staffing (1.4 FTEs) and skill mix enhancement to bring to peer levels. • Assign staff to CTAS triage RN during peak periods to improve consistency, etc. • Move to having MD in ER during peak periods for patient safety.
SMH Unit 5 Nurse Staffing	• Target identified staffing reductions for Unit 5 after interdisciplinary relationships are improved, with a focus on improving nursing skill mix.
St. Mary's Surgical Services Throughput	• Consider options to increase service throughput across the surgical services within existing staffing complement.
St. Mary's Mental Health Staffing	• Target staffing reduction (1.1 FTEs) for Unit 3 to align to recommended HPPD.
Rural Site Resource Alignment	• There are several opportunities for resource realignment across the rural sites available for consideration. These opportunities should be explored further in the context of broader regional community health needs, before action is taken.
Sexual Health Clinics	• Consider reallocating resources and offering regularly scheduled sexual health and STD clinics on a drop in basis.

Regional Opportunity Map and Reference Guide

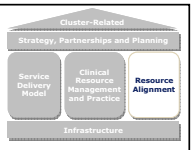
Resource Alignment (continued)



Key Opportunities	Description
DI Staffing Requirements	• Determine staffing requirements for DI once service utilization and siting planning is complete for ECH and Associate Partner sites.
OT/SLP/Audiology Staffing	• Consider staffing investments in Occupational Therapy and SLP/Audiology, as part of regional Rehabilitation Services Planning.
Social Work Discharge Planning Role	• Create common roles and responsibilities for Social Work related to discharge planning across the ECH and Associate Partners, which will require a staffing investment.
Recreation Therapy Staffing	• As part of regional planning to transition LTC to the Eden and DAL models, consider Recreation Therapy staffing efficiency opportunities.
Corporate Service Integration and Staffing	• Examine opportunities for further corporate service integration across ECH and the Associate Partners to contribute to staffing efficiency target.
Regional Decision Support Function	• Given staffing investment opportunity, explore the development of a common Decision Support function for the region and Associate Partners, supported by technology, with a focus on improving site-level management analysis support.

Regional Opportunity Map and Reference Guide

Resource Alignment (continued)



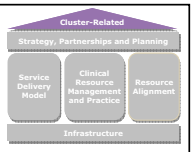
Key Opportunities	Description
Human Resources Staffing	• Integrate ECH and Associate Partner HR and OH&S functions, supported by identified staffing investment, and aligned to broader regional re-focus on HR strategy and management.
IT Staffing	• Consider staffing investment opportunity in IT, as part of broader regional resource planning for RSHIP and other IT initiatives.
Materiel Management Staffing	• Consider staffing investment opportunity in Materiel Management to align with increased ECH and Associate Partner integration, and in support of identified regional transportation opportunity.
Health Records Staffing	• Consider Health Records staffing investment to increase records purging, to alleviate storage space constraints.

Regional Opportunity Map and Reference Guide

Infrastructure

Key Opportunities	Description
ER Facilities Redevelopment Assessment	• As part of regional ER Strategy, consider infrastructure improvements to align Wainwright ER department to CTAS standards.
Technology-Based Security Solutions	• Explore options to implement technology-based solutions to provide added security to regional acute care sites, in alignment with regional ER strategy.
Automated Unit Dose Packaging Business Case	• Develop a business case for automated unit dose packaging, as part of a regionalized distribution model which uses St. Mary's as the hub.
TMS Functionality Improvement	• Review paper-based inspections processes with consideration of TMS functionality improvement and clerical support to reduce PHI administrative workload.
Regional Inventory Storage	• Consider expanding the planning for the new off-site inventory storage to play a broader regional inventory role.
Energy Management Plan and Business Case	• Develop a business case to examine benefits of investment in energy management plan, with consideration of identified facility role review.

Regional Opportunity Map and Reference Guide
Cluster/Provincial-Related



Key Opportunities	Description
Physician Alternative Payment Models	• Explore alternative payment models for physicians in the region, with an objective to improve resources and linkage to care/service delivery model. – Related to this opportunity, explore alternate staffing models to consider physician AFP options – e.g. APN/NP model in ER and community health clinics. – Consider medical compensation strategies that link to a regional medical HR plan.
Home Care Medication Payment Policies/ Procedures	• Establish clear policies and procedures for the payment of home care medications, and communicate to key stakeholders.

Regional Opportunity Prioritization
Introduction

- Based on a facilitated working session with the Region's Senior Management Team, the Project Team have developed an Opportunity Prioritization Map.
- Opportunity prioritization focused on sequencing, based on five key factors:
  - Opportunity Inter-Dependencies
  - Resource Requirements (Leadership, People, Financial, External Support)
  - Identified Risks
  - Timeline Feasibility
  - Priority Level to the Region
- The opportunity mapping (timeline) has six phases of effort:
  - Phase 1: 0-6 months
  - Phase 2: 6-12 months
  - Phase 3: 12-24 months
  - Phase 4: 24-30 months
  - Phase 5: 30-46 months
  - Phase 6: 36-42 months

Regional Opportunity Prioritization
Introduction (continued)

- During the working session with the region's Executive Team, opportunities were reviewed by phase of effort to discuss the appropriateness and feasibility of the preliminary prioritization.
- Throughout the discussion, a "go-forward determination" was also assigned to each opportunity to establish if phasing needs to be changed, deferred and / or not pursued:

  - ***Priority*** – Opportunities that are considered priorities for achievement by the region over the 42-month planning period.

  - ***Deferred*** – Opportunities which must be deferred at this stage, but which will be re-considered for pursuit in the future.

  - ***Not Pursued*** – Opportunities which are not considered as regional priorities, and so will not be pursued.

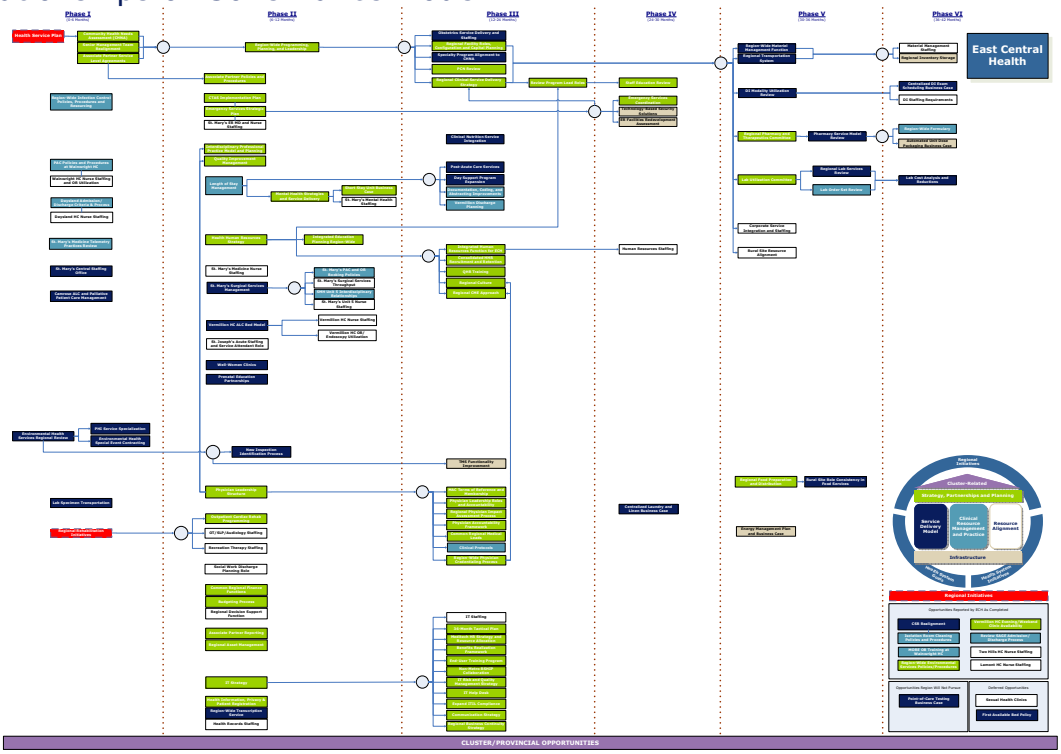
Regional Opportunity Prioritization
Introduction (continued)

- The final opportunity map has been developed in collaboration with the region, based on those opportunities identified as priorities by the region.

- For ECH specifically, two versions of the opportunity map are presented, to demonstrate the significant impact of the existing Associate Partner governance model on regional service delivery, and what ECH is able to do with or without those Partners in their current governance model:
  - The **full set** of opportunities that are 'Achievable by ECH **through** Improved Associate Partner Service Relationships or Governance Model'
  - The **subset** of opportunities that are 'Achievable by ECH **without** Improved Associate Partner Service Relationships or Governance Model'

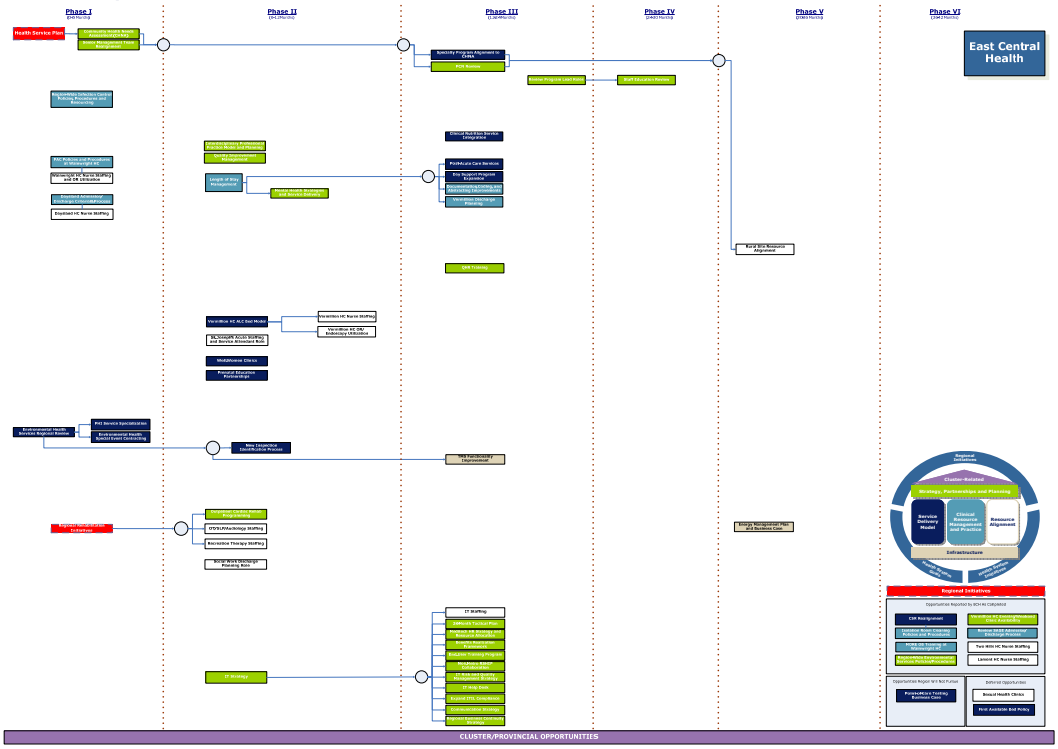
- Following these two versions of ECH's Opportunity Prioritization Map, a summary of the ECH Senior Leaders responsible for opportunity achievement is presented, which assumes that the full set of opportunities are targeted.

Regional Opportunity Prioritization Map – With Associates
Achievable by ECH **through** Improved Associate Partner Service Relationships or Governance Model



Regional Opportunity Prioritization Map – No Associates

Achievable by ECH **without** Improved Associate Partner Service Relationships or Governance Model



Regional Opportunity Prioritization

Regional Leads – Phase 1

Opportunity Name	Responsible Senior Lead
Community Health Needs Assessment	Steve Petz
Senior Management Team Realignment	Steve Petz
Associate Partner Service Level Agreements	Steve Petz
Region-Wide Infection Control Policies, Procedures and Resourcing	Dr. Odell Olson Phyllis Hempel
PAC Policies and Procedures at Wainwright HC	Phyllis Hempel
Wainwright HC Nurse Staffing	Phyllis Hempel
Daysland Admission/ Discharge Criteria and Process	Phyllis Hempel
Daysland HC Nurse Staff Mix	Phyllis Hempel
St. Mary's Medicine Telemetry Practices Review	Phyllis Hempel
St. Mary's Central Staffing Office	Phyllis Hempel
Camrose ALC and Palliative Patient Care Management	Phyllis Hempel
Environmental Health Services Regional Review	Brian Stevenson
PHI Service Specialization	Malcolm Kirkland
Environmental Health Special Event Contracting	Malcolm Kirkland
Lab Specimen Transportation	Dr. Odell Olson

Regional Opportunity Prioritization
Regional Leads – Phase 2

Opportunity Name	Responsible Senior Lead
Region-Wide Programming, Planning, and Leadership	Malcolm Kirkland Phyllis Hempel
Associate Partner Policies and Procedures	Steve Petz
CTAS Implementation Plan	Phyllis Hempel
Emergency Services Strategic Plan	Malcolm Kirkland Phyllis Hempel
St. Mary's ER MD and Nurse Staffing	Phyllis Hempel
Interdisciplinary Professional Practice Model and Planning	Phyllis Hempel Dr. Odell Olson
Quality Improvement Management	Phyllis Hempel Dr. Odell Olson
Length of Stay Management	Phyllis Hempel Dr. Odell Olson
Mental Health Strategies and Service Delivery	Phyllis Hempel Dr. Odell Olson
Short Stay Unit Business Case	Phyllis Hempel Dr. Odell Olson
St. Mary's Mental Health Staffing	Phyllis Hempel

Regional Opportunity Prioritization
Regional Leads – Phase 2 (continued)

Opportunity Name	Responsible Senior Lead
Health Human Resources Strategy	Malcolm Kirkland
Integrated Education Planning Region-Wide	Malcolm Kirkland
St. Mary's Medicine Nurse Staffing	Phyllis Hempel
St. Mary's Surgical Services Management	Phyllis Hempel
St. Mary's PAC and OR Booking Policies	Phyllis Hempel
St. Mary's Surgical Services Throughput	Phyllis Hempel
SMH Unit 5 Interdisciplinary Relationships	Dr. Odell Olson Phyllis Hempel
St. Mary's Unit 5 Nurse Staffing	Phyllis Hempel
Vermillion HC ALC Bed Model	Phyllis Hempel
Vermillion HC Nurse Staffing	Phyllis Hempel
Vermillion HC OR/ Endoscopy Utilization	Phyllis Hempel
St. Joseph's Acute Staffing and Service Attendant Role	Phyllis Hempel
Prenatal Education Partnerships	Phyllis Hempel
Well-Women Clinics	Phyllis Hempel

Regional Opportunity Prioritization

Regional Leads – Phase 2 (continued)

Opportunity Name	Responsible Senior Lead
New Inspection Identification Process	Malcolm Kirkland
Physician Leadership Structure	Dr. Odell Olson Malcolm Kirkland
Outpatient Cardiac Rehab Programming	Malcolm Kirkland
OT/SLP/Audiology Staffing	Malcolm Kirkland
Recreation Therapy Staffing	Malcolm Kirkland
Social Work Discharge Planning Role	Malcolm Kirkland
Common Regional Finance Functions	Norm Petherbridge
Budgeting Process	Norm Petherbridge
Regional Decision Support	Norm Petherbridge
Associate Partner Reporting	Norm Petherbridge
Regional Asset Management	Brian Stevenson
IT Strategy	Norm Petherbridge
Health Information, Privacy & Patient Registration	Norm Petherbridge
Region-Wide Transcription Service	Norm Petherbridge
Health Records Staffing	Norm Petherbridge

Regional Opportunity Prioritization

Regional Leads – Phase 3

Opportunity Name	Responsible Senior Lead
Obstetrics Service Delivery and Staffing	Phyllis Hempel
Regional Facility Roles, Configuration and Capital Planning	Steve Petz
Specialty Program Alignment to CHNA	Phyllis Hempel
Primary Care Network Review	Dr. Odell Olson Malcolm Kirkland
Regional Clinical Service Delivery Strategy	Phyllis Hempel Dr. Odell Olson
Review Program Lead Roles	Malcolm Kirkland Phyllis Hempel
Clinical Nutrition Service Integration	Brian Stevenson
Post-Acute Care Services	Phyllis Hempel
Day Support Program Expansion	Phyllis Hempel
Documentation, Coding and Abstracting Improvements	Norm Petherbridge Phyllis Hempel Dr. Odell Olson
Vermillion Discharge Planning	Phyllis Hempel

Regional Opportunity Prioritization

Regional Leads – Phase 3 (continued)

Opportunity Name	Responsible Senior Lead
Integrated Human Resources Function for ECH	Malcolm Kirkland
Consolidated HHR Recruitment and Retention	Malcolm Kirkland
QHR Training	Malcolm Kirkland
Regional Culture	Malcolm Kirkland
Regional CME Approach	Malcolm Kirkland Dr. Odell Olson
TMS Functionality Improvement	Malcolm Kirkland Norm Petherbridge
MAC Terms of Reference and Membership	Dr. Odell Olson
Physician Leadership Roles and Accountability	Dr. Odell Olson
Regional Physician Impact Assessment Process	Dr. Odell Olson Norm Petherbridge
Physician Accountability Framework	Dr. Odell Olson
Common Regional Medical Leads	Dr. Odell Olson
Clinical Protocols	Dr. Odell Olson Phyllis Hempel
Regional-Wide Physician Credentialing Process	Dr. Odell Olson

Regional Opportunity Prioritization

Regional Leads – Phase 3 (continued)

Opportunity Name	Responsible Senior Lead
IT Staffing	Norm Petherbridge
36-Month Tactical Plan	Norm Petherbridge
Meditech HR Strategy and Resource Allocation	Norm Petherbridge
Benefits Realization Framework	Norm Petherbridge
End-User Training Program	Norm Petherbridge
Non-Metro RSHIP Collaboration	Norm Petherbridge
IT Risk and Quality Management Strategy	Norm Petherbridge
IT Help Desk	Norm Petherbridge
Expand ITIL Compliance	Norm Petherbridge
Communication Strategy	Norm Petherbridge
Regional Business Continuity Strategy	Norm Petherbridge

Regional Opportunity Prioritization

Regional Leads – Phase 4

Opportunity Name	Responsible Senior Lead
Staff Education Review	Malcolm Kirkland
Emergency Services Coordination	Phyllis Hempel Dr. Odell Olson
Technology-Based Security Solutions	Phyllis Hempel Norm Petherbridge
ER Facilities Redevelopment Assessment	Brian Stevenson
Human Resources Staffing	Malcolm Kirkland
Centralized Laundry and Linen Business Case	Brian Stevenson

Regional Opportunity Prioritization

Regional Leads – Phase 5

Opportunity Name	Responsible Senior Lead
Region-Wide Material Management Function	Brian Stevenson
Regional Transcription System	Norm Petherbridge
DI Modality Utilization Review	Dr. Odell Olson
Regional Pharmacy and Therapeutics Committee	Dr. Odell Olson
Pharmacy Service Model Review	Dr. Odell Olson
Lab Utilization Committee	Dr. Odell Olson
Regional Lab Services Review	Dr. Odell Olson
Lab Order Set Review	Dr. Odell Olson
Corporate Services Integration and Staffing	Steve Petz Norm Petherbridge Malcolm Kirkland Brian Stevenson
Rural Site Resource Alignment	Phyllis Hempel
Regional Food Preparation and Distribution	Brian Stevenson
Rural Site Role Consistency in Food Services	Brian Stevenson
Energy Management Plan and Business Case	Brian Stevenson

Regional Opportunity Prioritization

Regional Leads – Phase 6

Opportunity Name	Responsible Senior Lead
Material Management Staffing	Brian Stevenson
Regional Inventory Storage	Brian Stevenson
Centralized DI Exam Scheduling Business Case	Dr. Odell Olson
DI Staffing Requirements	Dr. Odell Olson
Region-Wide Formulary	Dr. Odell Olson
Automated Unit Dose Packaging Business Case	Dr. Odell Olson
Lab Cost Analysis and Reductions	Dr. Odell Olson

Regional Opportunity Prioritization

Opportunities Deferred or Not Pursued

- The following opportunities were identified by the region as being either 'Deferred' or 'Not Pursued'. Regional commentary for these decisions is also provided.

Opportunity Name	Status	Commentary
Sexual Health Clinics	Deferred	• ECH has deferred decision on this opportunity until the completion of the Community Health Needs Assessment.
First Available Bed Policy	Deferred	• ECH has deferred decision on this opportunity, due to the existence of a voluntary first available bed policy in the region, and in consideration of ongoing work in their Long Term Care plan and model transition.
Point-of-Care Testing Business Case	Not Pursued	• ECH reports earlier consideration of Point-of-Care Testing, and that there is limited perceived benefit from this opportunity.