Deloitte.

AHW RHA Efficiency Review
Palliser Health Region

Governance and Accountability Overview

Final Report

July 13, 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

PHR Three-Year Plan

Three Year Plan

PHR Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Palliser Health Region'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
Regional Strategic Focus 1: Promoting and Protecting Health	

Deloitte Observations at the Operational Level

- One corresponding strategy identified related to **Wellness and Healthy Living.**
- Our consultation process has identified the following:
  - The 10 year Healthy Living Plan (2004) sets goals and strategies for increasing healthy behaviours and reducing chronic disease.
  - The recently completed community needs assessment provides a baseline from which to inform health care planning and monitor progress in achieving improvement in health status.
  - Health Promotion utilizes a population health approach, with programs in community nutrition, smoke free communities, injury prevention, and other areas. Consultation findings indicated an opportunity to expand injury prevention services.
  - The Chronic Disease Management, Living Healthy Program offers a number of programs aimed at enhancing healthy living and wellness.
  - Public Health provides a full range of services but there is an opportunity to expand sexual health services.
- Overall, regional planning related to this strategy appears to be robust, and performance indicators are clearly identified for both three-year and longer-term targets for success.

Three Year Plan

PHR Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Palliser Health Region'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 our region.
Regional Strategic Focus: Assessing the Needs of the Population	

Deloitte Observations at the Operational Level	• Although not separately identified as part of the region's four-part Strategic Focus framework, the region has identified this additional assessment focus as a key priority in its three-year health plan. • Two corresponding strategies are identified: – **1.1 Needs Assessment** – **1.2 Community Health Councils** • Both of these strategies are important elements to the ongoing health service planning and connection / responsiveness to communities served. • The region conducts regular community health needs assessments, which significantly supports its ongoing planning and development of health services. • The 2005 Community Needs assessment was developed through both community consultation and data gathering, and is providing information to inform health care planning in the Region. The region is currently in process of incorporating the findings from this assessment into planning. • The region currently has three CHCs: Central, Northern and Western. Stakeholders report ongoing challenges with respect to the engagement of the Western CHC in regional vs. local issues.

Three Year Plan

PHR Strategy Mapping AH&W Goals & Legislated Responsibility

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

Health System Goals 3 and 4	Legislated Responsibilities 3 and 4
• Improve Access to Health Services • Improve Health Services Outcomes	• Determine priorities in the provision of health services in the region and allocate resources accordingly. • Ensure that reasonable access to quality health services is provided in and through the health region

Deloitte Observations at the Operational Level	• Five corresponding strategies identified: – **3.1 Access to Services** – **3.2 Quality of Service** – **3.3 Primary Care** – **3.4 Mental Health** – **3.5 Continuing Care** – **3.6 Aboriginal Health** • Strategies/programs in Mental Health are integrated across the continuum of care, including the Child/adolescent program and Partial Hospitalization program. Community treatment plans accompany inpatient admissions, which supports continuity of care. • Recent development of Quality Committees is a good strategy, however it has substantial work effort related to pulling all initiatives together and linking it to decision-making. • The Primary Care clinic offered at Bassano was one of the first programs offered in Alberta and is recognized as leading practice. • The implementation of the Geriatric Assessment Program will positively impact quality of care provided to seniors through the seniors outreach (day hospital), vascular prevention clinic and the community outreach team. The regional Palliative Care Program supports continuity of care from acute to community. • The implementation of the MDS tool will provide valuable information continuing care clients. • Aboriginal health delivery is embedded in general care delivery. Other special target populations also warrant focus. • Although several wait time measures are identified to support strategy 3.1 that still require performance indicators to drive and track progress to the strategy (e.g. Prostate Cancer)

Three Year Plan

PHR Strategy Mapping AH&W Goals & Legislated Responsibility

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

Health System Goals 5 and 6	Legislated Responsibility 5
• Health System Sustainability • Create Organizational Excellence	• Promote the provision of health services in a manner responsive to the needs of individuals and communities and support the integration of services and facilities in the region.
Regional Strategic Focus 3: Adapting Technology and Resources **Regional Strategic Focus 4: Improving Delivery and Efficiency**	

Deloitte Observations at the Operational Level	• **Three corresponding strategies identified:**
	  – **3.7 Workforce**
	  – **4.1 Information and Technology**
	  – **4.2 Cost of Services**
	• The organization has developed a nursing workforce planning document and is in the process of working through the action plan. Once complete it will be rolled out to other professions. Innovative strategies include the use of supernumerary positions for new graduate nurses and the adoption of HPNet.
	• Education skills days offered for nurses at Medicine Hat are now being expanded to the rural sites.
	• Health Human Resource Plan (May 06) is developed, however it does not include the level of detail required for effective physician human resource planning. The region is planning to develop a comprehensive workforce plan in Fall 06 – it is suggested that this include management, staff and physicians workforce needs throughout the region.
	• The region is focused heavily on the Meditech implementation to drive strategy 4.1, with no specific measures or actions about other IT systems initiatives. The region's current lack of an IT strategic plan is an important missing input into the health plan.
	• Although the region has identified cost of services as a strategic focus, no measures have yet been identified.

Three Year Plan

PHR Challenges and Opportunities Section

- Deloitte's review of Palliser Health Region'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, with clear performance measures and year-over-year targets to track progress to the tactical approaches for each strategic focus.
  - Consultation findings across the strategic areas of focus and supporting tactical approaches have identified generally good progress towards the health plan.
  - The establishment of a regular community health needs assessment for the region is an important input into planning, and should be maintained.
  - An Annual Plan is not separately developed in PHR as it is in some of the other regions, and so commentary is incorporated into three-year plan observations.

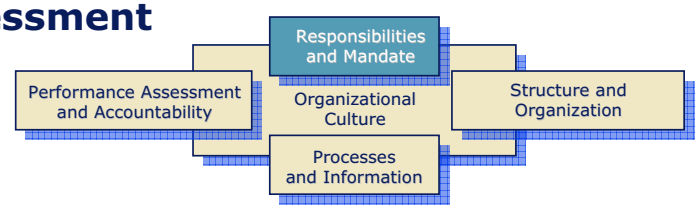
PHR Governance Assessment

PHR 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

PHR Governance Assessment

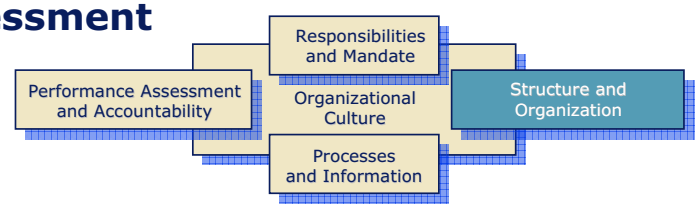
Responsibilities and Mandate



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 some members may not be completely familiar with their responsibilities and personal liabilities associated with their regional governance role, and that management is well-trusted to provide guidance to Board. This suggests an opportunity for further board development and education. • Board has regular involvement with community stakeholders by rotating its meetings through each community twice per year, and through the Community Health Councils.

PHR Governance Assessment

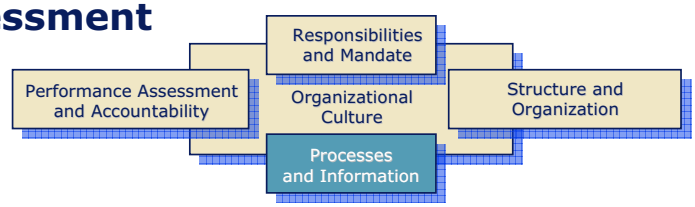
Structure and Organization



Areas of Assessment	• Appropriate number of members and meetings • Appropriate representation of communities • Committee structure • Self assessment
Deloitte Observations	• The Board currently has 13 members, with some members serving since 1995. The Board Chair reports a good mix of community representation. • Board self reports effective working structure for board, with 11 scheduled meetings to address regular Board work and ongoing needs. • The Board has established several committees to focus Board activities, with primarily reliance on the Corporate Services and Health Services Committees. A new Quality Improvement and Patient Safety Committee has been established in 2006-07 to better inform the Board on related issues. • The Board conducts annual self assessment, with consideration of meetings, structure and committees to support board processes.

PHR Governance Assessment

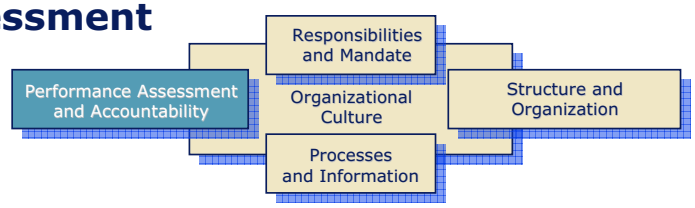
Processes and Information



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. • All board meetings are reported as being documented, to support decision-making. • Formal orientation process for new Board Members in place. • The Board Chair reports that there is a good mix of required skills and competencies across the board, and that this is not a focus for recruitment. • The Board operates under a set of by-laws and guidelines, which apply to the full Board and its committees.

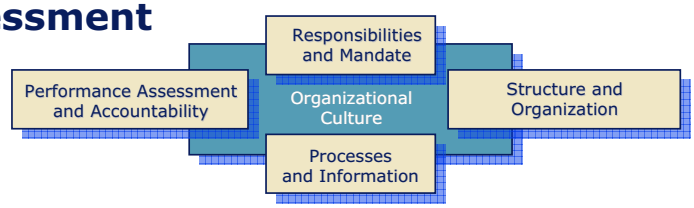
PHR Governance Assessment

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. An evaluation of the Board as a whole is conducted, as well as individual self-evaluation by Board members. • A separate Board evaluation of the CEO is also conducted annually by the Board, and Senior Management team feedback is also considered. The Board recognizes that it's primary employee relationship is through the CEO, and as such focuses on governance and policy vs. operations. • The Board reports that risk management reporting is in place at a Board level. In part, this is supported by an annual briefing of liability insurance.

PHR 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 three Community Health Councils, but the Western CHC is reported as being not effectively engaged in the region. The Board also reports good community representation in its own membership, which at times drives local vs. regional focus in Board discussions.

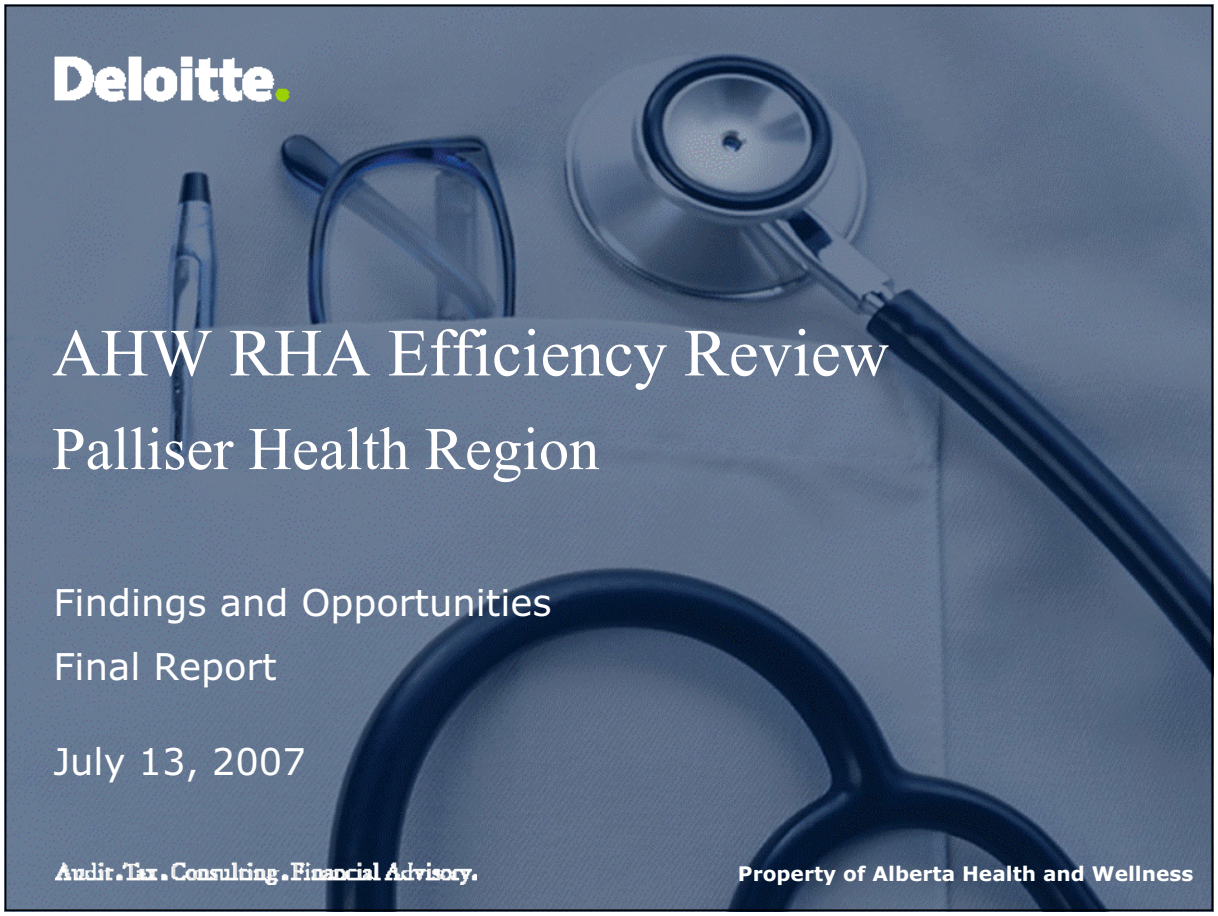
Concluding Comments
PHR

Strengths to build on include…

- **Established process for regular Community Health Needs Assessment**
- **Board commitment to regular rotation of meetings through regional communities**
- **Identification of need for renewed health human resource workforce planning**

Areas for further development and assessment…

- **Identification of measures to support Cost of Services strategic focus**
- **Expansion of Information Technology tactical approaches to incorporate regional IT strategic planning**
- **Integration of physician human resources strategy and workforce planning into broader regional initiative**
- **Improved regional engagement of Western CHC**



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Palliser Health Region

Findings and Opportunities

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Project Overview

Project Overview

Scope, Objectives and Business Drivers

Scope:

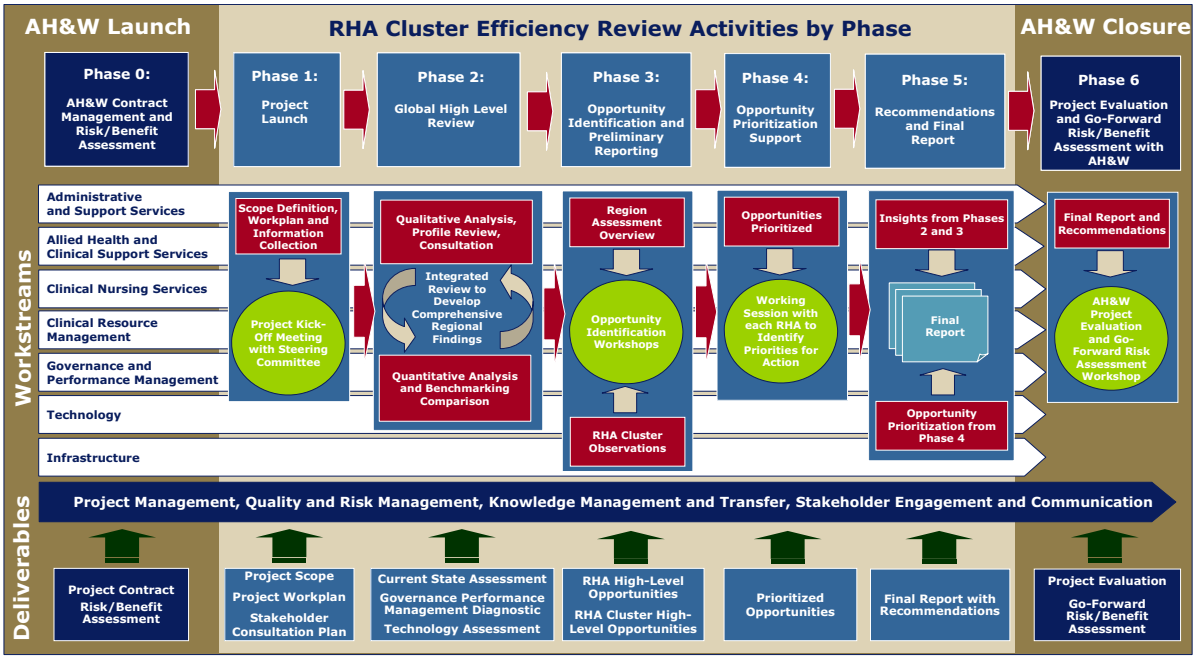
- Alberta Health and Wellness is undertaking an RHA Efficiency Review to identify potential efficiencies and opportunities for improvement within each of the RHAs in the province.
- To achieve this purpose, this Review is focusing its scope on improvements to deployment across five key dimensions:
  - 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 Strategy and Management
  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.

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 data. A straight-line projection on 2005-06 Q3 data was used to project patient 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 Palliser's acute ALOS by CMG to the CIHI acute ELOS. The analysis is based on the 2004-05 data.
  - 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.

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

CIHI Abstract Data (Region)

- The Top 10 Patient Services accounts for the 74% of the region's total caseload.
- Comparison over the past three fiscal years suggests a fairly consistent distribution of key patient services:
  - Gastroenterology represents 13%, Newborn and Obstetrics each represent 10%, Cardiology represents 9% and Psychiatry represents 8% of current volume

Patient Service	2003-04	2004-05	2005-06 Proj.	Variance
Gastroenterology	1,722	1,824	1,764	2%
Newborn	1,271	1,272	1,360	7%
Obstetrics Delivered	1,259	1,258	1,351	7%
Cardiology	1,196	1,259	1,260	5%
Psychiatry	1,098	1,027	1,151	5%
Traumatology	803	832	900	12%
General Medicine	796	664	777	-2%
Respirology	703	763	632	-10%
Urology	595	641	667	12%
Dentistry	563	490	492	-13%
Top 10 Patient Services Total	10,006	10,030	10,353	3%
Other Patient Services Total	2,558	2,848	3,725	46%
Region Patient Services Total	**12,564**	**12,878**	**14,079**	**12%**

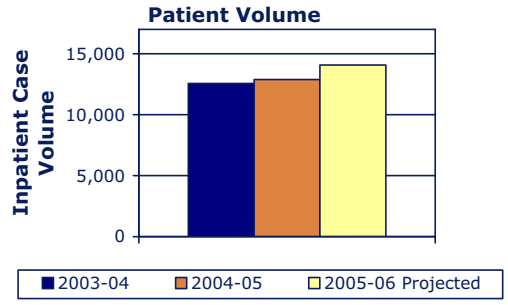
Top 10 Patient Services (2003-04 to 2005-06 Projected)

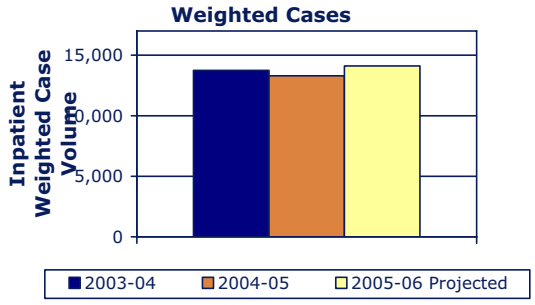
CIHI Abstract Data (Medicine Hat Regional Hospital)

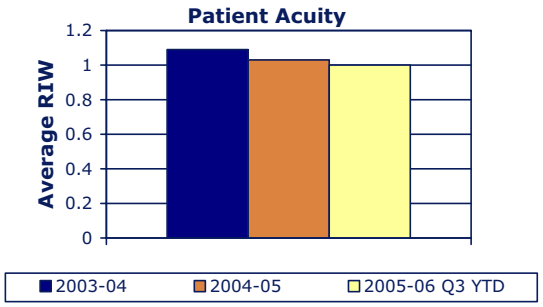
- The Top 10 Patient Services accounts for the 73% of the hospital's total caseload, and 56% of the region's caseload.
- Comparison over the past three fiscal years suggests an increase in several key patient services: Orthopedics, Traumatology and General Medicine.

Patient Service	2003-04	2004-05	2005-06 Proj.	Variance
Gastroenterology	1,296	1,382	1,325	2%
Newborn	953	992	1,037	9%
Obstetrics Delivered	939	974	1,025	9%
Cardiology	864	883	961	11%
Psychiatry	840	801	901	7%
Traumatology	606	658	709	17%
General Medicine	461	431	516	12%
Urology	459	468	503	10%
Orthopedics	332	441	436	31%
Dentistry	504	420	429	-15%
Top 10 Patient Services Total	**7,254**	**7,450**	**7,844**	**8%**
Other Patient Services Total	**2,089**	**2,258**	**2,951**	**41%**
MHRH Patient Services Total	**9,343**	**9,708**	**10,795**	**16%**

Patient Volume, Weighted Cases and Patient Acuity
(Region)

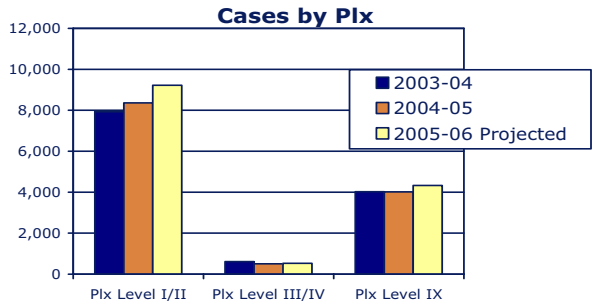


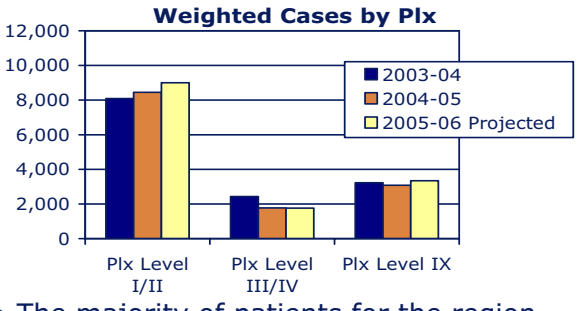


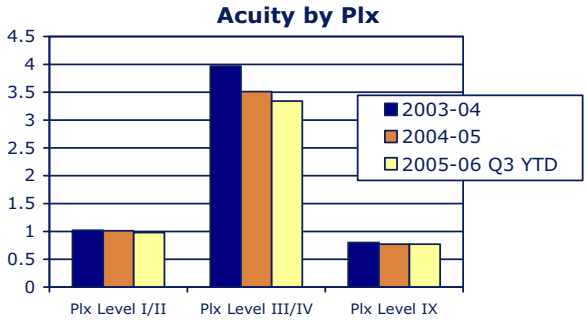


- Overall patient acuity for the region has declined by 8% since 2003-04.
- Although patient cases have increased by 12% over this same period, this decline in acuity has resulted in only a moderate change in weighted cases.

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







- The majority of patients for the region are Plx level I/II.
- Patient volumes have increased for Plx I/II and Plx IX while there has be a 14% decrease in Plx III/IV.
- Acuity decreased across all Plx levels, with the greatest decrease in Plx III/IV (16%).
  - Part of this may be driven by an increase in MNRH volumes.
  - A challenge in understanding acuity for 2005-06 is the reported backlog in coding and abstracting.

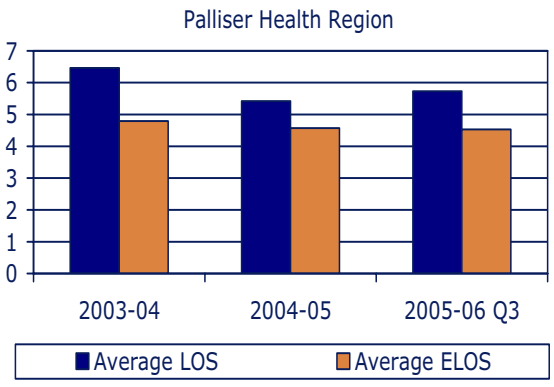
Import/Export Inpatient Volumes for Palliser
By Complexity for 2004-05 (Region)

As a % of Total Cases for each Plx	2004-05			
	Plx I/II	Plx III/IV	Plx IV	Total
% Imports	4%	1%	2%	3%
% Exports	15%	28%	9%	14%

- In examining the impact of import/export on inpatient volumes for 2004-05, an overall average of 3% of patients were imported into Palliser in 2004-05.
- Overall, 14% of inpatient volumes were exported from Palliser in 2004-05
  - Plx III/IV patients demonstrated the highest level of export, at 28%.
  - Further examination suggests that 87% of exported patients are sent to the Calgary Health Region.
- Although not demonstrated here, analysis suggests that imports/exports as a % of total cases has not changed significantly for Palliser over 2003-04 and 2004-05.
  - Further the proportion of import/export by Plx level has also been comparable over the two-year period.

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

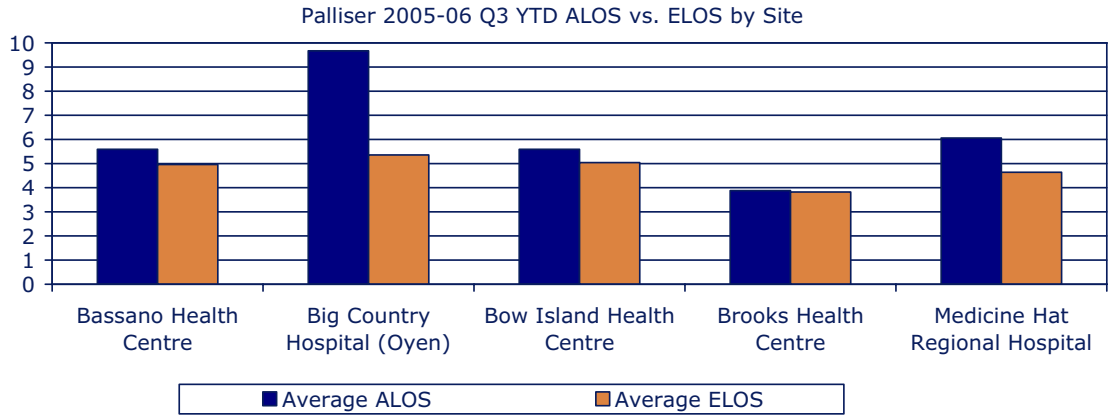
Average Length of Stay vs. Expected Length of Stay
(Region)



- Length of Stay analysis reveals that Palliser's average length of stay (ALOS) is consistently higher than the CIHI expected length of stay (ELOS).
- However, progress in effectively managing LOS is noted in that the ALOS – ELOS gap across all Plx categories has been decreasing over the trended period, which suggests the benefits in the usage of the Continuum Solutions system and other regional utilization management processes.
- The chart below shows that the patients in Plx I/II and III/IV are driving the ALOS – ELOS gap.

Fiscal Year	PLx Level I/II		Plx Level III/IV		Plx Level IX	
	ALOS	ELOS	ALOS	ELOS	ALOS	ELOS
2003-04	**6.0**	4.0	**20.0**	14.2	**5.4**	4.9
2004-05	**5.1**	4.0	**14.3**	13.6	**5.0**	4.6
2005-06 Actual	**5.4**	3.9	**16.0**	14.1	**5.2**	4.7

Average Length of Stay vs. Expected Length of Stay
By Site



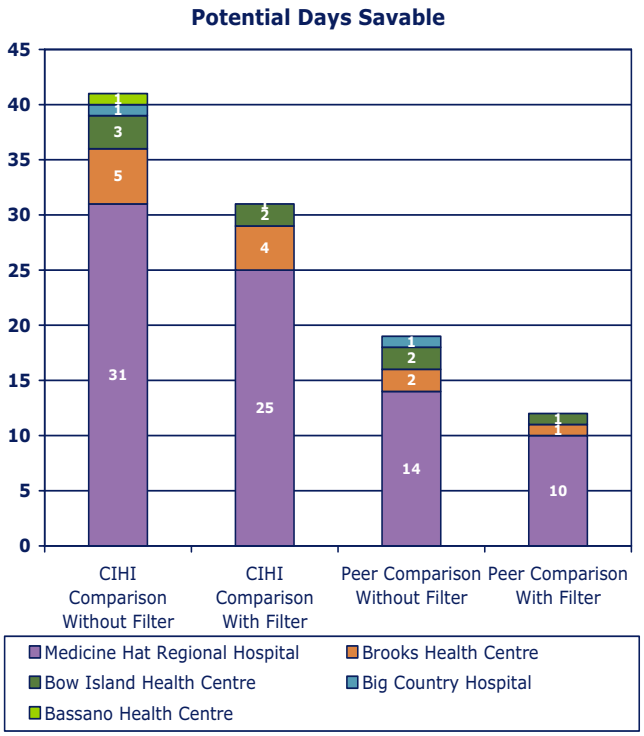
- All facilities demonstrated a higher ALOS relative to ELOS.
- The greatest gap between ALOS and ELOS is at Big Country Hospital in Oyen, however MHRH is the primary driver of the regional ALOS to ELOS gap, given higher patient volumes.

Top 10 CMGs by Potential Days Savable in 2004-05
(Region)

CMG	CMG Description	Total Cases	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	Other Factors Causing Hospitalization	276	11.0	6.2	4.8	1,324
773	Dementia with or without Delirium without Axis III Diagnosis	61	22.0	10.8	11.2	685
294	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disease	734	3.8	3.1	0.6	471
783	Psychoactive Substance Dependence	96	9.3	4.4	4.9	469
847	Other Specified Aftercare	126	12.2	9.1	3.1	391
253	Major Intestinal and Rectal Procedures	52	15.2	9.4	5.8	302
512	Other Transurethral or Biopsy Procedures (MNRH)	107	4.8	2.1	2.7	292
784	Psychoactive Substance Abuse	73	6.4	2.5	3.9	284
237	Arrhythmia	203	4.7	3.3	1.4	283
536	Urinary Obstruction (MNRH)	192	3.3	1.9	1.4	274
Top 10 Region CMGs Total		**1,920**				**4,775**
Other 320 Region CMGs Total		**10,958**				**6,718**
Total Region CMGs		**12,878**				**11,493**

- Leading CMGs for savable days are "Other Factors" and "Other Specified Aftercare", which suggest a cumulative opportunity of almost 5 beds savable. Although not shown here, 2005-06 analysis suggests that the opportunity for these two CMGs has increased to almost 7 beds savable. This suggests further analysis and potential coding improvements may be required to identify appropriate strategies for LOS management.
- Mental Health also shows opportunity across CMGs 773, 783, and 784, which suggests potential opportunity for expanding community-based mental health resources. Similar findings were observed in 2005-06 analysis.
- 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
(Region)



- Comparison of Palliser ALOS to CIHI ELOS suggests that the Region could save as many as 41 beds (total of 15,086 potential savable days).
- When compared to peers, using the filter process, the region's potential bed savable reduces to 12 beds (4,272 potential days), the majority of which are located at Medicine Hat Regional Hospital, suggesting a focus for opportunity for the region.

- 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.

Top 10 CMGs by Peer Potential Days Savable in 2004-05
(Medicine Hat Regional Hospital)

CMG	CMG Description	Total Cases	Average Length of Stay	Potential Days Savable
783	Psychoactive Substance Dependence	63	10.5	282
512	Other Transurethral or Biopsy Procedures (MNRH)	107	4.8	243
784	Psychoactive Substance Abuse	44	8.9	231
354	Knee Replacement	141	7.9	220
781	Alcohol Induced Organic Mental Disorders without Axis III Diagnosis	15	18.9	168
536	Urinary Obstruction (MNRH)	97	4.2	156
138	Respiratory Neoplasms	31	16.6	153
237	Arrhythmia	132	5.5	134
609	Vaginal Delivery with Complicating Diagnosis	247	3.2	129
253	Major Intestinal and Rectal Procedures	52	15.2	128
Top 10 CMGs Total		**929**		**1,844**
Other 313 CMGs Total		**8,779**		**1,648**
Total CMGs		**9,708**		**3,492**

- Mental Health CMGs 783, 784 and 781 show a cumulative opportunity close to 2 beds, which suggests potential opportunity for expanding community-based mental health resources.
- Opportunity for CMGs 512 and 536 suggest the need to shift to a day procedure model, which could potentially yield approximately 1 bed savable.
- The region also has several CMGs which are uncommon among peers for inpatient admissions, such as CMG 93 – Tonsillectomy (in 2005/06 Q3, there were 265 cases).
- The remaining days savable for MHRH are distributed across multiple CMGs, and may be difficult to achieve.
- 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 a Registered Nurse certified in MCAP. She reviewed the charts of all admitted inpatients in the Acute Care settings between July 10 to July 13, 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?

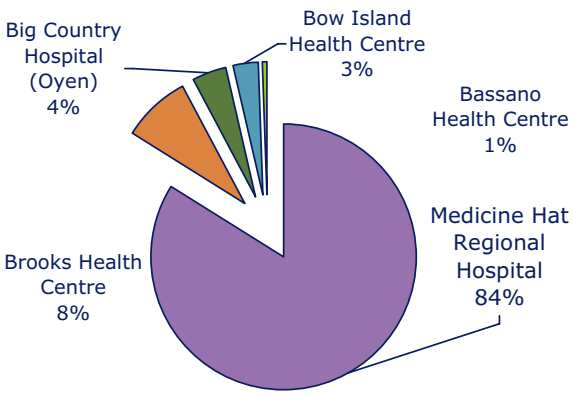
Patient Profile

PHR Acute Care

- 191 patients were reviewed at the acute care sites within the Palliser Health Region. This represents 76% of the total number of acute care bed capacity (250) within these sites.
- The average age of patients was 63 years. Medicine Regional Health Centre, with an average age of 63, clearly drives this average - the average age at Brooks is 41 years whereas the other centre's average is 70-88 years.
- 58% of patients were female and 42% were male.

Site	Total Number of Beds	Number of Beds Reviewed
Medicine Hat Regional Hospital	178*	160
Brooks Health Centre	36	16
Big Country Hospital (Oyen)	10	8
Bow Island Health Centre	10	6
Bassano Health Centre	4	1
Grand Total	**238**	**191**

Proportion of Beds Reviewed



*Medicine Hat Regional Hospital closed 12 beds during the2006 summer season. Typically, MHRH has a total of 190 beds.

Patient Profile by Site and Service

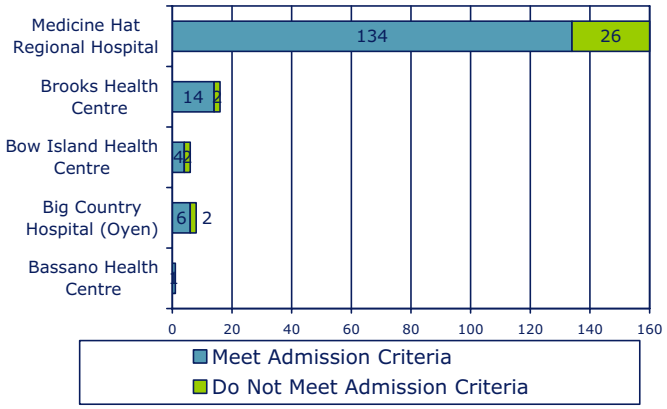
PHR Acute Care

Site	Patient Service	Number of Beds Reviewed
Brooks Health Centre	Medicine	8
	Obstetrics	7
	Paediatrics	1
Brooks Health Centre Total		**16**
Big Country Hospital (Oyen)	Combined Medicine-Surgery	8
Big Country Hospital (Oyen) Total		**8**
Bow Island Health Centre	Combined Medicine-Surgery	6
Bow Island Health Centre Total		**6**
Bassano Health Centre	Combined Medicine-Surgery	1
Bassano Health Centre Total		**1**
Regional Site Total		**31**

Site	Patient Service	Number of Beds Reviewed
Medicine Hat Regional Hospital	Medicine	76
	Combined Medicine-Surgery	41
	Psychiatry	17
	Obstetrics	12
	Paediatrics	5
	ICU	4
	Gynaecology	3
	NICU	2
Medicine Hat Regional Hospital Total		**160**
Regional Total		**191**

Patients Who Meet Clinical Criteria for Admission

PHR Acute Care

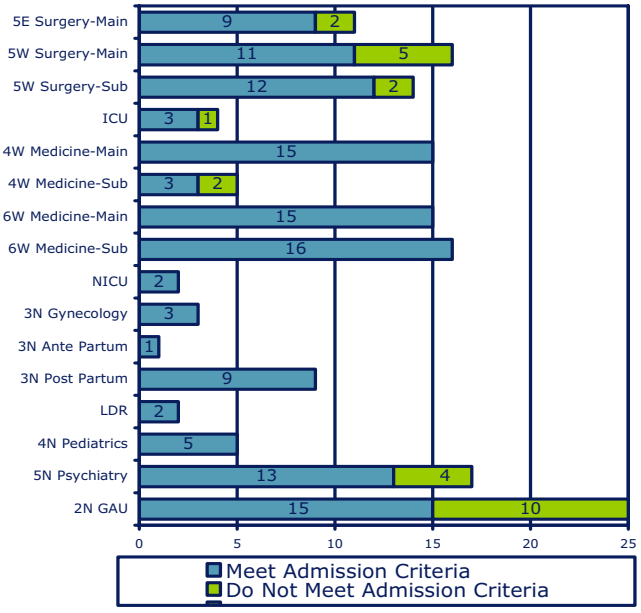


Site	Percent at Appropriate Level
Bassano Health Centre	100%
Big Country Hospital (Oyen)	75%
Bow Island Health Centre	67%
Brooks Health Centre	88%
Medicine Hat Regional Hospital	84%
Total for Region	**83%**

- For the patient charts reviewed across PHR, 159 out of 191 patients (or 83%) met clinical criteria for admission to the service they were on.
- Our experience with other regions and hospitals in Canada suggest that PHR is performing above average. The observed average for Canadian facilities ranges between 65-75% of patients in the most appropriate care setting.
- This performance supports stakeholder reports of good success with the implementation of the Continuum Solutions system and the region's utilization management initiatives.

Patients Who Meet Clinical Criteria for Admission

Medicine Hat Regional Hospital Acute Care

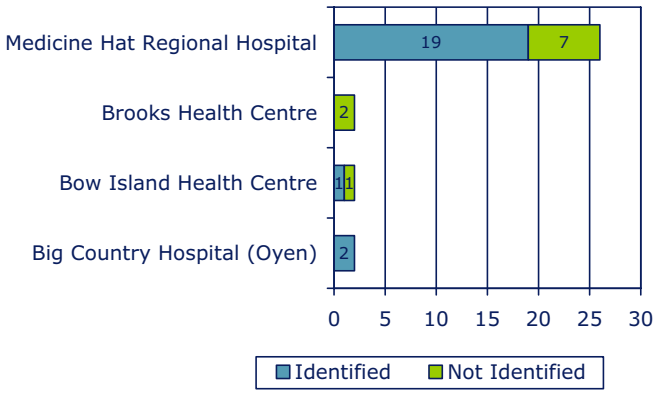


Service	Unit	Percent Meeting Clinical Criteria for Admission
Surgery	5E Main	82%
	5W Main	69%
	5W Sub	86%
Surgery Total		78%
Medicine	ICU	75%
	4W Main	100%
	4W Sub	60%
	6W Main	100%
	6W Sub	100%
Medicine Total		95%
Perinatal and Pediatrics	NICU	100%
	3N Main	100%
	3N Main Ante Partum	100%
	3N Main Post Partum	100%
	LDR	100%
	4N Pediatrics	100%
Perinatal and Pediatrics Total		100%
Psychiatry	5N Main	76%
Geriatric Assessment	2N GAU	60%
Grand Total		**84%**

- Further examination of the MHRH revealed that overall, 134 out of the 160 patients reviewed (84%) meet the clinical criteria for admission – demonstrating a small opportunity for improvement.

Patients Identified as Requiring a Different Level of Care

PHR Acute Care



Site	Percent Identified as Requiring a Different Level of Care
Big Country Hospital (Oyen)	100%
Medicine Hat Regional Hospital	73%
Bow Island Health Centre	50%
Brooks Health Centre	0%
Total for Region	**69%**

- Of the 32 patients who did ***not*** meet clinical criteria across the region, 22 (69%) of this group were already identified by the facilities as requiring a different level of care.
- This suggests that only 10 patients of the 191 patient charts reviewed did not meet clinical criteria and were not identified as such.

Required Level of Care for Patients

PHR Acute Care

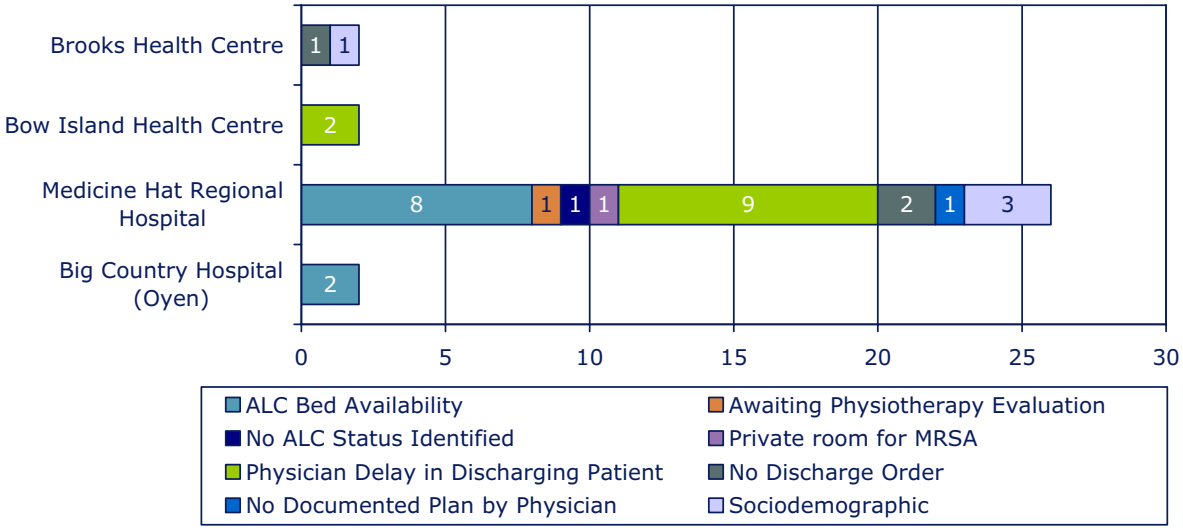
Required Level of Care	Big Country Hospital (Oyen)	Bow Island Health Centre	Brooks Health Centre	Medicine Hat Regional Hospital	Grand Total
Long Term Care	2	1		8	**11**
Home care		1		8	**9**
Outpatient Psychiatry			1	4	**5**
Alternative Level of Care				3	**3**
Acute (see below)				2	**2**
Rehabilitation				1	**1**
Home			1		**1**
Grand Total	**2**	**2**	**2**	**26**	**32**

- Of those patients who did ***not*** meet clinical criteria for acute care admission, the most frequently observed level of care required was Continuing Care and Home Care.
- Of the patients who required a different level of Acute setting, one patient in ICU required a private surgical room due to MRSA and the other patient required acute care in a "closer to home" acute hospital.

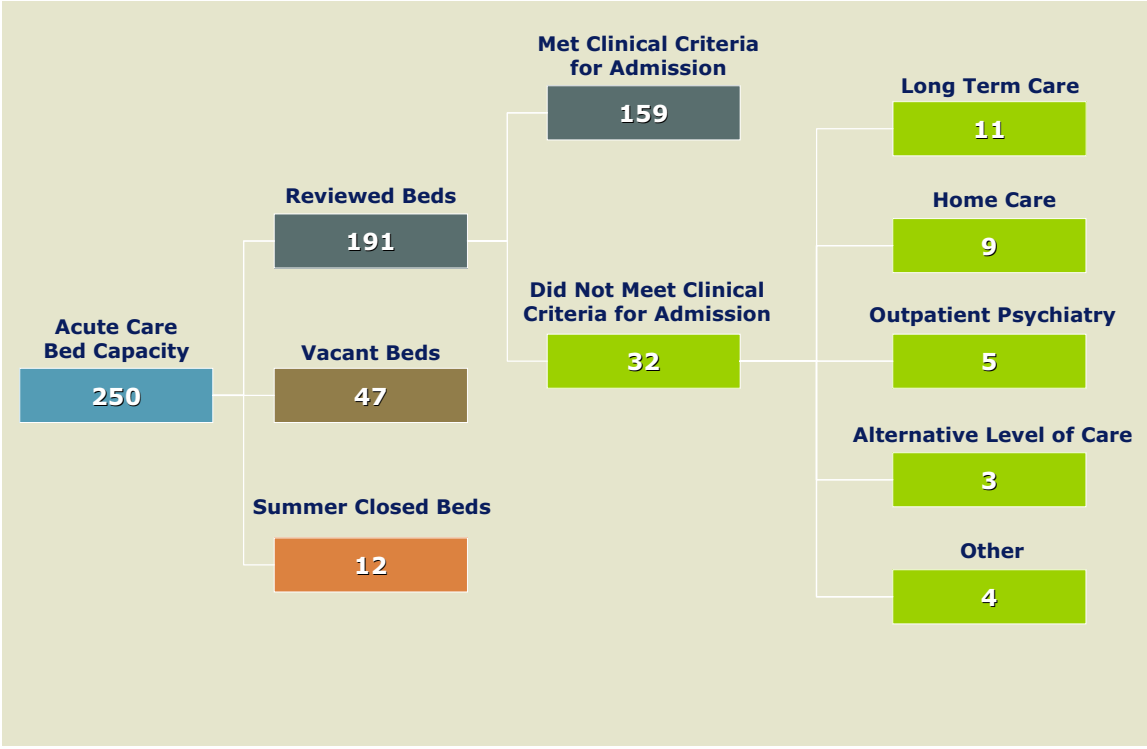
Reasons Patients Did Not Meet Clinical Criteria

PHR Acute Care

- Of the 32 patients who did ***not*** meet clinical criteria, 34% were due to a physician delay in discharging the patient.
- The second most common reason was due to challenges in accessing an ALC bed within the region (31%).



PHR Acute Care Profile Summary: July 10 – 13, 2006



Clinical Resource Management Opportunities

Opportunities	Findings
1. Continue to develop strategies for LOS management focused on the following: – Develop and implement policies to increase use of day procedures across identified areas to achieve improved bed utilization. – Assess need for improvements to regional coding and abstracting. – Continue planning efforts to increase continuing care capacity. – Improve discharge planning and coordination across continuum for mental health population to reduce mental health related LOS targets.	• CMG analysis revealed several CMGs with uncommon admissions relative to peers, typically being classified as MNRH. Examples include tonsillectomies and other ENT procedures, biopsy procedures, and several urinary-related procedures. • Consultation findings support observations related to a high level of inpatient admissions of tonsillectomy procedures, which is out of line with peer practice.
	• Analysis identified CMG 851 (Other Factors Causing Hospitalization) and CMG 847 (Other Specified Aftercare) as having a high potential days savable to both ELOS and peers. • Additional coding and abstracting focus is required to help the region more discretely identify and manage this patient volume.
	• The MCAP review found that 11 out of 32 patients in PHR who did not meet acute care criteria for admission that required long term care or assisted living services and facilities.
	• Based on the CMG analysis relative to peers, PHR has an opportunity to reduce length of stay across several CMGs, particularly in mental health. • The MCAP review found that several admitted patients required out-patient mental health services.

Clinical Service Delivery Review
Introduction

- Our review of the clinical programs and facility-based care across PHR 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 Acute Care Findings and Opportunities
  - Acute Care Site and Program Findings and Opportunities
  - Community Health Services 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 Acute Care Findings and Opportunities

Region Acute Care Findings and Opportunities

Opportunities	Findings
1. Review and determine desired organization model such as program management and corresponding structure, with consideration of: • MHRH-based vs. regional • Health Continuum (e.g. acute only, cross-continuum) • Leadership (nursing/medical co-leads) • Extent of Authority (budget vs. planning)	• The organizational structure is in transition on several fronts, specifically related to the evolution to program management and the shift to Patient Care Managers. • In addition, there have been a number of vacancies in supervisory and management positions. • This combination of factors has resulted at times in unclear or split lines of accountability (e.g. Medicine) and opportunities to improve resource management (e.g. ICU/ER). • Stakeholder consultation in the allied health areas report a preference to stay in current organization model, and not shift to program-based delivery.
2. Conduct regional assessment of CTAS use in the ER to determine resources, education support, and policies and procedures required to standardize use across the region.	• Consultation findings suggests several issues related to CTAS in the rural sites, including: – Physical plant does not support CTAS standards (e.g. first point of contact is a triage desk, staffed by nursing, waiting room not visible to nurses) – Varied compliance to CTAS recording

Region Acute Care Findings and Opportunities (continued)

Opportunities	Findings
3. Continue to support the roll out of full scope of practice for RNs and LPNs.	<u>Nursing Education</u> • Palliser provides an extensive array of professional development (including orientation) opportunities to staff. Of particular note are the skill review and nursing education days which provide staff access to a number of topics within one day, A rural education day was piloted in Brooks in June and one was scheduled in Oyen for the fall. • An Education Passport has been developed which allows staff a simple but effective way of tracking education completed. • The organization is to be commended on its regional nursing practice committee and its move to standardized regional documentation systems and processes. • Nursing staff are moving toward a modified primary care model, with LPN and RN staff functioning at full scope with individual patient assignments. An educational process was provided by the Regional Educators, consisting of 2 classroom days and 2 days individual unit based buddying and support for LPNs, as well as sessions for RNs on change, and charge nurse responsibilities. Nursing staff will continue to require support as this change rolls out. • RNs continue to require support in moving from traditional roles (e.g. med nurse) to taking a full patient assignment, including expanded discharge planning and patient education.

Region Acute Care Findings and Opportunities
(continued)

Opportunities	Findings
4. Review skill mix, including the roles of health care aides to ensure that they are operating within an appropriate scope of practice within the acute care setting.	• Skill Mix analysis indicates that in many units the percentage of Registered Nursing staff is lower than peer practice. According to CARNA, the more complex and unpredictable the environment, the more qualified the provider needs to be to provide the full range of potential care requirements, assess changes, re-establish priorities and recognize the need for additional resources as required – Most medical/surgical nursing units at MHRH have health care aides, many of who were absorbed after the CCC beds were closed. Consultation findings indicated that these individuals are involved in patient care, including bathing, simple dressings, etc. Peer experience indicates that when health care aides move from CCC to acute care, they may continue to perform similar care activities with more acute patients. – Employers and registered nursing staff are responsible for determining what tasks are appropriate for unregulated care providers (UCPs) and ensuring that on a daily basis there is an assessment of each client's situation and condition, the activity and associated risk, and the environmental supports available. Employers are responsible for ensuring client safety when UCPs are allowed to perform tasks without considering the context of the client's situation. **Source: College & Association of Registered Nurses of Alberta. Guidelines for Assignment of Client Care and Staffing Decisions, March 2004**

Region Acute Care Findings and Opportunities
(continued)

Opportunities	Findings
5. Palliser should implement medical protocols, as opposed to standing orders. CARNA states that • " Medical protocols apply to a range of clients who meet certain conditions or criteria… Medical protocols are evidence-based and pre-approved by the appropriate medical and nursing authority within an agency, and are supported by agency and nursing policy. Medical protocols should be reviewed on a regular basis to ensure that they continue to reflect best practice knowledge. Medical protocols must identify the specific medication(s), condition(s), and circumstances(s) that must be present before being implemented." **Source: College & Association of Registered Nurses of Alberta. Medication Administration: Guidelines for Registered Nurses, December 2005.**	• There are 167 Standing Orders in place across the region. They require physician signature but consultation findings indicate that sometimes this is a telephone order or is obtained after the fact, which presents a risk to the organization. This is a particular concern in ICU as nurses report reluctance to call certain Internists at night. • CARNA does not recommend standing orders for the following reasons: – "In contrast to medical protocols, standing medication orders are not developed from a multidisciplinary perspective, are not evidence-based, and provide limited information to care providers. Because they do not specifically identify the conditions and circumstances that must be present before being implemented, they are not considered as representing best practice knowledge"

Region Acute Care Findings and Opportunities
(continued)

Opportunities	Findings
6. Review staffing and scheduling processes as well as schedules to ensure adequate baseline staffing, consistent staffing patterns, and sufficient replacement staff.	• Current schedules and staffing/scheduling processes cause challenges at times: – Mix of 8 and 12 on some units causes difficulty in finding replacement. As a result, 4 West has recently moved to all 8 hour shifts which has caused some staff unrest. – Several units report that staffing is different (unplanned) on days of the week/weekend – due to contractual issues. For example, 2 of 4 weekends on 5 West there are 3 RNs and 3 LPNs, on the other 2 weekends there are 4 RNs and 2 LPNs. – Some units do own replacement staffing, others request it of Staffing Office – Consultation findings indicate that while there is a small float pool, there are inadequate numbers of staff available for replacement and as a result there is an increasing use of mandatory overtime to cover staff shortages, sick relief and workload. This is a vicious cycle. – The organization is nowhere near the 70% FT mix, which is generally seen as leading practice. • The organization should perform an analysis of their nursing human resources, including age, expected retirements, and satisfaction with current position, in order to determine if there are opportunities to increase the number of FT positions.
7. Investigate potential of adding additional resources to infection control.	• Infection Control resources are low (1.8 FTEs in total), when compared to external standards. For example, APIC standards require: – 1 FTE per every 150 acute care beds. – 1 FTE per every 250 long term care beds. • Additionally there is little or no clerical support provided.

Region Acute Care Findings & Opportunities
Medicine Hat Regional Hospital (MHRH)

Opportunities	Findings
8. Review MHRH unit clerk model and roles, and align resources appropriately. • See housekeeping for further opportunities.	• Services at MHRH to support nursing and patient care, including portering, clerical support and bed making are challenged at times. • Portering services are reported as limited within MHRH, especially noted within Surgery. • MHRH Unit Clerk hours vary by unit – All the 36 bed units have the two desk areas – which is challenging for 1 clerk to manage. – There is a new float unit clerk on evenings – from 1600 – 0000, which is reported to be very positive.

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Acute Care Site and Program Findings and Opportunities

Acute Care Site and Clinical Program Review
Introduction

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

MHRH and Regional Clinical Programs
MHRH Medicine, Critical Care and Emergency Services
MHRH Surgical and Perioperative Services
MHRH Obstetrics and Pediatrics Services
MHRH Emergency Department and Ambulatory Care Services
Geriatric Assessment unit/Senior Services (2 North)
Regional Mental Health Services
Homecare
Population Health

Acute Care Site and Clinical Program Review

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/case/visit (HPPD/C/V) 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.

MHRH Medicine, Critical Care and Emergency Departments

Acute Care Site and Program Findings and Opportunities

PHR Emergency Department Volumes by Triage Level

Triage Level		2003-04 PHR Emergency Visits	2005-06 Proj. PHR Emergency Visits	% of Total PHR Emergency Visits Volume (2005-06)	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	198	169	0.2%	0.4%	0.2%
II	Emergency	3,007	2,357	3.0%	9.9%	8.5%
III	Urgent	11,933	12,545	15.8%	37.9%	38.9%
IV	Semi-Urgent	26,861	34,603	43.6%	41.9%	45.3%
V	Non-Urgent	28,175	25,928	32.7%	9.5%	6.7%
IX	Unavailable	5,718	3,693	4.7%	0.0%	0.0%
Total Visits		75,892	79,295	100%	100%	100%

- A review of Palliser's emergency visits found good alignment to national CTAS averages for triage levels I and IV, but a high level of Non-Urgent and Unavailable visits is observed that is disproportionate to national averages.
- 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 challenges in maintaining consistency in CTAS coding across the region, which may also be impacting reported triage volumes.

Acute Care Site and Program Findings and Opportunities

MHRH Emergency Department Volumes by Triage Level

Triage Level		2003-04 MHRH Emergency Visits	2005-06 Proj. MHRH Emergency Visits	% of Total MHRH Emergency Visits Volume (2005-06)	CTAS National Averages: Weekday	CTAS National Averages: Weekend
I	Resuscitation	149	121	0.3%	0.4%	0.2%
II	Emergency	2,294	1,648	4.5%	9.9%	8.5%
III	Urgent	7,984	8,008	21.9%	37.9%	38.9%
IV	Semi-Urgent	16,763	18,505	50.5%	41.9%	45.3%
V	Non-Urgent	7,962	6,939	18.9%	9.5%	6.7%
IX	Unavailable	2,432	1,401	3.8%	0.0%	0.0%
Total Visits		37,584	36,623	100.0%	100%	100%

- A specific review of MHRH's emergency visits also found good alignment to national CTAS averages for triage levels I, but variation across the other triage levels.
- A decrease in the number of visits with an "Unavailable" triage level is observed at MHRH, supporting observations at regional level, however the 2005-06 volumes in this category suggest opportunity for continued improvement.
- A high level of 'Semi-Urgent' and 'Non-Urgent' visits suggests that the regional hospital is still receiving a larger than average ambulatory visit population to the ED.

Acute Care Site and Program Findings and Opportunities
MHRH – Emergency

Opportunities	Findings
1. Target potential staffing investment with focus on: – Separating Triage from Charge Nurse positions during the day and evening shifts. – Reviewing nurse assignment practices to ensure equitable workloads and alignment between patient needs and nurse staffing. – Removing patient care responsibilities from paramedic.	• Consultation findings suggest the need to realign roles and responsibilities consistent with peer practice. – Paramedic takes full patient assignment and is in regular nursing rotation. This is a challenge to care delivery, and a a risk to patient safety, as skills do not align to required nursing competencies. – Triage and charge roles are combined. – Nurse assignments are not equal in terms of workload. – ICU staff are not cross trained to Emergency (see Critical Care)

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPV 2004-05	Actual HPPV 2005-06	Recom'd HPPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06
ER	24.3	24.1	1.0	1.0	1.3	5.8	98%

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

Acute Care Site and Program Findings and Opportunities
MHRH – Emergency (continued)

Opportunities	Findings
2. Explore options to improve management of workflow for CTAS 4 and 5 patients with consideration of: – Review benefit of a dedicated fast track area. – Shifting of Triage 4/5 volumes to PCN to improve ER flow. – Involvement of physicians to ensure alignment of practice to process, which may require a shift in funding model. – Continue to liaise with both Day Medicine and Home Care to reinforce continued support for shifting non-emergency patients out of the ER.	• The hospital has determined that a fast track system in the ER would not be effective at the present time. – We recommend that this be reviewed on a regular basis, considering patient waiting time, adherence to triage standards, etc. • There appears to be some inappropriate utilization of the ER: – ENT and Plastics doing procedures in ER vs. outpatient setting. – Consultation findings suggest that some patients who could be served better elsewhere are being referred into Emergency (patients with dressings, IV meds, and patients requiring a second opinion). The hospital has established a Day Medicine program which is reported to be effective. • Some of this may be reduced with the newly formed Primary Care Network. – Patients that could be served by home care come into the ER after hours.

Acute Care Site and Program Findings and Opportunities
MHRH –ICU

Opportunities	Findings
1. Redefine definitions for ICU admission and discharge criteria with the goal of appropriate utilisation of this resource.	• 10 bed combination ICU/CCU, all rooms are private; only one with capacity for negative pressure isolation. • Average census is 4.5 beds, and MCAP findings suggest 1 of 4 patients is not appropriate for an ICU bed.
2. ICU nursing staff should be cross trained and expected to support ER during times of low occupancy. 3. Consideration should be given based on the number of telemetry packs to empower the 4 West nurses through education to be responsible and accountable for the telemetry patients.	• Baseline staffing is 4 RNs/24 hours. It is rare that all 10 beds are being utilized, and occupancy averages 46%. • While nursing staff are the Code Blue Team for the hospital (with the exception of ER and OR), they are not cross-trained or expected to support ER during times of low occupancy. – Nursing staff monitor up to 16 telemetry packs on 4 West. – Pediatric patients over 16 are admitted under the Pediatrician, children under 16 and neonates are transferred to Calgary. • Although staffing comparison indicates potential opportunity for savings, it is suggested that this needs to be achieved through ICU staff cross-training with the ER.

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 2005-06
ICU	22.6	22.6	23.2	22.3	15.7	(6.7)	100%

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

Acute Care Site and Program Findings and Opportunities
MHRH – Medicine 6 West

Opportunities	Findings
1. Examine management structure for Medicine and Critical Care units, in relationship to regional program model considerations. 2. Review schedules and assignment practices with the goal of leveling day and night staffing.	• The Medicine units management structure is fragmented. Responsibility for medical units is shared between the PCM of Critical Care and the PCM of Medicine, with shared responsibility for Ambulatory Care/Day Medicine. <u>6 West</u> • The mix of adult medicine, geriatric medicine and palliative care results in a heavy workload. The physical layout of the unit impacts workload as staff are geographically separated. • While overall HPPD are in line with peers, the staffing pattern is focused more heavily on the day shift. In addition, the skill mix (% RN) is 51% which is quite low when compared to peers. (similar to 4 West). • Stakeholders report that patient Care is impacted by the lack of physiotherapy on the evenings and weekends (e.g. patients recovering from stroke). • Consultation findings indicated that nursing staff do not devote sufficient time to discharge planning and patient education.

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 2005-06
6 West	36.3	37.9	4.9	5.2	5.2	-	51%

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

Acute Care Site and Program Findings and Opportunities
MHRH –Medicine 4 West

Opportunities	Findings
1. Conduct a review of Medicine unit telemetry practices and develop evidence based indications for the initiation and discontinuation of telemetry. 2. Review admission and discharge criteria involving the Medicine/ICU staff. 3. Continue to support LPN move to full scope of practice, as part of move to modified primary care model. 4. Consider enhancing the skill mix, as well as increasing the budget to reflect actual HPPD.	• Consultation findings show no clear protocols or guidelines for the practice of monitoring and discontinuing telemetry care on the unit. • Current HPPD are in line with peer practice, although consultation findings indicated that the unit is operating over budget by approximately 2 FTEs. In addition, the skill mix (% RN) is 51% which is quite low when compared to peers. • LPNs are not yet at full scope of practice on this unit. Some are reportedly not comfortable doing orders – and as a result, some RNs do not take a full patient assignment.

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 2005-06
4 West	34.8	35.5	4.7	5.0	5.0	-	51%

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

Acute Care Site and Program Findings and Opportunities
MHRH –Day Medicine, Ambulatory Clinics and Palliative Care

Opportunities	Findings
1. Investigate feasibility of extending hours of Day Medicine into evenings and weekends.	<u>Day Medicine/Ambulatory Clinics</u> • Consists of Day Medicine (chemo, blood transfusions, dressing changes, IV antibiotics, urology, etc.), Pain Clinic, Ophthalmology Clinic, Urodynamics, Neurology Clinics. • Currently only open during from 0900 until 1900 Monday to Friday, which impacts ER after hours and on weekends. <u>Palliative Care</u> • Regional Palliative Care program works out of 6 West with 4 Palliative Care Nurse Consultants located out of Medicine Hat Regional Hospital who provide support to the community and region. One Palliative Care Resource Nurse is located out of Brooks Health Centre. Program staff provide service on a consultative basis to patients in acute, continuing care and home care. • Staff report that the ability to follow patients from acute to the community supports continuity of care.

MHRH Surgical and Perioperative Services

Acute Care Site and Program Findings and Opportunities
MHRH – Surgery

Opportunities	Findings
1. Examine management structure for Surgery, in relationship to regional program model considerations. As part of this, realign frontline manager positions to two positions - 1 for OR/PARR/DS/ Preadmission and Endoscopy; 1 for the inpatient units.	• The Surgical management structure is in transition to a regional model. • During the consultation, the structure consisted of 2 PCMs, 1 with responsibility for inpatient, day surgery, pre-admission and Endoscopy, and the other with responsibility for OR and PARR . The Inpatient PCM is supported by a Supervisor while the OR/PARR PCM is supported by an Assistant Manager. Both the Inpatient PCM and Supervisor were vacant effective mid July.
2. Explore a dedicated area for medication preparation within the unit to decrease interruptions.	• Medication distribution is currently in the hallway and nurses are frequently interrupted causing potential medication errors.
3. Review clinical rationale for admission of some colonoscopy patients the night before the procedure. (See Endoscopy).	• Consultation findings indicated that despite the increase in hours of Endoscopy, some patients are still being admitted for colonoscopy.

Acute Care Site and Program Findings and Opportunities
MHRH – Surgery (continued)

Opportunities	Findings
4. Revise the care delivery model on 5 West to eliminate the Care Coordinator role, shift some resources to the evening and night shift and enhance skill mix.	• There is opportunity to revise the care delivery model on 5 West to address role overlap between Care Coordinator and Team Leader on 5 West. With full scope of practice the Team Leader role should not be required. • Staffing on evenings and particularly on nights is low in comparison to the day shift. With the OR extended hours patients are frequently being admitted back to the unit on evening shift. • Staffing comparison finds that both inpatient surgical units have small efficiency opportunities. • Day Surgery and PAC were physically co-located in fall 2004. The budgets were combined for the 05/06 year. Staffing is in line with peer practice.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD/V 2004-05	Actual HPPD/V 2005-06	Recom'd HPPD/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06
5 East	19.4	19.3	5.9	6.0	5.5	(1.5)	69%
5 West	33.6	35.2	5.5	5.8	5.5	(1.9)	59%
Day Surgery/PAC	7.9	6.9	2.3	2.1	2.1	0.0	96%

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

Acute Care Site and Program Findings and Opportunities
MHRH – Perioperative Services

Opportunities	Findings
1. Explore the conversion of all OR's to latex free. 2. Formalize an interdisciplinary team for Perioperative Services that oversees planning as well as quality, access and efficient use of resources.	• MHRH has 6 OR theatres in total, one of which is latex free. Physical plant is not optimal, with small theatres and lack of sufficient equipment storage space. • MHRH has a Surgical Suite Advisory Committee comprising of the Senior VP Health Services, VP Medical, 4 Chiefs of Services, the Regional Program Manager Surgical Services, and the OR Manager. The committee meets monthly, or as necessary. – Leading Practice is to have a shared interdisciplinary leadership team for this function, which meets on a regular (i.e. monthly) basis with responsibility to oversee planning as well as quality, access and ensure efficient use of resources. • OR documentation is being revised in preparation for moving to electronic systems. Moving towards standardization across the region, including prompts and legends. • New Manager has developed a stronger process for capital equipment . For example, the process now requires signatures of all members of service before capital requests are submitted to the regional review committee.

Acute Care Site and Program Findings and Opportunities
MHRH – Perioperative Services (continued)

Opportunities	Findings
3. Regular audit of reasons for late starts and turnaround practice to develop targeted strategies for improvement. 4. Organization policy to clearly define what cases are appropriate for off-hours and a regular process to review. Surgeons should be involved in the review and negotiation processes. 5. Expand performance measurement report to support decision making and quality monitoring (see page 55).	<u>Utilization</u> • Staff start at 0700 with a team meeting to review slate, etc. First case is booked till 745 am but consultation indicated that they are frequently late due to tardiness of Surgeons and/or Anesthetists. • Regular hours until 1715 pm. There is an evening on call line of 4 RNS for add-ons and urgent/emergent. – Surgeons responsible for determining urgency -some abuse is admitted. Avg 8 – 10 hours on Saturdays, less than that on Sundays. – They did a cost benefit analysis of permanent evening and weekend shifts vs. overtime and concluded overtime was more cost effective. • The OR/PARR Scorecard contains some information on utilization including utilization rate, number of emergency and add-on cases and wait times for hip, knee and cataracts. While some indicators are collected, there is no consistent process to review and manage results on a regular basis: – Utilization of assigned OR time is monitored. 4th quarter 05/06 results was 97% of assigned time and 78% of block booking time. A more appropriate measure of utilization would be of % of total operative time available – which would provide a more accurate measure of capacity. – A review of 05/06 turnaround time indicates it ranges between 7 and 13 minutes. Community hospital peer benchmarks are approximately 14 minutes so this is an excellent result. Other utilization data is collected although it not all rolled up into the Performance Scorecard.

Acute Care Site and Program Findings and Opportunities
MHRH – Perioperative Services (continued)

Opportunities	Findings
6. Consider expanding the use of regularly collected quality indicators as presented on the following page.	<u>Quality & Safety</u> • Have several patient safety initiatives underway including clipping vs. shaving; timely administration of pre-op antibiotics and temp on arrival and recovery. • While staff do not conform to surgical pause as it is defined, they do a comprehensive check while the patient is awake, involving all staff. Surgeon signs the right side of patient prior to surgery. • Have a transfer checklist which is used upon transfer of patient from PARR to the inpatient units. • Regularly collected quality indicators include wait times, complaints and incidents. • Wait time (50%) is higher than Alberta median for –Cataract surgery (single provider) 21 vs. 11.6 weeks –Knee replacement 26 vs. 22.4 weeks –Urological (single provider) 8 vs. 4.9 weeks –General Surgery: 7 vs. 4 weeks –Gynecological: 13 vs. 7.1 weeks –Gall Bladder and Hip Replacement are at provincial median • Have adopted several strategies to improve staff culture, teamwork and communication, which was reported to be having a positive improvement.

Acute Care Site and Program Findings and Opportunities
Suggested Performance Indicators: OR/PARR

- Quality
  - Wait Times
  - Post Surgical Mortality
  - Intra-operative Mortality
  - Complications
  - Infection Rates
  - Unexpected Admission to ICU
  - Unexpected Admission of Outpatients
  - Patient Satisfaction
  - Cancelled Cases
  - Unplanned Return to Surgery
- Utilization
  - Service and Surgeon Utilization
  - Percentage of Outpatients
  - Night Time and Weekend Activity
  - PACU Time and By Pass Rates
  - Standardization of Supplies
  - Post-Operative Length of Stay
  - Variance to Targets

Acute Care Site and Program Findings and Opportunities
MHRH – Perioperative Services (continued)

Opportunities	Findings
7. Increase utilization of regularly scheduled hours to improve staffing efficiency. – Ensure regular hours and staffing matches surgical demand. 8. Expand Educator support to include OR. 9. Consider requiring nurses to obtain C.N.A Perioperative Certification, in the absence of a formal OR course.	• Staffing model is consistent with leading practice including an all RN staff, cross trained between OR and Recovery, and able to work in all the specialties. • Staffing HPPV are higher than peers due in part to utilization issues including downtime and the use of after hours for urgent cases. Staffing efficiency is also impacted by the practice of having 3 RNs per theatre plus Team Leader (100%) and Charge Nurse (25% relief). • Absenteeism was lower than budgeted in 05/06 (1565 vs. 2391 hrs). • Have Educator support for PARR but not OR. • Do own 3 month in house education and orientation for nurses as there is no local OR Course available.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPC/V 2004-05	Actual HPPC/V 2005-06	Recom'd HPPC/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06
OR/PARR	29.3	31.2	7.0	6.5	6.1	(1.9)	100%

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

Acute Care Site and Program Findings and Opportunities

MHRH – Perioperative Services

Opportunities	Findings
• See portering opportunity in Housekeeping.	• The OR has a porter from 0700-1815h, 3 days per week and 0700-1500h, 2 days a week. However, nursing and/or clerical staff are often required to deliver stretchers/beds to the OR or to assist in patient transport to and from the OR.
10. Trial the use of wheelchairs to transport patients to the Operating Room. This could be expanded to include walking appropriate patients to the OR.	• The OR Manager has a plan to trial use of wheelchairs instead of stretchers but this is reported to have been met with some resistance by Surgeons.

MHRH Perinatal and Pediatric Services

Acute Care Site and Program Findings and Opportunities
MHRH– Perinatal Services

Opportunities	Findings
1. Explore the concept of "Rooming in" 24/7 to keep in line with evidence-based practice, and as a staging toward LDRP. 2. Conduct a review to determine feasibility of moving to an LDRP model of care, with consideration of care model, staffing and facilities. 3. Examine Perinatal Services management structure in relationship to regional program model considerations. 4. Ensure that all ambulatory visits are consistently captured and reported in regional statistics (e.g. NSTs).	• Program consists of acute services (antenatal, LDR, postpartum, normal newborn, level 2 NICU and gynecological surgery) as well as the Family Medical Maternity Clinic (FMMC) located on 6 East. – Approximately 1000 births per year – Gynecology averages 3–5 cases per day – 8 bed NICU (average census 3.4) staffed by 2 nurses 24/7 – 19 bed normal newborn nursery – with all babies in nursery at night is not consistent with leading practice. • The C-Section rate is approximately 24% which is lower than provincial average – Sections are performed on the unit, with OR and NICU staffing attending. – After hours emergencies are covered by the anesthetist on call. • In process of implementing MORE^{ob} program.

Acute Care Site and Program Findings and Opportunities
MHRH– Perinatal Services (continued)

Opportunities	Findings
5. Continue to promote cross training between all areas – e.g. so that all staff have a major and a minor focus. 6. Link with Calgary for preceptorship program to maintain NICU skills. 7. Explore planning opportunities for future co-locating of Perinatal services.	• Nurse Staffing –LDR and NICU are all RN staffing which is appropriate –1 RN during days is responsible for NSTs –Some nurses float between L&D and Mat/Child and between NICU and L&D, which is consistent with leading practice. • Nurses are senior and experienced staff which will create recruitment challenges in the future as they retire. • The physical plant impacts care delivery and efficiency of operations with 3 separate areas patient units • Low NICU occupancy may lead to risk of maintaining skill sets – should link with Calgary for preceptorship model to maintain skills. • All 3 areas have staffing efficiency opportunity when compared to peer practice. However, required minimum staffing levels will impact ability to achieve savings with the current physical plant and volumes. •Minimum staffing requirements exist for LDR, 3 North and NICU, however, which suggests that there is no realistic opportunity for staff savings.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPV/ HPPD 2004-05	Actual HPPV/ HPPD 2005-06	Recom'd HPPV/HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06
LDR	14.5	13.1	24.6	21.2	9.5	(7.2) See Above	100%
3 North	17.1	18.5	6.6	7.7	5.4	(5.4) See Above	64%
NICU	11.5	12.3	21.5	16.5	10.2	(4.7) See Above	100%

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

Acute Care Site and Program Findings and Opportunities

MHRH– Pediatrics

Opportunities	Findings
1. Consider combining management of obstetrics and paediatric services, with relationship to regional program model considerations. 2. Consider cross-training staff between Paediatrics and NICU. 3. Review ENT services in the Region to align service to needs, and consider ambulatory service delivery model to align to best practice.	• The Paediatric Program consists of 14 inpatient beds (including 2 high observation rooms & 4 negative pressure), PAC, 10 bed Day Surgery plus Day Medical (IV therapy, diabetes education program, eating disorder clinic, outreach clinics, telehealth, etc.) – Average inpatient occupancy is 50% – Matrix reporting to both SVP and VP Community Health – Nursing staff cross-trained to work the inpatient unit and the clinic area – Member of the Southern Alberta Child & Youth Network • Paediatrics is a separate program from Perinatal and is not regional, although the Manager shares policies and procedures with Brooks. • ENT practice appears inconsistent with best evidence – Tonsillectomies are performed as inpatient procedures, typically during one OR block. Because most patients are admitted, this results in a number of admissions to the inpatient unit at the same time. • Nurse Staffing – Nurses are all certified in PALS and function to full scope of practice – 0.8 Team Leader does not have a patient assignment, but spends 50% of her time in direct care (e.g. admissions, discharges) – Senior and experienced staff which will create future recruitment challenges. – Staffing efficiency opportunity in comparison to peer practice will be difficult to achieve with current model and volumes.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPV 2004-05	Actual HPV 2005-06	Recom'd HPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06	Skill Mix 2005-06
Paeds	18.7	18.7	12.9	12.3	9.7	(3.9) See Above	73%

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

MHRH Geriatric Assessment Unit

Acute Care Site and Program Findings and Opportunities

MHRH Geriatric Assessment Unit/Senior Services (2 North)

Opportunities	Findings
1. Continue planning for the reconfiguration of 2N, to establish: • clear vision • role • model of care • Admission/discharge criteria • associated nursing and allied health resourcing	• GAU Program currently consists of: – A 30 bed unit, with a mix of acute, geriatric assessment, rehabilitation and ALC beds. Patients are assigned priority for admission based on level of need; – Seniors Outreach (Day Hospital); – Vascular Prevention Clinic (3 Geriatricians and 1 Psychiatrist – staffed M-F for both inpatients and outpatients); and – A Community Outreach team (under development), which is consistent with leading practice. • Utilization – Staff report challenges in providing care for psycho-geriatric patients due to lack of an area that can be locked, combined with difficulty in accessing beds on psychiatry – Active discharge planning, starting on admission • Nurse staffing is not appropriate for an acute/geriatric assessment/rehab unit with a high number of HCAs. – Staffing on nights is a particular concern with only 1 RN and 2 NAs • While the majority of staff are long term, there are recruitment challenges for RNs, LPNs and HCAs. • The unit is currently in transition to an increased proportion of rehabilitative care on the unit, however planning for this was still underway at the time of review.

Mental Health

Mental Health Outpatient Activity
PHR Overview

- As presented below, PHR Enrolments and Events increased by 12% between 2002-03 and 2004-05.
- Enrolments have increased most significantly at Medicine Hat Mental Health Clinic between 2002-03 and 2005-06, while Brooks demonstrates the most significant increase for Event volumes over the same period.
- Where variances between Event and Enrollment increases exist (e.g. Brooks), this may be due, in part, to information capture capacity, but may also speak to changes in programming.

Clinics	Enrolments				Events			
	2002-03	2003-04	2004-05	3-Year Variance	2002-03	2003-04	2004-05	3-Year Variance
Brooks Mental Health Clinic	486	399	489	1%	3,281	3,661	4,004	22%
Medicine Hat Mental Health Clinic	1,957	2,133	2,258	15%	42,921	45,671	47,724	11%
Grand Total	2,443	2,532	2,747	12%	46,202	49,332	51,728	12%

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity
PHR Events by Type

Type of Event	Type of Activity	2002-03	2003-04	2004-05	3-Year Variance
Face-to-Face	Assessment	1,744	1,518	2,003	15%
	Consultation	998	1,224	2,061	107%
	Group Work	964	39	23	-98%
	Therapeutic Intervention	25,937	26,634	26,215	1%
Face-to-Face Total		29,643	29,415	30,302	2%
Telephone		4,683	5,731	7,400	58%
Videoconference			16	64	n/a
Not Specified		11,876	14,170	13,962	18%
Grand Total		46,202	49,332	51,728	12%

Source: ARMHIS Database 2002-03 to 2004-05

- As demonstrated above, outpatient mental health activity in PHR has been increasing over the past three years by 12% - driven primarily by face-to-face consultations and telephone interventions.
- Group work as a type of activity has seen a significant decline in volume since 2003-04, which may be due in part to a change in coding.

Mental Health Outpatient Activity

PHR Top 10 Diagnoses Driving Enrolments Year over Year

Diagnoses	2002-03	2003-04	2004-05	3-Year Variance
Major Depression	440	456	485	10%
Parent-Child Relational Problem	360	383	357	-1%
Adjustment Disorder	175	236	236	35%
Relational Problem NOS	69	147	184	167%
Unspecified Mental Disorder	382	180	170	-55%
Bipolar Disorder	109	109	150	38%
Anxiety Disorder	70	91	119	70%
Attention-Deficit Hyperactivity Disorder	40	80	111	178%
Sexual Abuse of Child	105	111	76	-28%
Substance Abuse Related Diagnosis	47	40	75	60%
Top 10 Diagnoses Total	1,868	1,893	2,026	7%
PHR Total	2,443	2,532	2,747	12%

Source: ARMHIS Database 2002-03 to 2004-05

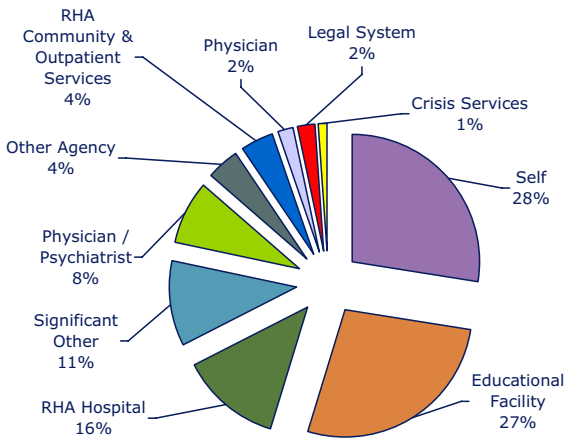
- The top 10 diagnoses driving enrolments have increased by approximately 7% over the past three years, and represent approximately 74% of total enrolments in 2004-05.
- Notable increases are observed for Attention Deficit Hyperactivity Disorder (178%), Relational Problem NOS (167%), Anxiety Disorder (70%), and Major Depression (10%).
- An decrease in "Unspecified Mental disorder" (-55%) indicates an improvement in coding for submitting clinics.

Mental Health Outpatient Activity

PHR Top 10 Referral Sources

- The top 10 referral sources for mental health enrolments in PHR represent almost 97% of total enrolments. From these top 10 sources, the main referral source for Mental Health enrolments in PHR was Self-Referral, at 27% in 2004-05
- Overall regional average time between referral and intake call for PHR in 2004-05 was 13.2 days, which is a 2% increase from 2003-04. This increased intake time is driven by Medicine Hat Mental Health Clinic. The time between intake call and initiation of services is not available.
- Referral source data for 2002-03 was not used due to the high number of unidentified referral sources.

PHR Top 10 Enrolment Referral Sources



Mental Health Clinics	Average Days Between Referral & Intake Call	
	2003-04	2004-05
Brooks Mental Health Clinic	12.0	11.6
Medicine Hat Mental Health Clinic	13.0	13.5
PHR Average	12.9	13.2

Source: ARMHIS Database 2003-04 and 2004-05

PHR Mental Health Program
Regional Findings and Opportunities

Opportunities	Findings
1. Opportunity to create stronger links with AADAC for community addictions support. 2. Monitor MHRH inpatient bed utilization. 3. Continue to expand community-based mental health services to support inpatient activity.	• Regional Program consisting of a 31 bed adult inpatient unit supported by Family Practice & Psychiatry. Programs include child/adolescent; access/early intervention, seniors mental health, and a wide range of community programs and teams (adult team, children's team, parenting, ACT, crisis response, etc.) • Expanding services to the Region. – Last year had 1st annual regional workshop for staff. – In process of developing a mental health crisis service in Brooks. • Received innovation funding for several new programs, including Rural Family Mental Health Nurse, Concurrent Disorder Treatment Centre Liaison Coordinator, Regional Mental Health and Wellness Program, etc. These programs are not sustainable however without additional base funding. • 45% of MHRH inpatients have concurrent substance use and mental disorders. Currently there is no addictions treatment available in the region, thus patients are referred outside. – In new Master plan there is a plan for an additional 12 – 14 beds for assessment & referral of patients with concurrent disorders. This will build on the use of 12 of the existing unit beds for addictions residents. • CRM/MCAP findings at MHRH indicate some opportunity to save Mental Health beds through improved outpatient service availability, but not enough to meet this identified bed expansion by the region. – There is a provincial psychiatric bed utilization review in process.

PHR Mental Health Program
MHRH Findings and Opportunities

Opportunities	Findings
1. Clarify MHRH Mental Health role and mandate with respect to other hospital services, including clarification and communication of admission criteria.	• Perception raised during consultation that MHRH Psychiatry is not consistently responsive to receiving geriatric mental health patients. • Philosophy is to treat the geriatric patients where they are and support them in place with mobile resources. • Care Delivery has many innovative elements including: – Interdisciplinary case/treatment/discharge conferences are conducted weekly for inpatients, supported by outpatient program staff. – Several programs are integrated across the continuum of care, including Child/adolescent program, Partial hospitalization program, etc. – Community treatment plans accompany inpatient admissions. – Innovative Farm Stress Line program offered in partnership with Saskatchewan government. <u>MHRH Mental Health Nurse staffing</u> • In process of implementing full scope of practice for all LPNs and RNs. • Primary Care Nursing Model in place which is consistent with leading practice. • Small efficiency opportunity in comparison to 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 2005-06
MHRH 5N Mental Health	29	29.5	5.2	5.3	4.9	(2.4)	91%

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

Bow Island Health Centre

Acute Care Site and Program Findings and Opportunities
Bow Island Health Centre

Opportunities	Findings
1. Explore alternative service setting for clinic visits seen in the ER. 2. Additional clinical educational support required, with consideration of use of simulators to train teams for the rare emergencies that develop. 3. Move to full ACLS and TNCC training for all staff.	• The ER sees patients for procedures or treatments due to the lack of community based alternatives, particularly during off hours and weekends. • Acute care beds are being used for day medical or to provide treatment to outpatients seen in ER, which is an effective use of empty beds. CTAS standards are not consistently met – Some patients not triaged by nursing – Patient first point of contact is not an ER nurse – The waiting area is not visible to ER nursing staff • Stakeholders report that although regional education exists, access is limited. • Some ER nursing staff have ACLS and TNCC, but these certifications are not mandatory.

Acute Care Site and Program Findings and Opportunities

Bow Island Health Centre

Opportunities	Findings
• See HR section for targeted Regional Recruitment & Retention Strategy.	• Clinical placements are provided for both nursing and medical students interns/residents. • Recruitment and retention challenges are: –Limited access to human resource support –Nursing staff shortages result in the use of overtime and double time to cover replacement –Projected senior nurse staff retirements (4) • Pharmacy has limited services and no pharmacist available on site.
• No opportunity identified.	<u>Nurse Staffing</u> • Many staff are cross trained which is appropriate for a health centre of this size. –Nursing staff rotate between acute and LTC –ER RN responsible for LTC • Efficiency opportunity of 1.9 FTEs is not achievable given minimum staffing requirements.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD/V/C 2004-05	Actual HPPD/V/C 2005-06	Recom'd HPPD/V/C	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Combined Inpatient Acute/ER/OR	13.1	13.2	7.0	9.5	8.1	(1.9) See Above
LTC	12.7	12.5	3.0	2.8	2.8	-

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

Big Country Hospital (Oyen)

Acute Care Site and Program Findings and Opportunities

Big Country Hospital (Oyen)

Opportunities	Findings
1. As part of regional education strategy, explore on-site continued education or access through telehealth to support current specialized skills and knowledge in obstetrics. 2. Monitor LTC staffing relative to 2006/07 target.	• 10 Bed acute centre with a 70% occupancy. – Patients wait in an acute bed for LTC bed as limited access to lodge or assisted living option is available in the community. – During consultation, a concern was raised regarding inconsistent approaches to placement as a result of the lack of standardized processes, as well as social work hours are not available to assist with social issues/placement concerns. • ER visits are increasing due in part to lack of community alternatives for after hours care. The ER/OPD area is slated for construction to facilitate ambulatory care service delivery. • Maternity cases have increased in 05/06 and are expected to double this year. In process of implementing MORE^{OB} , all staff are NRP trained. • Good co-location with physicians clinic, enables easier ER coverage and flow. However, the community recently lost one physician in Oyen, and now has only 2 physicians for the town. • Nurses in acute care are cross trained to enable flexibility in coverage. Comparison of acute care 2005/06 staffing relative to peer practice shows that Big Country is in line. Although there are no vacancies, stakeholders report recruitment is an ongoing challenge. • Little clerical support was noted as a challenge by stakeholders, as was limited access to onsite education. • An efficiency opportunity exists in LTC relative to peers, however this must be considered relative to 2006-07 funding.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD/V 2004-05	Actual HPPD/V 2005-06	Recom'd HPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Combined Acute/ER	10.5	11.4	8.4	6.8	6.9	0.1
LTC	17.0	17.6	2.8	2.7	2.4	(2.0)

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

Brooks Health Centre

Acute Care Site and Program Findings and Opportunities

Brooks Health Centre

Opportunities	Findings
1. Revisit the administration structure and administrative clerical support.	• Brooks currently has 3 supervisor positions plus a Site Manager, which is higher than expected for a Centre of this size. May be impacted by limited clerical support. • The hospital has made progress in improving utilization and has decreased ALOS while holding admissions stable. – Surgical services has additional unused capacity. Volumes declined by 24% from 01/02 to 03/04, due primarily to discontinuation of the ENT service. • Additional resources have been added to the ER to support the triage function, however, even with planned renovations, patients arriving for an ER visit will not have first point of contact with a triage nurse. – On call ER physician will see office patients in department. – Further, stakeholders report challenges exist in differences in physician practice about call, and variability in which physician to call for ER coverage. • Nurse Staffing – The use of part time staff in OR enhances efficiency and flexibility. – Nursing is responsible for all portering, for housekeeping after 9 pm; clerical support is limited and non existent in ER. – Reinvestment opportunity in Emergency.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD/C/V 2004-05	Actual HPPD/C/V 2005-06	Recom'd HPPD/C/V	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Combined Inpatient	34.7	35.6	5.4	5.8	5.8	-
OR/RR	2.8	2.7	5.0	4.6	4.1	(0.3)
ER	12.4	13.2	0.8	0.8	0.9	1.9
LTC	40.5	41.7	2.5	2.6	2.8	2.5

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

Bassano Health Centre

Acute Care Site and Program Findings and Opportunities

Bassano Health Centre

Opportunities	Findings
• No opportunity identified.	• Management has taken steps to support efficient operations in a small facility. – All nursing staff are 0.63 base, with extra as required/desired – Nursing staff are cross-trained to work more then one area. – No opportunity to achieve peer staffing efficiency opportunity due to minimal staffing • While all nurses have ACLS and TNCC, there is no formalized mentoring or orientation program in place. – Only one RN on duty per shift – During consultation it was raised that Bassano nursing staff received limited educational support from the Regional Educators. – Some challenges in recruiting nursing staff • The PCN clinic (available without referral) is staffed by physicians, dieticians, social worker, RN and mental health services. – Patients are seen by the ER physician when the clinic is closed. • Could benefit from point of care testing, and access to an on site pharmacist support (provided out of Brooks, with local pharmacy available for supplying after hours medication. • Every morning there is an inter-professional team meeting, which is consistent with leading practice and promotes patient flow and discharge planning. • Physical plant is aging, and security has been a concern after hours.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06	Actual HPPD/V 2004-05	Actual HPPD/V 2005-06	Recom'd HPV	Recom'd FTE (Effic.)/ Re-Invest. 2005-06
Combined Acute/LTC/ER	10.6	12.3	19.0	25.6	16.8	(4.2) See above

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

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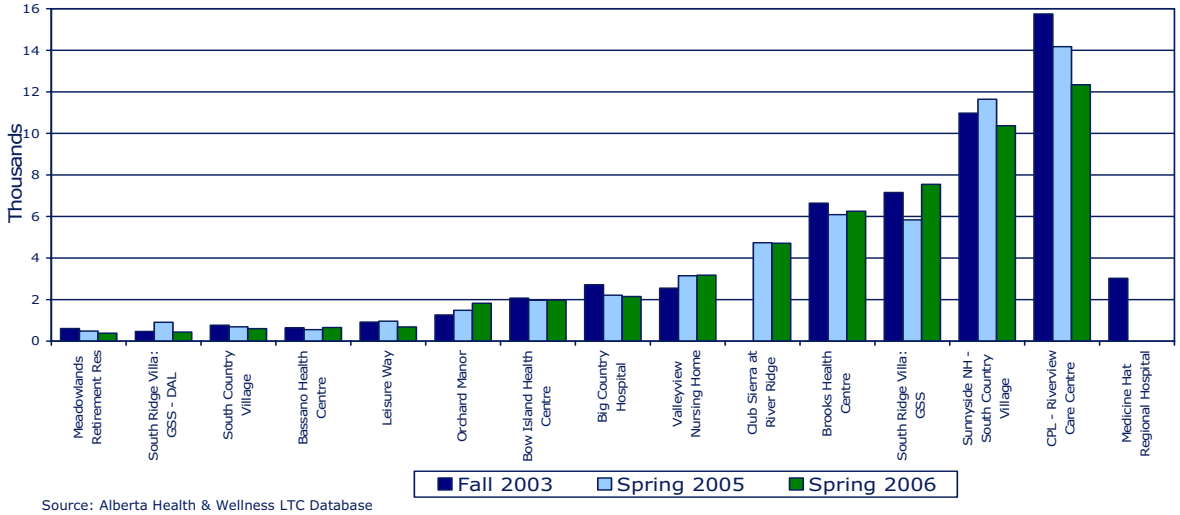
Community Health Services Findings and Opportunities

Regional Continuing Care, Home Care and Coordinated Access

Continuing Care Activity Analysis

PHR Weighted Cases by Facility

- As depicted below, PHR had 53,108 continuing care weighted cases in Spring 2006, which represents an overall decrease in weighted cases by 4% from Fall 2003.
  - Regional continuing care beds increased by 18% for the same period (from 540 beds to 635 beds), but cases decreased by 26%.
  - Given the overall large decrease in cases, PHR's weighted case decline was minimized by an increase in the region's average CMI from 71 to 92 over this same period, an increase of 30%.
  - In part, this reduction in weighted case volumes reflects traction in the region's efforts to shift the care model from tradition long-term care facility-based services to a DAL model.



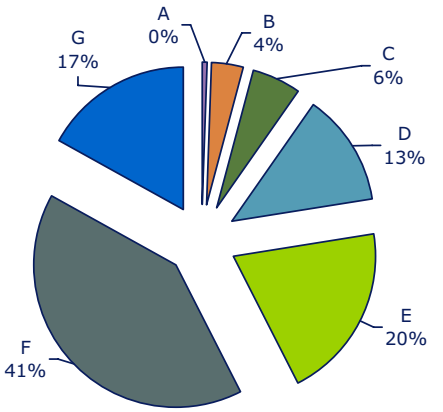
Source: Alberta Health & Wellness LTC Database

Continuing Care Activity Analysis

PHR Weighted Cases by Classification

Classification	Spring 2006 Continuing Care Weighted Cases	Spring 2006 Proportion of Total Cases	Proportion Variance Fall 2003 to Spring 2006
A	247	0%	300%
B	1,988	4%	21%
C	2,984	6%	6%
D	6,708	13%	22%
E	10,659	20%	-20%
F	21,550	41%	-4%
G	8,972	17%	-8%
PHR Total	53,108	100%	-4%

Proportion of Weighted Cases by Classification



Source: Alberta Health & Wellness LTC Database

- Approximately 78% of PHR's continuing care weighted cases are distributed across classifications E, F and G as of Spring 2006.
  - Overall proportion of F and G weighted cases has remained relatively stable from 58% in Fall 2003 to 57% in Spring 2006, while E weighted cases have declined by 4%.
  - The overall proportion of B, C & D cases have increased slightly, with the greatest increase in D cases from 10% in Fall 2003 to 13% in Spring 2006.

Coordinated Access

Opportunities	Findings
1. Consider the balance of regional vs. local policy and service delivery to create consistent criteria, processes and equitable access. 2. Ensure all staff have access to Continuum solutions software	• Coordinated Access is not a regional service and each site is responsible for coordinating the placement of individuals into DAL (Medicine Hat and Brooks) and LTC (all sites). – Each site has a separate waitlist of clients – Coordinated Access/Patient Placement coordinator reports to the Regional Program Manager Home Care/Continuing Care – Placement Coordinator Brooks reports to the Nursing Supervisor Brooks Home Care – Coordinated Access for Bow Island and Oyen is handled through the local Home Care offices. • Limited clerical support (0.34 FTE in Medicine Hat) which necessitates Coordinators spending time in clerical and administrative functions. • Coordinated Access staff and transition nurses in Medicine Hat have access to Continuum solutions and are able to both view and input patient information. The Home Care nurse in Brooks does not have access. • Facilities are limited for young disabled and brain injured clients, for clients with addictions and for clients with mental health conditions.

Home Care

Opportunities	Findings
1. Consider options to increase service delivery, including the potential for: – additional respite beds – expanded day programs – expanded evening and weekend home care service.	• Home Care is programmed regionally, but managed locally. Supervisors in each area report to respective Directors. The Regional Program Manager in Medicine Hat is responsible for policy and program direction overall, but responsibility for local operations and budgets is with respective Directors. • Transition Nurses are assigned to acute care in Medicine Hat and Brooks to facilitate flow from acute to community, consistent with leading practice. In Bow Island and Oyen, the Home Care Nurse works with emergency and acute care staff to identify clients requiring placement. <u>Service Delivery</u> • There is no wait list for home care in the region. • ER referrals are taken on the weekend day shifts, with some evening and weekend coverage. • During consultation it was reported that existing day programs cannot manage clients with heavy care needs, and since respite services are limited, this impacts family caregivers. • Limited social work services (0.63 FTE). • No Home Physiotherapy available in Oyen. • Limited dietician services. • All clients with difficult wounds are referred to Calgary due to lack of enterostomal therapy nurse.

Public Health, Health Promotion, Chronic Disease Prevention and Environmental Health

Public Health

Opportunities	Findings
1. Consider expanding sexual health /STD clinic hours to 6 hours per week. Provide some hours in regional facilities as well as MHRH.	• Public Health is a regional program providing a full of services including immunization, prenatal/mother and baby, school health, communicable disease control, travel health, newcomers health, genetics outreach and sexual health: – Sexual Health is a new clinic offered since April 06 – 2 hrs per week. Ontario standards are 8 hours per week (4 for SH and 4 for STD) per 150,000 population. – Needle exchange is partially grant-funded through the HIV/AIDS Network. – Offer some extended hours clinics for well child, adult and travel immunization. – Provide some services outside of Region boundaries, including yellow fever immunization to Chinook Region and immunizations for some Saskatchewan residents due to proximity. • The recently completed community health needs assessment will be analyzed to determine if any changes are required in service delivery. • Have recently moved from a generalist model to specialized teams of nurses who have the ability to cross cover one another. • Utilization and workload are monitored as are performance indicators (immunization standards achievement, teen birth rates, communicable diseases, satisfaction, etc.) • Despite the use of Language Lines are challenged by the number of new immigrants into region who do not understand English. • Currently in process of developing and implementing electronic documentation through the RSHIP program, which is resource intensive as Meditech Public Health module was not well developed.

Health Promotion

Opportunities	Findings
1. Examine health promotion resources relative to required services in alignment to recent PHR community health needs assessment.	• Health Promotion works closely with Public Health & Chronic Disease Prevention in designing primary population based health promotion. The service also provides some individual service in the areas of dental health and nutrition for paediatric and perinatal populations • All programs are planned and coordinated regionally and are driven from the community health needs assessment as well as the 10 year Healthy Living Plan completed in December 2004. • Due to resource constraints, services are focused on prenatal clients, infants, toddlers and school age children and families. Programs focused on workplace health are limited. • In the process of developing utilization tools for population health. • Measure outcome plus process indicators as presented in Healthy Living Plan, individual programs develop Logic Models to represent individual program services in relation to the overall Health Promotion Plan. • Not able to meet the demand for Chronic Disease Prevention – Working with 100 schools to promote physical activity and healthy eating using a capacity building approach • Despite the use of Language Lines are challenged by the number of new immigrants into region who do not understand English.

Chronic Disease Prevention: Living Healthy

Opportunities	Findings
1. Continue to expand multidisciplinary and multisectoral programming for CDP. 2. Clarify CDP role and mandate with respect to chronic disease education in acute and home care. 3. Related to CDP role clarification, review and clarify role of RNs. 4. Examine resources required to enable this program to expand into other areas such as vascular clinic, pacemaker checks, and insulin pump support.	• The Living Healthy Program (LHP), part of Chronic Disease Management services, is a regional program operating out of Brooks and MHRH. It includes Actions for Life, a program providing workshops to all five sites in the Palliser Health Region (PHR). In Medicine Hat the program includes Cardiac Rehab; Community Education and Exercise; Diabetes Education Clinic, Actions for Life; Primary Care Project (PRIISME); Functional Capacity Assessment and Testing; Cardiac Post-op Telehealth Clinic and Telehealth Assessment Clinics. • CDP is in development mode: moving from traditional programs offered in separate physical space to co-located and coordinated program. Moving to new space in 2007 (Medicine Hat). Also moving to a generalist model, consistent with leading practice. • Work closely with Health Promotion – further opportunities exist to integrate programming across the continuum from primary and secondary prevention to treatment, across acute, community, public health, etc. For example, obesity/eating disorder programs. • Perceptions raised during consultation that insufficient support is provided to inpatients. • Perception raised during consultation that Educators are not sufficiently involved. • Resources are limited: – Has to purchase acute care therapist hours – Very lean staffing and administrative structure - 1 Supervisor for Clinical Nutrition and 0.1 for each of 2 rural facilities. • Opportunity to expand services in several areas: – To encompass Vascular Clinic/Stroke programming – To perform pacemaker checks – To support insulin pumps for patients over 18 years (vs. using ER for service) – To extend the use of telehealth for Living Healthy clinics.

Environmental Health

Opportunities	Findings
1. Increase focus on achieving AB Blue Book Standards in Environmental Health. 2. Explore options to improve PHI utilization through enhanced technology, including: – Computerized Scheduling – In-Field Mobile Technology – Reduced Duplicate Data Entry by Clerks.	• PHR has a regional Environmental Health service. Program areas are administered by having each Public Health Inspector function at two levels: operational and advisory. This approach improves the region's ability to span across its geographic boundaries, while also providing specific expertise to inspections work. – At the operational level, the inspector is a generalist and is responsible for his/her assigned geographic area. – At an advisory level, the inspector is a specialist in a program area. Within his/her sphere of specialization, the inspector provides technical expertise, initiates and guides procedure and policy development and in some cases, delivers direct services. • The region faces challenges in its ability to maintain service to Blue Book standards, reporting only a 63% compliance rate in food inspections, and varied compliance across other areas. This has resulted in key environmental health risks related to food safety and private water testing in the region. • Currently, Public Health Inspectors utilize paper form reports in the field, and clerks the duplicate data entry into computer. • The region is in the process of implementing Total Management System (TMS) for its information system, which will enable computerized scheduling, and facilitate consistent tracking of activity. Consultation with other regions report some challenges with achieving full functionality in TMS, and maintaining strong IT support. • Stakeholders identify several recruitment challenges for public health inspectors, which are anticipated to increase over the next five years. As part of its strategy to address recruitment challenges, the region works with local colleges to take on student PHIs.

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Physician Findings and Opportunities

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 Governance and Leadership

Physician Human Resources Planning and Management

Quality, Risk and Performance Management

Program Review and Organization

Physician Findings and Opportunities

Physician Findings and Opportunities
Governance and Leadership

Findings

- As MHRH has evolved and matured from a community to a regional hospital, its physician governance model has continued to undergo change.
- However, the role distinction of MAC, President and Executive of the medical staff and the office of the VP Medical Services is unclear. Interactions between administration and physicians have been challenging, such as advocacy and operational issues at the MAC.
  - The PHR MAC tends to focus on advocacy over quality management. Potential conflict of interest is present with respect to advocacy and quality management, as the MAC Chair and President of the Medical Staff is the same person at the same time.
- Policies outlining expectations of physicians are lacking. MAC exists but is considered quite ineffective.
- General perception that the short supply of physicians creates risk in challenging physician behaviour given their risk of departure and the corresponding workload and coverage challenge. However, consultation with physicians suggest that this perception is inflated, and that clearer, higher expectations and accountabilities should be required.
- Chiefs of Service (department heads) are elected by department members, members of MAC representing the department members, and theoretically report to the VP Medical Services, although this is not clear or adequate.
- Representatives from the all regional sites sit on MAC. Stakeholders report that discussion is MHRH-centric.
- Consultations suggest that the physicians and administration are not working together to facilitate tough discussions required for difficult decisions. There are, however, strengths in the relationship to build on. Generally, physicians respect Administration and their work effort.

Opportunities

See next page.

Physician Findings and Opportunities
Governance and Leadership (continued)

Opportunities

1. Separate the roles of Chair of MAC and President of Medical Staff ,and delineate clear roles for medical staff leadership, such as:
   - quality through the MAC,
   - advocacy through the President and Executive of the medical staff, and
   - administration through the office of the VP Medical Services.
   - appropriate mechanisms and options should be put in place to address these aspects with identification of processes for follow up.
2. Revise the Terms of Reference for the MAC Chair to ensure that individual is selected for the position and appointed by the Board. A nomination committee that includes medical staff and administration should be created.
3. The MAC should design and implement policies that contribute to patient care quality and/or safety.
4. The Board, the Executive and the MAC need to establish quality and behaviour standards for physicians in PHR, including outlining expectations of practicing optimal care and policies on disruptive behaviour.
5. The region should consider several changes to its current identification, terms and support for Department Heads, including:
   - Department heads should be selected (not elected)
   - Set terms (e.g. 3 years), with clear terms of reference that outline expectations and how administration will support their challenges, including education.
   - A stipend that reflects PHR's commitment to physician leadership and their expectation that leadership must be provided.
8. Mechanisms for joint problem solving with physicians and administration should be created and be based PHR leadership values and the broader principles of organizational justice.

Physician Findings and Opportunities
Physician Human Resources

Findings

- PHR is required to credential physicians practicing in the community, but has little or no responsibility and authority over what they do and how they behave.
- Recruitment is initiated by each Department and PHR funds the costs of advertising, site visits, moving and incentive packages if required. Candidate approval is departmental.
- Consultation with several stakeholders indicate that there are times when the need for a specific new recruit is identified by members of another department, but that there is no mechanism in place in the region to manage this process. For example, Family Practice may perceive needs in Internal Medicine, but the need is not supported by Internal Medicine.
- Recruitment incentives may be required for bringing new people to PHR but it can create retention challenges for the current workforce.
- Consultation with broader service delivery areas in the region reported mixed involvement in program planning as it relates to physician impact analysis.

Opportunities

1. Develop a mechanism by which physician recruitment and planning incorporates input from across departments. This process requires a mechanism to resolve real / perceived issues where a department decides not to recruit a new member where a need is identified.
2. Given the payment for recruitment costs, PHR should establish itself as a stronger partner in physician recruitment, and therefore have presence and authority during the recruitment process.
3. Develop a service level agreement model with physicians, such that PHR enters into a contract with MDs outlining their expectations to maintain credentials in the region.
4. Develop a consistent regional Physician Impact Assessment process for physician recruitment needs, workforce planning, and program planning.

Physician Findings and Opportunities
Quality, Risk, and Performance Management

Findings

- Consultation findings suggest the region does not have mechanisms to promote evidence-based practice.
  - Most departments do not have effective quality management practices, adherence to standards or identification of risk issues. Although some departments do have partial systems in place, very few if any have all components.
  - Lack of availability of specific evidence/data on clinical practice makes it difficult to enforce MD accountability.
- Quality management in small departments is complex as it is difficult to assist other members improve suboptimal practice.
- Some physicians are unwilling to take part in quality programs such as Safer Healthcare Now, whereas others are providing important quality leadership, such as in the MORE Ob program.
- Quality management has recently been given greater attention by the formation of the Quality committee, co-chaired by the Vice Presidents of Health Services and of Medical Services.
- PHR has a program to train International Medical Graduates to ensure competence prior to receiving a position in the region.

Opportunities

1. The MAC and administration must take the leadership required to ensure that concerns of quality of care or conflict are managed appropriately.
   - Create policies to set standards for quality/risk/performance and the evaluation framework and management tools in support of the standards.
   - PHR should establish a mechanism by which Department Heads (in smaller departments) can work with the VP Medical Services so that appropriate action can be taken as required to improve quality and performance.
   - PHR should also consider use of independent, external reviews where specific challenges emerge in physician practice and quality of care, to provide an objective evaluation and recommendations.
2. Administration and physicians should make a commitment to create and use appropriate performance indicators for some selected programs and eventually expand to all programs.

Physician Findings and Opportunities

Program Review and Organization

Findings

- MDs are paid for clinical work as well as administrative leadership. There appears to be confusion between the role of the AMA in negotiating better incomes for MDs vs. the opportunity to take advantage of RHAs to supplement clinical earnings
- Alternate Funding Packages (AFPs) are not well supported. Currently, Department Heads receive $900 plus additional payments for attending meetings.
- There are some programs that seem to be progressing reasonably well - these programs tend to have leadership outside PHR that is recognized and then internalized - such as MORE Ob, paediatrics, stroke care - where the external leadership is used as a push to move forward. Nevertheless, uptake and progress in these areas is also based upon internal recognition and leadership with respect to program development.
- The concepts of Chief of Staff, Regional Chief and Program Medical Director are not clearly worked out. In part, this may relate to the drift / inclination to program management. The number of physicians willing and able to take part in administrative matters may be inadequate to support all these needs.

Opportunities

1. The Department Head stipend should be increased significantly (0.1-0.2 FTE), in conjunction with a clearer definition of the selection process and accountabilities.
2. PHR must determine if it will shift to program management, and this must be supported by a clear plan, leadership and associated leadership organization structure to ensure success.
3. Clarify roles and responsibilities of physician leaders at the regional level (VP Medicine, Regional Chiefs of Services), the local level (local Chiefs of Staff and Chiefs of Services), and where regional and local activities cross over.

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 PHR 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
71435	Respiratory Therapy
71440	Pharmacy
71445	Clinical Nutrition
71450	Physiotherapy
71455	Occupational Therapy
71460	Audiology And Speech/Language Pathology
71470	Social Work
71485	Recreation

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Clinical Laboratory

Opportunities	Findings
1. Develop a regional Laboratory Utilization Committee to continue to promote regional collaboration, formally sharing best practices, and supporting lab utilization management. 2. Develop business case to asses cost benefit of integrating Medicine Hat Community Lab Keane lab results into regional Meditech system.	• MHRH provides regional testing for Brooks, Bow Island, Bassano and Oyen, supported by a regional lab courier system. Specialized testing is centralized in Medicine Hat. Brooks also provides on-site testing and referred out service and other sites provide limited lab services. • The region has moved to increase point-of-care testing to improve lab efficiencies (e.g. glucose, hemoglobin, cardiac enzymes) • PHR has established a good working relationship with a community lab in Medicine Hat, which enables good utilization of lab services for high volume work. The two organizations have focused on building common training, technical standards, procedures and order sets, and also share some purchasing contracts for equipment and reagents. • A challenge exists in the information transfer between these two organizations, however, as there is still a need for investment into the integration of the region's Meditech system and the community lab's Keane system. Integration would lead to improved information flow and lab utilization management. • Consultation suggests that there is general acceptance of best practices to help drive decision-making, however this is typically driven through an MD peer-to-peer process. There is no regional laboratory utilization committee to support the drive to best practice and utilization management.

Clinical Support and Allied Health Services
Clinical Laboratory

Opportunities	Findings
3. Develop targeted strategies for clinical laboratory to address vacancies and increased staff demand as part of regional workforce planning.	• Consultation findings also identified staffing challenges related to recruitment, retention and workforce planning. – The region is currently running 3.0 FTE vacancies in Labs. – Population growth in Brooks has increased demand on Labs. • Given the varied models of lab services across the RHAs, a comparison based on lab costs/procedure was performed. – This comparison found that PHR had the second lowest lab cost per procedure among the Alberta non-metro regions. – This finding confirms the efficiencies gained by the region in managing workload across its hospital-based and community based lab service providers.

Area Description	Lab Cost/Procedure 2004-05	Alberta Peer Lab Cost/Procedure MIN	Alberta Peer Lab Cost/Procedure MAX
Clinical Laboratory	$7.45	$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. Explore options to improve Meditech functionality to address identified data capture issues for DI 2. Integrate DI into community-wide scheduling.	• DI is a regional service. Fluoroscopy and ultrasound is provided out of both MHRH and Brooks. Mammography, CT, Nuclear Medicine and MRI is provided only out of MHRH. Radiology (basic x-ray) is provided at all sites. • The region has focused on standardization of operations and functionality in all five imaging facilities. All sites use a common Radiology Information System (RIS), policy and procedures, list of routine examinations and protocols, regional documentation, and equipment. • PACS implementation is currently in progress. The region has re-skilled its film library staff to support digital archiving. • PHR has established a preventative maintenance program for equipment, and current capital plans will result in the majority of DI equipment being relatively new. • Stakeholder consultation indicates Meditech challenges that have resulted in an overall decrease in functionality – for example: requesting MD is not captured, inpatient exams are cancelled when patients are discharged. • Further, DI scheduling is not yet well integrated with the community-wide scheduling module in Meditech, which would facilitate service delivery and wait list management.

Clinical Support and Allied Health Services
Diagnostic Imaging

Opportunities	Findings
3. As part of regional HR planning, Develop a targeted DI recruitment and retention plan to address anticipated staff shortages and increased demand, as part of regional HR planning.	• Stakeholders report staffing challenges in recruitment and retention, specifically related to Brooks staffing, and recruitment of CXLTs to the smaller sites. • Consultation also indicates limited access to radiologist services at Brooks so overflow of patients go to private or public facilities in MHRH or Calgary for fluoroscopy. • Currently, there is no permanent radiologist at Brooks to supervise contrast enhancement, so these exams are performed under the supervision of hospital GPs. • The continued population growth in Brooks is reported as placing increased workload and staffing demands on DI. • Staffing comparison finds that PHR is in line with peers for DI 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.
Diagnostic Imaging	42.7	0.30	0.23	0.42	0.30	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Respiratory Therapy

Opportunities	Findings
1. Explore service delivery models that includes Respiratory Therapists in the OR, with consideration of balancing related nurse staffing. 2. Continue to explore options to improve Meditech and QHR analysis and reporting capabilities. 3. Consolidate Asthma education into regionally coordinated program.	• Respiratory Therapy is a regional acute service operating 24/7 and is centrally located at MHRH. A small number of acute care visits occur in Brooks and are delivered by the outpatient staff working in the Brooks Asthma Education Program. Acute care visits are also provided to a lesser extent in Bow Island and Oyen by the regional outpatient therapist as time permits. • Consultation findings indicate that the Brooks and Medicine Hat Asthma Education programs are currently separated. • Respiratory Therapy outpatient staff are cross trained to provide support to the acute care staff during periods of heavy workload or staff shortages. A consistent prioritization mechanism is used to manage RT caseloads. • RTs currently work at full scope and are able to drive own clinical decisions. However, RTs are not currently working in the OR, due to historical practice patterns with nursing. This is out of line with leading practice for the OR. • The transition to the Meditech and QHR systems has been a challenge for Respiratory Therapy, as stakeholders report that there is currently minimal data available for analysis and quality monitoring during the implementation. • Overtime was 2.1% in 2005-06, which is higher than observed across other allied health disciplines. • Staffing comparison finds that PHR is in line with peers for Respiratory Therapy, 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.
Respiratory Therapy	13.7	0.10	0.02	0.19	0.10	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Pharmacy

Opportunities	Findings
1. Proceed with regionalizing Pharmacy that: • facilitates leading practice • optimizes operational efficiencies and • identifies regional transportation service requirements (as a critical enabler). 2. Continue to examine increased role for Pharmacy Technicians and innovative payment practices for Pharmacists (e.g. location pay) to address current staffing shortages. 3. Explore options to improve Meditech functionality in Pharmacy.	• Pharmacy services are coordinated across MHRH and BI, but is not a fully regionalized service. PHR has adopted a regional formulary and some standardized medication protocols, but the region is just beginning discussions on the process required to regionalize pharmacy. • Well developed dispensary operations and clinical pharmacy program, although limited resources prevent further expansion of clinical pharmacy. PAC-Med currently has additional capacity. However, there are insufficient FTEs to expand dispensary and clinical operations due to both shortages and competition with retail pharmacy. The region has started to expand roles of Pharmacy Technicians to alleviate need for Pharmacists in dispensary. • Challenge in utilizing laundry truck 3x/week to transport medication to Bow Island due to outdated medication cards, and an identified need for more frequent delivery. • Current space challenges will be exacerbated if MHRH is to expand coverage to other sites, however this will be addressed through the Ambulatory Care Tower expansion. • Significant recruitment issues that has limited Pharmacy's expansion of services. Would also like to develop a Residency training program but there is insufficient staff to support it. • Implementation of the new Meditech system has resulted in a 'step backwards', as the new system has created challenges in processing orders, managing inventory and drug control as efficiently as the BDM system. Associated challenges are reported to have also contributed to recent Pharmacist departures. • Staffing comparison finds that PHR has a staffing investment opportunity relative to peers at the 50th percentile, which is in line with current vacancies.

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	21.4	0.15	0.13	0.25	0.17	3.0

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Clinical Nutrition

Opportunities	Findings
1. Regionalize Clinical Nutrition to establish common programming, practice, and staff cross coverage across the continuum.	• Clinical Nutrition is not currently a regional program, but the region has recently started to provide some service to Oyen and Bow Island. • Clinical Nutrition services are provided to MHRH as well as 1 day per month (contracted) to the Alfred Egan Home. The region also provides outpatient nutrition consultations to high risk patients, although there is a 6 – 8 week waiting list. Community Nutrition services are provided through Health Promotion. • At MHRH, Clinical Dieticians screen charts for select diagnosis on a daily basis for acute patients, to identify patients at high nutritional risk. They also participate in multi-disciplinary rounds. Both of these are leading practices. • The department is impacted by staff shortages due to maternity leaves, lack of relief or casual staff. Outpatient nutrition services are suspended during vacation or other times of staff absences.
• No opportunity identified.	• Staffing comparison for Clinical Nutrition finds that PHR is in line with 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.
Clinical Nutrition	7.0	0.05	0.04	0.12	0.05	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Physiotherapy and Occupational Therapy

Opportunities	Findings
1. Clarify policies and procedures for accessing Physiotherapy across the health continuum to ensure consistency.	• Physiotherapy and Occupational Therapy are regional services that support all sites and communities across the health continuum. • Services are provided primarily Monday-Friday, 0800-1615, however PT and OT has some weekend coverage in Medicine Hat. Consultations suggest that there is still further need for PT and OT weekend services, to cover orthopaedic and other services and reduce LOS impacts. This is anticipated to be a further challenge given the change in focus of the 2N unit to rehabilitation. • PT and OT share some aide staff, where appropriate. • Consultation findings suggest that PT and OT services would benefit by having Medical Leadership to advocate, and provide education. Note: this should be considered pending a program management decision. • The transition to the Meditech and QHR systems has been a challenge for PT and OT, as stakeholders report that there is currently minimal data available for analysis and quality monitoring during the implementation. • Stakeholders across clinical programs also identified some challenges in accessing PT services, and varied models for payment of PT (e.g. global funded for acute vs. pay for service for Chronic Disease Management). • With the exception of urgent requests, OT Services uses a Determination of Need form to establish priority for services. Have established standards for acceptable timeframes for patients to be seen.

Clinical Support and Allied Health Services
Physiotherapy and Occupational Therapy (continued)

Opportunities	Findings
2. Consider increased PT staffing with respect to required support for 2N rehabilitation unit and weekend coverage in MHRH, CHADS program services, and existing contract services.	• Staffing comparison finds that PHR has an investment opportunity for Physiotherapy and is in line for Occupational Therapy, 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.
Physiotherapy	34.9	0.24	0.10	0.31	0.26	1.8
Occupational Therapy	22.6	0.16	0.11	0.20	0.16	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Audiology, Speech Language Pathology and CHADS

Opportunities	Findings
1. Continue to explore SLP/Audiology program expansion opportunities within existing resources, in alignment with PHR community health needs assessment.	• Acute SLP/Audiology and CHADS are regional services, coordinated centrally in Medicine Hat across the continuum of care. Stakeholders report that transitioning patients within across the continuum is 'seamless'. • The service has established consistent regional policies and procedures, and active caseload guidelines are used to standardize caseloads. Reports suggest that this has enabled improved prioritization, and a reduction in service wait times. • The region also participates in a cross-regional SLP/Audiology Network in Alberta, to support new program development, best practice and policy review, and comparative benchmarking. • The region also has a Medical Director for CHADS, who provides important clinical leadership. • SLP/Audiology has identified several opportunities for program expansion, including behavioural work, home care, and increased use of telehealth, among others. • Potential to develop a regional children's service referral/intake program may be useful. Telehealth will be an opportunity to reach smaller communities. • Recruitment challenges for SLPs nationally. Significant number of maternity leaves & modified schedules to accommodate staff. • Consultation findings indicate good equipment support for both SLP and Audiology. Identified space challenges at MHRH and Brooks are expected to be resolved through current capital plans. • Staffing comparison finds that PHR has a potential staffing efficiency opportunity for SLP/Audiology. Given direct funding of several FTEs by SHIP, however, no opportunity exists for operational staffing efficiencies.

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.
Speech Language Pathology and Audiology	24.5	0.17	0.07	0.18	0.16	(2.3) See Above

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Social Work

Opportunities	Findings
1. Examine the role and allocation of Social Work resources in the region, to determine ability to improve service access and patient flow across region.	• Consultation findings indicate that the region does not currently have a regionally managed Social Work program, although several Social Workers are in place supporting discharge planning. • A number of the smaller sites in the region identified challenges in accessing social work services. • Staffing comparison finds that PHR is in line with peers for Social Work 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.
Social Work	7.4	0.05	0.01	0.07	0.05	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Clinical Support and Allied Health Services
Recreation

Opportunities	Findings
1. Continue to monitor Recreation staffing requirements as part of broader regional continuing care staffing model.	• Recreation primarily supports continuing care settings in the region. • Staffing comparison finds that PHR has a staffing investment opportunity for Recreation, relative to peers at the 50th percentile. • This opportunity should be considered relative to broader continuing care staffing in the region, especially given the shifting model of continuing care delivery in the region. The region should continue to monitor staffing levels across continuing care disciplines before pursuing this potential investment.

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	8.1	0.06	0.06	0.21	0.15	13.4

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 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 PHR 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	Clinical Affairs and Education
71125	Systems Support – Regional IT
71135	Materiel Management (includes all CSR for the region)
71145	Housekeeping
71150	Laundry And Linen (excluding any CSR staff)
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
General and Nursing Administration Combined

Opportunities	Findings
• No opportunity identified.	• The region has established a robust and comprehensive capital planning process: – Stakeholders report good involvement across the clinical, support service and administrative areas of the organization. – A clear set of criteria are used to determine capital priorities, which have been developed and agreed to by a cross-section of stakeholders. – Capital needs are identified by stakeholders from across the organization. • Stakeholders report good satisfaction with capital planning and equipment processes.
• No opportunity identified.	• Staffing comparison finds that PHR is in line with peers for General and Nursing Administration combined, at the 50th percentile. • Note: community services management and clerical support are included in this comparison, to ensure comparability 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.
General & Nursing Admin. Combined	70.1	0.49	0.42	0.61	0.49	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Finance

Opportunities	Findings
1. Consider investment of resources to ensure continued Decision Support functionality in the region. 2. Explore options for expanding Director and Manager involvement in annual budgeting processes, enabled by Decision Support.	• Finance is a regional service and centralized in Medicine Hat. • Consultation across Finance, HR, Materials Management reports good collaboration in coordinated functions such as payroll and accounts payable. • The regional budgeting process is described as a top-down approach that uses the previous year's budget with adjustments for such costs as inflation, labour, utilities, drugs, etc. Consultation and comparison to other organizations suggests that limited Director/Manager involvement in budgeting may impact the region's support for program innovation and manager ownership of budgets. • The region has a decision support function that has been re-focused on Meditech report writing to support the current implementation. While this is necessary to enable the region to realize the full value of the Meditech Phase 1 implementation, it reduces the functionality of this group to support management decision making across the organization. • Staffing comparison finds that PHR has an investment opportunity relative to peers at the 50th percentile. By expanding decision support functionality through this investment, managers could be enabled to have more active involvement in annual budgeting.

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	18.5	0.13	0.12	0.22	0.14	1.4

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Human Resources

Opportunities	Findings
1. Target staffing investment in HR to support strategic focus in the region. • See HR Strategy and Management section (near end of document) for additional opportunities.	• Human Resources is a regional service including recruitment, workforce planning, labour relations, performance management, classification, occupational health & safety, education (related to management and OHS issues) and disability management. Staff are cross-trained in HR, to enable cross coverage and flexibility in service delivery. • Over the last 6 years, priorities have evolved from labour relations and disability management to a greater focus on occupational health and safety and attendance management. Current HR priorities are in leadership development, succession planning, workforce planning and cultural transformation. • Consultation with HR and other stakeholders identified challenges in meeting current HR service delivery workload. – HR reports challenges in meeting service requests, which impacts its ability to more strategically support the organization while maintaining service. – Several program areas identified recruiting support challenges, and so perform some functions independent of HR, such as reference checking. • Staffing comparison finds that PHR HR is below peers at the 50th percentile, and has an opportunity for staffing investment in this area.

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	14.3	0.10	0.07	0.18	0.12	2.8

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Education

Opportunities	Findings
1. Continue to expand on-site regional education across the rural sites. • See HR Strategy and Management section (near end of document) for additional opportunities.	• Stakeholder consultations indicate a good level of satisfaction with broad education in the region, with specific note of the leadership and management development and training in place. • Consultation with the rural sites, however, indicate past challenges in accessing regional education on-site. The region has recently instituted Rural Education Days, which are anticipated to address this gap. • Staffing comparison finds that PHR Education is in line with 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.
Education	11.9	0.08	0.02	0.10	0.08	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Systems Support

Opportunities	Findings
• Please refer to Technology section (later in document) for additional opportunities.	• Staffing comparison finds that PHR IT is in line with peers at the 50th percentile. • 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	14.3	0.10	0.07	0.16	0.10	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Materiel Management

Opportunities	Findings
1. Continue efforts to drive product standardization across the region. 2. Continue efforts to standardize SPD practices at Brooks, with consideration of increased regional management presence on-site.	• Materials Management is a regional function centrally managed from MHRH. • The region has undertaken several initiatives to improve processes (e.g. changing time for top-up cart restocking). • Good progress is reported in standardizing capital equipment and products through a regional Product Evaluation Committee. – However, reports suggest that some physicians still select products by personal preference. This is reported as especially a challenge for standardizing SPD trays. • In SPD, while staff are allocated by site, there is flexibility through cross-training and some cross-coverage between MHRH and Brooks. • PHR has developed common policies and procedures for SPD for decontamination and sterilization across the region. However, stakeholders report challenges with standardizing Brooks SPD practices despite regional guidelines. – In part, this has been driven by an inability to fill Brooks SPD Supervisor vacancy, and challenges for regional management to have increased on-site presence. • Consultation findings indicate challenges in recruiting casual staff into areas such as SPD, and an anticipated need for targeted workforce planning to recruit younger staff.

Corporate and Support Services
Materiel Management (continued)

Opportunities	Findings
3. Develop a regional approach to asset management and tracking to support capital planning. 4. Develop a targeted workforce plan for Materiel Management as part of regional workforce planning.	• Although the region has established a comprehensive capital planning process, stakeholder consultation suggests that there is limited focus on asset management and tracking. • Staffing comparison finds that PHR is in line with peers at the 50th percentile for Materiel Management.

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	35.9	0.25	0.20	0.53	0.25	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Housekeeping

Opportunities	Findings
1. Consider regionalization of housekeeping services to standardize management, technology, policies and procedures. 2. Continue development of standardized infection control policies across region.	• Housekeeping services are decentralized (MHRH & Bow Island are managed together; Brooks, Bow Island & Bassano are managed independently). Foremost, Oyen and Cereal use contracted housekeeping services with contracts managed by MHRH. • Although some coordination exists, PHR has not yet adopted region-wide policies and procedures in place for Housekeeping, and variations exist across sites around technology and management enablers (e.g. Task Tracker at MHRH only). • Stakeholders reported isolation cleaning as a potential risk particularly during the day and night shifts, due to limited policies and communication between housekeeping and nursing staff. The region is in process of creating regional policies and procedures aligned to infection control standards.

Corporate and Support Services
Housekeeping (continued)

Opportunities	Findings
3. Consider identified staffing investment to increase housekeeping service responsiveness and internal patient portering at MHRH. 4. Investigate options to improve ADT linkage to Housekeeping to improve bed making and room cleaning notification.	• Consultations across stakeholder groups identified that high workload impacts several service areas, for example: – At MHRH, the ability of the bed making team to consistently respond in a timely manner. Information systems support to enable better communication to the bed making team was also identified as a need. – Quick turnaround for OR cleaning. • Although not traditionally a role of housekeeping, stakeholders also identified the need for internal patient porters at MHRH. • Payroll analysis identified that Housekeeping sick time was at 4.8% for 2005-06, which is above the support service average in the region. • Staffing comparison identified that PHR Housekeeping has a staffing investment opportunity 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.
Housekeeping	79.1	0.55	0.55	0.75	0.64	13.3

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Laundry and Linen

Opportunities	Findings
1. Develop a casual recruitment strategy for Laundry and Housekeeping, as part of regional workforce planning.	• PHR has a regional laundry service, with central laundry in MHRH providing service to all sites except Oyen. Oyen continues to have on-site laundry facilities due to geography, but utilizes MHRH linen inventory. The region also has some revenue generating service through laundry (e.g. to the Military Base). • The service has undertaken several initiative to achieve efficiencies (e.g. chemical delivery system, laundry equipment, etc.). • Further plans for technology enhancement include a new shuttle system and dryer system, which are anticipated by department management to drive increased revenue opportunities. • Stakeholders report high satisfaction with laundry quality. • Successful cross-training of staff has been achieved between housekeeping and laundry, which helps to facilitate ongoing challenges retaining casual staff in these areas. • Staffing comparison finds that PHR Laundry is in line with 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.
Laundry and Linen	29.2	0.20	0.15	0.27	0.20	-

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services
Plant Operations, Maintenance and Biomedical Engineering Combined

Opportunities	Findings
1. Continue to ensure new version of Cendec is made available to smaller sites to streamline maintenance requests. 2. Consider staffing investments in Plant Operations to support capital projects and facility maintenance in the region.	• Plant Operations, Maintenance & Biomedical Engineering is a regional service. Day to day operations and maintenance for all sites is the responsibility of the site Maintenance Supervisor who each report to the Regional Manager. Biomedical Engineering is in-house, and some trades (refrigeration, electrical and electronics) are provided out of MHRH. • At MHRH, maintenance requests are made via PalliserNet and voicemail. All other sites currently utilize voice mail for maintenance requests. Pallisernet will be made available at all sites as part of CENDEC maintenance software upgrade this Fall. • The region reports good ability to keep a consistent preventative maintenance program, to enable good facility management. • Stakeholders identify anticipated challenges with the quantity and complexity of new biomedical equipment. Recruiting, training and retaining new staff is especially a challenge in this regard. • The current capital planning in the region will bring additional workload to Plant Operations, which stakeholders have identified will be a challenge to current resourcing. • Staffing comparison finds that PHR Plant Operations has a staffing investment 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.
Plant Ops, Maint., and Biomed.	43.5	0.30	0.29	0.41	0.33	3.6

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

Corporate and Support Services

Health Records, Patient Registration and Telecommunications Combined

Opportunities	Findings
1. Develop a plan to address Health Records chart storage, with consideration of facilities and technology-based solutions.	• Health Records and Patient Registration is regionally managed, with some cross-coverage of staff across sites. • As part of recent portfolio changes, Health Records and Patient Registration are now aligned to regional IMTS department to facilitate the movement towards the EHR. • Stakeholders reported significant space constraints for staff as well as storage space for charts in Health Records. The region is planning to utilize a scanning and archiving system to move towards EHR and alleviate the current space challenges, and planned expansion at MHRH may also resolve these challenges.
2. Consider development of a single multi-site phone system to enable cross-coverage of switchboard and reception functions in the region, as part of capital planning. 3. Explore the business case for establishing centralized booking at MHRH, with consideration of physical vs. technology-based centralization.	• Phone system is site specific and there is no cross coverage across sites. • Stakeholders report challenges in multiple points of booking across MHRH related to coordination. Recent implementation of Meditech Community Wide Scheduling Module may offer improved coordination – although stakeholder consultation indicates that this has not been explored.

Corporate and Support Services

Health Records, Patient Registration and Telecommunications Combined (continued)

Opportunities	Findings
4. Target staffing investment in Health Records and Patient Registration to address current backlogs in coding, abstracting and transcription (will need to determine appropriate level of investment given current outsourcing of transcription which is impacting target to some extent).	• Stakeholder consultations indicated challenges in meeting Health Records workload, with backlogs in coding, abstracting and transcription. However, the region has outsourced some transcription service to offset current backlogs. – In part, stakeholders report this backlog has being driven by the increased workload associated with the Meditech implementation. • Patient registration reported current vacancies of approximately 2.0 FTEs in the department. • Staffing comparison finds PHR has a staffing investment opportunity for Health Records and Patient Registration, relative to peers at the 50th percentile. In part, this opportunity may be related to the region's recent outsourcing of transcription services.

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., Telecom Pt Reg. Combined	52.0	0.36	0.36	0.58	0.45	12.3

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

Corporate and Support Services
Patient and Non-Patient Food Services

Opportunities	Findings
1. Consider regionalization of Food Services throughout PHR to achieve common standards, policies and procedures. 2. Develop a business case to examine the potential shift to centralized food service production and distribution. 3. Determine required staffing to support a regionalized food service model, before targeting identified investments.	• Food services is not yet regionalized in PHR. MHRH Food Services does oversee Bow Island, however, and shared processes and standardization is beginning to occur. All sites operate with raw food production, and MHRH is just beginning to look at trends around cook-chill-retherm options. • Because food services is site specific, there are a number of service delivery elements that have not yet been standardized across the region. Examples include: – Regional menus, – Regional policies and procedure., – Regional job descriptions. – Improved communication. – Regional staffing and recruitment. • Limited casual staff availability. • The region is using the CBORD IT system, but stakeholders reported limited support from IT in maintaining or modifying the system to meet end-user needs. • Staffing comparison finds that PHR is below peer staffing levels at the 50th percentile, and has an opportunity for investment. – In part, this is driven by outsourced retail food operations in MHRH, as well as the majority of continuing care facilities in the region being provided by private or voluntary organizations, however this finding requires further exploration.

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.
Pt. & Non-Pt. Food Services Combined	77.0	0.54	0.48	0.86	0.79	36.0

Source: AHW MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05 & 2005-06, PHR Payroll 2005-06

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 organizations operational spending.
- Other key cost drivers for consideration 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	446	2.7%	3.1%	2.5
Nursing Inpatient Services	520	4.1%	4.0%	2.3
Ambulatory Care Services	119	3.7%	3.7%	0.9
Allied Health	257	1.7%	2.0%	0.7
Community & Social Services	207	3.2%	3.2%	0.7

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	446	1.0%	1.0%	$154,259
Nursing Inpatient Services	520	2.5%	2.7%	$322,670
Ambulatory Care Services	119	1.3%	1.2%	$65,560
Allied Health	257	2.2%	2.2%	$282,277
Community & Social Services	207	0.7%	0.9%	$32,893

Source: PHR Payroll 2004-05, 2005-06

- Sick time and over time rates on average increased slightly from 2004-05 to 2005-06.
- 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 7.1 FTEs in sick time improvement, and almost $857,659 in overtime premium cost savings, which would need to be explored within a broader HR framework for change.

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 $6.4 million, or 22%, between 2003-04 and 2005-06.
  - The main drivers of the increase include General Department Supplies and Sundries, Staff Travel, and Data Processing fees.
- Although not shown here, it also important to note several other non-salary cost drivers in the region:
  - The cost for patient transport has increased by over $146,000 (16%) since 2003-04.
  - The cost for building and land rental has increased by over $137,000 (357%) in 2005-06, although this is anticipated to be a temporary cost driver until the Medicine Hat Ambulatory Care Tower is developed.

Account	2003-04	2004-05	2005-06	Variance 2003-04 to 2005-06
General Department Supplies	$22,154,386	$24,892,939	$27,049,993	22%
General Sundries	$1,769,631	$3,368,954	$1,937,222	9%
Staff Travel	$707,354	$749,668	$825,437	17%
Data Processing and Communication	$129,734	$117,752	$371,482	186%
Long Distance	$93,378	$116,914	$183,531	97%
Printed Forms	$157,050	$165,088	$234,299	49%
Sub-Total	$25,011,533	$29,411,315	$30,601,964	22%
Other Accounts	$4,444,826	$4,861,355	$5,284,036	19%
Total	$29,456,359	$34,272,670	$35,886,000	22%

Source: PHR General Ledger 2003-04, 2004-05, 2005-06.

Med/Surg, Drugs and Food Supply Costs

- Medical/Surgical, Drugs and Food Supply expenses were examined relative to adjusted patient days for PHR and other rural RHAs in Alberta.
- In comparison to Alberta peers, PHR was found to be at the mid-point for Medical/Surgical Supplies and Drugs and Medical Gases Expenses per APD, respectively.
- For Food and Dietary Supplies, PHR was found to have the lowest costs/APD among the rural Alberta RHAs.

Supply Costs as a % of Total Expenses	2005-06 Actual Expenses	2005-06 Expense/APD	Alberta Peers Expense/APD MIN	Alberta Peers Expense/APD MAX
Medical/Surgical Supplies	$4,332,540	$14.91	$3.94	$25.14
Drugs and Medical Gases	$3,780,446	$13.01	$4.40	$19.80
Food and Dietary Supplies	$1,315,424	$4.53	$4.53	$12.76

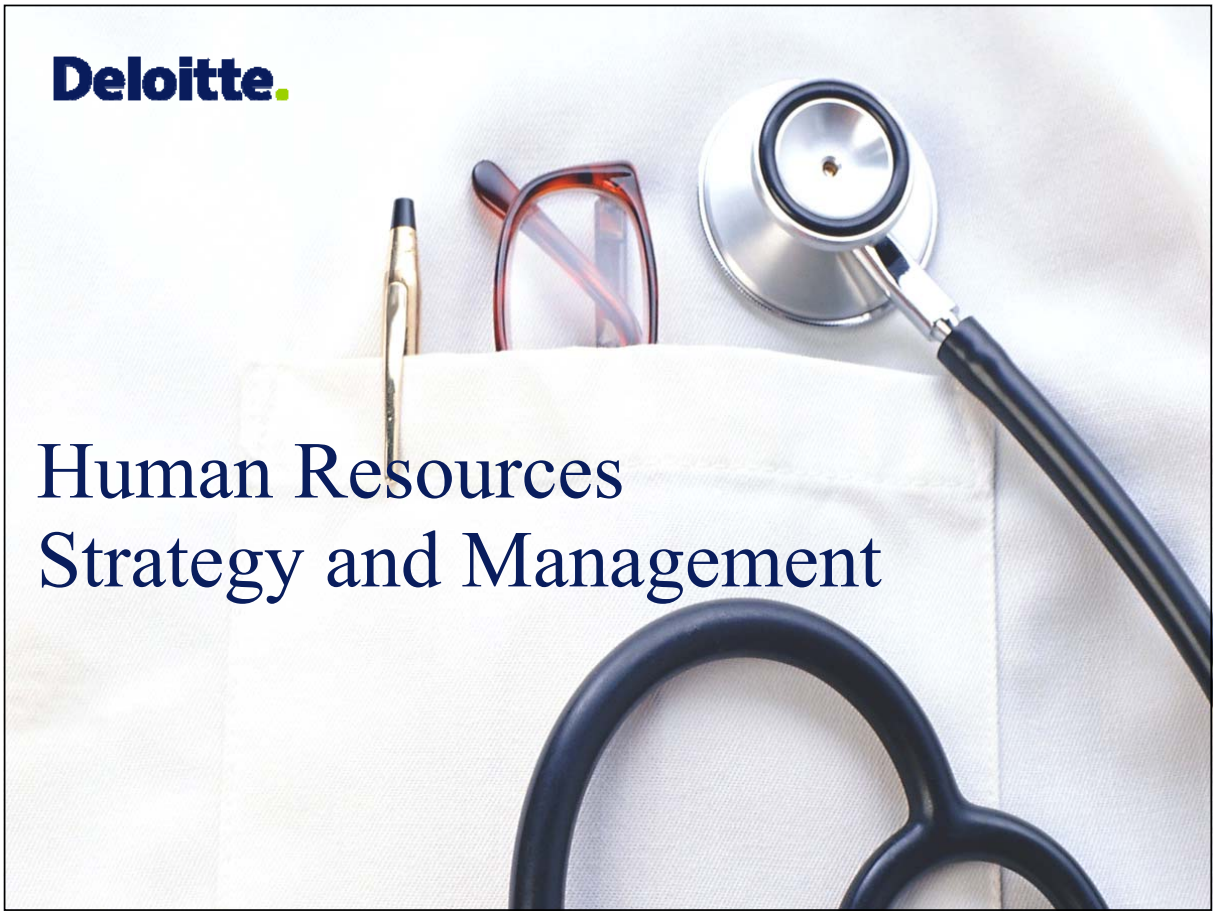
Source: AHW MIS for 2004-05, RHA-Provided GL Data for 2005-06

Financial Profile Across the Care Continuum

- A financial profile of PHR 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, PHR is at the mid-point of peers for its % of total operating expenses in its Corporate Services and Emergency, Day and Ambulatory Services.
- PHR also has the second highest % of total operating expenses in Acute Nursing, Residential Nursing and Allied Health services.
- Conversely, PHR is currently spending the lowest % of total operating expenses on Community Health Services, which supports findings about challenges to maintain services in Environmental Health and other community services.

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	8.9%	6.3%	12.4%
Support Services	16.1%	12.6%	22.2%
Acute Nursing	23.0%	14.9%	26.4%
Residential Nursing	17.6%	4.6%	18.2%
Emergency, Day and Ambulatory Services	6.7%	4.4%	8.2%
Telehealth	0.0%	0.0%	0.3%
Allied Health	17.7%	13.8%	17.9%
Community Health Services	10.1%	10.1%	15.9%
Marketed Services	-0.1%	-0.1%	13.7%
Undistributed	0.0%	0.0%	5.6%

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

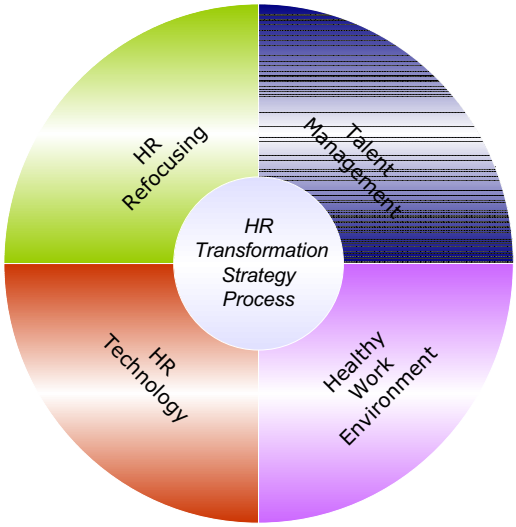


Human Resources Overview

- Talented people – or shortage of talented people – can make or break any organization's strategy. In the past, health care in general has taken the people and talent issues for granted. Our people plans – including plans to hire 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. What was once tactical has now become strategic.
- Coming into 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 Overview
(continued)

- Our findings are based on a review of relevant documentation and consultation. From these, we will identify opportunities for Regions to consider. Our model for review, findings reporting and opportunity identification follows a four part framework:
- ***Talent Management*** – the integration of processes, programs, technologies and staff to Develop, Deploy and Connect 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 Re-focus*** – efforts to enhance HR capacity and capability to support service and management priorities of the Region.
- ***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 work environment 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. Continue development of a single, comprehensive health human resources workforce plan for PHR that aligns health human resources needs and priorities to regional strategic objectives, and which includes Physicians in planning. 2. Consider the development of a senior level HR position to drive the strategic priority of HR for the organization.	• The region has a health human resources strategy that was recently developed in May 2006. • To support this strategy, the region is currently in the process of developing a workforce plan that aligns health human resource needs and priorities to the strategic objectives and health services planning. • Stakeholder feedback suggests that because staffing shortages have not been a challenge in the past, this has not been an area of historical strategic focus, however the organization is renewing its focus on HR through several initiatives (e.g. workforce planning, cultural transformation). • Although Human Resources has been able to focus on some initiatives, reported staff shortage has focused the department on maintaining transactional workload.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
Talent Management	
1. Develop an integrated health human resources recruitment and retention plan, which is based on workforce planning and aligned to HR strategy.	• The region has invested in several elements of talent management to support regional recruitment, operations and culture. Examples include: – A supernumerary program, which supports the mentoring and placement of new graduates. – Close connections with several colleges, which provide placements for RN, LPN, OT, PT, SW and other disciplines. – Planned implementation of HPNet, a central placement database for nursing which facilitates nursing student placements. • A cultural transformation initiative is currently underway in the region, which is anticipated to help the region re-focus on talent management by building a stronger culture that will continue to attract and retain health human resources. • These current efforts will contribute to ongoing regional recruitment, retention and broader talent management. However, the region still has areas for improvement in recruitment and retention planning – for example an integrated plan that includes physicians, and which considers HHR requirements for physician impact analysis planning.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
Talent Management (continued)	
2. Re-focus efforts on performance management as a regional priority, to ensure individual performance alignment to regional strategies and objectives.	• The region has invested in creating an online performance management system supported by training, but stakeholders report low compliance with performance management across the organization. • This can result in a lack of alignment between regional strategic objectives, operational plans and individual actions that drive regional operations and performance.
3. Explore the development and investment in management training for regional physician leaders.	• Although the region has invested in leadership development and training for management and staff, stakeholder consultations suggest a gap in management training for physician leaders. • It is anticipated that management training for regional physician leaders would enable further physician engagement in regional clinical operations. • Several programs exist that may provide support to regional physician management training, such as those offered through the Physician Management Institute.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
HR Technology	
1. Explore options to improve functionality of QHR, supported by management training to leverage HR management at the regional and site levels.	• The region has adopted QHR as its HRIS, but stakeholders report several challenges with the system's current functionality: – Limited attendance management support for managers. – Limited management reporting. – Limited ability to modify scheduling rules to fit different contract rules. – Limited ability for non-clinical areas to use QHR for schedule development and management.
2. Continue to build telehealth and e-learning as key HR technologies supporting regional education.	• The region is starting to use telehealth and e-learning to support remote learning. However, opportunity exists to build on current progress to improve access to telehealth-based education.

Human Resources Strategy and Management
Findings and Opportunities

Opportunities	Findings
Healthy Work Environment	
1. Establish processes and communication mechanisms to provide staff and physicians with an ability to discuss and resolve inter-professional issues.	• Stakeholder consultations indicate a generally healthy work environment, supported by: – Good OH&S departmental support to the region. – Good relations across management and staff. – Good relations between physicians and administration • Some stakeholders did report challenges in a lack of process to support staff-physician issues.

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
Facilities Re-Development

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

Opportunities	Findings
1. Ensure alignment of current capital planning to service planning and setting of care requirements (also based on community health needs assessment and leading practices).	• At MHRH, the current triangle-model for the inpatient units can be a challenge to resource management, as it requires that two nursing stations are staffed, with limited visibility between stations. – The region has, however, re-configured many units to address some of these challenges. • Observations during site tours at MHRH noted several areas with equipment in hallways, but the region has identified a plan to address this impact on physical flow. • Several areas reported physical space challenges (e.g. OR, Pharmacy, DI). • At MHRH, the physical plant impairs LDRP achievement, because L&D and Post-Partum are physically separated in the current configuration. • An MHRH re-development plan in place to address many space issues, which includes the development of an Ambulatory Care tower.
	• At Oyen, an ER/OPD re-development is currently underway to improve overall physical facilities. • A full facility replacement is planned at Brooks that will integrate acute care, ambulatory care and community health services. • Bow Island and Bassano facility replacements also being considered by the region. • The region has recently completed a community health needs assessment.

Facilities and Equipment
CTAS Standards and Telehealth

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

Opportunities	Findings
2. Examine facility re-design options to support CTAS standards in the EDs at Bow Island and Bassano.	• As identified in the Emergency Program findings and opportunity, some of the smaller sites across the region have challenges in meeting CTAS standards, some of which are driven by physical facility configuration: – At Bow Island, the waiting room is not visible to triage. – At Bassano, there is no formal triage space, and the ER Bay and overall facilities are outdated to current standards. • CTAS standards are achieved at MHRH and Brooks, however, it is anticipated that the ER/OPD re-development at Oyen will incorporate CTAS standards in facility design.
3. Explore opportunities to expand use of telehealth in the region, with consideration of equipment and operational resource requirements.	• Although the region has invested in telehealth technology across its sites, stakeholders reported some challenges in its use: – There is a perceived need for more administrative and technology support to end-users. – There is a reported need to expand telehealth technology to community health clinics in the region (e.g. Living Healthy).

Facilities and Equipment
Laundry

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

Opportunities	Findings
4. Develop a business case for the replacement of aged Laundry equipment and the installation of a new shuttle system.	• Stakeholder consultations identified initial planning to install a shuttle system to drive increased efficiencies and revenue capacity in laundry. • Further, stakeholders identified concern about existing dryers being at their end-of-life.

Technology

Leveraging the Value of Information Technology through IT Governance

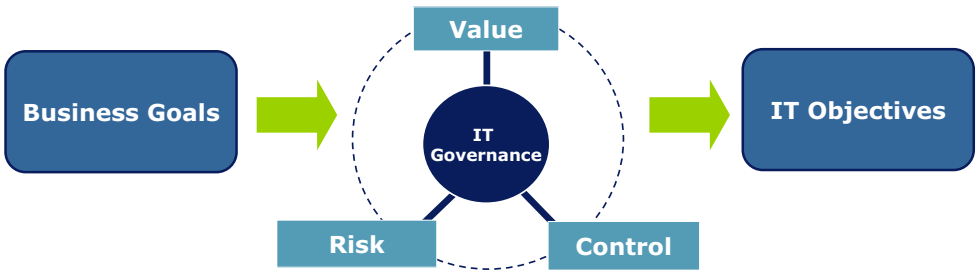
- Information and the Technology that supports it often represent the most valuable but least understood asset in an organization.
- The essential elements of IT governance are to ensure that value is received from spending on technology and then to control and safeguard information.
- The purpose of an IT governance framework is to institutionalize good practices that ensure an organization's IT investment supports business objectives. These objectives are identified through the Palliser Health Region's goal of ensuring "healthy people in health region."

  And involves:

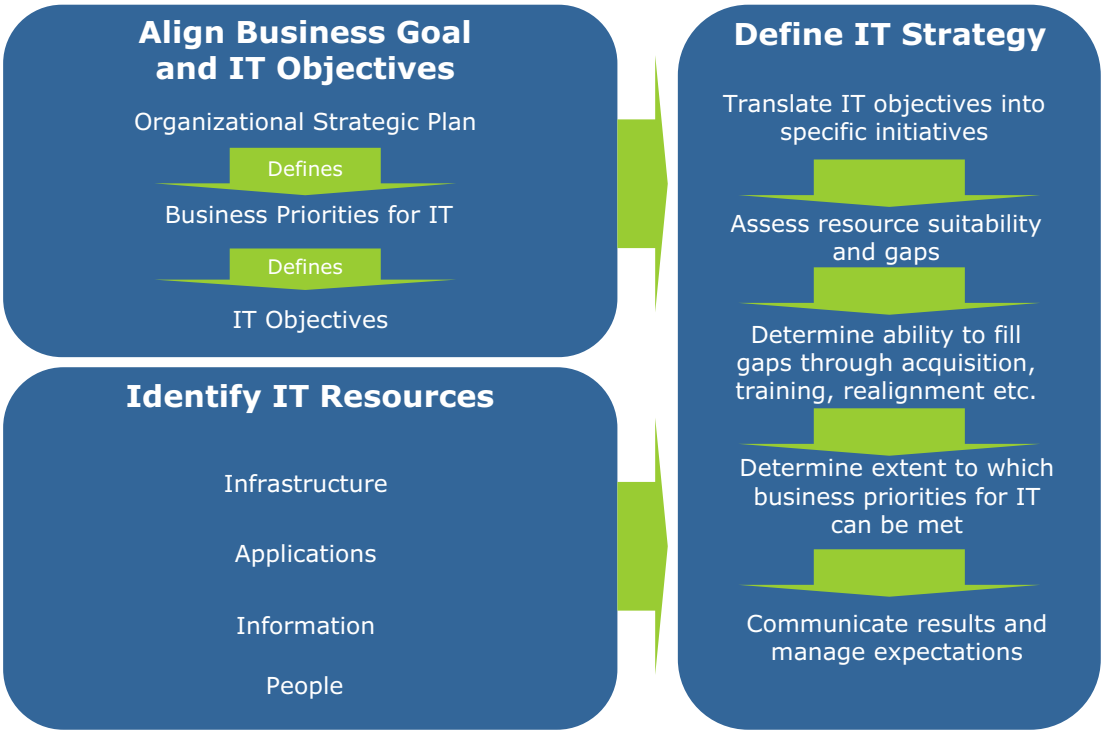
  - ensuring senior management and frontline providers are involved in determining the direction and goals of the IT department
  - evaluation of service delivery from two perspectives, the total cost of technology operations and monitoring of project outcomes
  - ongoing support and maintenance intended 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



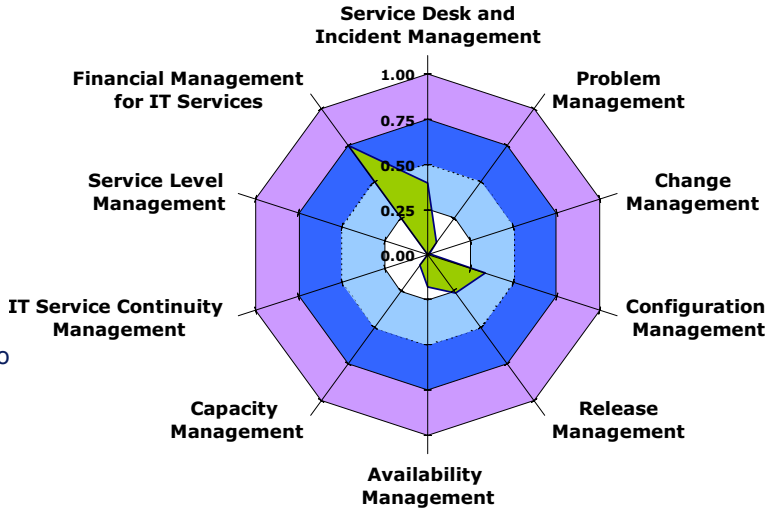
Technology

- 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 Palliser Health Region:
  - Profiles – Palliser Health Region
  - 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, although the region shows good traction with respect to Financial 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	• Palliser currently does not have a 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. • 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. • For RSHIP implementation, the Region has a monthly executive communication debriefing.
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 Medicine Hat, and travel to sites as needed. • The IS department provides a 2-tiered help desk service for non-RSHIP requests. An IT Infrastructure Library (ITIL)-compliant tool is being used to facilitate help desk operations and management. The help desk is supported by knowledgeable and experienced IS staff. • The region finds it hard to recruit IS talent who have Meditech experience. • IS end-users report relatively good satisfaction with the IS department, but many report concerns of the sustainability of IS and end-user operational resources into Phase II of the Meditech implementation.
Potential Opportunities	1. Continue to expand the compliance with ITIL to optimize service delivery and service support. 2. Develop a PHR-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. 4. Conduct periodic IS resource reviews to incorporate new user needs and priorities, and to align to regional IT Strategic Plan.

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	• Meditech super users also hold ongoing operational roles across regional departments. As a result, end-users report challenges in maintaining operations throughout the Meditech implementation. • The gap analysis during phase I is reported to have been underestimated with respect to workload and resource requirements to support implementation. • 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. Encourage more end-user engagement in the planning and implementation of IS initiatives. 7. 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	• 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. • Although business users from most areas report good involvement in the Meditech implementation, they also note the challenge of the corresponding strain on their resources available for daily operations. • Further, end-users reported limited value in the training received for the Meditech implementation. • 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. • The region had mixed uptake by end-users in identifying the benefits and work process changes that would result from the Meditech implementation. Where this pre-implementation planning was not done by departments, stakeholders reported challenges in implementation.
Potential Opportunities	1. For Phase II implementation, ensure consistent end-user commitment and completion of pre-implementation planning to establish a region-wide benefits realization framework that identifies, promotes, monitors and assesses benefits realization for each key department as the new Meditech system is implemented, as well as identify work process impacts.

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. • There is a noted concern of lack of basic PC skills among users. The Meditech implementation required users to use sophisticated integrated applications directly from an environment that was paper-based. • The region also has some infrastructure in place to support risk management, but does not have a disaster recovery strategy. • 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.
Potential Opportunities	1. Develop a training plan to provide focused basic computer skills training among users. 2. Develop a disaster recovery strategy and explore the possibility of having off-site back up storage. 3. Develop and implement operational resource requirements aligned to an IT risk management framework for both IT and end-users in the Region.

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	• SLAs exist in the contracts signed between the Region and RSHIP. • Although the region has several other quality control mechanisms in place for internal IT operations and service delivery, there appear to be limited quality controls with respect to the region's relationship and ongoing operational requirements with RSHIP. • 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 implement quality management mechanisms, with increased focus on ongoing quality control monitoring related to RSHIP. 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:

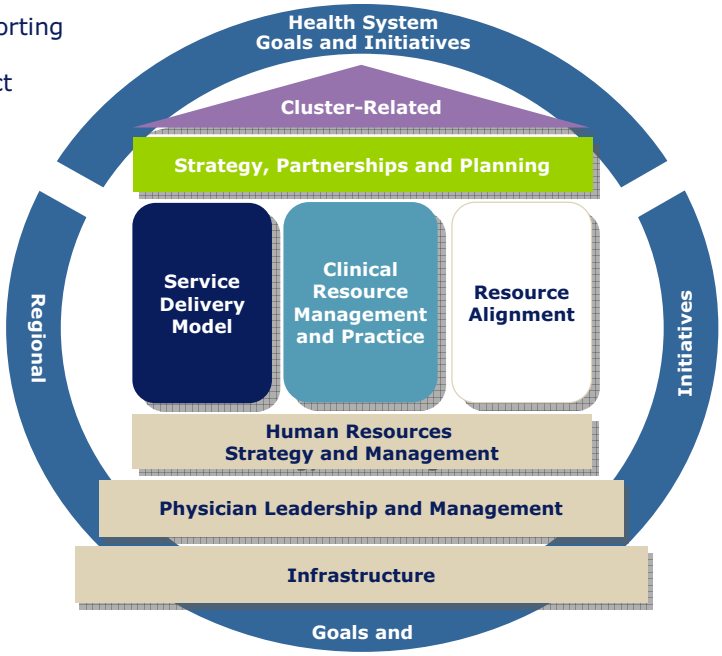
  - Where the opportunity requires a *solution larger than 1 Region's capacity* (as it may require cross-region collaboration, provincial collaboration or investment).
  - Where a *cross region collaboration* and solution development will *deliver greater value (either qualitative or quantitative)* than 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

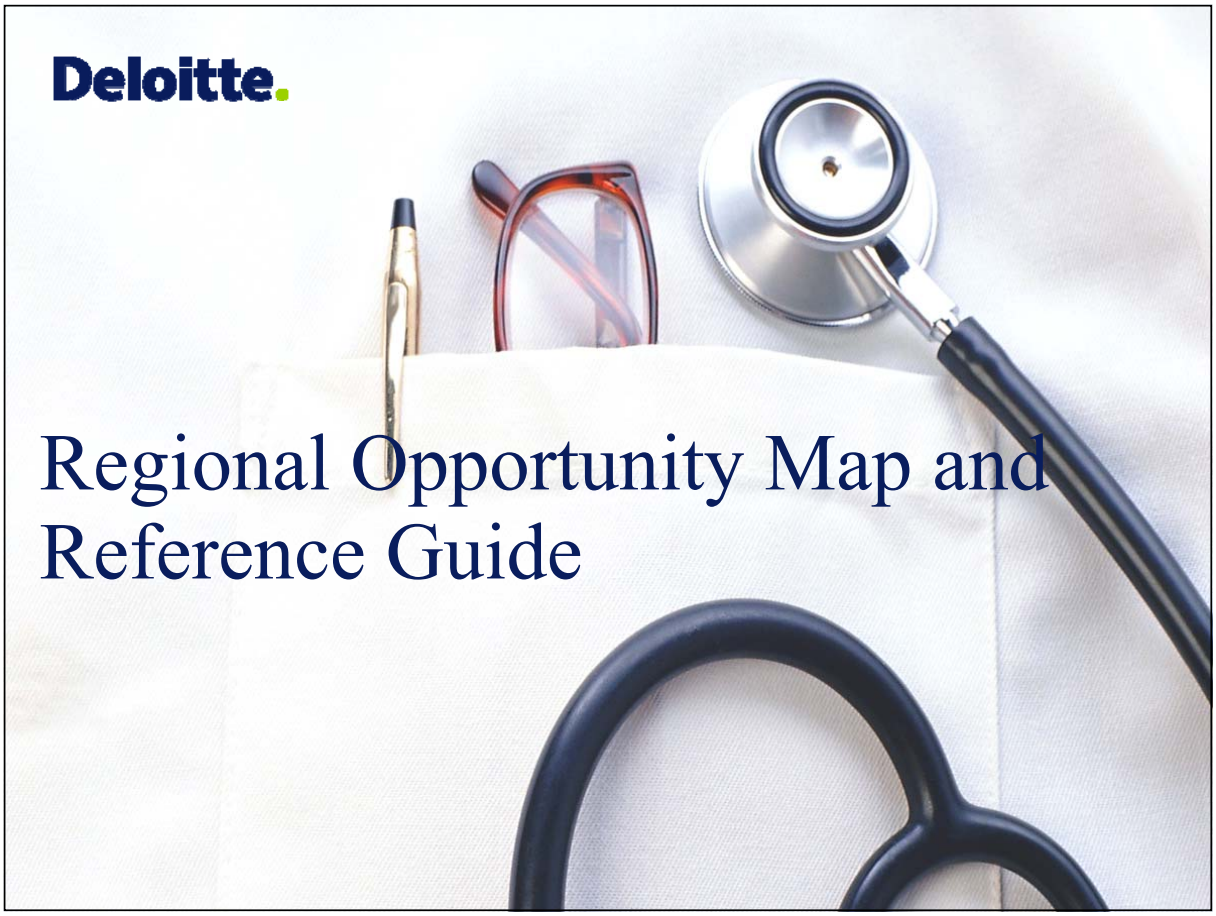
I. Conduct a comprehensive review of the RSHIP Meditech implementation to ensure success and sustainability, with consideration of:
   - Planning
   - Investments
   - Staffing
   - Training
   - Benefits
   - Module Functionality (e.g. Pharmacy, Materiel Management, Clinical Nutrition)
   - Service 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.

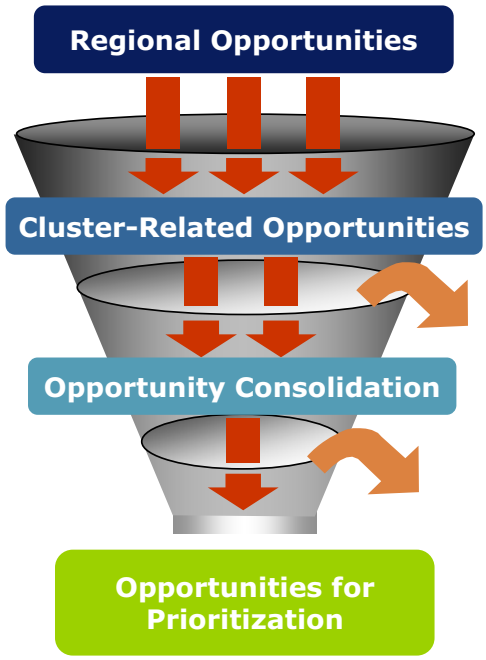
IV. Improve coordination of Alberta Infrastructure, AHW and the RHAs to align facilities capital funding to provincial and regional health services plans and community health needs assessments.

Deloitte.



Regional Opportunity Map and Reference Guide

Regional Opportunity Map and Reference Guide
Introduction

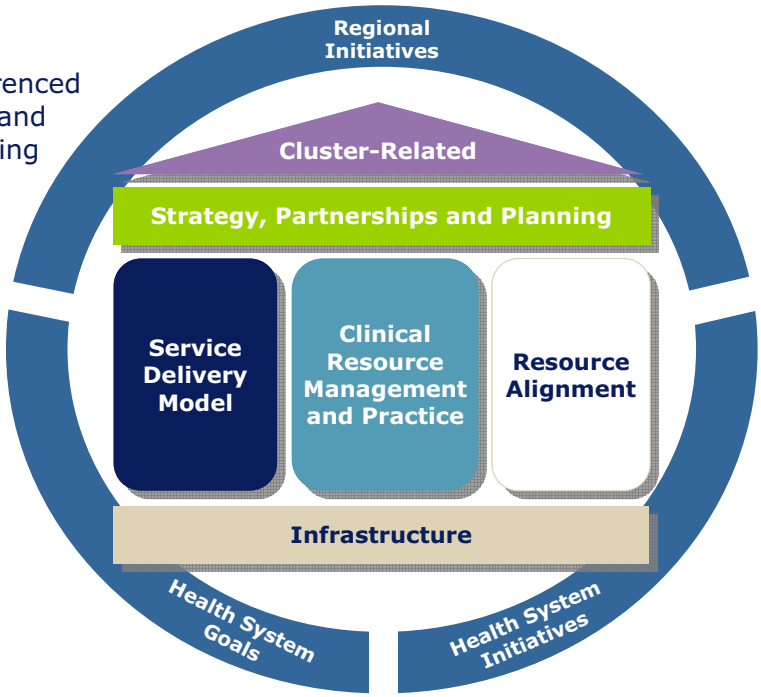


- For today's discussion, we have developed a reference guide for the opportunities identified in the region's report.
- Opportunities have been filtered to facilitate discussion.
- **Filter 1:** The overlap of cluster and regional opportunities is one filter.
  - Cluster Opportunities will be driven by a separate process through a collaboration of AHW and the Cluster 2 regions, and so have not been prioritized for today's discussion.
  - 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

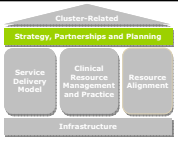
Opportunity Alignment

- To facilitate prioritization, opportunities are aligned across five areas, shown in framework below.
- This framework will be referenced throughout our discussion, and will 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.



Palliser Health Region

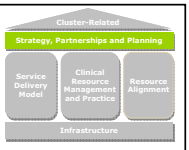
Strategy, Partnerships and Planning



Key Opportunities	Description
Health Human Resources Recruitment and Retention Plan and Processes	• The region is currently developing an HHR workforce plan and strategy. Several opportunities relate to this effort, which identify areas of focus (Physicians, Labs, DI, Materiel Management, etc.)
Regional Senior HR Leader	• Consider the development of a senior level HR position to drive the strategic priority of HR for the organization.
HR Performance Management	• Re-focus efforts on performance management as a regional priority, to ensure individual performance alignment to regional strategies and objectives.
Separate MAC Chair and MSA President Roles	• Separate the roles of Chair of MAC and President of Medical Staff ,and delineate clear roles for medical staff leadership, such as: quality through the MAC, advocacy through the President and Executive of the medical staff, and administration through the office of the VP Medical Services. Appropriate mechanisms and options should be put in place to address these aspects with identification of processes for follow-up.
Physician Leadership Terms and Roles	• Clear roles, responsibilities, terms and resources for Chief of Staff, Regional Chief and Program Medical Director need to be defined.

Palliser Health Region

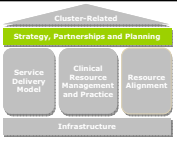
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
MAC Policies and Mechanisms on Quality, Patient Safety, and MD Behaviour	• The Board, the Executive and the MAC need to establish quality and behaviour standards for physicians in PHR, including outlining expectations of practicing optimal care and policies on disruptive behaviour, and which focus on the achievement of high patient care quality and safety.
Physician-Management Joint Problem Mechanisms	• Mechanisms for joint problem solving with physicians and administration should be created and be based PHR leadership values and the broader principles of organizational justice.
Physician Leadership Training	• Explore the development and investment in management training for regional physician leaders.
Interprofessional Conflict Management Process	• Establish processes and communication mechanisms to provide staff and physicians with an ability to discuss and resolve inter-professional issues.
Program Performance Indicators	• Develop and use appropriate performance indicators for some selected programs and eventually expand to all programs.

Palliser Health Region

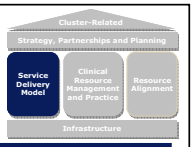
Strategy, Partnerships and Planning (continued)



Key Opportunities	Description
Brooks Administration And Support Structure	• Revisit the administration structure and administrative support.
Director/Manager Role in Budgeting	• Explore options for expanding Director and Manager involvement in annual budgeting processes, enabled by Decision Support.
Coordinated Access Balance	• Consider the balance of regional vs. local policy and service delivery to create consistent criteria, processes and equitable access.
Community Mental Health	• Opportunity exists to create stronger links with AADAC for community addictions support, and to continue to expand community-based mental health services in the region.
Asthma Education Program	• Consolidate Asthma education into regionally coordinated program.
Regional Asset Management	• Develop a regional approach to asset management and tracking to support capital planning.
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.

Palliser Health Region

Service Delivery Model



Key Opportunities	Description
Regional Organizational Model	• PHR must determine if it will shift to program management, and this must be supported by a clear plan, leadership and associated leadership organization structure to ensure success. Several related opportunities identify the need to define this model for the management of Medicine/ICU, Perioperative, and Perinatal/Pediatric services.
MHRH LDRP Model and Rooming In	• Conduct a review to determine feasibility of moving to an LDRP model of care, with consideration of care model, staffing and facilities. Consider "Rooming in" 24/7 to keep in line with evidence-based practice, and as a staging toward LDRP.
ENT Service Review	• Review ENT services in the Region to align service to needs, and consider ambulatory service delivery model to align to best practice.
RT Role in OR	• Explore service delivery models that includes Respiratory Therapists in the OR, with consideration of balancing related nurse staffing.
MHRH ER Model	• Explore options to improve management of workflow for CTAS 4 and 5 patients with consideration of: establishment of a dedicated fast track area, shifting of Triage 4/5 volumes to PCN to improve ER flow, involvement of physicians to ensure alignment to ensure alignment of practice to process, liaise with home care to expand evening and weekend services, liaise with Day Medicine to reinforce support for the continued shift of patients to day medicine area.
Bow Island ER Visit Alternative Service Setting	• Explore alternative service setting for clinic visits seen in the ER.

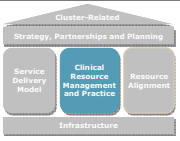
Palliser Health Region

Service Delivery Model (continued)

Key Opportunities	Description
Home Care Expansion	• Consider options to increase service delivery, including the potential for: additional respite beds, expanded day programs, and expanded evening and weekend home care service.
Social Work Role	• Examine the role and allocation of Social Work resources in the region, to determine ability to improve service access and patient flow across region.
Regional Pharmacy Service	• Proceed with regionalizing Pharmacy that facilitates leading practice, optimizes operational efficiencies and identifies regional transportation service requirements (as a critical enabler).
Physiotherapy Policies	• Clarify policies and procedures for accessing Physiotherapy across the health continuum to ensure consistency.
Regional Clinical Nutrition Service	• Regionalize Clinical Nutrition to establish common programming, practice, and staff cross coverage across the continuum.
Regional Food Services Model, Business Case, and Staffing	• Consider regionalization of Food Services throughout PHR to achieve common standards, policies and procedures, supported by a business case to examine a potential shift to centralized service delivery and required staffing.
Regional Housekeeping Services	• Consider regionalization of housekeeping services to standardize management, technology, policies and procedures.
Telehealth and eLearning Utilization	• Continue to build telehealth and e-learning as key HR technologies supporting regional education.

Palliser Health Region

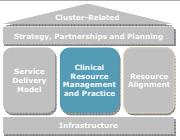
Clinical Resource Management and Practice



Key Opportunities	Description
Perioperative Services Team	• Formalize an interdisciplinary team for Perioperative Services that oversees planning as well as quality, access and efficient use of resources.
Perioperative Services Performance and Quality Management	• Several opportunities were identified related to OR Late Starts and Turnaround Times, OR Case Scheduling Policy, converting all OR's to be Latex-Free, expanding Performance Management and Quality Indicators, mandating CNA Certification, exploring Patient Wheelchair Transportation, and reviewing Colonoscopy Admission Criteria.
CDP and Living Healthy Role, Mandate, and Resources	• Clarify CDP role and mandate with respect to chronic disease education in acute and home care, role of RNs in CDP, and examine resources required to enable Living Healthy to expand into other areas such as vascular clinic, pacemaker checks, and insulin pump support.
CTAS Assessment in Rural Sites	• Conduct regional assessment of CTAS use in the ER to determine resources, education support, and policies and procedures required to standardize use across the region.
Bow Island ACLS and TNCC Staff Training	• Move to full ACLS and TNCC training for all staff.
Medical Protocols	• Palliser should implement medical protocols, as opposed to standing orders.

Palliser Health Region

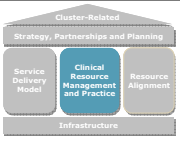
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
Continued Length of Stay Management	• Continue to develop strategies for LOS management focused on the following: – Develop and implement policies to increase use of day procedures across identified areas to achieve improved bed utilization – Assess need for improvements to regional coding and abstracting; – Continue planning efforts to increase continuing care capacity. – Improve discharge planning and coordination across continuum for mental health population to reduce mental health related LOS targets.
Medicine/ICU Admission/Discharge Criteria	• Review admission and discharge criteria involving the Medicine/ICU staff. Redefine definitions for ICU admission and discharge criteria with the goal of appropriate utilization of this resource.
Continuum Software Access	• Ensure all Coordinated Access staff have access to Continuum solutions software.
Telemetry Practice and Education	• Conduct a review of Medicine unit telemetry practices and develop evidence based indications for the initiation and discontinuation of telemetry.
Skill Mix	• Review skill mix, including the roles of health care aides to ensure that they are operating within an appropriate scope of practice within the acute care setting.

Palliser Health Region

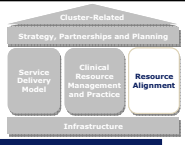
Clinical Resource Management and Practice (continued)



Key Opportunities	Description
Obstetrics Data Capture	• Ensure that all ambulatory visits are consistently captured and reported in regional statistics (e.g. NSTs).
Calgary NICU Preceptorship	• Link with Calgary for preceptorship program to maintain NICU skills.
MHRH Mental Health Bed Utilization, Role, and Mandate	• Clarify MHRH Mental Health role and mandate with respect to other hospital services, including clarification and communication of admission criteria. In addition, monitor MHRH inpatient mental health bed utilization.
Lab Utilization Committee	• Develop a regional Laboratory Utilization Committee to continue to promote regional collaboration, formally sharing best practices, and supporting lab utilization management.
Pharmacy Technicians and Pharmacist Payments	• Continue to examine increased role for Pharmacy Technicians and innovative payment practices for Pharmacists (e.g. isolation pay) to address current staffing shortages.

Palliser Health Region

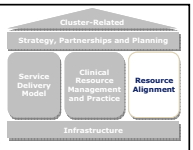
Resource Alignment



Key Opportunities	Description
Regional Staffing and Scheduling	• Review staffing and scheduling processes as well as schedules to ensure adequate baseline staffing, consistent staffing patterns, and sufficient replacement staff.
MHRH Unit Clerk Model and Roles	• Review MHRH unit clerk model and roles, and align resources appropriately.
MHRH 4 West Skill Mix and Resources	• Consider enhancing the skill mix, as well as increasing the budget to reflect actual HPPD.
MHRH 6 West Scheduling	• Review schedules and assignment practices with the goal of leveling day and night staffing.
MHRH 5 West Staffing Model	• Revise the care delivery model on 5 West to eliminate the Care Coordinator role, shift some resources to the evening and night shift and enhance skill mix.
Expand Day Medicine	• Investigate feasibility of extending hours of Day Medicine into evenings and weekends.
MHRH Pediatrics/NICU Cross-Training	• Consider cross-training staff between Paediatrics and NICU.
OR Staff Utilization	• Increase utilization of regularly scheduled hours to improve staffing efficiency. Ensure regular hours and staffing matches surgical demand.
OR Educator Support	• Expand Educator support to include OR.

Palliser Health Region

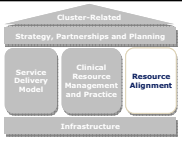
Resource Alignment (continued)



Key Opportunities	Description
MHRH ER Staffing	• Target potential MHRH ER staffing investment with focus on: – Separating Triage from Charge Nurse positions during day/evening shifts; – Reviewing nurse assignment practices to ensure equitable workloads and alignment between patient needs and nurse staffing; and – Removing patient care responsibilities from paramedic.
MHRH ICU/ER Staff Cross-Training	• ICU nursing staff should be cross trained and expected to support ER during times of low occupancy.
Rural On-Site Education	• Additional clinical educational support required, with consideration of use of simulators to train teams for the rare emergencies that develop, and further leveraging of telehealth to support training.
Infection Control Resources	• Investigate potential of adding additional resources to infection control.
Health Promotion Resources	• Examine health promotion resources relative to required services in alignment to recent PHR community health needs assessment.
Sexual Health Clinic Expansion	• Consider expanding sexual health /STD clinic hours to 6 hours per week. Provide some hours in regional facilities as well as MHRH.

Palliser Health Region

Resource Alignment (continued)

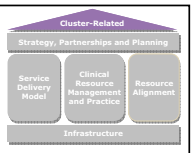


Key Opportunities	Description
Physiotherapy Staffing	• Consider increased PT staffing with respect to required support for 2N rehabilitation unit and weekend coverage in MHRH, CHADS program services, and existing contract services.
Decision Support Staffing	• Consider investment of resources to ensure continued Decision Support functionality in the region.
Human Resources Staffing	• Target staffing investment in HR to support strategic focus in the region.
Health Records Staffing	• Target staffing investment in Health Records and Patient Registration to address current backlogs in coding, abstracting and transcription (will need to determine appropriate level of investment given current outsourcing of transcription which is impacting target to some extent).
Housekeeping Resources	• Consider identified staffing investment to increase housekeeping service responsiveness and internal patient portering at MHRH.
Plant Operations Resources	• Consider staffing investments in Plant Operations to support capital projects and facility maintenance in the region.

Palliser Health Region
Infrastructure

Key Opportunities	Description
MHRH Medication Preparation	• Explore a dedicated area for medication preparation within the MHRH units to decrease interruptions.
Perinatal Service Co-location	• Explore planning opportunities for future co-locating of Perinatal services.
Health Records Chart Storage	• Develop a plan to address Health Records chart storage, with consideration of facilities and technology-based solutions.
MHRH Centralized Booking	• Explore the business case for establishing centralized booking at MHRH, with consideration of physical vs. technology-based centralization.
Regional Telecommunications System	• Consider development of a single multi-site phone system to enable cross-coverage of switchboard and reception functions in the region, as part of capital planning.
QHR Functionality and Training	• Explore options to improve functionality of QHR, supported by management training to leverage HR management at the regional and site levels.
Laundry Equipment Business Case	• Develop a business case for the replacement of aged Laundry equipment and the installation of a new shuttle system.

Palliser Health Region
Cluster/Provincial-Related



Key Opportunities	Description
Physician Roles and Accountabilities	• Delineation of physician roles, responsibilities and accountability in the region.
Physician Impact Assessment	• Develop a consistent regional Physician Impact Assessment process for physician recruitment needs, workforce planning, and program planning.
Physician Service Level Agreements	• Develop a service level agreement model with physicians, such that PHR enters into a contract with MDs outlining their expectations to maintain credentials in the region.
Public Health Inspector Utilization through Technology	• Explore options to improve PHI utilization through enhanced technology, including: – Computerized Scheduling – In-Field Mobile Technology – Reduced Duplicate Data Entry by Clerks.
Environmental Health Standards	• Increase focus on achieving AB Blue Book Standards in Environmental Health.
Pharmacy Meditech Functionality	• Explore options to improve Meditech functionality in Pharmacy.

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 has 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 four phases of effort:
  - Phase 1: 0-10 months (June 2007 – March 2008)
  - Phase 2: 11-22 months (April 2008 – March 2009)
  - Phase 3: 23-34 months (April 2009 – March 2010)
  - Phase 4: 35-46 months (April 2010 – March 2011)

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 opportunity 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 46-month planning period.

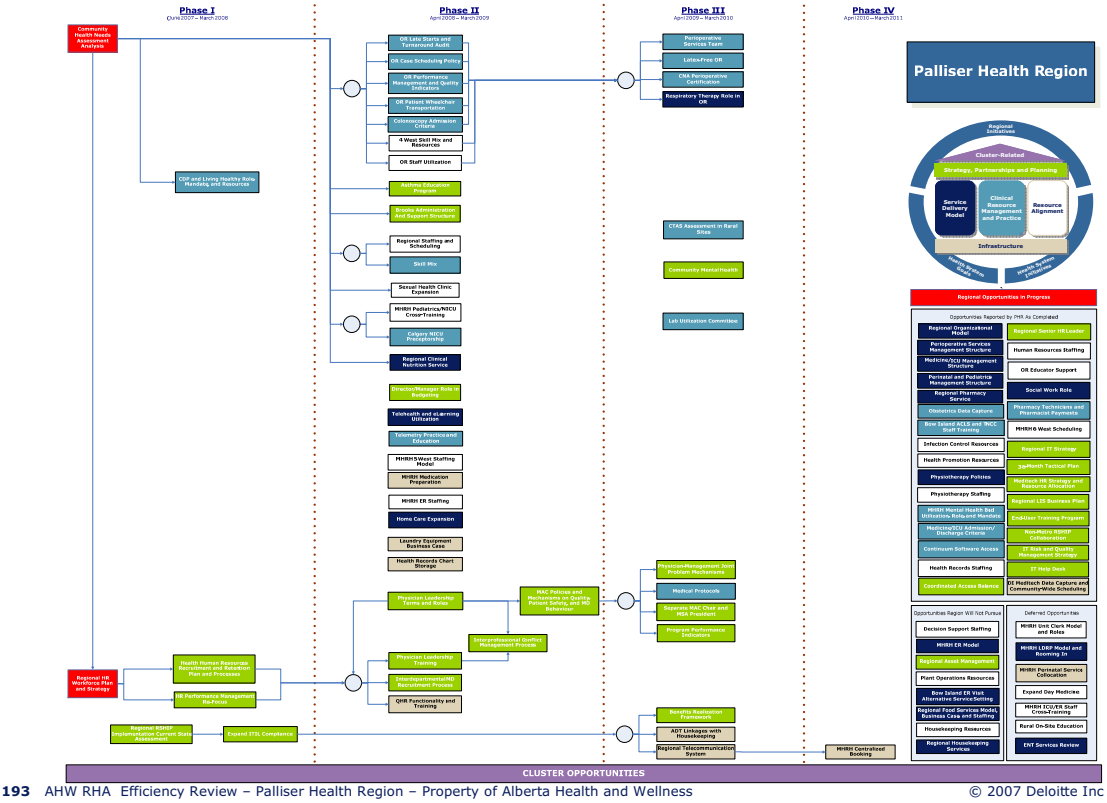
  - ***Deferred*** – Opportunities which must be deferred at this stage, but which will be re-considered for pursuit in the future.

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

- The regional opportunity map is presented on the next page, followed by the Senior Leads identified by the region as being responsible for the achievement of each prioritized opportunity.
- In addition, information is provided about the opportunities that the region has decided to defer or not pursue.

Regional Opportunity Prioritization

Final Opportunity Map



Regional Opportunity Prioritization
Regional Leads – Phase 1

Opportunity Name	Responsible Senior Lead
CDP and Living Healthy Role, Mandate, and Resources	Janice Blair
Health Human Resources Recruitment and Retention	Blaine Ball
HR Performance Management Re-Focus	Blaine Ball
Regional RSHIP Implementation Current State Assessment	Cal Niebergall
Expand ITIL Compliance	Cal Niebergall

Regional Opportunity Prioritization
Regional Leads – Phase 2

Opportunity Name	Responsible Senior Lead
OR Late-Starts Turnaround Audit	Linda Iwasiw
OR Case Scheduling Policy	Linda Iwasiw
OR Performance Management and Quality Indicators	Linda Iwasiw
OR Patient Wheelchair Transportation	Linda Iwasiw
Colonoscopy Admission Criteria	Linda Iwasiw, Dr. Vince Di Ninno
4 West Skill Mix and Resources	Linda Iwasiw
OR Staff Utilization	Linda Iwasiw
Asthma Education Program	Janice Blair
Brooks Administration and Support Structure	Linda Iwasiw
Regional Staffing and Scheduling	Linda Iwasiw

Regional Opportunity Prioritization

Regional Leads – Phase 2 (continued)

Opportunity Name	Responsible Senior Lead
Skill Mix	Linda Iwasiw
Sexual Health Clinic Expansion	Janice Blair
MHRH Pediatrics / NICU Cross-Training	Linda Iwasiw
Calgary NICU Preceptorship	Linda Iwasiw
Regional Clinical Nutrition Service	Janice Blair
Director / Manager Role in Budgeting	Seamus O'Fuarthain
Telehealth and eLearning Utilization	Linda Iwasiw
Telemetry Practice and Education	Linda Iwasiw
MHRH 5 West Staffing Model	Linda Iwasiw
MHRH Medication Preparation	Linda Iwasiw

Regional Opportunity Prioritization

Regional Leads – Phase 2 (continued)

Opportunity Name	Responsible Senior Lead
MHRH ER Staffing	Linda Iwasiw
Home Care Expansion	Linda Iwasiw
Laundry Equipment Business Case	Cal Niebergall
Health Records Chart Storage	Cal Niebergall
Physician Leadership Team and Roles	Dr. Vince Di Ninno
MAC Policies and Mechanisms on Quality, Patient Safety, and MD Behaviour.	Dr. Vince Di Ninno
Interprofessional Conflict Management Process	Dr. Vince Di Ninno, Linda Iwasiw
Physician Leadership Training	Dr. Vince Di Ninno
Interdepartmental MD Recruitment Process	Dr. Vince Di Ninno, Blaine Ball
QHR Functionality and Training	Blaine Ball, Seamus O'Fuarthain

Regional Opportunity Prioritization
Regional Leads – Phase 3

Opportunity Name	Responsible Senior Lead
Perioperative Services Team	Linda Iwasiw
Latex-Free OR	Linda Iwasiw
CNA Perioperative Certification	Linda Iwasiw
Respiratory Therapy Role in OR	Linda Iwasiw
CTAS Assessment in Rural Sites	Linda Iwasiw, Dr. Vince Di Ninno
Community Mental Health	Linda Iwasiw, Janice Blair
Lab Utilization Committee	Linda Iwasiw, Dr. Vince Di Ninno

Regional Opportunity Prioritization
Regional Leads – Phase 3 (continued)

Opportunity Name	Responsible Senior Lead
Physician-Management Joint Problem Solving Mechanisms	Tom Seaman, Dr. Vince Di Ninno
Medical Protocols	Linda Iwasiw, Dr. Vince Di Ninno
Separate MAC Chair and MSA President	Tom Seaman, Dr. Vince Di Ninno
Program Performance Indicators	Dr. Vince Di Ninno
Benefits Realization Framework	Cal Niebergall
ADT Linkages with Housekeeping	Cal Niebergall
Regional Telecommunication System	Cal Niebergall

Regional Opportunity Prioritization

Regional Leads – Phase 4

Opportunity Name	Responsible Senior Lead
MHRH Centralized Booking	Cal Niebergall

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
MHRH Unit Clerk Model and Roles	Deferred	• The region reports that it has added some resources in 2007/08. Due to resource implications, however, any further changes are deferred
MHRH LDRP Model and Rooming In	Deferred	• The region notes that they have made some minor changes but that any further change requires significant capital, and is deferred pending approval by AHW
MHRH Perinatal Service Collocation	Deferred	• The region notes that further change requires significant capital, and is deferred pending approval by AHW
Expand Day Medicine	Deferred	• Due to resource implications, the region has deferred this opportunity at the present time
MHRH ICU/ER Staff Cross-Training	Deferred	• The region reports that since the time of review, the MHRH ICU has significantly increased its utilization, and is facing staffing challenges, so this opportunity may be considered at a future date

Regional Opportunity Prioritization
Opportunities Deferred or Not Pursued (continued)

- 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
Rural On-Site Education	Deferred	• Due to resource implications, the region has deferred this opportunity at the present time
ENT Services Review	Deferred	• The region has decided to defer this opportunity to a future date, due to current physician practice
Decision Support Staffing	Not Pursued	• The region reports that it has made investment in related areas, and so will not be pursuing this specific opportunity
MHRH ER Model	Not Pursued	• The region reports that a previous fast-track business case, physician practice and other challenges will prevent opportunity pursuit
Bow Island ER Visit Alternative Service Setting	Not Pursued	• The region reports that physician practice and other challenges prevent opportunity pursuit at the present time

Regional Opportunity Prioritization
Opportunities Deferred or Not Pursued (continued)

- 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
Regional Asset Management	Not Pursued	• The region identifies that it has what it feels is needed in this area, and so will not pursue the opportunity
Plant Operations Resources	Not Pursued	• The region identifies that it assesses resource adequacy on a regular basis and so will not pursue this opportunity at the present time
Housekeeping Resources	Not Pursued	• The region identifies that it is sufficiently staffed in this area, and so will not pursue the opportunity
Regional Housekeeping Services	Not Pursued	• The region has identified that this is not a priority at this time, and so will not pursue the opportunity.
Regional Food Services Model, Business Case , and Staffing	Not Pursued	• The region has identified that this is not a priority at this time, and that it is sufficiently staffed in this area, so it will not pursue the opportunity.

Deloitte.

AHW RHA Efficiency Review
Palliser Health Region

Performance Management Overview

Final Report

July 13, 2007

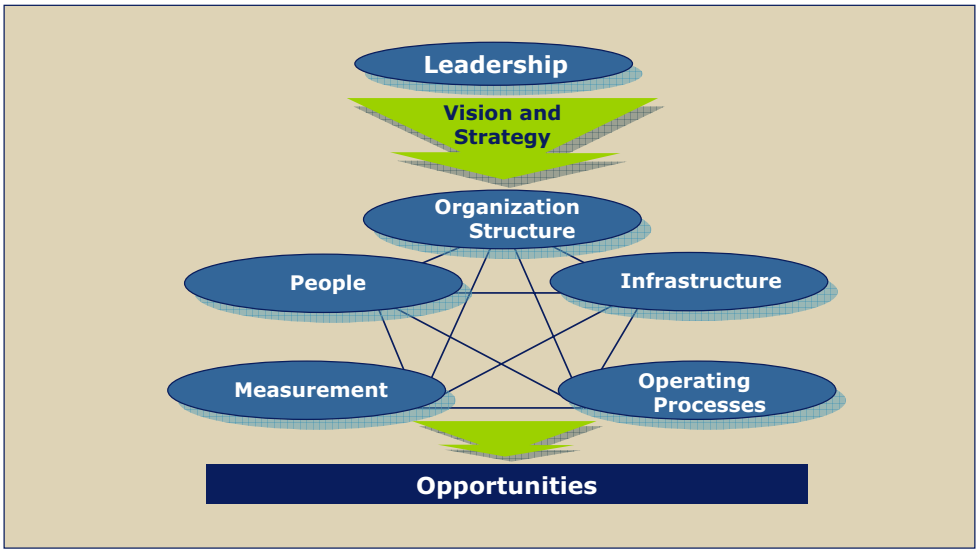
Audit. Tax. Consulting. Financial Advisory.

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 (except Culture), 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; Annual Business Plan; Annual Report • Organization Charts	• Significant challenges foreseen with succession planning due to gap in candidates interested and readiness for leadership roles. • Require more visible and active Medical Leadership to support various Clinical Support Services.

Deloitte Observations	• Leadership roles will be critical to the evolving organizational model and associated structure. • Leadership needs to collectively determine the organizational model and structure, with respect to considerations of program management. • The Region has invested in Leadership training for senior leaders and should continue to develop leaders to build competencies and 'bench-strength' for support required succession. Increase focus on physician leaders is needed. • Board, MAC and Administration need to come to terms and accept that retention of Physicians will be based on defined quality and behaviour standards and any deviation will not be accepted. Defined roles and responsibilities for physicians and physician leaders will be critical to this success.

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; Annual Business Plan; Annual Report. • Community Health Needs Assessment	• Stakeholders identify that operations do map to strategy, and are able to identify operational initiatives in their areas that support regional planning. • Quality and patient safety are key focal points for region. • PHR has developed a number of innovative initiatives in primary care to support health system sustainability, which stakeholder see as actively progressing

Deloitte Observations	• The region has a clearly articulated mission, vision and principles, which are supported by the three-year plan and annual business plan. • Three-year plan show alignment to AHW requirements, and performance indicators are in place to track progress to plans. Each strategic focus has been clearly articulated with corresponding tactical approaches, measures and timeline. As well, they have each been clearly cross referenced to AHW expectations. • The region's longstanding history provides a strong foundation on which to build strong vision and strategy. Supporting this, the region's commitment to a regular community health needs assessment every 5 years is an important success factor. • One consideration for continued management attention is the balance of how many strategies can be tackled relative to the resource requirements across regional initiatives.

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 • Role descriptions (select management roles)	• The Chair of MAC is also the President of the Medical Staff (elected by Medical Staff) which results in a conflict of interest with respect to advocacy and quality management. • The organization is in a state of transition, as it considers a shift to program.

Deloitte Observations	• The job descriptions for the Medical Directors indicates they are co-leaders but consultation found they generally are less involved. Further clarity on the roles and relationships of the Medical Directors to the VP Medicine is suggested. • Overlap with the Chief role and the Medical Director role and acceptance of accountability is often described as "a lot of push and pull". • A separation of the President of the MSA and MAC Chair is suggested to facilitate the distinction and focus on regional issues. • Implementation of Regional structure is moving slowly in some areas, which suggests that further focus on regionalizing services would support efficiency and effectiveness of service delivery. • As the region continues to evolve its organization model, further consideration should be given to align senior team portfolios and management structure to service delivery. For example, three areas for suggested ongoing focus include: – The emerging role of the Regional Rural Director suggests a review of the required management support on-site at select sites such as Brooks. – The higher level of workload associated with the Senior VP Health Services portfolio vs. VP Community Services. – Nursing management structure is in transition and there are opportunities to streamline several areas given existing points of role overlap and nurse manager vacancies.

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**
• HR Recruitment and Retention Plan • Organization Structure	• There are limited HR resources to assist programs with developing an integrated workforce planning strategy. • Challenges identified across organization with succession planning, recruitment of casual staff and retention of younger staff. • A performance management review process, exists, but there is low compliance across the organization. • The region is embarking on a cultural transformation initiative that is anticipated to help increase the region's retention and attraction of new talent.

Deloitte Observations	• Although stakeholders report that staff shortages has not been as challenging as observed in other regions, nursing recruitment and retention is still observed to be an issue compounded by the insufficient HR staff providing services. The region's current workforce planning initiative should help to drive change in this area, and focus should include physician workforce planning to ensure alignment across regional HHR planning. • There is an opportunity to review nursing schedules and rotations to enhance coverage, decrease reliance on casual staff and enhance staff satisfaction. A program that is supporting this is the initiation of New Grad program, which allows for new staff members to be supernumerary on the nursing units.

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
• IT planning documents • Capital Redevelopment Submissions	• Stakeholders report good access to funding and regional process for capital equipment acquisitions. Equipment across the organization is in fairly good condition and age. • The region's IT initiatives are resource-intensive but are expected to provide a good information foundation for operations. • Experiencing challenges with recent implementation of Meditech due to decreased functionality and time consuming reporting in many areas. • Some areas are experiencing space issues (e.g. Pharmacy, Patient Registration, Health Records) that will be addressed in future capital projects.

Deloitte Observations	• The Capital Equipment approval processes and resources observed in the region are strong and effective in supporting regional planning in a coordinated and collaborative manner. • Although the RSHIP is an important investment by the region, the region needs to evaluate the level of time and resource investment required for Phase II before proceeding, to ensure the sustainability of current IT infrastructure and to prepare for the impact on end-user operational stakeholders. • Further, it is equally important for the region to balance other IT initiatives to support service delivery. Key to this is the development of a regional strategic plan that guides alignment of IT initiatives to regional business objectives.

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; Annual Business Plan; Annual Report, • Annual Reports	• The region's performance management framework for individuals is not consistently used across the organization. • There is mixed traction in applying performance management and measures across operational initiatives. For example, stakeholders report that infection control reports are being responded to at MAC and Administration, which is good. But other issues, e.g. disruptive MDs, not being responded to. • The region's implementation of Continuum has achieved good progress in improving clinical utilization performance management.

Deloitte Observations	• The region has performance management in place through the three-year and annual planning processes. • The Region has invested effort into performance management, including the development of a quality framework. • A Regional Coordinator is responsible for quality improvement, balanced scorecard, accreditation and patient safety. • Important to the success of regional performance management is the integration of clear roles, responsibilities and accountabilities for physicians. • Given the investments made by the region in creating an online performance management system and framework, this is an area for renewed focus of senior management attention. • A key focus for ongoing senior management attention in this area is that 'measurement should lead to change'.

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**
• Annual Business Plan • Accreditation Report • Care documentation (charts) • Policy/Procedure • Risk Management Framework	• Process standardization is variable across the region, where a mix of regionalized and site-based services, policies and procedures exist. • Managers report a good understanding of their budgets, and alignment of their operational initiatives to regional plans. • Board reports a good understanding of regional risks, and this cascades throughout the organization – which was observed through consultations in which stakeholders were readily able to identify operational risks and related strategies. • Multi-disciplinary approach required to address needs and understand impacts of program expansion and practices of new physician.

Deloitte Observations	
	• Although some services are regionalized, the region has not fully explored business case based opportunities across several areas (e.g. Housekeeping, Pharmacy, Food Services). • The region should continue efforts to standardize policies, procedures, roles, etc., with consideration of geographic and operating differences between sites. • To support ongoing management decision-making and operational planning, the region should attempt to protect the existing Decision Support resources, and not allow them to be pulled into the RSHIP Meditech report writing needs. • To ensure strong program planning, the region needs to further build on its analysis for program, operational support and physician impact analysis.

Summary Remarks

Strengths to build on include:

- **Good alignment between the three-year plan and annual program planning process**
- **Community Health Needs Assessment approach to informed health services planning**
- **Comprehensive capital planning processes**
- **Existing online Performance Management system for individual performance**

Areas for further consideration:

- **Determination of organization model with respect to program model considerations and associated management portfolios**
- **Delineation of physician roles, responsibilities and accountability in the region**
- **Creation of a regional IT Strategy that is aligned to regional objectives**
- **Improved balance across Meditech vs. other IT initiatives vs. end-user operations**