Best Practices Review

Western Health Care Corporation

February 10, 2005

HayGroup

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1.0 Background & Objectives

1.1 Project Background

Western Health Care Corporation

The Western Health Care Corporation (WHCC) is responsible for the delivery of institutional health services in the Western Region of Newfoundland and Labrador. The Western Region extends from Burgeo/Ramea on the south coast to Bartlett's Harbour on the northern peninsula and on the eastern boundary north to Jackson's Arm. It has a population of 82,000 residents. The population of the region has decreased by 14% from 95,000 persons in 1991.

The Corporation operates two hospitals:

- Western Memorial Regional Hospital in Corner Brook,
- Sir Thomas Roddick Hospital in Stephenville,

four health centres:

- Rufus Guinchard Health Centre in Port Saunders,
- Bonne Bay Health Centre in Norris Point,
- Dr. Charles L. Legrow Health Centre in Port Aux Basques,
- Calder Health Centre in Burgeo,

three nursing homes:

- Dr. J.I. O'Connell Centre,
- Interfaith Home for Senior Citizens,
- Bay St. George Long-Term Care Centre,

and medical clinics located in a number of communities. There are 262 acute beds and 446 long-term care beds in the region.

In providing services to the people of Western Newfoundland WHCC collaborates with Health and Community Services Western (HCSW)[1]. The collaboration includes the provision of office space to HCSW at WMRH and at WHCC health centers and provision of IT and other administrative services.

[1] HCSW provides health and community services such as: Communicable disease investigation and control, Health promotion, Continuing care, Personal care homes (monitoring and licensing), Addictions services, Environmental health, Community rehabilitative services, Community mental health, Child welfare, Community corrections, Family and Rehabilitative services.

The Corporation's shareable operating expenses for 2003/04 are estimated to be $157 $ million. Shareable operations have generated an operating deficit in each of the past five years (through 2003/04). The ongoing operating deficits have not only resulted in an accumulated deficit of $23.5 million, but have created the need for a significant bank overdraft of over $15 million at March 31, 2004.

1.2 Project Objective

The Minister of Health and Community Services is concerned about the continuing deterioration of the fiscal health of the Western Health Care Corporation (WHCC). To address this situation the Minister has commissioned the Hay Health Care Consulting Group to conduct a 'Best Practice Review' of WHCC. Simultaneously, Hay has conducted a similar best practices review of the Grenfell Regional Health Services Board.

1.3 Project Scope of Work and Approach

The Best Practices Review has been designed to provide recommendations to assist WHCC in bringing about a healthy financial position while providing quality services and programs that fall within its mandate. The Best Practices Review has included:

1. Review the governance and management structures and processes and identify opportunities, if any, for improvements to better meet the organization's mandate.

2. Identification of the major cost drivers that have contributed to and that continue to contribute to the operating deficits of the Corporation.

3. Identification of efficiency measures already adopted by the Corporation to address its cost pressures.

4. A population based review of the utilization of acute care services to determine the appropriateness of the current use of key areas such as ED visits, inpatient admissions, surgeries, diagnostic imaging, and laboratory services. This will include a consideration of the appropriateness of the current rates of referral of cases to secondary and tertiary care centers.

5. A population based utilization review of long-term care services to determine the appropriateness of their current use.

6. Assessment of the current revenue generation by the region to identify opportunities to increase revenues from sources other than the Department.

7. Assessment of the current productivity of acute care, rehabilitation, long term care, community and air transportation services to identify opportunities for improvement in efficiency through comparison to best practice models and available benchmarks for similar services within and outside the Province. This has included consideration of:

   - Clinical Efficiency: Use of Same Day Surgery and Average Lengths of Stay
   - Operating Efficiency: The productivity of functional centers that provide and/or support the delivery of regional services.

8. Assessment of the IT infrastructure requirements, tools and human resources necessary for effective operations and identify strategic IT investments, if any, that would enable further cost savings.

9. Assessment of the current organization and delivery of services and compare these with best practices from across Canada to identify opportunities to reduce costs and/or improve the quality of services through alternate approaches to meeting the health needs of the populations served by the WHCC.

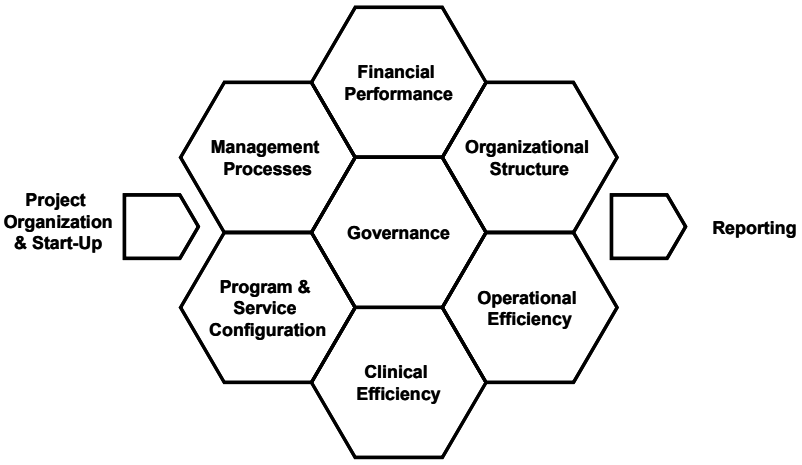
10. Determination of the priority health services that can be delivered within the funding available to these organizations and determine if there are services which are of lesser priority that might be reduced or discontinued so that resources can be reallocated to address higher priority needs.

11. Recommendation of appropriate staffing levels in relation to the current and proposed configuration of services

12. Develop a financial recovery plan to achieve a balanced budget in 2004/05 and to retire the accumulated deficit over a maximum ten-year period.

7 Phase Workplan for theBest Practices Review of WHCC.

Hay Health Care Consulting Group conducted this review. We employed a 7-phase work plan for conducting the review of WHCC. This approach is presented schematically in the exhibit following:



Phase 1: Project organization, confirmation of objectives, scope and approach, resolution of methodological issues and assembly and refinement of WHCC data and measurements of costs, operating efficiency, clinical efficiency and population utilization of hospital services

Phase 2: Review and evaluation of governance and management planning and decision-making processes

Phase 3: Review of financial performance of the hospital since amalgamation and evaluation of the Corporation's financial management processes.

Phase 4: Review of programs and services to assess current need, appropriateness, efficacy and efficiency of the organization and delivery of services in the region

Phase 5: Review and evaluation of the clinical efficiency of clinical processes in the region and of the effectiveness of WHCC utilization management process.

Phase 6: Review and evaluation of the efficiency of department and functional centre operations to identify opportunities to reduce costs in the short and longer-term.

Phase 7: Reporting on the findings of the review and the development of a plan to improve governance, management, clinical efficiency and operational efficiency and a plan to restore the hospital to a positive financial position.

The review was conducted from March to July 2004 and addressed the governance, management and operations of

WHCC primarily during the period from April 2002 to through March 31, 2004[2].

1.4 The Steering Committee

The project was conducted by the consultants under the direction the Department of Health and Community Services. The study received advice from a Steering Committee made up of representatives of Grenfell Regional Health Services Board, Western Health Care Corporation, the Department of Health and Community Services and Treasury Board. The Steering Committee was responsible for directing the execution of the study and reviewing and commenting on interim and final reports. As the funder of the review, the Department reserved for itself responsibility for defining and managing the scope of work to be conducted. The members of the Steering Committee were:

Chair	Deborah E. Fry, Deputy Minister, Department of Health & Community Services
WHCC Representatives	Bernd Staeben, Board Chair, WHCC
	Allan Kendall, CEO, WHCC
GRHSB Representatives	Robert Mesher, Board Chair, GRHSB
	John Budgell, Executive Director, GRHSB
Department of Health and Community Services	Moira Hennessey, Assistant Deputy Minister, Board Services & Project Director, Department of Health & Community Services
	Donna Brewer, Assistant Deputy Minister, Financial Services, Department of Health & Community Services
	Dr. Ed Hunt, Medical Consultant, Department of Health & Community Services
	John Rumboldt, Director (A), Board Services & Project Manager, Department of Health & Community Services
	Jim Strong, Director, Financial Services, Department of Health & Community Services
	Beverly Griffiths, Regional Consultant, Department of Health & Community Services

[2] Issues of data availability required that analysis of population need and hospital utilization was based on data from 2001/02.

Treasury Board	Brenda Caul, Assistant Secretary, Financial Services, Treasury Board

2.0 Financial Review

This section looks at the overall financial performance of the organization over the past five years. This perspective helps us to view the specific departmental and site findings within the context of the organization's overall financial situation. It also may help to identify other trends or changes that have affected the corporation's financial performance.

WHCC had an accumulated operating deficit of $21,052,402 at March 31, 2003[3]. Coupled with a reported[4] operating deficit of $1,500,000 in 2003/04, the accumulated operating deficit that must be addressed is about $22.5 million.

WHCC's financial statements paint a bleak picture:

- The Corporation is carrying a large Bank Overdraft ($15,325,040 at March 31, 2004).
- Shareable operations have generated an operating deficit in all of the past five years (through 2003/04).
- WHCC Board has an accumulated operating deficit of $23 - 24 million for government reporting purposes.
- Non-shareable items, although largely accounting accruals, do include the interest on the Corporation's bank loan ($1.16 million over the past five years). This represents a direct drain on the Board Funds.
- Board Funds have eroded such that the Board owed the Corporation some $2.1 at March 31, 2004.

2.1 Operating Deficit

Shareable operations have generated an operating deficit in all of the past five years (through 2003/04). As can be seen in Exhibit 2.1, the operating deficit was significantly reduced (to less than 0.4%) in 2001/02 and 2002/03, but is projected to increase (to 1.5%) in 2003/04.

The ongoing operating deficits not only have created the need for a significant bank overdraft, they have accumulated to $22.5 million for government reporting purposes. This is an

[3] Department of Health & Community Services

[4] Actual operating deficit was provided by the Department of Health and Community Services after the completion of the analyses for this report.

amount that the Board must address through positive fiscal performance.

The accumulated operating deficit does not appear in the Financial Statements. As noted in the WHCC Financial Statements (March 31, 2003):

"As at the date of release of these financial statements, the Department of Health has not completed its review and, as such, these financial statements do not include any transfers of surpluses or deficits from the Operating Fund to the Board for the March 31, 1997 to March 31, 2003 fiscal periods."

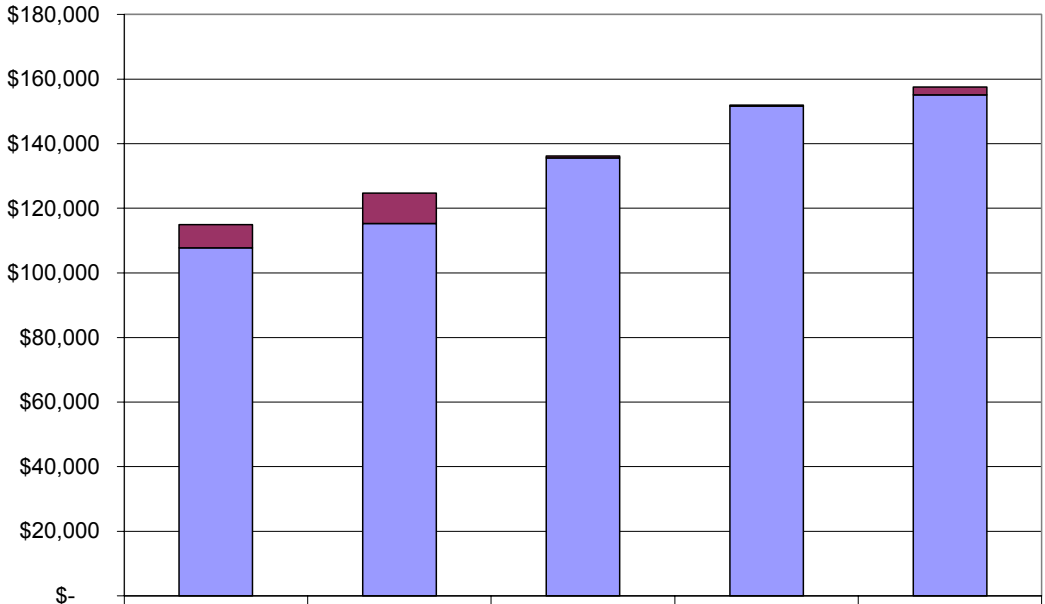
The overall deficit situation underscores the need to address and improve WHCC's fiscal performance.

2.2 Revenues

Estimated revenues for 2003/04 were $155.1 million. Revenues have increased 44% since 1999/00. Exhibit 2.2 shows the revenues by major revenue category over the period. Provincial plan revenue contributes over 80% (81.2% in 2003/04). MCP Physician revenue has increased by 86% over the period and as a result has grown to 8.7% of total revenue. Although long-term care resident income has increased over the period, it has declined as a percentage of total revenue to 3.9%. The contribution of Food services revenue has declined from 1.5% to 1.3% of total revenue.

Other Recoveries have increased by only 13.5% over the period. If they had increased in line with total revenues, their contribution to total revenue would have been $1.25 million greater in 2003/04.

Exhibit 2.1
WHCC Operating Experience



	2000	2001	2002	2003	2004 est.
Deficit	$7,187	$9,398	$478	$303	$2,442
Revenue	$107,735	$115,299	$135,675	$151,637	$155,107

Exhibit 2.2
WHCC Operating Revenues

$ in thousands	2000	2001	2002	2003	2004 est.	Change	%
Provincial Plan	87,012	91,542	110,482	123,361	125,907	38,895	44.7%
MCP physician	7,261	9,120	11,015	12,332	13,489	6,228	85.8%
Inpatient	1,078	853	1,011	1,387	1,589	511	47.5%
Outpatient	671	896	537	702	924	253	37.7%
LTC Resident	5,489	5,870	5,994	6,382	6,051	562	10.2%
Mortgage Interest Subsidy	150	150	102	54	54	(96)	-64.2%
Food Services	1,606	1,954	2,012	2,086	2,089	483	30.1%
Other Recoveries	4,096	4,469	3,833	4,495	4,650	554	13.5%
Other Revenue	371	387	689	838	353	(18)	-4.8%
	107,735	115,241	135,675	151,637	155,107	47,372	44.0%

2.3 Shareable Operating Expenses

Shareable operating expenses have increased by 37.1% since 1999/00 as shown in Exhibit 2.3. Benefits costs rose faster than other expense categories, increasing from 18.3% of total expenditures in 1999/00 to 18.9% in 2003/04.

Exhibit 2.3
WHCC Shareable Operating Expenses by Category5

$ in thousands	2000	2001	2002	2003	2004 est.	% Change
Salaries	74,789	81,648	89,384	99,818	102,688	37.3%
Benefits	13,692	14,712	16,557	19,058	19,432	41.9%
Supplies	26,053	20,970	22,239	23,401	25,823	34.6%
Other Shareable Expenses		6,897	7,433	8,756	9,243	
Long Term Debt	388	469	539	906	363	-6.6%
Total Expenditures	114,922	124,697	136,153	151,939	157,549	37.1%

Shareable operating expenses by organizational area are shown in Exhibit 2.4. Support Services (17.1%) and Education (17.8%) have increased significantly less than the overall increase of 37.1%. Medical Services increased 67.6% (partly supported by the increase in MCP Physician revenue). There was a significant shift of about $3.0 million in rehabilitation services[6] (and funding revenue) from Health and Community Services Western in 2001/02. Excluding that shift of services, Diagnostic and Therapeutic areas operating expenses were up about 42% over the period.

Exhibit 2.4
WHCC Shareable Operating Expenses by Organizational Area

$ in thousands	2000	2001	2002	2003	2004 est.	% Change
Total Administration	11,456	11,756	12,803	14,846	15,015	31.1%
Total Support Services	27,772	28,012	29,880	31,174	32,528	17.1%
Total Nursing Inpatient Services	43,338	48,354	50,171	57,427	57,868	33.5%
Medical Services	9,142	10,996	12,832	14,102	15,320	67.6%
Ambulatory Care Services	7,702	8,960	9,974	11,775	12,622	63.9%
Total Diagnostic & Therapeutic	10,978	11,886	16,245	17,298	18,634	69.7%
Education	3,281	3,379	2,994	3,793	3,866	17.8%
Undistributed	1,253	1,354	1,253	1,525	1,694	35.2%
Total Expenditures	114,922	124,697	136,153	151,939	157,549	37.1%

2.4 Capital Spending

WHCC has spent $4.0 to $10.6 million per year on capital purchases over the past five years as shown in Exhibit 2.5. The majority of funds for these purchases have been provided through provincial equipment and facility capital grants. A Capital Lease of $5.6 million in 2002/03 provided funds for

[5] Supplies and Other Shareable Expenses were combined for calculation of the % Change.

[6] The departments included Physiotherapy, Occupational Therapy, Social Work, Psychological Services, and an institutional based homecare support nurse.

equipment acquired under an Energy Performance Contract with Johnson Controls. The lease payments are to be covered through operating savings.

Exhibit 2.5
WHCC Capital Spending

$ in thousands	2000	2001	2002	2003	2004 est.
Capital Purchases	6,080	4,031	5,618	10,637	
Sources of Funds					
Prov. capital equip grant in current year	1,925	3,207	2,272	3,524	
Prov. Facility capital grant in current year	3,429	1,216	1,975	1,324	
Add: deferred capital grant from prior year	5,265	5,511	7,293	7,478	8,164
Less: deferred capital grant from current year	(5,511)	(7,293)	(7,478)	(8,164)	
	5,109	2,640	4,062	4,161	8,164
Other Contributions					
Foundations, auxiliaries and Other	437	1,092	1,461	891	
NFLD Cancer Trtmnt & Research Foundation	300	216	95		
Provincial Y2K funding	234	82			
	971	1,391	1,556	891	-
Approved Borrowing: Capital Lease				5,585	
Total Funding	6,080	4,031	5,618	10,637	8,164
Surplus (Deficit) on capital purchases	-	-	-	-	8,164

2.5 Board Fund and Bank Overdraft

The Board of Trustees Fund contains special purpose assets and those that may be expended at the discretion of the Board. Revenue consists mainly of investment income and revenue not directly related to hospital operations. Expenditures of this fund consist of hospital operating expenditures not shared by government and those approved by the Board.[7] Over the years non-shareable expenses have exceeded the revenues available to the Board so the Board has been in a negative funds position for the past five years. The history is shown in Exhibit 2.6.

Exhibit 2.6
WHCC Due from Associated Funds

$ in thousands	2000	2001	2002	2003	2004
Board of Trustees Fund	2,105	2,207	1,840	1,806	2,080
Cottages	36	204	350	570	801
Associated Foundations	25	13	28	22	65
	2,166	2,424	2,218	2,398	2,945

WHCC has carried a bank overdraft ranging from $11.4 million in 1999/00 to $18.3 million in 2000/01. The bank

[7] WHCC Operating Fund Notes to Financial Statements March 31, 2003.

overdraft at March 31, 2004 was $15.3 million. The operating deficit is the significant contributor to the overdraft position. The bank overdraft has cost the Board Fund $1,169,670 in non-shareable interest expense over the past five years. An operating surplus is required to enable the Corporation to begin to reduce this financial burden.

Amounts due from associated funds are also a drain on the Corporation. These are non-interest bearing with no set terms of repayment. The Corporation does the accounting for the Cottages, whose accounts are managed separately. Moneys are transferred periodically to reimburse the Corporation for Cottages expenses. The 2004 number is unusually high because the transfer was not completed before year-end. Since March, 2004 year-end the Corporation has received a payment of $609,731 from the Cottages.

2.6 Impact of Changes on Worked Hours

Data were only available for 2002/03 and 2003/04 fiscal years. Worked hours remained virtually unchanged overall with only a 0.58% increase from 2002/03 to 2003/04.

Exhibit 2.7
WHCC Total Worked Hours

	2000/01	2001/02	2002/03	2003/04	Change
711 Admin & Support			1,118,156	1,115,074	
712 Inpatient Nursing			1,344,164	1,345,342	
713 Ambulatory Services			187,245	195,854	
714 Diagnostic & Therapeutic			417,359	427,994	
715 Community Services			13,219	13,636	
Grand Total			3,080,142	3,097,900	0.58%

2.7 Impact of Changes on Wage Rates

Hours data were only available for 2002/03 and 2003/04 fiscal years. Total Worked Salaries are shown in Exhibit 2.8. Worked Salary costs increased by 24.2% over the period 2000/01 through 2002/03. About 17.5% of this increase is attributable to salary contract increases. The average wage rate (worked salary expense / worked hours) increased by 6.64% from 2002/03 to 2003/04. These changes in worked salaries cost and average wage rates would have been influenced by the combined impact of several factors:

- Staff moving up in the pay range with increased seniority
- Application of negotiated union salary increases

- Application of non-union salary increases
- Reduction in lower wage positions/hours (such as clerical or support) combined with increase in higher wage positions/hours (nursing or technical)
- Changes in the number of premium hours or premium rates for various categories of premium hours

Exhibit 2.8
WHCC Total Worked Hour Salaries

	2000/01	2001/02	2002/03	Change	2003/04	Change
	A	B	C	C - A	D	D - C
711 Admin & Support	$ 22,224,744	$ 23,486,993	$25,192,945	13.4%	$26,670,829	
712 Inpatient Nursing	$ 32,932,263	$ 34,431,545	$40,396,311	22.7%	$43,068,800	
713 Ambulatory Services	$ 4,191,914	$ 4,757,875	$ 5,725,420	36.6%	$ 6,389,618	
714 Diagnostic & Therapeutic	$ 7,832,112	$ 10,921,195	$12,308,606	57.2%	$13,537,411	
715 Community Services	$ 411,642	$ 289,609	$ 354,309	-13.9%	$ 404,363	
Grand Total	$ 67,592,674	$ 73,887,218	$83,977,592	24.2%	$90,071,022	7.26%

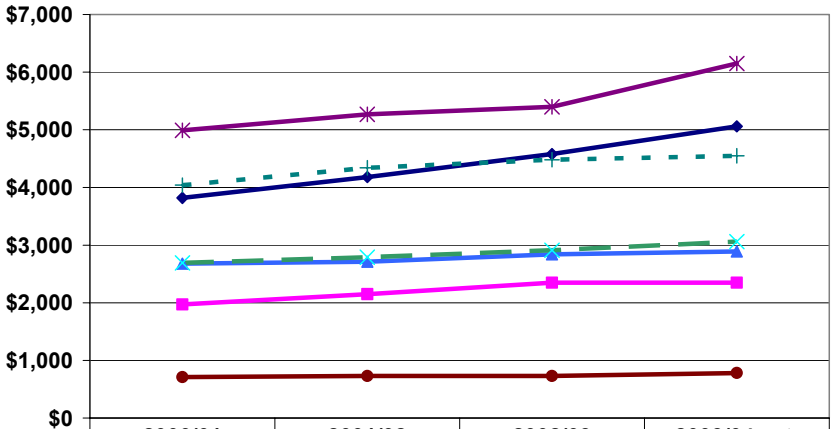
Exhibit 2.9
WHCC Average Worked Hour Rates

	2000/01	2001/02	2002/03	2003/04	Change
711 Admin & Support			$ 22.53	$ 23.92	
712 Inpatient Nursing			$ 30.05	$ 32.01	
713 Ambulatory Services			$ 30.58	$ 32.62	
714 Diagnostic & Therapeutic			$ 29.49	$ 31.63	
715 Community Services			$ 26.80	$ 29.65	
Grand Total			$ 27.26	$ 29.07	6.64%

2.8 Impact of Supplies Costs

Overall supplies costs have increased by 34.6% over the past five years. Supplies costs have increased less than labour costs over the period and less than increases in revenues. Several major categories of supplies expense are highlighted in Exhibit 2.10.

Exhibit 2.10
WHCC Supplies Costs ($ in thousands)



	2000/01	2001/02	2002/03	2003/04 est.
Drugs	$3,820	$4,180	$4,580	$5,060
Diag & Ther Supplies	$1,970	$2,150	$2,350	$2,350
Food	$2,680	$2,710	$2,840	$2,890
General Supplies	$2,690	$2,790	$2,910	$3,060
Med/Surg Supplies	$4,990	$5,270	$5,400	$6,150
Laundry	$710	$730	$730	$780
Plant Supplies	$4,040	$4,340	$4,480	$4,550

3.0 Governance and Management

3.1 The Province and the Corporation

The government has increasingly stressed the accountability of Regional Boards for the effectiveness, efficiency and the long-term viability of health and community services in the province.

Health and Community Service Regions in Newfoundland and Labrador are significantly dependent on the provincial government for their operating and capital funds. The public holds the provincial government accountable for the funding, organization, delivery and, to a large extent, the quality of health and community services. However, regions are private entities, owned by the regional corporation, and governed by an independent Board of Directors. Because of the public's perspective and the amount of public funds being provided to health and community service regions, the government has increasingly stressed the accountability of health regions and their Boards for the use of these public funds and for the effectiveness, efficiency and the long-term viability of the health services under their jurisdiction.

The Department of Health and Community Services is responsible for determining and ensuring a planned and coordinated system of health care and community services. The responsibilities of a regional board are to manage and deliver its mandated services in the most effective and efficient manner it can, to optimize the use of the resources available to it and to strive continuously to improve the availability and quality of its services. The regional board defines its mandate within the framework established by the Department of Health and Community Services.

3.2 Health Care Governance

Governance is the exercise by the Board of Directors of Authority, Direction and Control over the organization.

Governance is the exercise by the Board of Directors of authority, direction and control over a health care organization[8]. Fundamental responsibilities of governance are:

- defining the purposes, principles, and objectives of the organization
- ensuring and monitoring the quality of services
- ensuring fiscal integrity and long-term future

[8] From "Into the 21st Century: Ontario's Public Hospitals, Report of the Steering Committee, Public Hospitals Act Review, Ontario Ministry of Health, Toronto, Ontario, February, 1992.

- arranging for and monitoring the effectiveness of management
- approving annual operating plans and budgets

At its most elemental, governance is the culture of getting things done. This does not mean, however, that there are no limits upon governance. Directors have a number of duties or obligations[9] in developing the culture of the corporation, including the duties:

- of knowledge[10]
- of care[11]
- of skill & prudence[12]
- of diligence[13]
- to manage[14]
- fiduciary[15]

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9 There is a measure of overlap in the list that follows and in the corresponding descriptions in the footnotes. These are all taken from "Duties and Responsibilities of Directors of Non-Profit Corporations", by Hugh M. Kelly and Mark R. Frederick, Canadian Society of Association Executives, 1999.

10 Knowledge must include at least the statutory framework under which the corporation operates; its constating documents; its Mission, Vision and Values; its By-laws (by which purposes become actions), and the policies adopted to guide Board decisions.

11 The duty of care requires a Director to act honestly, in good faith and in best interest of corporation.

12 The duty of skill and prudence requires a Director to act with practicality not necessarily expertise, and cautiously, and to anticipate consequences of actions.

13 The duty of diligence requires a Director to act in the best interest of corporation, and to preserve its integrity and reputation; in practice, this duty requires a Director to review agenda and related material, attend meetings, discuss matters knowledgeably, and to vote on all matters unless prohibited by law or conflict of interest.

14 The duty to manage (in a limited sense) requires the Director and the Board to enact appropriate by-laws**,** to appoint and supervise staff, to elect officers, to establish and monitor policies, and to comply with legal requirements.

15 The fiduciary duty requires a Director to act honestly and in good faith; to be loyal to the best interest of corporation; to act in the best interest of corporation; and to avoid conflict of interest by subordinating personal or other conflicting interest to the interest of the corporation.

- to avoid conflict of interest[16]
- act in scope of authority[17]

Generally, the Board of a voluntary corporation is directly accountable to its corporation. The Board and corporation are accountable to the patients, clients and communities served by the organization, to the provincial government that funds the Corporation on behalf of these patients and communities as well as to staff of the Corporation.

The Board and the fiscal integrity of the organization.

A fundamental responsibility of the Board is the fiscal integrity of the organization and its long-term solvency. It is accountable to:

- the corporation,
- the community and
- the province acting on behalf of that community

Boards that allow the organization's debt to exceed its ability to repay that debt are putting the organization, its ability to provide service to the community and the health and well-being of the community at risk.

for the long-term viability of the health services in the region. The Board should be monitoring and ensuring effective fiscal management. The fiscal solvency of the organization is critical to its ability to respond to the care requirements of the community. Boards that allow the organization's debt to exceed its ability to repay that debt are putting the organization, its ability to provide service to the community and the health and well being of the community at risk. This is not good or reasonable stewardship of public and charitable funds and is not in keeping with the Board's and the corporation's long-term obligations to its community. If a Board puts the long-term solvency and viability of the organization at risk, it is incumbent on the provincial government to take action in the interest of the local community and the province as a whole. If lesser actions are unsuccessful in correcting the situation, it may be necessary for the government to assume ownership and governance responsibility for the health services in the region through the appointment of a Supervisor.

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[16] A Director cannot profit from position at expense of corporation, but must place corporation's interest first (and must remain neutral if a Director of two corporations); cannot get indirect benefit (to others); avoidance of conflict is achieved by disclosure of interest and declining to influence result.

[17] A Director must know the authority, of corporation, and of self as Director, failing which there can be personal liability if action is *ultra vires* of corporation or of Director; liability can be avoided by opposing and demanding record of opposition.

3.3 Governance Structures and Processes

The following paragraphs provide a brief description and evaluation of the governance structures and processes of the Board of the Western Health Care Corporation. The review is based primarily upon:

- Review of minutes, including all the public and in-camera meetings of the Board of Directors over the past 12 months.
- Review of selected documents related to Board governance.
- Personal interviews with the Chair and Vice-Chairs of the Board, the Chairs of Board Committees.

3.3.1 Western Health Care Corporation

The Western Health Care Corporation was formed in 1996 through the amalgamation of 6 autonomous health boards.

The Board of Directors is to be composed of not less than nine and not more than eighteen members. The Minister of Health and Community Services appoints all of the Directors. Currently there are 13 members of the Board.

3.3.2 Composition and Size of Board

The Bylaws of the WHCC prescribe the size and composition of the Board, as has been described above. The current size of the Board is reasonable for its objects and responsibilities. Also, the size allows it to have members that reflect the various geographies and communities to be served by the Corporation.

We have found, and governance literature generally supports our conclusion, that Boards of voluntary organizations are most efficient and effective when there are between 15 to 20 members. And fewer are often better.

Current Board size is not a significant impediment to effective decision-making.

And perhaps most importantly, the current size is not a significant impediment to effective decision-making by the WHCC Board. Changing the number of Board members is not critical to the future success of the organization.

The persons who serve on the Board of WHCC are unquestionably dedicated and hard working, and they firmly believe that they fully comply with their duties.

Directors have a duty to make the interests of the corporation pre-eminent in their decision making.

Directors have a duty[18,19] to make the interests of the corporation pre-eminent in their decision making at the Board. WHCC Directors assert that they both understand and observe their obligation to make the interests of WHCC pre-eminent in their consideration of issues and their decision-making. However, it appears that many Directors have an inherent inability to give priority to the interests of WHCC over the interests of their home community. There is a clear and repeated articulation of a belief by many of the appointees of that they serve on the Board to represent and advocate for the interests of their home community. Not only is this proposition not necessarily so, its articulation demonstrates a perspective that places the sequence of priorities in exactly the reverse of what the fiduciary obligation requires. To the extent that the interest of the member's home community is equated to, or even placed above the interest of WHCC as a whole, there is an inadvertent omission to place the interest of the Board in the priority required by this duty.

A significant number of Board members come to the Board with the agenda of their home community.

Many Board members seem to perceive that they have an accountability, through appointment, to their home community and, thus, an interest in furthering the agenda of that community. This intended result can only be expected to continue to place the interest of the home communities at par, if not above the interests of WHCC. This will, and has, created conflict between the interests and advocates of the different communities. Of greater importance, the Board is impeded in developing a focus solely on the interests of WHCC. Some Board members attempt to reference and root the interests of WHCC with those of each individual community served as reflected by the members appointed from each community on the WHCC Board.

This is not to say that the interests and history of the communities served by the Corporation should not be considered and given importance in the decisions of the Board of WHCC. It is only that continuing to make appointees who perceive themselves to be accountable to their home

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[18] The duty of diligence requires a Director to act in the best interest of corporation, and to preserve its integrity and reputation; in practice, this duty requires a Director to review agenda and related material, attend meetings, discuss matters knowledgeably, and to vote on all matters unless prohibited by law or conflict of interest.

[19] The fiduciary duty requires a Director to act honestly and in good faith; to be loyal to the best interest of corporation; to act in the best interest of corporation; and to avoid conflict of interest by subordinating personal or other conflicting interest to the interest of the corporation.

community, keeps the Board looking myopically at the needs of individual communities rather than the region as a whole. It is an impediment to the organization transcending local interests to create a health and social services system that can meet the needs of the entire community in the current and in the future.

The Minister and the Board should alter the appointment and orientation of new Board members so that appointees clearly understand that they are appointed to reflect the perspectives of their local community, not to represent it. The responsibilities of Board members to the Corporation and to the region as a whole should be emphasized.

Recommendations:

It is recommended that:

(1) The Minister of Health should ensure that appointees to the WHCC are aware that they are appointed to reflect the interests of, not represent or advocate for their home communities.

(2) The Board of WHCC should modify the orientation process for new Board members so that they are clearly made aware of their responsibilities to the Corporation.

Board Orientation

Given the considerable complexity of health care in Newfoundland and Labrador generally and of the operations of WHCC in particular, what has been provided as orientation for new Board members is quite useful, but could be improved. It does not meet the training needs of new (and perhaps longer serving) members of the Board. Although the Board of Trustees Handbook provides a comprehensive survey of the foundational information required by a member of the Board of the corporation, a more comprehensive program of orientation would unquestionably assist Board members to understand the intricacies of the duties and responsibilities of the office, and such a program should be both mandatory and involve all Board members.

The Board should establish a formal orientation program for new directors.

The Board should establish a formal and reasonably detailed program (which may include written materials, a building tour, and personal presentations by other Directors and staff of the Corporation staff) for the orientation of Board members. Participation in the Board orientation process should be mandatory and a condition of appointment to the Board. The Board should encourage Directors, both new and those with

longer tenure, to attend sessions on health services governance. Additionally, the Board should build on the current work of its Policy Committee to embark upon a planned program of Board development focusing on the Corporation as a whole.

Board Self Assessment

Many health care boards in Canada have instituted assessment processes intended to evaluate their performance. These processes provide for regular evaluation of the efficiency and effectiveness of Board structures, processes and decision-making. The Board should implement a Board Assessment process that includes both self-evaluation and evaluation of their decision-making processes by representatives of key stakeholders such as Senior Management, Senior Medical Staff, Union Leadership, the Foundation Board and Community Leaders and senior staff of the Department of Health and Community Services. This would both provide differing perspectives on the operation and effectiveness of the governance processes of the Corporation as well as reinforce the accountability of the Board not only to the Minister of Health and Community Services, but also to the communities served and to the staff of the Corporation.

It should be noted that at its May 2004 meeting the Board passed a resolution calling for the development and implementation of a Board Self Assessment Process.

Recommendations:

It is recommended that:

(3) The Board should develop and implement a formal, comprehensive program for the orientation of Board members.

(4) The Board should make participation in the Board orientation program mandatory for all Board members.

(5) The Board should develop a Board evaluation process that includes input from Board members and key stakeholders.

3.3.3 Committee Structure

The Bylaws provide that the Audit and Finance Committee is the only standing Committee of the Board. Additionally the Board "may from time to time establish any special committee

as may be necessary or advisable.....[20]". Currently there are also 4 Special Committees of the Board

- Executive Committee
- Policy Committee
- Ethics Committee
- Quality Council

Additionally, the Board receives input from several District Advisory Committees who present the interests, issues and concerns of the communities served by WHCC.

These committees and their functions are reasonable for the governance of a regional health services authority like WHCC. Most of the work of the Board is conducted by the full Board without delegation to committees, which is not an unreasonable approach to governance. However, it means that the full Board will need to carry a very full workload. In many governance models, most of the work of the Board is delegated to standing and as necessary ad-hoc committees of the Board. The benefit of this approach is that committees can review information and debate issues more comprehensively than could be achieved by the full Board. Committees would then:

- Report their recommendations for Board action.
- Support their recommendations with documentation of issues related to the recommendations and related discussions that took place at the committee level.
- The committees should also provide the detail of the any alternatives considered, for the information of the full Board.
- The committees should also provide the minutes of their meetings for the information of the full Board.

Except in unusual circumstances, these processes and practices will minimize the need for the full Board to reconsider and re-debate issues that have been dealt with at the committee level. In its review of its governance processes, the Policy Committee of the Board should consider the desirability and feasibility of delegating its work to committees of the Board. In reviewing the recommendations of subcommittees, Board members can ask the subcommittee

[20] WHCC Bylaws, as amended April 2, 1998.

to clarify facts, issues and recommendations; however, the Board should not repeat the debate that has already taken place at the subcommittee level and that has been documented in the committee's report and meeting minutes. The Board should have enough information to vote on the recommendation of the Committee, accepting or rejecting the recommendation as appropriate. This approach to deliberation and decision-making makes Board meetings more efficient. It allows the full Board to focus and devote sufficient time to its deliberations on the most critical issues.

3.3.4 Board Processes

Public Meetings of the Board

WHCC Board meetings are not open to the public. There are some valid reasons for excluding non-members from Board meetings, for example, because in the discussion of the matter, there could be disclosure of personal information; or that the matter involved pending litigation. On the other hand, an often posed reason that is not defensible, is that the Directors could feel constrained in expressing their views if the public were present. There are statutory examples of how to resolve the issue of whether and when the exclusion of the public is defensible.[21] A reasonable policy would provide that, subject to limited exceptions, meetings of the Board and its Committees would be open to the public, and no person could be excluded from a meeting that is open to the public except for improper conduct. The public may be excluded, however, when the subject matter under consideration involves the one of the following:

- the security of the property of the Board;
- the disclosure of intimate, personal or financial information in respect of a member of the Board or Committee, or an employee or prospective employee, or a patient or member of a patient's family;
- the acquisition or disposal of real property;
- decisions in respect of negotiations with employees;
- litigation affecting the Board.

We encourage the Board to adopt a policy for public meetings of the Board, narrowly defining what matters may be discussed in camera, and this policy should provide that the

[21] The example that follows comes from the *Education Act*, R.S.O. 1990, ch.E.2, as amended, §207.

majority of the business of the Board should be conducted in public.

Recommendations:

It is recommended that:

(6) The Corporation should establish a policy that opens meetings of the Board of WHCC and of its committees to the public.

(7) The Board should establish a clear policy that articulates a narrowly defined set of subject matters that will be discussed in camera by the Board and its committees.

3.3.5 Information to Support Decision-Making

The Corporation should improve further the utility of the information that is used to measure and monitor performance to support both governance and management.

Board members generally feel that they receive adequate information to support the functioning of the Corporation. And we find that the Board is kept well informed of the operations and issues related to the services of the Corporation. Although most Directors feel that the Board is effectively kept apprised of the financial performance of the organization, Board and management continue to work on getting better, more meaningful and more timely financial and performance information to support the operations of the Board. We feel that management should focus its efforts on improving the information that it provides to the Board on the efficiency, effectiveness and quality of care and service in the region. Potential areas for improvement are discussed and described in later sections of this chapter of our report.

Recommendation:

It is recommended that:

(8) The Board Chair should direct management to enhance the information supplied to the Board related to the Board's critical governance responsibilities.

3.3.6 Defining & Maintaining Purposes & Principles of Health Service Organizations

Planning is a critical component of governance and management.

The health care industry has clearly recognized the importance for health service organizations to develop coherent sets of objectives and plans. Planning is recognized as a critical component of health services governance and management. Boards should develop plans in response to the needs of the

community and in collaboration with the community and other health care and social service agencies. Effective health services planning should include the following elements:

- Identifying the communities to be served by the organization
- Establishing the objectives for the organization (Mission, Vision and Core Values)
- Selecting the health needs of the composite community that might be appropriately served by the organization (Role Statement)
- Defining and describing the programs and services required to be offered by the organization to respond to the health needs of the population and achieve the organization's objectives (Long-Range Plan)
- Detailing plans for implementing the program and service goals of the long-range plan and thus achieving the Vision and fulfilling the Mission of the organization (Strategic Plan)
- Translating the objectives, plans and strategies into specific activities to be initiated in the next fiscal year (Operational Plan)

A Mission/Vision Statement, Role Statement, Long Range Plan and Strategic Plan are critical to the successful governance and management of a health service organization.

We believe that a Mission/Vision Statement, Role Statement, Long Range Plan and Strategic Plan are critical to the successful governance and management of a health service organization. Decision-making in the absence of clearly articulated Long- Range and Strategic Plans is often uncoordinated and inconsistent. The complexity of a health service region and its levels of governance and management require that decisions must be made with reference to a set of long-term objectives (Mission/Vision/Role) and plans for achieving these objectives (Long-Range and Strategic Plans) that are generally accepted by the critical stakeholders in the services of the region. These documents provide a framework for annual operational planning and budgeting. If prepared through the collaboration of the Directors, the medical staff, management and Corporation staff and in consultation with the community and other health care agencies, they can become the basis for clear communication of the Corporation's priorities and for collaborative and supportive actions to achieve the Corporation's objectives.

In keeping with the need to distinguish between governance and management, organizational objectives and long-range goals for programs and services should be considered

primarily a responsibility of governance; strategies and operational plans for achieving these objectives and goals should be considered primarily a responsibility of management. Although primarily a responsibility of governance, it is unrealistic to expect that Boards can or should develop long range objectives or plans independently. Although led by the Board, management staff of the organization will support the development of these statements and plans.

At its December 9, 2003 meeting, the Board of WHCC adopted its Strategic Plan. The plan follows the template established by Treasury Board to ensure compliance with the requirements of the accountability framework for public bodies established by the Government in 2000. Elements of the plan include:

Mission The Board adopted the following statement as its Mission:

"By 2010, Western Health Care Corporation will match service delivery to the health needs of those we serve in specified areas in order to improve quality, sustainability and accessibility of health care services in the region."

Vision It then went on to articulate a vision for the organization: Its vision is:

Western Health Care Corporation's vision is of "the highest quality health care"

Values And the Board has also developed a list of the organization's values. The Board has articulated the following:

The core values explain the organizational character promoted by the WHCC Board. They identify a range of actions and behaviours that are critical to the achievement of the organization's mission and vision:

- Accountability
- Collaboration
- Commitment
- Equity
- Honesty
- Respect
- Transparency

Communities to be Served

The Board has identified, in keeping with its regional mandate that it will provide provides health care services to the residents of the Western Region of Newfoundland.

Role Statement

And the organization has clearly articulated the role it will play in responding to the needs of these communities in:

- Primary Health Care
- Emergency Care
- Secondary Acute Care
- Adult Rehabilitation Care
- Long Term Care (Institutional and Assisted)
- Education

And the Strategic Plan incorporates two Strategic Issues that will be addressed by management to allow the organization to fulfill its mission and realize its vision.

- Quality of Inpatient Utilization Data
- Policy Direction

By following the Department's template the Corporation has achieved the structural requirements of a successful strategic plan, but we are concerned by both the choice of direction and the choice of language. In its current form the document will not be effective in either setting the direction for the organization or instilling any excitement about the organizations future among its internal and external stakeholders.

The Mission statement adopted by the Board is more of a goal statement than a description of the reason for the organization. A better expression of the mission might be...to provide high quality, accessible and sustainable health care services in response to the health needs of those we serve. The role statement (statement of business lines) can serve to limit the range of services to those that are within the scope of practice of the region.

In their current form the Board's 'Strategic Issues' will focus the organization on 'means' and not 'ends'.

And the issues do not provide strategic direction to the organization. They are much more about tools that will enable a direction than the direction required by the organization. In their current form they will focus the organization on 'means' and not 'ends'. We believe the ends implied by the issues are appropriate to the organization. The Board should develop statements of strategic directions related to improving quality

and efficiency and related to access to quality services taking into account the human and economic resources of the region.

Recommendation:

It is recommended that:

(9) The Board of WHCC should revisit its articulation of 'strategic issues' to focus on the desired directions for the organization.

3.3.7 Ensuring & Monitoring Financial Health

For the Board of a regional authority to exercise its responsibility in ensuring effective management of the financial health of the organization, there must be strong processes for operational planning and budgeting and for reporting on progress in achieving these plans and budgets.

The primary link between a public body's budgeting and strategic planning processes is the annual operational plan.

"The primary link between a public body's budgeting and strategic planning processes is the annual operational plan, which translates long-term goals and objectives into a clear operating framework for a one year period……. Operating plans generate the context for the detailed financial information required in the annual budget."[22]

Although the Corporation has developed strategic and long-range plans to guide its future growth and development, operating planning and budgeting continues to focus on incremental changes based on prior years activity and performance, driven by providers' descriptions of needs, rather than (as it should be) flowing from the Corporation's long term objectives and targets for patient volumes and related workload.

A Board should start the operational planning process by setting the annual objectives for the organization and defining the parameters for operational planning and budgeting.

The Board of a health services organization should start the annual operational planning process by drawing from the organization's strategic and long-range plans to set the annual objectives for the organization and to define the parameters for operational planning and budgeting. Without clearly articulated objectives, it is not possible for the Board to evaluate the organization's performance. The WHCC Board is not setting annual objectives for the organization.

[22] Government of Newfoundland and Labrador Treasury Board, "Achieving Excellence 2000-A Guidebook for the Improved Accountability of Public Bodies".

The Board must take the initiative in setting operational goals, performance targets and initial targets for the size of the organization's operating surplus or loss for the coming year. Budget targets should take into account the Board's responsibility to ensure the current and future financial health of the organization. The Board should then critically review and approve the operating plan and budget developed by management to achieve its objectives and to accommodate its budget parameters. If the Board's resources are insufficient to implement the Board's plans, then the Board of Directors must take responsibility for directing management to defer initiatives, suggest alternative strategies for achieving the organization's vision or, if necessary, to rethink the vision for the organization. Although management reports to the Board on its progress in developing the operating plan and budget for the organization, the Board does not seem to be formally establishing parameters for the organizations operational planning and budgeting processes.

Recommendations:

It is recommended that:

(10) The Board should draw upon its Strategic Plan to formally articulate annual objectives for the organization.

(11) The Board should formally articulate the organization's parameters for its annual operating plan and budget.

The Board's strategy in dealing with operating losses has put the financial health of the organization in jeopardy.

Although the Board is not setting annual objectives for the organization, it does review and then approve the budget for the organization. But, the Board's strategy in dealing with organization's operating losses (budgeting for operating losses and accepting costs and losses that exceed its budgets) has put the financial health of the Corporation in jeopardy.

The Board of Directors has devoted significant attention to the Corporation's financial position and deficit. The common theme of the Board's deliberations seems to be that the Board wishes to be fiscally responsible, has instructed management to assess and report upon alternatives by which WHCC could eliminate the gap between expense and revenues, and considered such reports. But the Board has not taken the necessary actions to reduce costs, increase revenue and/or reduce services to better match the operating funds available to it. For example:

> *At it's meeting in December 2003, the Board Considered the response from Department of Health & Community Services regarding the Board's request for authorization of it's Budget for 2003/04. The Board was informed that correspondence had been received from Minister Marshall advising that the Corporation's recast budget of ($1.7) Million operating loss was not approved. The Minister referred to the former Deputy Minister's request that the Corporation develop a plan to balance the budget.*

This reference seems to provide an unequivocal statement form the government that the Corporation was expected to operate within the funds available to it.

However, rather than taking action to reduce its costs, the Board considered a the outcome of a meeting with the Minister and Deputy Minister in late July and Deputy's support for completion of a Best Practices Review. Based on the outcome of that meeting, the Board concluded that the Corporation's operating deficit would yet be approved and that the best course of action was to lobby with local MHAs for more funding for the Corporation.

> *The Deputy was quoted as commenting at the meeting that they would approve the budget, subject to a recovery plan coming out of the Best Practices Review. It was suggested that a meeting with all area MHA's be set up as soon as possible to discuss the Department's current position and lobby for funding for the Corporation*.

It seems that Board is unwilling to accept its own responsibility for managing its affairs within the approved funding. The Corporation continues operations without making the necessary changes to achieve a surplus. In fact, at the same December Board meeting, the Board approved an expansion of service at its Corner Brook clinic which would increase the Corporation's operating costs by $75,000 per year. The Board approved a plan wherein "the annual cost of the clinic, which is currently $175,000 will rise to $250,000" without any provision for an increase in revenues or other actions to fully off-set the increase in costs

The Board continues to wait for the province to increase funding to solve its problems or to grant permission for the Board to take action.

The Corporation continues to incur operating losses and watch its working capital position deteriorate. The Board continues to wait for the province to increase funding to solve its problems or to grant permission for the Board to take action. It is unwilling to take action on its own to preserve the fiscal integrity of the organization. It should be noted, however, that

the Government and the Department have not been supportive of initiatives proposed by the Board. There are numerous examples of reasonable actions proposed by the Board that, when asked, have not been approved by the Department; and in most cases the Department has explicitly instructed the Board not to take action.

It is hoped that the findings of this Best Practices Review will provide the Corporation with insight into the appropriate actions that it might pursue to achieve an operating surplus and over time retire its debt and/or provide evidence that the Department should increase funding to the Corporation. It is also hoped that the Department will be supportive of these initiatives to improve care and reduce costs.

The Corporation must be more aggressive in pursuit of opportunities to reduce costs through improved clinical and operational efficiency and/or reduced content of care before it considers reducing service volume or seeks additional funding from theDepartment.

It should be noted that effective accountability requires a commitment by both parties to fulfill their respective roles and to respect and support the other party in the process. The Department must clearly identify its expectations (both service delivery and financial) to the Board, and then allow the Board to make the changes necessary to meet these expectations. In turn, the Board should take more responsibility for the financial health of the region by insisting that management aggressively pursue opportunities to minimize costs. The Board should direct management to more aggressively pursue opportunities to increase non-government revenues or reduce costs through improved clinical and operational efficiency and/or reduced content of care before considering reductions in the volume of services or seeking additional funding from the Department. And if there are no further opportunities to increases revenues or reduce costs, rather than incur losses, the Board must be prepared to implement service restructuring that will reduce costs and finally, reduce service volumes. It cannot continue to spend more funds than are provided by the Department of Health and Community Services. And in the end, it should not look to the Department to provide license for it to take action. As the Board has witnessed repeatedly, the Department, if asked, is unlikely to, or be allowed to give permission for unpopular changes in the efficiency, content or location of services. The Board is accountable for the operation of health and community services in the Western region, and it must assume the responsibility to take the actions necessary to ensure the continuing fiscal integrity of the organization.

Recommendations:

It is recommended that:

(12) The Board should take more responsibility for the financial health of the Region by insisting that management aggressively pursue opportunities to minimize costs and maximize non-government revenues.

(13) The Board should take more responsibility for the financial health of the Region by implementing reasonable service restructuring to achieve necessary cost savings.

3.3.7.1 Monitoring Financial Health

The Board is receiving reports that provide the annual budget, current month actual, budget and variance and YTD actual, budget and variance. A written narrative that summarizes the region's current position and explains the sources of variances in revenues and expenses supports these reports. However the focus is on explaining the variances, not on initiatives that might correct for forecasts of significant year-end variances from plan.

Importantly, the Board also receives a forecast of the region's year-end position based on activity to date and known endogenous and exogenous events

There are weaknesses in the analyses of variances in current and projected performance.

There are several opportunities to improve the Region's approach to analyzing variances from plans and budgets. We feel that financial and performance reporting to the Board should help it to understand:

- the causes of variances from plan,
- the impact of the variances on the running rate of costs for the Corporation,
- the potential impact on year-end results.

and should identify variances that might be corrected through management initiatives. Thus variances from budgeted levels of expenditure should be identified and measured as variances that are caused by:

- Variances from planned volumes/workload
- Variances from planned unit costs (of labour or materials)
- Variances from planned levels of productivity

Making these analyses available to the Board would allow Board members to better exercise their responsibility for monitoring and maintaining the financial health of the organization.

Thus we feel that the effectiveness of financial reporting to the Board could be enhanced with the following changes:

- The narrative component of the report should be expanded and enhanced to provide a discussion of opportunities for corrective action to achieve the operating plan or budget targets and an explanation of actions undertaken or planned to correct for negative variances. We further suggest that the Board should direct management to propose and undertake these mid-year corrective actions to achieve budgeted levels of performance.
- The reports should present selected volume statistics for the corporation as a whole (separations, patient days, etc.) and selected operating units and services (OR Cases, Emergency Visits, MRI Exams, etc.), and variances from the plan.
- The reports should also include a set of corporate performance indicators that present a comparison of the corporation to benchmark levels of performance of other like organizations (or elements of like organizations). Indicators for the hospital, for example, could include nursing and total paid hours per patient day; total paid hours per adult weighted case; adult and newborn average length of stay; administrative expenses as a % of total operating expenses, etc. Also, performance on these indicators should be contrasted with budgeted levels of performance. The reports should provide explanations of variance and planned corrective actions for these productivity measures as well as for financial measures.
- And, it should not be acceptable for the organization to achieve only average levels of performance relative to its peers. WHCC should be striving to be a high performing organization.

It should be noted, however, that the organization is improving the information available to support variance analysis. It now needs to take advantage of this information to better control costs in relation to plans. And the Board has recently taken action in this direction. At its May 2004 meeting the Board noted that the Audit & Finance Committee had discussed setting up financial indicators related to

workloads. It was reported that cost per patient data is currently available. It was suggested that a process be established to provide operating statistics.

Recommendations:

It is recommended that:

(14) The CFO should further expand and enhance financial and statistical reporting to the Board to include more comprehensive analyses of variances from plan that provide not only the cause of the variance but also planned potential corrective actions.

(15) The CFO should expand financial reporting to the Board to include reporting of the clinical and operational performance underlying the region's financial performance.

(16) The CFO should further expand and enhance statistical performance reporting to the Board to provide comparisons with similar organizations in Canada.

3.3.8 Ensuring & Monitoring Quality of Services

A fundamental responsibility of governance is ensuring and monitoring the quality of services.

A fundamental responsibility of governance is ensuring and monitoring the quality of services and continuing improvement of quality in all aspects of operations. WHCC has recognized this as one of its fundamental activities and seems to have assigned this responsibility to its Quality Council.

The Quality Council meets monthly, reviews performance indicators and receives reports from the Performance Improvement Teams. Performance Improvement Teams have been established for each patient care, diagnostic, therapeutic, and support service. A member of the senior administration acts as sponsor for each Team. Each senior administrator sits on four or five teams and they find it difficult to consistently participate. Physician involvement in the teams is uneven.

Quality of care indicator measurement results and trend data is routinely being provided to the Board.

A wide range of quality of care measurements and trend data are routinely being provided to the Board. The Board is to be commended on its structured approach to measuring and monitoring quality of services. The Quality Council monitors performance of the organization through reviews of corporate performance indicators contained in the corporate scorecard.

The corporation's performance indicators relate to the CCHSA four dimensions of quality:

1. Responsiveness: How the organization responds to the changing needs and expectations of its clients/environment.

2. System Competency: How well the organization achieves of desired benefit for clients with cost-effective use of our resources.

3. Client Community Focus: How well the organization encourages community participation and partnerships.

4. Work-Life: How well the organization encourages performance excellence, involvement of staff personal and professional growth, health, well being and satisfaction.

The Quality Council has a predetermined schedule for review of these corporate indicators. The schedule ensures that there is at least 6 months between reviews of individual indicators. However, if a particular indicator result suggests the need for action, the Quality Council often does not confirm that the necessary action has been taken until it next reviews that indicator.

The Board should establish a multi-level set of indicators of quality for use in monitoring and ultimately maintaining and improving quality of service.

We believe that the Board, through the Quality Council, should establish a multi-level set of indicators of quality for use in monitoring and ultimately maintaining and improving quality of service.

At the first level the Board, through its Quality Council, should routinely (at each meeting) receive performance measurement results for a small number of more critical, overarching corporate performance indicators. Management should identify critical or sentinel indicators and/or summary metrics related to each dimension of quality that can be used by the Board to measure the changing performance of the Corporation over time[23]. It is important for the Board to be assured that the Corporation is maintaining or improving its levels of performance. And it is important for the Board to be assured that management is taking corrective action if performance begins to deteriorate.

[23] The number of these key indicators should be appropriated for Board level reporting.

These indicator results should be provided for information only, unless the results fall outside a predetermined performance range. Where the performance is outside the range, the Quality Council should require management to report on the steps being taken by Region to address the factors that have contributed to the deviation in performance, and to identify whether changes in policies are recommended. The Quality Council should report to the full Board the measurements, an explanation of the reason and locus of any deterioration in performance and any resulting management initiatives.

At this level consideration should be given to routine Board monitoring of key corporate indicators such as:

- Patient satisfaction
- Unplanned readmission rates
- Complications following surgery
- Infection Rates
- Risk adjusted in-hospital mortality
- Hospital and program occupancy rates
- Length of stay performance relative to CIHI expected length of stay

Additionally, given its mission to address the health needs of the community, consideration should also be given to reporting, at least on an annual basis on changes in the health status of the population and comparisons with like communities across Canada.

At a second level the Quality Council should be monitoring, as it is, a wider range of indicators related to each of the CCHSA dimensions of quality. Perhaps quarterly a meeting of the Council should be devoted to one of these dimensions of quality. In this way, each year the Council will review each dimension, and any findings and necessary corrective action reported to the full Board.

And, as a third level of measurement, the Quality Council should be monitoring a similar range of indicators for each clinical program, for each site, for each service modality and

each function[24] offered by the Region. Again, these indicator results should be provided for information only, unless the results fall outside a predetermined performance range. Where the performance is outside the range, the Quality Council should require management to report on the steps being taken by Region to address the factors that have contributed to the deviation in performance, and to identify whether changes in policies are recommended. The findings from these indicators should be useful in directing the work of the region's Performance Improvement Teams.

As has been recognized and implemented by the region, it is important to monitor the selected indicators over time so that the region can be confident that quality of care is being maintained or enhanced.

The Region should compare its performance with external benchmarks to determine whether it's performance is as good as or better than peer organizations.

The Region should compare its performance with external benchmarks to determine whether its performance is as good as or better than peer organizations. This will make the information provided to the Board much more useful in understanding the need for and/or opportunities to improve the quality of care and service being provide by the region.

Although the Board is receiving measurements of quality, the minutes of the Board do not show evidence of any recommendation to establish or modify policies related to patient care as a result of this information. While specific risk situations are discussed, and general operational concerns that might impact risk or quality are raised, they are not explicitly linked to existing or needed policies or initiatives.

Also, significant utilization issues are sometimes identified by the Performance Improvement Teams or during the review of Corporate Indicators, and the Quality Council discusses the importance of these issues being brought to the attention of the Regional MAC. However, it is not clear that the Regional MAC consistently takes action, and there is seldom any documented follow-up by the Quality Council.

[24] The Region might consider developing or obtaining quality measurement tools for other key areas of performance such as dietary, housekeeping, imaging, laboratories and providing summaries of these measurements to the Quality Council.

Recommendations:

It is recommended that:

(17) The Board should direct that management further enhance the Board's Corporate Performance Improvement Program to provide for more comprehensive monitoring of quality, for comparisons with external benchmarks and for more focused and structured reporting to the Board.

(18) The Quality Council should ensure that important utilization and quality issues identified during Performance Improvement Team presentations or corporate indicator reviews are referred to the appropriate individuals or groups and followed up at subsequent meetings to ensure that appropriate action has been taken.

3.3.9 Monitoring Effectiveness of Management

The Board of a health services organization bears overall responsibility for the effectiveness of the organization in fulfilling its mission. It is, however, dependent on management to provide it with sufficient information to fulfill this responsibility. We feel that reporting structures and mechanisms established by WHCC have not allowed the Board to effectively monitor the effectiveness of management.

The Board receives regular reports from the Chair and CEO. Each report provides an update of current issues facing the corporation. The Board also receives a report from each of its committees. These committees are actively engaged in monitoring operational and management issues facing the organization.

As we have discussed, the Board is not setting annual objectives against which the effectiveness of management can be evaluated. Although its strategic plan will communicate to management the Board's desires regarding the organization's focus, management has not established a framework for formally and systematically reporting on its actions in relation to these directions. And as we have discussed, the Board is not receiving overarching reports of the organization's overall performance related to its:

- Responsiveness to community needs
- Quality of care

- Efficiency of care
- Quality of Work life
- Improvements in health of the community

in a way that would allow it to track the organization's/management's performance or success in fulfilling the corporation's mission and achieving the corporation's vision.

3.3.10 Annual Objectives and Performance Review of CEO.

The annual process of setting and communicating the objectives for the CEO is critical in setting the direction for the entire organization.

Formally, the Board interacts with and provides direction to the organization through its CEO. The annual process of setting and communicating the objectives for the CEO is critical in setting the direction for the entire organization. The review of the CEOs performance in relation both to these objectives and to the responsibilities of the position is a critical tool for reinforcing the importance of both the objectives and also the values and desired culture of the organization. The performance of the CEO is critical to success of the organization.

In setting annual personal objectives for the CEO, the Board should provide both critical responsibilities and also measurable objectives related to those responsibilities and related to the Board's annual objectives for the organization.

The annual objectives for the CEO should include, as their fundamental component, the annual objectives for the corporation. As has been discussed, the Board of WHCC does not set annual objectives for the organization.

The CEO evaluation process used by the Board in 2002/03 was based on a 360-degree evaluation process soliciting responses from each member of the Board, each member of Senior Management and a self-assessment by the CEO. This baseline evaluation was considered a formative process, that being done for the purpose of shaping future direction. The Board has indicated that once the Corporation's Strategic Plan is completed, the evaluation will be revised based on the goals contained in that plan.

In evaluating the critical responsibilities of the CEO, the Board might consider extending the "360 degree" feedback process to include the following:

- CEO for self-evaluation
- Board of Directors
- Medical leadership
- Executive Team
- Selected managers and front-line staff

- Selected external stakeholders

A summary report of the overall evaluation of the CEO should be prepared and reviewed with the Board Chair and then with the CEO. The report should consider the CEO's achievements relative to the annual goals and objectives for the region, relative to his personal goals and objectives and his standing relative to the necessary competencies for the position. The Board Chair should meet with the CEO to discuss the results of the evaluation.

Recommendation:

It is recommended that:

(19) The Board should set annual performance expectations and objectives for the CEO that incorporate the objectives for the organization.

3.4 Management Structures & Processes

Management is responsible for the effective and efficient operation of the organization in accordance with the direction set by the Board.

It is generally accepted in the health care industry that management is "responsible for the effective and efficient operation of the organization in accordance with the direction set by the Board".[25] Management of a health region is expected to fulfill its responsibility by:

- Providing leadership to the health services community
- Developing and implementing strategies for achieving the region's objectives
- Creating organizational structures and processes
- Directing and overseeing the delivery of health services
- Improving efficiency of health services
- Improving effectiveness and quality of health services and care
- Recruiting and developing staff
- Reporting to the Board on the effectiveness of the services operated by the region

The organizational health and effectiveness of a health services organization is dependent on the successful execution

[25] From "Into the 21st Century: Ontario's Public Hospitals, Report of the Steering Committee, Public Hospitals Act Review, Ontario Ministry of Health, Toronto, Ontario, February, 1992.

of these responsibilities. Generally, the management of WHCC Board has been and continues to be effective in most of its areas of responsibility. Its major failing has been its inability implement strategies to improve efficiency, reduce costs and improve the quality of care that address the full magnitude of the corporation's fiscal challenge.

3.4.1 Senior Management Organization

Senior management at WHCC is challenged by the need to operate a wide variety ofservices on sites throughout the region while integrating programs and services across modalities of care and sites.

Senior management at WHCC is challenged by the need to operate a wide variety of services on sites throughout the region while integrating programs and services across modalities of care and sites. In 2001 the region reorganized it management functions with the intent establish consistent processes and practices across the region. WHCC has chosen a modified matrix approach to the management of sites and services. This is a reasonable and potentially effective approach to addressing a significant management challenge. However, the assignment of responsibilities among managers, may have over-weighted the need for consistency to the detriment of local leadership, oversight and cost management.

The most significant issue appears to be related to difficulties in implementing the roles of regional directors and site administration:

- difficulty with lines of communication,
- delays in decision-making,
- difficulty accessing regional directors,
- the number of directors a site administrator needs to contact with information and/or to get a decision,
- the challenges of geography for regional directors who have direct line responsibility for staff at remote sites.

There is an expectation that Directors of Nursing will manage all aspects of patient/resident care within a Health Centre, however, they have no authority to manage staff other than nursing.

At the Health Centres, there are Directors of Nursing reporting to a Vice President. The Directors of Nursing have responsibility for direct supervision of nursing staff within the centre and site administration on a day-to-day basis of all other staff on the site. There is an expectation that within their role these individuals will manage all aspects of patient/resident care within the facility. However, the Directors of Nursing have no authority to manage staff other than nursing and have significant frustrations addressing problems of communication among disciplines and between professional and support staff. The title of these individuals does not reflect the role they have in coordinating and directing the activities associated with patient/resident care.

There also may be an opportunity to manage the budget for the sites more effectively if a different administrative model were in place.

In a matrix structure there are always difficulties with reporting and accountability. It appears the model in WHCC is not functioning well. There is an opportunity to improve operational management and advance practice support for professionals by shifting the responsibility for all staff to the site administrator with regional directors filling a consultative, professional practice support role.

Also, as is discussed later in this report, there is a need to create a separate position of Chief Nursing Officer within the Senior Management Team.

The CEO has initiated a review of the management structure in the region and the preliminary findings indicate widespread and multi-faceted concerns. We feel that there is an opportunity and a need to further refine the management structure of the corporation.

Recommendation:

It is recommended that:

(20) The CEO should develop a refined model for organizing and managing the services delivered by the corporation.

3.4.2 Operational Planning & Budgeting

Operational planning and budgeting are the annual management processes through which a health services organization implements its long-range plans and fulfills its mission.

Operational planning and budgeting are the annual management processes through which a health care organization implements its long-range plans and fulfills its mission. Typically these processes will include setting:

- Annual objectives for the organization
- Plans for the development, enhancement, maintenance, contraction or elimination of programs and/or services
- Performance expectations related to the
  - volume,
  - productivity,
  - cost and
  - quality

of services provided by each program and by each therapeutic, diagnostic, support and administrative service department.

- Targeted expenditure levels for each element of the program
- Estimates of revenues

A health care organization needs the operating plan and related budget to describe and quantify its annual objectives and its planned program, service and fiscal initiatives. The plan and budget should be reviewed and approved by the Board, and thus is one of the most effective vehicles for ensuring accountability of health care organization management and staff to the Board, and to the health care organization corporation and the communities served by the health care organization.

WHCC has developed a budgeting process that substantially meets these criteria for effective planning and budgeting. The minimal process and content for operational planning and budgeting for health service regions in Newfoundland and Labrador has been codified through regulations articulated by the Department of Health and Community Services. WHCC has developed operational planning and budgeting processes that incorporate the regulated processes.

However the operational planning and budgeting process at WHCC focuses first on prior year's staffing and costs and responds to needs to incrementally add staff and seeks opportunities to incrementally reduce staffing and costs. Ideally, the process would focus first on plans for operations, and then translate these plans into the budget for the year. The focus should be operations, not costs.

Annual Objectives

Annual objectives should start the annual operational planning and budgeting process and should provide the framework for setting planning parameters and performance targets. WHCC does not set formal annual objectives for the organization.

To the extent that the Board considers annual objectives, they relate more to performance characteristics rather than providing specific performance and achievement targets.

For maximum effect the region's operating plan, the budget and the evaluation of the CEO should be based on the same sets of organizational objectives, targets and performance measures. WHCC would benefit from a formal process for

setting annual objectives and from having these three processes brought into alignment.

Recommendation:

It is recommended that:

(21) The Chair of the Board should direct management to establish a process for setting annual objectives for the health care organization.

Performance Expectations

As stated previously the operational planning and budgeting process should start with an articulation of performance expectations related to the volume, productivity, cost and quality of services should be provided to each site and therapeutic, diagnostic, support and administrative service department. We feel that an effective operational planning and budgeting process should be based on:

- Estimates of patient volume
- Targets for Clinical Efficiency
  - % Ambulatory
  - ALOS
- Targets for Content of Care
  - Departmental Workload per Separation/Ambulatory Procedure/Clinic Visit or other appropriate activity measure
- Targets for Operating Efficiency
  - Departmental Productivity
  - Unit Cost Estimates for Labour
    - targeted worked hours %
    - targeted benefit hours %
- Targets for Material and Supplies Productivity

The operational planning and budgeting process established by WHCC does not explicitly relate costs to patient volume or workload. Nor does it explicitly consider potential changes to the content of care. It does not incorporate productivity targets, or external benchmarks for performance. And there is little if any explicit discussion regarding expectations regarding quality of care.

Communication of plans and budgets tended to focus on costs almost to the exclusion of discussion of patient volumes

workload, productivity and quality. Discourse regarding operating plans and budgets along with planning tools should be expanded to include specification of expectations regarding patient volume, content of care, workload and quality.

Recommendation:

It is recommended that:

(22) The CEO and the CFO should modify the operational planning and budgeting process to more formally and explicitly include consideration of patient volume, content of care, departmental workload and productivity targets.

3.4.3 Controlling Expenditures

To be effective in the execution of its responsibilities, management needs to be able to influence and ultimately manage all aspects of the clinical and non-clinical activities of a region.

The primary focus of management of a health service organization is providing for and ensuring the effective and efficient provision of patient care and community services. Controlling expenditures suggests that management needs to set in place processes for managing efficiency. These processes should include:

- Cost Management-Controlling the cost of each unit of labour and material used by each department of the in providing its services or producing its products.
- Productivity Management-Measuring, monitoring and controlling the number of units of labour and materials employed in producing departmental services.
- Utilization Management-Measuring, monitoring and controlling the resources used in each episode of patient care (including length of stay in health care organization).
- Utilization Management-Ensuring the appropriateness of each episode of patient care.
- Production Management-Measuring, monitoring and controlling the number of episodes of patient care.

Management of a health region uses these processes to manage the overall content and cost of operations. To be effective in the execution of its responsibilities, management needs to be able to influence and ultimately manage all aspects of the clinical and non-clinical activities of a health region.

Through its management structure and management processes, the management of WHCC has and is establishing structures and processes that will allow it to manage costs of the

corporation. However, best practice would provide for more focused and more aggressive control of costs.

New Quarterly Review Processes reinforces accountability and provides a forum for identifying, discussing and planning for resolution of operational issues.

Of particular note is a quarterly review process being established by many health care organizations and health regions that focuses on financial performance, utilization, quality, and goals and objectives. These reviews reinforce accountability and provide a forum for identifying and discussing operational issues, and facilitating communication around key results areas.

Often using an 'accountability framework' as an organization-wide approach to assigning accountability and monitoring performance. The framework is the basis for conducting quarterly reviews incorporating:

- goals,
- objectives,
- action plans,
- indicators,
- monitoring and evaluation of performance, and
- communication

Each Vice President[26] would be responsible for a formal quarterly review of each component of the portfolio. These Quarterly Accountability Reviews measure and monitor:

- Progress toward operating plan objectives
- Patient volume indicators
- Efficiency indicators
- Quality indicators
- Progress toward corporate goals
- Financial performance
- Variances from Plans
  - volume variances,
  - productivity variances or
  - cost variances
  - quality variances

[26] And the Corporate Director Clinical Decision Support

External benchmarks/targets have been used to support these reviews including CIHI/Hay Benchmarking Study, CCHSA Accreditation Reports, OHA Report Card, Johnson & Johnson Operating Room Benchmarks, CIHI Databases, etc.

These reviews form the basis for Quarterly Reports to the Board on selected indicators related to the health care organization's corporate goals.

The most important aspect of variance analysis is not the determination of the cause of the variance, but rather the determination whether it is a controllable variance.

Variance analysis is critical to the success of the Quarterly Review Process. In refining its approach to variance analysis, it will be important for the region to remember that the most important aspect of variance analysis is not the determination of the cause of the variance, but rather the determination whether it is a controllable variance. If the variance is controllable then corrective action should be initiated; if it is an uncontrollable variance, then replanning and rebudgeting should be considered to reflect the uncontrollable/unplanned event. Corrective actions should be taken in response to significant departmental variances. When these actions will impact on departments outside the portfolio, the proposed plan of action should be reviewed with Senior Management prior to implementation. Corrective actions with significant implications for the region and/or rebudgeting with significant implications for year-end results should be reviewed with the Board.

Recommendation:

It is recommended that:

(23) The CEO, CFO and Corporate Director Clinical Decision Support should introduce a Quarterly Review Process to provide for better performance management and expenditure control.

3.4.4 Management Reporting

Management information should focus on the "critical success factors" of an organization.

There must be a balance in management reporting. Too little information and too much information should both be avoided. Management information should focus on the "critical success factors" of an organization. For any organization, the critical success factors are the limited number of areas in which satisfactory results must be achieved in order to ensure the successful performance of the organization. These are the few key areas where "things must go right" for the organization to flourish. If results in these few significant areas are good, the organization will be successful. If results in these few areas are not adequate, the organization's overall performance for

this period will be less than desired. The critical factors are areas of activity that should receive constant, careful attention from management. The current status of performance in each area should be continuously measured and made available to the appropriate managers.

The critical volume, productivity, cost, revenue and overall performance targets specified in an operational plan/budget should provide the foundation for effective management reporting.

The critical volume, productivity, cost, revenue and overall performance targets specified in an operational plan/budget should provide the foundation for effective management reporting. Management reports should provide managers with an indication of departmental performance in relation to operating targets and budgets for:

1. Utilization (e.g. Laboratory Tests per Separation)
2. Volume (Laboratory Tests)
3. Workload (Laboratory Workload Units)
4. Productivity (workload units per variable worked hour – per UPP worked hour)
5. Variable/UPP worked hours
   - with separate reporting of overtime and call-back hours
6. Overhead worked hours (Management and Operational Support hours)
7. Benefit hours
   - with separate reporting of sick time
8. Total paid hours
9. Total Labour Costs
10. Labour cost per paid hour
11. Total Supplies Costs
12. Total Operating Costs
13. Revenues
14. Quality of service

Then, throughout the year, an effective management reporting system will concentrate on:

- Comparing actual results to targets

- Providing this information in a timely and accurate manner to support operating decisions

so that managers are able to understand and explain significant variances and develop plans for corrective actions to achieve the budgeted levels of performance. (Alternatively, if the causes of variance are outside the control of the health care organization, consideration might be given to formally changing the performance targets.)

Reporting for Departmental Managers should be enhanced.

WHCC currently provides senior management and functional centre managers with Current Period and Year-to-Date Reporting of Budget, Actual and Variance for:

- Hours
- Worked Hours
- Non-Worked Hours
- Total Paid Hours
- Salary Costs
- Benefit Costs
- Other Expenses
- Recoveries
- Net Expenses

Managers are also provided with a listing of current period transactions.

The level of detail provided by these reports is most useful for

- Monitoring financial performance in relation to plan, and
- Documenting individual expenditure items within categories of spending.

Other than financial performance, the reports do not provide an easily usable summary information on variances from other critical operating targets.

Other than financial performance, the reports do not provide an easily usable summary information on variances from other critical operating targets. They do not identify the critical variances requiring investigation and corrective action. Departments do not appear to receive regular reporting or analysis of budgeted and actual workload or productivity. There is no indication of the sources of workload by program.

The level of detail currently being provided will help department managers to understand and explain the expenditure items that may have led to variances from targets. But they are difficult to use in identifying the causes of these variances. As a result, reporting to front-line managers is not as effective as it might be in supporting the management of departmental activity or controlling costs.

The corporation should work to provide each department with higher level summaries of departmental performance in relation to the critical operating and budget targets listed above. These can then be the basis for more effective variance analysis within the organization and discussion of causes of variances from plan related to one or more of patient volume, patient mix, departmental workload, productivity, and unit costs.

Recommendations:

It is recommended that:

(24) The CFO and the Corporate Director Decision Support should extend management reporting to include measures that will better support identification and explanation of variance from plans.

(25) The CFO should ensure that all analysis of variance includes consideration of corrective action and/or the implications of the variance for year-end departmental, program and corporate results.

3.4.5 Absenteeism Control

It is recognized that the WHCC is but one participant in the provincial bargaining process and is therefore unable, on its own, to negotiate changes to the provincial agreements. There are, however, three areas where leadership is required in advancing change that could result in significant cost savings for the organization and other health regions in the province.

Sick time provisions

The collective agreement provisions that provide for the accumulation of a "bank" of sick days are contributing to a culture of entitlement to days off as opposed to the intended purpose of providing income protection for employees experiencing legitimate illness. And yet, the agreement does not provide any income protection for employees who experience a non-work related long-term illness or disability. Additionally, the voluntary nature of employee participation in

early return to work programs is not in either the employer's or the employee's interest.

Personal Paid Leave

The collective agreement also provides for personal paid leave in addition to paid leave for vacation, holidays and illness. We understand that employees are taking on average 2 of the 3 days of paid personal leave available to them subject to the qualifying criteria. Paid personal leave does not exist in most other jurisdictions. The high rate of utilization of this entitlement is further exacerbating the health care organization's high replacement costs.

Overtime payments to nurses for providing report

Over time for nurses is calculated in 30-minute intervals at 1.5 times their rate of pay. Nurses working beyond their daily hours of work are therefore entitled to a minimum payment for 45 minutes, regardless of the actual time worked. Nurses have a professional responsibility for communicating the status of their patients to their peers at the change of shift. The fulfillment of this professional responsibility should not result in an automatic payment of 45 minutes. An overtime grace period not exceeding 15 minutes at shift exchange should be considered for the purpose of providing report and fulfilling this professional responsibility of nurses working at WHCC.

The current provisions of the collective agreement both inhibit the ability of employer to legitimately manage employee absence and do not meet the income protection needs of employees**.** It will be important for the Board and for the Province as a whole for the VP Human Resources to continue advocating, independently and through the provincial bargaining process, for changes to the collective agreement provisions governing over time for nurses and sick leave and personal paid leave provisions for all union employees.

Attendance Management

There is significant opportunity and need to reduce the amount employee absence due to illness and/or accident at WHCC. This is the element of benefit costs most immediately affected by management. At the same time there are potentially significant differences in the rules that determine qualification for, and payment of paid sick time benefits among health care organizations across Canada. To help to put regional differences in perspective along with the performance of the region, we compared the 2002/03 sick time usage of WHCC both to the performance of the Newfoundland and Labrador peers, and to the performance of peers from elsewhere in the country.

Exhibit 3.1 shows WHCC Sick time usage compared to Newfoundland & Labrador peers. The comparison shows sick time hours as a percentage of worked hours for the four major reporting groups for hospital services. All areas showed potential, adding up to 70,807 hours if their sick time usage could be reduced to the peer 25th percentile usage level. Even reducing sick time usage to the Median would achieve a reduction of 35,995 hours.

Exhibit 3.1
WHCC Sick Time Hours as a Percentage of Worked Hours (2002/03)

Area	WHCC	Newfoundland & Labrador Peers				Potential @ 25th %ile
		Low	25th	MEDIAN	MEAN	Hours
Administration & Support	**8.2%**	2.6%	6.6%	7.9%	7.7%	17,193
Inpatient Nursing	**9.2%**	4.9%	6.7%	7.4%	7.5%	34,041
Ambulatory Care	**8.3%**	0.0%	5.8%	6.4%	5.8%	4,770
Diagnostic & Therapeutic	**6.6%**	0.4%	3.0%	5.1%	4.4%	14,803
			Potential @ 25th %ile			70,807

Exhibit 3.2 shows WHCC Sick time usage compared to peers located elsewhere in Canada. The comparison shows sick time hours as a percentage of worked hours for the four major reporting groups for hospital services. Sick time usage rates appear to be significantly lower in the other provinces. All areas were worse than the 25th percentile of these peers, for a total potential saving of 145,501 hours if the 25th percentile could be achieved.

Exhibit 3.2
WHCC Sick Time Hours as a Percentage of Worked Hours (2002/03)

Area	WHCC	NON N & L PEERS				Potential @ 25th %ile
		Low	25th	MEDIAN	MEAN	Hours
Administration & Support	**8.2%**	3.8%	4.6%	5.3%	5.5%	40,056
Inpatient Nursing	**9.2%**	1.9%	3.6%	5.2%	5.2%	74,715
Ambulatory Care	**8.3%**	1.0%	2.7%	3.9%	4.2%	10,544
Diagnostic & Therapeutic	**6.6%**	0.4%	1.7%	2.8%	2.8%	20,185
			Potential @ 25th %ile			145,501

Senior Management and the Board have identified this significant opportunity to improve the organization's employee absence experience, resulting from illness and/or accident. An Attendance Management program has been developed and implemented incorporating the following key elements:

- A focus on health identifying both opportunities for intervention to improve attendance and providing for recognition of good attendance.
- The development and implementation of comprehensive policies and procedures to guide the organization supported by a comprehensive communications plan.
- A comprehensive training initiative including community physicians to provide for a uniform application of the program and understanding of the underlying philosophy.
- An intensive review of employee attendance in consultation with managers resulting in interventions within excess of 250 employees since January of this year.
- Implementation of an early return to work program involving the dedicated resources of three Occupational Therapists to facilitate the early return to work of employees off due to work related illness/accident.

Management is to be commended for these initiatives based upon the following proven formula for success:

Awareness + Intervention = Reduction in employee absence and Cost Savings.

The Vice President Human Resources has expressed his pride in the efforts of the team to date and indicated that the early results are promising. The results of that effort first started to show up in Sept/Oct of 2003. As a result, the organization has reduced sick time hours by 5.3% (13,897 hours) in 2003/04 and has achieved annual savings already of about $600,000.

There are additional opportunities that can contribute to the success of their efforts. Our comments and recommendations are as follows:

Attendance Management Data Collection and Analysis

Effective management of human resources, especially attendance management requires information systems support. The Corporation's Meditech I.T. platform is functional, reliable and the platform of choice for a large number of Canadian hospitals. The financial and payroll programs however are not user friendly when it comes to producing information for Human Resources management. As a result many Meditech hospitals are acquiring HRIS software complementary to Meditech to provide management with the information needed to effectively manage their Human Resources including attendance. The Vice President, Human Resources should take the necessary steps to acquire HRIS

software to support the human resources management at WHCC.

Recommendation:

It is recommended that:

(26) The Vice President, Human Resources should acquire HRIS software to support human resources management at WHCC.

Employee Health and Wellness

Employees who become ill while on the job and require attention are currently sent to clinics and/or the emergency department. As a result opportunities for early intervention and return to work as early as the same day are being missed. Nurses currently expected to perform occupational health functions are in practice infection control nurses whose first priority are infection control functions.

Employee wellness programs are an important component for improving employee health and attendance and are currently not part of the equation.

The success of the early return to work program for employees off due to work related illness/accident can and should be replicated for early return to work of employees off due to non-work related illness/accident. There is an equal and/or greater opportunity to improve attendance and reduce costs for this group of employees. The Vice President Human Resources should develop a proposal to acquire occupational health resources dedicated to early return to work for employees off due to non work related illness/accident, employee health triage for employees who become ill while at work and employee wellness program planning, for the consideration of senior management.

Recommendation:

It is recommended that:

(27) The Vice President Human Resources should provide for occupational health resources for employee health triage for employees who become ill while at work, employee wellness program planning and for early return to work for employees off due to non-work related illness/accident.

A final point to be addressed relates to the collection of data by the provincial association for the purpose of comparing absenteeism experience due to illness/accident both work and

non-work related. A standard reporting format has been developed in other provinces and a similar approach should be taken in this province to provide for accurate and meaningful comparisons between organizations. Notwithstanding this point, the Human Resources leadership team has acknowledged the opportunity for their organization and is to be commended for their efforts to date. The team is encouraged to build upon their efforts and early success with sustained commitment to their Attendance Management program and our recommendations for enhancement.

WHCC should continue its focus on reducing absenteeism. It should set a medium term target of reducing absenteeism to the 1st quartile performance of other health and health and community services boards in Newfoundland and Labrador. This would provide a reduction of 70,000 sick time hours from the corporation's experience in 2002/03. WHCC's current efforts have provided a reduction of 13,000 hours in 2003/04. If it were to achieve a further reduction of 57,000 hours, it would realize a savings in operating costs of approximately $1,400,000. The derivation of this estimate is presented in the exhibit following.

Exhibit 3.3
Estimating Savings from Reducing Sick Time

Potential reduction in sick time at Nfld 1st quartile	70,000 hours
Sick time reduction realized in 2003/04	13,000 hours
Remaining potential reduction in sick time	57,000 hours
% sick time replaced by WHCC	74%
Reduced sick time hours subject to replacement	42,180 hours
Average salary & benefit cost per worked hour	$33.81
Potential additional savings from reducing sick time	$1,426,106

3.5 Medical Staff Involvement in Governance and Management

The review of the Medical Staff involvement in governance and management of WHCC has included the following:

- One-to-one interviews with the CEO and Medical Staff Leaders,
- Tours of each of the Health care organizations and Health Centres, visits to a select number of primary care clinics,
- Review of documentation including minutes of the RMAC, Medical Staff Bylaws, Physician Manpower Plan, previous External Reports and other documents provided by staff and physicians.

3.5.1 Organizational Climate

Physician Leaders are generally frustrated with the apparent lack of progress on needed changes in the organization.

Physician Leaders are generally frustrated with the apparent lack of progress and follow through on corporate changes that need to be made such as those identified by the Performance Improvement Teams (PIT). They are disillusioned about the positioning of the Region in the province with respect to acquisition of capital equipment, renovation and construction of physical facilities and implementation of basic systems such as modern dictation, PACS and Meditech.

Many medical leaders indicated that corporate directions and policy are not being enforced.

Leaders described the Medical Staff Organization as "powerless" and "lacking teeth" to make changes to physician behavior regarding issues of inappropriate resource utilization in particular but also in regard to issues relating to quality of patient care. In fact many medical leaders indicated that no authority within the Regional Organization, including the senior management and the Board seemed to use their "executive power" to appropriately enforce corporate directions and policy with the Medical Staff.

Medical Staff should use its influence to improve patient safety, quality of care and utilization management.

On the other hand, members of the Medical Staff including its Leadership have indeed exerted their collective influence from time to time within the Corporation to oppose and modify initiatives of management and the Board. If such influence exists, the medical staff has a responsibility to use it constructively. Ideally, if such influence exists, the Medical Staff has a responsibility to, and should use this influence to focus on improving patient safety, quality of care and utilization management.

Leaders expressed the opinion that the Western Health Care Region has a negative reputation arising from strained relationships, fiscal constraints and lack of reasonable physical facilities and equipment and that these issues have presented major obstacles in the recruitment of local medical graduates from Memorial University and Dalhousie University.

The current attitudes and culture of the Medical Staff is a significant liability to the Western Health Care Corporation.

The current attitudes and culture of the Medical Staff is a significant liability to the Western Health Care Corporation and a serious effort must be made to change its tone and direction. The Medical Staff leadership should seriously reflect on the role it has played in the last five years in de-stabilizing the progress of the Western Health Care Corporation. The Medical Staff have a responsibility to use their influence wisely and responsibly and the Leadership should take the initiative to reflect on their behavior, lead a

change in attitude and support the Corporation with the organizational, and operational changes that need to be made.

3.5.2 Physician Leadership and Organizational Structure

There is no Regional Chief of Staff.

The medical staff structure consists of a combination of regional and local governance. There is a Chair of the Regional Medical Advisory Committee (RMAC) who is appointed by the Board for a term of three years upon recommendation from the RMAC. The current RMAC Chair has held this role for four months. There is no Regional Chief of Staff and the Regional RMAC Chair is not officially designated as such.

There are six local Chiefs of Staff.

There are six local Chiefs of Staff appointed by the Board for a five-year term upon the recommendation of a local Medical Advisory Committee (LMAC) to the RMAC and from the RMAC to the Board. In general terms the Chiefs of Staff are accountable directly to the Board through the RMAC for the medical care provided at each site. More specifically the local Chief of Staff is responsible for:

- Quality initiatives with support from the administrative organization, and in consultation and collaboration with Regional Chiefs of Discipline and the Medical Director,
- Resource Management in consultation and collaboration with the Regional Chief of Discipline,
- Planning for medical manpower in collaboration with the Medical Director and the Regional Chief of Discipline,
- Communication between the LMAC, local medical staff and the Board.

The accountability relationships for the local Chiefs of Staff are complex and confusing.

The accountability relationships for the local Chiefs of Staff are complex and confusing. They have accountability to the Board through the RMAC but yet they have no direct accountabilities to the RMAC Chair. They have accountabilities to both the Regional Chiefs of Discipline and the VP-Medical Services but the issues for which they are accountable to each of these authorities are not entirely clear.

Ordinarily the local Chiefs of Staff and the Regional Discipline Chiefs would be accountable to a Regional Chief of Staff who would chair the RMAC. The local Chiefs of Staff and the Regional Discipline Chiefs would be responsible for the quality of physician practice, initial credentialling and appointment, as well as annual review and reappointment and midterm action and other initiatives as outlined in the Bylaws.

The Regional Chiefs of Discipline are accountable to the RMAC and have a variety of responsibilities including the efficient use of resources. The responsibility for resource use is executed in collaboration with the VP-Medical Services, local Chiefs of Staff and the RMAC and its committees. However the VP-Medical Services does not currently play an active role in assessing the resource management structures and processes across the Region and the effectiveness of utilization management efforts.

The Medical Staff Leaders are not effective in relation to the management of both quality and utilization.

The Medical Staff Leaders are not executing on their responsibilities in an effective manner with regard to both quality and utilization initiatives. There is no obvious evaluation of their activities and little effort is being made to initiate a comprehensive and effective approach to measuring, monitoring or improving medical quality or utilization. A number of factors are contributing to their performance gap. Some of the factors include lack of knowledge in some instances, inadequate data in other cases, a reluctance to confront colleagues about poor performance for fear of loosing patient referrals, inadequate support by the VP Medical Services.

In a Region as geographically disbursed and fiscally challenged as the Western Health Care Corporation, the VP-Medical Services must play an active role as the Senior Medical Administrative Leader in review and management of the Corporation's resources. The VP-Medical Services must become actively involved in the regional utilization review efforts. He must actively support the Chair of the Regional Utilization Review Committee until such time as an appropriate URM Program is established and working well within the Region.

The RMAC Chair and the VP Medical Services must take the leadership in collaboration with the RMAC in setting expectations for physician performance and addressing gaps so that local Chiefs of Staff and Regional Chiefs of Disciplines are supported in their efforts.

Since local Chiefs of Staff and Regional Chiefs of Discipline are often reluctant to deal with colleagues in an appropriate manner for breaches of quality standards or inappropriate use of resource, the Corporation must find a mechanism support the Chiefs to ensure that quality and utilization efforts are meaningful and effective. The RMAC Chair and the VP Medical Services must take the leadership in collaboration with the RMAC as a whole in setting expectations for physician performance and addressing gaps so that local Chiefs of Staff and Regional Chiefs of Disciplines are supported in their efforts.

Local Chiefs of Staff and Regional Chiefs of Discipline are generally selected through a nomination process limited to the

local site or the specific discipline. While this may not be unusual in community health care organization settings, the process does not necessarily provide the Board and Senior Administration of the Organization with an appropriate opportunity to input into the selection of individuals.

The appointment of local Chiefs of Staff and Regional Chiefs of Discipline who are willing and able to carry out their responsibilities is a very important consideration for the Board and Senior Administration of the Corporation. The Board and Senior Management must become more actively involved in ensuring that the right leaders are in place, expectations are set and support is given. A more formal recruitment and selection process for the Regional Discipline Chiefs and local Chiefs of Staff with active participation from management should be developed jointly by the Regional Chief of Staff and the Vice President Medical Services.

A Regional Chief of Staff role should be created and the Regional Chief of Staff should chair the RMAC.

Without clearly articulated lines of accountability there are no means to ensure that appropriate goals and objectives are set for Medical Leaders, performance evaluation is effectively conducted and issues are resolved in an expeditious manner. A Regional Chief of Staff role should be created and the Regional Chief of Staff should chair the RMAC. The local Chiefs of Staff and the Regional Chiefs of Disciplines should be responsible to the Regional Chief of Staff for all aspects of the quality of medical care and professional practice.

The Medical Staff Bylaws were last reviewed and revised in January 1999. Since that time, some changes have occurred that would warrant Bylaw amendments. As an example, the Regional Utilization Review Committee (RRUC) which was a Committee of the Board has now been designated as a standing committee of the RMAC. The senior management structure that is noted in the Bylaws has also changed. The Medical Staff Bylaws should be revised to reflect the current situation within the Corporation.

Recommendations:

It is recommended that:

(28) The Board should modify its medical staff bylaws to create the role of Regional Chief of Staff.

(29) The Board should modify its medical staff bylaws so that the Regional Chief of Staff serves as Chair of the RMAC.

(30) The Board should modify its medical staff bylaws to clearly articulate that Local Chiefs of Staff and the Regional Chiefs of Disciplines are responsible to the Regional Chief of Staff for all aspects of the quality of medical care and professional practice.

(31) The Board should review, revise and update its Medical Staff Bylaws.

(32) The Regional Chief of Staff and the Vice President Medical Services should develop and implement a more formal recruitment and selection process for the Regional Discipline Chiefs and local Chiefs of Staff.

A number of attempts have been made over the years to engage physician leaders in educational programs to enhance administrative skills. Some programs have been cancelled because of inadequate registration and others have had poor attendance. Unless Medical Staff leaders have the education and tools to be successful in their roles, the Organization will not move forward in many aspects of its operations. The Corporation has not been successful in enticing its Medical Staff leaders to attend educational programs that are necessary for their success as leaders. An evaluation of the barriers to acceptance of or attendance at educational programs should be conducted and a strategy developed to make the educational sessions a priority for physician leaders.

Recommendation:

It is recommended that:

(33) The VP Medical Services should develop a strategy to make educational sessions related to leadership and management skills a priority for physician leaders.

The RMAC Chair is neither a member of the Board nor a member of the Senior Management Team.

The RMAC Chair is not a member of the Board and is likewise not a member of the Senior Management Team. The relationships between the Medical Staff and Senior Management are critical and so too are the relationships between the Medical Staff and the Board. The Bylaws do not provide for the RMAC Chair to be a member of the Board and this is not required under provincial legislation in Newfoundland as it is in some other provinces. However it is difficult to forge a strong partnership when key players are excluded from both executive and operational decision making. The CEO should seriously consider asking the Chair

of RMAC, acting in the proposed role of Regional Chief of Staff, to become a full member of the Senior Management Team. Some of the other Medical Staff leaders might also be invited to join the team on a regular or periodic basis. Some mechanism should also be established to develop better relationships between the Board and the RMAC. In the longer term, once the relationships among the medical staff, the Board and management have been normalized, consideration might be given to making the Regional Chief of Staff and the RMAC accountable to the Board through the CEO.

Recommendation:

It is recommended that:

(34) The CEO should make the Chair of RMAC a member of the Senior Management Team.

3.5.3 Committee Structure

The RMAC and its various committees are not effectively executing the responsibilities ascribed to them under the Medical Staff Bylaws.

At the Regional level there is a Regional Medical Advisory Committee (RMAC) and a variety of regional standing committees. As outlined in the Bylaws dated January 1999, the committees include Credentials Committee, Local Medical Advisory Committees (LMAC), Continuing Medical Education Committee, Infection Control Committee, Pharmacy and Therapeutics Committee, Joint Conference Committee, Bylaws and Rules Committee. The RMAC now has a seventh standing committee, the Regional Resource Utilization Committee (RURM) that is not yet reflected in the Bylaws. This committee originally reported to the Board. In general terms, the RMAC and its various committees are not effectively executing on the responsibilities ascribed to them under the Medical Staff Bylaws.

3.5.3.1 The Regional Medical Advisory Committee

The RMAC is expected to meet at least 10 times per year. In 2003 the RMAC met a total of 11 times including every month of the year with the exception of August. In 2004 the RMAC has met each month except the month of January. The RMAC membership includes both appointed and elected members from the Medical Staff. The Bylaws indicate that the members of the RMAC include the Chiefs of Staff (6 sites), Chiefs of Disciplines (9), Area representatives (2), Regional President, CEO (ex officio), Executive Director - Health and Community Services (Western, ex officio), VP-Medical Services, VP Operations – Acute Care, VP Operations – Long Term Care.

The senior management has been reorganized since these Bylaws were written. The senior management now consists of a VP Medical Services, VP Clinical Operations (Corner Brook), VP Clinical Operations (Rural) and VP Clinical Operations (BSG). The Bylaws need to be updated.

There are a number of physicians who are absent from meetings more often than acceptable (Minutes of December 2003 Page 7,) and concerns have been expressed about the attendance of the senior management (Minutes of December 2003, Page 5). However there was sufficient attendance at each meeting in 2003 and to date in 2004 to reach a quorum. A quorum consists of a simple majority of members.

The ability of the RMAC to conduct its business is affected significantly when key members are not present. The time and date of these meetings is known well in advance, allowing individuals ample time to organize clinical and personal schedules. Except for unexpected illness or emergency, attendance should be mandatory and the consequences of inappropriate absences should be articulated.

Attendance at meetings of the RMAC is essential if the committee is going to be effective.

Attendance at meetings of the RMAC is essential if the committee is going to be effective. The RMAC Chair should indicate to all members that their attendance is not optional and that absences from meetings are tolerable only under very limited circumstances. The committee should agree on its recourse in dealing with unacceptable absenteeism.

Recommendation:

It is recommended that:

(35) The RMAC should develop and implement policies and procedures for dealing with unacceptable absenteeism of members of the RMAC.

The responsibilities of the RMAC are outlined in the Bylaws on page 31. In general terms the RMAC is responsible to the Board for all matters relating to patient and resident care, professional practice, quality of care, utilization of resources, adoption of policies and rules, development of a physician resource plan and facilitation of research.

The RMAC is not dealing effectively with many of its responsibilities.

In general terms the RMAC is not dealing effectively with many of its responsibilities. This lapse will be outlined in more detail under the discussion of the RMAC standing committees in the next section. The RMAC has not received reports from many of its standing committees since January

2003. When Committee Reports are brought forward there are no questions or discussion. Sub-committees report at the discretion of the Committee Chair (RMAC Minutes May 2003).

The RMAC is not devoting sufficient attention to substantive issues of professional practice, quality of care and utilization of resources.

The minutes of RMAC meetings do not indicate substantive discussions about the review of quality of care or resource utilization and some of the discussions regarding physician privileges were left with inadequate resolutions. This latter point is addressed further under the Credentials Committee section. The agenda is heavy with many standard reporting items that may be best brought forward for information. The committee is not devoting sufficient attention and time on its agenda to deal with the substantive issues of professional practice, quality of care and utilization of resources.

The new RMAC Chair should critically review the agenda and functioning of the RMAC and realign the discussions so that the work of the committee is more meaningful and productive and its responsibilities are achieved.

RMAC decision-making process appears slow and cumbersome with matters remainining unresolved for extended periods of time.

The RMAC decision-making process appears slow and cumbersome with unresolved matters coming forward time and again each month. One example is the topic of "wound care" which was first evident on the agenda in January 2003 and continued on the agenda most months until March 2004 which is the latest set of minutes provided to the external team. Another example is the issue of escort assignment where discussion began in June 2003 and as of February 2004 the "Escort Task Force" had still not met and no follow-up was reported. A final example is the case of "magnesium sulfate" which was first introduced to the agenda in May 2003 and in February 2004 the topic was once again deferred because of absences of some committee members.

The RMAC Chair along with the VP Medical Services should develop a process to ensure that items on the RMAC agenda have been adequately researched and that information is available to support the committee's decision making. Action items should be clearly recorded and the most responsible person noted. A process should be developed to ensure that outstanding items are brought forward for resolution in a timely manner.

Recommendations:

It is recommended that:

(36) The Chair of the RMAC should restructure the RMAC agenda to provide for more time for discussion related to critical decisions.

(37) The Chair of the RMAC and the VP Medical Services should ensure that items on the RMAC agenda have sufficient information to support decision making.

(38) The VP Medical Services should develop a process to ensure that outstanding items are brought forward for resolution in a timely manner.

3.5.3.2 Local Medical Advisory Committees

The Bylaws indicate that the Local Medical Advisory Committees are composed of the local Chief of Staff, locally elected members of the Medical Staff, CEO (ex officio), VP-Medical Services or representative (ex officio), Chair RMAC (ex officio), Chiefs of Disciplines (ex officio), Area Manager (ex officio) and others as may be deemed appropriate by the local MAC. The Bylaws do not specify the Chair of these Committees.

The Committee's responsibilities involve the appointment of subcommittees as required to supervise, review and analyze the clinical work at the site, ensure the continuing performance of clinical appraisal activity and maintain a desirable level of quality of professional service and continuing education. Additionally the local MAC must keep the Medical Staff informed of accreditation and make recommendations to the RMAC pertaining to the Clinical Organization, medical equipment and other relevant medico-administrative matters.

It is entirely reasonable that the Medical Staff from each of the Corporation's sites should have a forum to provide input to the RMAC regarding the development of relevant policy governing the Medical Staff across the Corporation and to have policy interpreted so that it is consistently applied across each site. The role of the MAC in a Corporation is indeed to create policy and rules for management of the affairs of the Medical Staff within the parameters set by the Board under the Bylaws and to describe the Medical staff Structure and Responsibilities of its Officers and Leaders.

There should be only one governing authority of the Medical Staff within the Region, and that authority should be delegated from the Board to the RMAC.

However there can be only one Governing Authority of the Medical Staff within the Region. That Authority finalizes recommendations to the Board regarding the Medical Staff Bylaws, develops the conditions for appointment of the Medical Staff, recommends the appointment and re-appointment of physicians, Discipline Chiefs and Chiefs of Staff to the Board, sets the standards for professional practice, supervises the overall quality of care and use of the Corporation's resources by the Medical Staff and ensures that the Medical staff is appropriately structured.

The Western Health Care Corporation has established 7 Medical Advisory Committees.

The Western Health Care Corporation has, in effect, established 7 Medical Advisory Committees where one is the Regional Committee. In this model however there is opportunity for confusion and conflict about where the final authority rests. Only one Medical Advisory Committee should exist within the Corporation's structure. The Regional Medical Advisory Committee has sufficient representation from all sites and disciplines within the region to ensure that there is appropriate discussion of issues and full input from across the region is captured.

The six site-specific local Committees should function in an advisory capacity to the RMAC and act as a communication forum for physicians.

The six site-specific local Committees should function in an advisory capacity to the RMAC and act as a communication forum for physicians. Their nomenclature should be changed and terms of reference revisited so that there is no question about their role and responsibilities. The local committees can remain as sub-committees of the MAC and be assigned specific responsibilities including those related to quality of care and resource use. They can continue to provide a good forum for communication between the local physicians and the RMAC through the local Chief of Staff and area representatives.

Recommendation:

It is recommended that:

(39) The Board should eliminate all Local Medical Advisory Committees.

3.5.3.3 Credentials Committee

The Medical Staff Bylaws make provision for a Credentials Committee composed of the Chief of Discipline, Chief of Staff of the primary site and the VP-Medical Services or designate. The Committee's responsibility includes the investigation of credentials, assessment of qualifications, experience and medical competence of applicants to the medical staff and the

recommendation to RMAC of initial appointment, category of appointment, granting of privileges, reappointment and change of category or privileges.

The process for investigating credentials, assigning privileges, appointment and reappointment is not appropriately controlled.

It is somewhat disturbing to note from the minutes of the RMAC that the members of the RMAC do not know of their responsibility under the Bylaws to constitute a Credentials Committee and that the process for investigating credentials, assigning privileges, appointment and reappointment is not appropriately controlled.

In point of fact, in the RMAC minutes of December 2003, a motion to create a Credentials Committee was defeated in a vote of 4 in favor and 5 against. The RMAC agreed that credentials continue to be handled as usual. Currently each Discipline and/or local Chief of Staff is managing the credentials process at the Discipline or site specific level and making representation directly to the RMAC for initial appointment, assignment of privileges, change in category and reappointment. This process is inappropriate, it is not well managed and it presents many current and potential problems for the Corporation.

It was further noted in the RMAC minutes of April 2003 that a suggestion was made to strike a Credentials Committee to develop a new process for reappointment and that such a subcommittee of RMAC would be "the best way to go". The matter was referred to the Bylaws Committee for action but no action came forward in subsequent minutes.

The VP Medical Services and the RMAC Chair should move immediately to establish a Credentials Committee as provided for in the Bylaws.

The VP Medical Services and the RMAC Chair should move immediately to establish a Credentials Committee as provided for in the Bylaws. The Committee should coordinate and manage all credentialling and privileging requirements and appointments and re-appointments to the medical staff across the Region. It should ensure that credentials are verified, standards and policies are approved by the RMAC for the assignment of privileges and that the re-appointment process gives due consideration to the performance of physicians on a periodic basis.

In the minutes of March 2004 a draft policy and letter regarding requirements by general practitioners for ACLS and BCLS training was circulated to the meeting. It was noted that these items should be included in an orientation package. While the inclusion of these items in an orientation package may be important, it is essential that the education and skill requirements of all specialists and subspecialties practicing

within the Corporation are clearly articulated and managed through a centralized Credentials Committee reporting to the RMAC.

Additionally when new physicians are recruited who require a period of evaluation or mentoring, the requirements should be clearly articulated, the mentor identified and a formal process of evaluation established through the Credentials Committee. In the minutes of June 2003, under the section "Amendment of Privileges" the RMAC did not adequately assure themselves of the skills of a particular physician regarding solo work in the ER. The physician in question was asked to read the ACLS manual and commit to upgrading of his skills but no verification process was established to ensure that the physician had carried through on his commitment. The RMAC further concluded that a "shadowing program" should be established for physicians who wish to work in the ER if they have not worked in an ER for the previous five years. However there was no assigned individual to carry this forward and no presentation on this item again in any of the subsequent RMAC meetings up to and including March 2004.

A process must be developed to address any outstanding issues regarding the professional performance or inappropriate behavior among the medical staff.

Finally, a process must be developed to address any outstanding issues regarding the professional performance or inappropriate behavior among the medical staff and the satisfactory resolution of these issues should be linked to the physician's ongoing privileges and potentially his/her ongoing relationship with the Corporation. In the minutes of May 2003, the RMAC reflected on whether it should conduct an audit to determine if conditions that were placed on a member of the medical staff four years earlier by an internal review committee were actually followed by the sanctioned physician.

Recommendations:

It is recommended that:

(40) The VP Medical Services and the RMAC Chair should move immediately to establish a Credentials Committee as provided for in the Bylaws.

(41) The RMAC Chair must ensure that a reliable and comprehensive process is established to ensure implementation of professional performance directives of the RMAC.

3.5.3.4 Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee appears to be one of the only active sub-committees of the RMAC. The RMAC gets regular updates on drug utilization. However suggested changes in drug usage are presented for information and not for approval. Approval authority appears to reside within the Discipline. While it is obviously essential to consult with relevant Discipline Members, it is the prerogative of the RMAC to make final decisions on the business of the Pharmacy and Therapeutics Committee including drug substitution.

All matters relating to the business of the Pharmacy and Therapeutics Committee should be approved by the RMAC. The responsibilities of the RMAC regarding alterations to the formulary and substitution of drugs cannot be delegated to the Disciplines. Consultation with Disciplines is essential but such consultation is not a substitution for the responsibilities of the RMAC, the only Authority that can authorize changes to the formulary or policy regarding drug substitution.

Criteria for the use of new drugs must be developed and approved by the RMAC, not Senior Management.

Guidelines for use of new drugs must be developed proactively and communicated in a clear manner to the medical staff. This process should be an automatic part of the function of the Pharmacy and Therapeutics Committee but yet there is some question about whether the process is followed consistently. The RMAC minutes of October 2003 regarding the introduction of Xigris to the Drug Formulary documented a discussion indicating that the criteria for the use of Xigris were to be developed before presentation to the Senior Management. The criteria for use of new drugs must be developed and approved by the RMAC, not the Senior Management of the Corporation.

The Pharmacy and Therapeutics Committee must develop criteria and guidelines for the use of new drugs that are introduced to the formulary and the criteria and guidelines must be approved by the RMAC at the time that approval of the addition of the drug to the formulary is given.

The process by which proposals for the addition of new drugs to the Formulary are brought forward to the RMAC is unusual. The request is made by a member of the RMAC versus through the recommendation of the Pharmacy and Therapeutics Committee. The Chairman of the P&T Committee would ordinarily attend the RMAC meeting, present his report, facilitate discussion and address questions.

There is no evidence in the minuted RMAC discussions of a rigorous analysis of the financial impact of new drugs.

The Chair of the Pharmacy and Therapeutics Committee should present his/her report to the RMAC and deal directly with discussion and questions. The presentation should address the rationale behind the addition or substitution of a drug, the indications for use, restrictions on use and the financial impact. The financial impact should also be considered and approved by the Senior Management before the drug is introduced to the formulary.

Recommendations:

It is recommended that:

(42) The RMAC Chair should ensure that the RMAC is the only entity that can authorize changes to the formulary or policies regarding drug substitution.

(43) The Pharmacy and Therapeutics Committee should develop criteria for the introduction of new drugs into the formulary.

(44) The Chair of the RMAC should ensure that the financial impact of a proposed new drug is approved by the Senior Management before the drug is approved by the RMAC for introduction into the formulary.

3.5.3.5 Joint Conference Committee

The Joint Conference Committee is intended to provide a forum for open communication among the Medical Staff, Senior Management and the Board.

The Bylaws provide for the development of a Joint Conference Committee consisting of three members of the Medical Staff, three representatives from the Senior Management and three members of the Board. The Committee is intended to meet semi annually and provide a forum for open communication with the Medical Staff and discussion of matters of mutual interest.

Attendance of the medical leadership at Board meetings does not fulfill the intent of the Joint Conference Committee.

The Joint Conference Committee has not been active for the last three years and there is no other forum that would allow the open discussion contemplated by the Joint Conference Committee setting. The President and Vice President of the Medical Staff and Chair of the RMAC do attend meetings of the Board but the opportunity for dialogue at meetings of the Board is constrained by the nature of the meeting and the fact that the medical staff are only attendees at the meeting, not members of the committee. The attendance of the medical

leadership at Board meetings does not fulfill the intent of the Joint Conference Committee.

There is a great deal of tension among the members of the Medical Staff in this Region and constructive dialogue is essential. The Board and Management may be well advised to consider options for opening the avenues for serious discussion whether through a Joint Conference Committee or another forum.

The Board and Management should revisit the Bylaws and make a decision about the usefulness of a Joint Conference Committee. If such a Committee is not developed, then the Bylaws should be amended in this regard. In any event, some forum for constructive and open dialogue among the Medical Staff, Board and Management will be essential to successfully dealing with the issues facing the Corporation.

Recommendation:

It is recommended that:

(45) The Chair of the Board should reactivate and establish a regular meeting schedule for the Joint Conference Committee.

3.5.3.6 Bylaws and Rules Committee

In the minutes of July 2003 the Bylaws Committee reported that it was "searching other parts of the province to see how they are doing things" Almost one year later there has been no report to the RMAC on the results of that search. Medical Staff Bylaws are a common document that can be found in every health care/hospital corporation in Canada. It should not take 12 months to find samples relevant to the Western Health Care Region.

On occasion, the Bylaws Committee is assigned an item for follow-up action by the RMAC. As an example, in the minutes of May 2003, the RMAC requested that the Bylaws Committee clarify the length of appointment of a Discipline Chief as well as the process for selection of Chiefs of Staff and Discipline Chiefs. A second example is noted in the minutes of October 2003 where a number of issues relating to Disciplines were discussed and it was noted that the Bylaws were silent in relation to Disciplines. The matter was referred to the Bylaws Committee for action. No follow up from the Bylaws Committee on either issue has been recorded in subsequent minutes.

The Bylaws Committee should review of the Medical Staff Bylaws and ensure that they reflect all changes in the Corporation since the Board last approved the Bylaws in 1999.

The Bylaws Committee should commence an immediate review of the Medical Staff Bylaws in their entirety. The Committee should ensure that revisions to the Bylaws reflect all changes that have been made in the Corporation since the Board last approved the Bylaws in 1999. The revisions should also address the outstanding issues from the RMAC and from this Report. The revised Bylaws should provide all the guidance that is required by the Medical Staff Organization to govern itself in a responsible and effective manner.

Recommendation:

It is recommended that:

(46) The Bylaws Committee should immediately review and recommend to the Board appropriate revisions the Medical Staff Bylaws.

3.5.3.7 Continuing Medical Education Committee

According to the Bylaws the Continuing Education Committee should be composed of the Regional Director of Education Services, representatives of the Medical Staff as appointed by the RMAC and the VP-Medical Services or delegate. The Committee should plan and develop CME programs for the Medical Staff based on needs assessment, maintain awareness of the availability of medical education programs, evaluate CME programs and work cooperatively with Staff Education to coordinate programs involving other health professionals.

In the RMAC minutes of May 2003, the RMAC addressed the question of whether the CME Committee should resume presentations to the RMAC bi-monthly or by invitation. The RMAC arrived at a consensus that the CME Committee could forward a monthly package to the RMAC for information purposes but would not attend the RMAC meeting on a regular basis.

There is little evidence that the CME Committee is given any priority, guidance or support by the RMAC.

There is little evidence in the minutes of the RMAC that the CME Committee is given any priority, guidance or support by the RMAC. In fact the Nursing Report to the RMAC addressed concerns on an ongoing basis about the inability to get physicians to enroll in a program to deal with concerns around wound care.

There are also a variety of educational requirements that physician leaders have throughout the Region to which the RMAC should give some consideration. It is evident that

many physician leaders are unsure of their roles and responsibilities and the boundaries within which they should function. The CME Committee should be asked to design and deliver educational events for physician leaders. Some attempts in the past have not been successful. However this is long overdue and a concerted effort must be made again.

In the minutes of the RMAC of September 2003 and again in October 2003 and December 2003 members of the RMAC debated the role of the Discipline Chief. In particular in December it was recorded that "medical staff members who are taking on the role of Chiefs should be aware of the full responsibility associated with their role…"

The RMAC should work with the CME Committee to identify the continuing education needs of physicians and actively support the Committee in developing and implementing a strategy to ensure that CME is attended across the Corporation.

Recommendations:

It is recommended that:

(47) The RMAC should work with the CME Committee to develop and implement a strategy to ensure that CME is attended across the Corporation.

(48) The Chair of the RMAC and the VP Medical Services should work with the CME Committee to develop and deliver educational sessions for physician leaders.

3.5.3.8 Infection Control Committee

The Infection Control Committee is composed of representatives of the medical staff as appointed by the RMAC, Regional Infection Control Officer, representatives of site Infection Control Nursing (rotating), other representatives from nursing –acute and long term care, communicable disease nurse and the VP-Medical Services or delegate.

Its functions are outlined in the Bylaws and include the establishment of written standards for Infection Prevention and Control in patients and employees, development of a consistent record of recording and evaluating nosocomial infection rates and consultation on the employee health program.

It appears from the minutes of the RMAC dated May 2003, page 6 that the Infection Control Committee was instructed in May 2002 that its Chair would not attend RMAC unless invited to report. In the minutes of the RMAC from January 2003 up to and including March 2004, there was no report from the Infection Control Committee.

The RMAC has no formal manner in which to evaluate the work of the Infection Control Committee because it has neglected to hear from it in any relevant or active manner for over one year.

The RMAC has a responsibility to provide guidance and support to its sub-committees and to ensure that the work of the committees is meeting expectations. The RMAC has no formal manner in which to evaluate the work of the Infection Control Committee or most of its other committees because it has neglected to hear from them in any relevant or active manner. This needs to change. The RMAC must establish a means of receiving timely and relevant information from the Infection Control Committee as part of a full and comprehensive Quality Review Initiative.

Recommendation:

It is recommended that:

(49) The RMAC Chair should establish a means of receiving timely and relevant information from the Infection Control Committee as part of a full and comprehensive Medical Quality Review Initiative.

3.5.4 The RMAC and Utilization Management: The Regional Resource Utilization Committee

Primary responsibility for utilization management in WHCC is assigned to the Regional Resource Utilization Committee (RRUC). The Regional Resource Utilization Committee (RRUC) reports to the RMAC and advises the senior team, the Quality Council (a Board subcommittee) and the individual Performance Improvement Teams established for each clinical, diagnostic, therapeutic, and support service.

The committee is chaired by one of the Discipline Chiefs. Other physician members include the Regional MAC Chair, the Chief of Staff, the VP Medical Services, and the Regional Chiefs of Medicine, Emergency, Surgery, and Family Practice. The Regional Chiefs of Radiology and Laboratory, and the local Chiefs of Medicine, are added as required. Non-medical RRUC members include the WHCC CEO, the VP Clinical Operations Corner Brook, Director of Acute Care Nursing WMRH, Regional Director Health Records, the Corporate Director Clinical Decision Support, the Regional Utilization Coordinator, and the CEO of the HCSW.

The RRUC meets monthly for an hour (immediately preceding the regular meeting of the Regional MAC). A member of the medical staff chairs the RRUC and the terms of reference for the RRUC identify the following responsibilities for review of utilization information:

- Length of stay by CMG, service and physician
- Laboratory usage
- Radiology usage
- Concurrent review
- Occupancy rates
- Ambulatory Care activity
- Emergency Department activity
- Department-specific Wait Times
- Physician consultation wait times
- Resource Intensity Weights

The terms of reference for the RRUC describe a process whereby individual physician's lengths of stay will be monitored against CIHI expected lengths of stay (ELOS). If a physician's average length of stay is more than one day over or under the ELOS for more than three consecutive quarters, a case-by-case analysis will be done to establish potential causes for the variance (it is not clear who will conduct this review). The LOS performance will then be compared with concurrent review results and if there are potentially avoidable days that have been characterized as "influenced by the physician", the Regional Chief of Discipline will become involved.

While ALOS for many physicians is consistently more than 1 day in excess of the CIHI ELOS, it does not appear that alteration of privileges has been actively considered by RRUC or RMAC.

A prior version of the RRUC terms of reference specified that the ongoing review could result in the alteration of privileges. While average lengths of stay for many physicians are consistently more than 1 day in excess of the CIHI ELOS, it does not appear that alteration of privileges for these physicians has been actively considered.

In September 2000 the RRUC terms of reference were changed to instead rely on the Chiefs of Service for follow up on aberrant patterns of utilization. Length of stay data for individual physicians has not been routinely reported to the physicians (although this is just being restarted), but has been available for the Chiefs to review. The corporation is in the process of developing discipline specific performance profiles

for the regional chiefs to review quarterly. Interviewees reported that Chiefs find it very difficult to challenge the utilization practices of their colleagues in the service, and feel that they are not sufficiently compensated to make up for the potential impact on their professional relationships of assuming the role of utilization enforcer.

Short meetings; lack of confidence in the LOS data; and a general lack of engagement of the medical staff in utilization management have acted as barriers to success of the RRUC.

Review of minutes from the RRUC for the past 3 years showed that there are regular discussions about data quality and the inadequacy of clinical documentation. There are seldom action items identified, and for those items identified as actionable, subsequent meeting minutes do not document follow up. At the March 21, 2001 RRUC meeting the minutes note that "the members noted that the committee needs to be more action oriented". This change does not appear to have happened. Interviewees suggested that the combination of the short meeting time (1 hour), the lack of confidence in the LOS data based on physician documentation, and the general lack of engagement of the medical staff in utilization management, have acted as barriers to success of the RRUC.

As a result, the Western Memorial Regional Hospital (WMRH) site has significant issues that have not been adequately addressed by the RMAC or its RRUC sub-committee. In particular our analysis of "Average Length of Stay" (ALOS) and "May Not Require Hospitalization" (MNRH) indicates that the Corporation does not perform well when compared with peer health care organizations. (This analysis is presented in Chapter 4 of this Report.)

Beds are not well managed at WMRH. Beds are opened to accommodate patients waiting in the ED or to accommodate an elective admission at the insistence of the attending physician.

The analysis of clinical efficiency also indicates that some areas of the WMRH site are experiencing occupancy rates above 100% and that 'unfunded' beds are opened to accommodate patients waiting in the ED or to accommodate an elective admission at the insistence of the attending physician.

There are patients occupying acute medical beds who are clearly "Alternate Level of Care" (ALC) but who have not been declared as such because the physicians do not want to place the burden of co-payment on the family. Surgeons are booking major cases in the OR when there is a good likelihood that a critical care bed will be required but without first arranging for the bed.

There is no real effort by the RMAC or its RRUC to manage the beds and services at the WMRH site and inappropriate use has been passively condoned.

These are but some of the utilization management issues facing the Corporation. The issues have been ongoing for a protracted time period. Efforts to deal with the physician who are not meeting expectations have met with resistance. The RMAC has not dealt adequately with the issue. Some if not all Discipline Chiefs have been reluctant to address the performance of their members for fear of loosing referrals. In general terms there is no real effort to manage the beds and services at the WMRH site and inappropriate use has been passively condoned.

The RMAC and the Regional Resource Utilization Committee must bring the use of beds under control at the WMRH site and deal once and for all with physicians who are abusing the system. Physicians must not be permitted to blatantly ignore efficient practices regarding ALOS expectations, MNRH or designation of ALC status. The RMAC must determine the appropriate consequences for physicians who continue to abuse the use of the Corporation's beds and the consequences must be implemented with the full endorsement and support of RMAC.

The Regional Resource Utilization Committee should seriously review all ALC patients including those patients known or suspected to be ALC but not yet designated. These patients should be designated ALC and a plan should be developed in concert with the Nursing Staff to cluster these patients geographically so that an appropriate level of care can be provided. If such a plan is developed the RMAC must ensure that additional beds are not added back into the WMH site through further mismanagement of bed utilization.

3.5.4.1 Regional Utilization Plan

The RRUC was identified as the "champion" of the Regional Utilization Plan.

The WHCC Regional Utilization Plan was drafted in February 2003 and approved in April 2003. The RRUC was identified as the "champion" of the utilization plan. The goals of the plan are:

1. To improve the availability of inpatient beds and services. This is to be achieved by reducing the number of inappropriate admissions to acute care, reducing lengths of stay, and reducing overall occupancy to 93% and thereby reducing off-service patients. An expected date of discharge pilot project has been completed.

2. To improve the quality of clinical information. This is to be achieved by conducting a review of clinical information

needs, improving identification and recording of diagnostic information contributing to CMG and complexity assignment, and initiating early identification of ALC patients.

3. To coordinate and improve the discharge planning process. This is to be achieved by developing and implementing a standardized discharge planning process, and by increasing patient/family awareness of discharge expectations.

4. To improve access to surgical services. This is to be achieved by developing a regional wait list, reconvening the WMRH OR committee, and improving access to day surgery.

5. To introduce best practices/models to promote quality improvement, accessibility and sustainability. This is to be achieved by developing clinical pathways, and by defining a process whereby guidelines/protocols are established.

6. To increase awareness regarding utilization. WHCC staff are reviewing structures and process in place in other regions and will establish a utilization management SWAT team at the WMRH site.

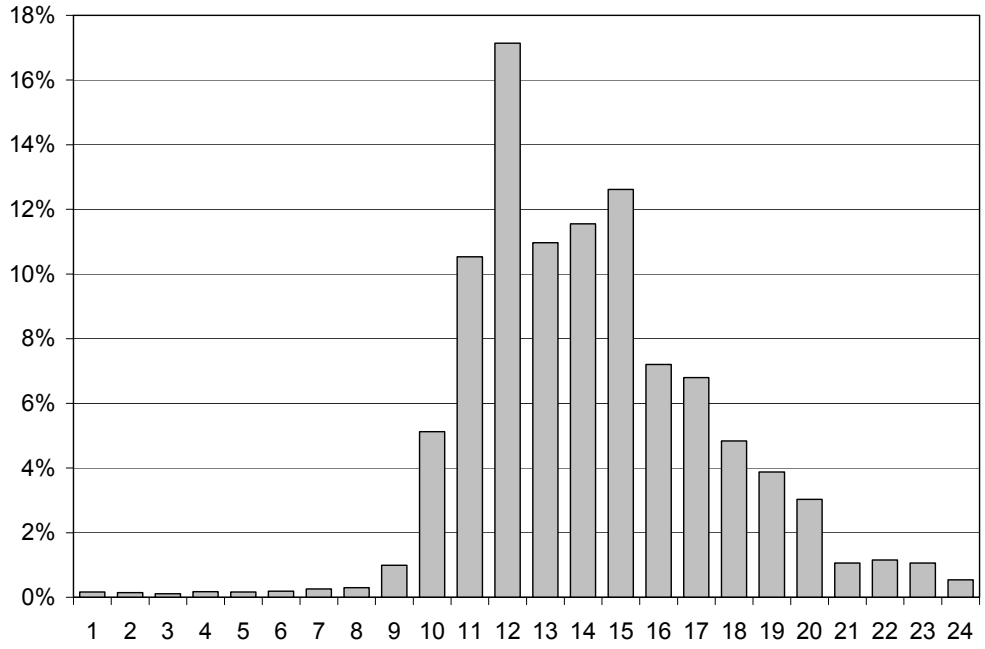
We support the goals of the utilization plan and the focus on increasing the awareness, participation, and support of the medical staff in utilization and quality improvement activities.

A current initiative of WHCC related to this plan is the 'Discharge by 11 a.m. Project'. WHCC policies require that physicians provide 24 hours notice of a patient's discharge and that they either make rounds early enough to support the 11 a.m. discharge or write the discharge order in advance. But medical staff were not complying with the policy.

In 2001/02, analysis of the WMRH CIHI data shows that only 18% of inpatients were discharged before 11 a.m. 22% of WMRH inpatients were discharged after 4 p.m., making it extremely difficult for the vacated bed to be used for new elective admissions.

Exhibit 3.4. shows the 2001/02 distribution of WMRH acute care inpatient discharges by discharge hour. The most common discharge time was between 12 and 1 p.m.

Exhibit 3.4
Distribution of WMRH 2001/02 Inpatient Discharges by Time of Discharge



The plan was updated in April 2004. Progress has been achieved with the implementation of the 11 a.m. discharge awareness campaign, the increased awareness of the importance of coding comorbidities resulting from the EDD pilot project, increased recording of ALC days, and preparation of draft physician profiles.

WHCC has not established specific targets for performance or improvement in clinical efficiency.

However, the plan does not include any targets for clinical efficiency in the region or any of its sites. And none of the Board, the administration, the RRUC, the Quality Council, or the Regional MAC have established specific, quantifiable targets for key utilization areas such as length of stay performance, occupancy, or ALC.

Recommendations:

It is recommended that:

(50) The RRUC should establish specific targets for key corporate utilization management indicators each year and monitor performance on a regular basis.

(51) The RRUC should establish targets for length of stay performance based on the Best Practice Review clinical efficiency targets and expressed in terms of CIHI ELOS performance.

In addition to clinical efficiency, there are significant operational issues that must be addressed by RMAC and management.

While the current mandate of the RRUC and the Regional Utilization Plan is focused primarily on the use of beds in the Corporation, there are other operational issues that must be addressed in a coordinated manner by the Corporation.

- Clinical Pathways: There has been some work on Clinical Pathways within the organization but there is much more that could be accomplished. A pathway has been implemented for the 5-day Cardiac Rehabilitation Protocol. Pathways are being developed for Total Knee Replacement, Transuretheral Resection of the Prostate. And the Medicine Performance Improvement Team has identified a need for pathways for COPD and strokes. The Maternal/Newborn team has identified a need for pathways for Caesarean Section, Premature Labour, and for Normal Delivery.
- Formulary Management: There is a need to ensure that drugs are scrutinized and the cost impact recognized and debated before drugs are added to the formulary was previously mentioned.
- Standardization of Instruments and Supplies: The medical staff should also be actively engaged in reviewing supplies and instrumentation to ensure standardization and to identify opportunities for cost reduction. There is no evidence that medical staff is engaged in any such discussions.

The Chief of Surgery should, immediately, bring a stop to the inappropriate use of the surgical suite for elective cases after hours and on weekends and the RMAC and its membership should provide him with its full, and unwavering support in this initiative.

- Surgical Suite Management: As is discussed elsewhere in this report, elective surgeries are now regularly scheduled after normal business hours in the evenings and on weekends. This is not an acceptable practice. The Chief of Surgery should put a stop to this practice immediately. The RMAC should instruct the Chief of Surgery to bring a stop to the inappropriate use of the surgical suite for elective cases. This intervention by the Chief of Surgery should be fully and unequivocally supported and endorsed by the RMAC and its membership (and the Board). Repeat offenders should have surgical privileges suspended and/or face financial penalties that may be more relevant such as in the case of the salaried surgeon.

The RMAC should further expand the mandate of the RRUC so that it takes a more comprehensive look at all aspects of clinical and operational efficiency as it relates to medical care and medical staff use of WHCC resources across the Corporation. Alternately the VP Medical Services should take the lead to ensure that a process is established to review all

aspects of clinical and operational efficiency related to the Medical Staff and medical care and present the findings to the RMAC for action. It was noted from the minutes of March 2004 that some effort may be underway to start this process.

Recommendations:

It is recommended that:

(52) The RMAC should expand the mandate of the Regional Resource Utilization Committee to include a more comprehensive look at all aspects of the impact of medical care on the resources of the corporation.

(53) The VP Medical Services should establish a process to facilitate review all aspects of the impact of medical care on the resources of the corporation.

(54) The Chief of Surgery should take action to stop the inappropriate use of the surgical suite for elective cases.

3.5.4.2 Clinical Data Quality and Reporting

Lack of confidence in the quality of clinical data has been a barrier to successful utilization management.

Lack of confidence in the quality (and timeliness) of clinical data has been repeatedly identified by the RRUC and the RMAC as a barrier to successful utilization management.

The Corporate Performance Improvement group and Health Records have distributed materials to physicians emphasizing the importance of complete documentation of patient conditions and comorbid diagnoses, but additional diagnoses (beyond the most responsible diagnosis) are still under-documented. One goal of the expected date of discharge (EDD) program has been to demonstrate to physicians the relationship between additional clinical information and the calculated EDD.

Utilization Management at WHCC has been frustrated by an apparent lack of engagement of many of the medical staff in providing comprehensive and timely clinical documentation for their patients.

We were impressed with the work that Corporate Performance Improvement and Health Records have done to generate information to support utilization management and quality improvement activities within the region. Their work has been frustrated by apparent lack of engagement of many of the medical staff in providing comprehensive and timely clinical documentation.

Until quite recently, ALC days were substantially under-reported, since only patients designated as having been medically discharged could be recorded as ALC. Now most

patients designated as having been ALC according to CIHI standards are recorded as ALC.

WHCC has used a version of the Appropriateness Evaluation Protocol to conduct periodic (and sometimes concurrent) assessments of the appropriateness of inpatient admissions and ongoing stays. The data has shown opportunities to reduce admissions and length of stay, but has not had a significant impact on utilization practices.

The medical staff often challenge the accuracy of utilization data. Our impressions from review of RRUC minutes was that the medical staff are unwilling to accept that there are limitations in most data, and have established a threshold for data quality that cannot be met, given the inadequacies of documentation provided by the medical staff.

The November 2003 WHCC draft strategic plan for September 2003 through March 2007 identifies improvement in the quality of inpatient utilization data as a priority for the organization to achieve a goal of evidence-based decision-making in the areas of mental health, medicine, and surgery, by 2007. It does however identify a requirement for an improved technological infrastructure as a prerequisite for achieving the goal of evidence-based decision-making. We caution WHCC not to assume that.

And, the strategic plan does not identify any specific targets for any of the identified measures of hospital performance.

3.5.4.3 Physician Engagement in Utilization Management

WMRH lengths of stay have been consistently more than 20% longer than the CIHI expected LOS since 1999/2000, and recently more than 30% above the CIHI ELOS.

WMRH lengths of stay have been consistently more than 20% longer than the CIHI expected LOS since 1999/2000, and recently more than 30% above the CIHI ELOS.

The long lengths of stay have contributed to the high occupancy rates, necessitating off-service placement of patients, and the potential risks associated with placing patients on units where the staff are not familiar with their care requirements. It was reported that many physicians see the high occupancy rates as an administrative problem. The long lengths of stay have also increased the costs of care and contributed to the WHCC deficit.

As has been discussed, WHCC has been unable to address physician utilization issues, particularly at WMRH. Although some early work has been completed in changing the job descriptions of the clinical chiefs to reinforce their

responsibility for ensuring efficient utilization and quality care. There is some concern that even with more clear descriptions it will be difficult for the chiefs to challenge their colleagues.

WHCC is planning to hire a physician to lead a WMRH Utilization Management Team. This individual would work exclusively on utilization issues and would not be dependent on referrals of patients from the other medical staff.

WHCC is also considering the implementation of a hospitalist program at WMRH, so that physicians knowledgeable in hospital processes and engaged in utilization management could assume responsibility for inpatients that would otherwise be managed through their hospital stay by family practitioners.

Given the longstanding challenges of engaging physicians in utilization management, we support both the introduction of a physician leader with responsibility for utilization management and the establishment of a hospitalist program at WMRH. It will be important, however, that part of the role of the physician UM leader is to increase the participation of other medical staff in utilization management activities, so that utilization management is not seen as someone else's responsibility. WHCC should consider hospitalist models that make use of local family practitioners and do not require that primary care physicians abandon all elements of hospital practice.

3.5.5 RMAC Quality Initiatives

A great deal of emphasis has been placed on Quality Initiatives over the last decade or more across Canada. It is reasonable to expect therefore that in the year 2004, Medical Staffs should have a well-developed Quality Review Program. This is not the case with the Western Health Care Region.

There is no Medical Staff Quality Review Program, either at the regional level or the department level. A meaningful program should be applicable to all Medical Departments across all sites and should include relevant benchmarks and indicators as well as mechanisms for evaluation and a mechanism for reporting to the RMAC.

Chart Audits, Trending Analyses, Mortality and Morbidity Rounds, Clinical Pathways, Patient Surveys and Peer Assessments are some of the vehicles that may be used as elements of the Program.

A complete and current medical record is an essential tool for ensuring the continuity, quality and safety of patient care. Medical staff must complete charts for their patients.

There are now more than 2500 incomplete medical charts at the WMRH site (and more than 4600 across the region) and charts are often coded without a complete discharge summary. If a patient whose chart is incomplete from a prior visit presents at the ED or is admitted, health records may not be able access the chart, since it would not yet be properly filed. The Medical Staff are not completing these in a timely fashion. The issue has been outstanding for far too long and the RMAC must ensure that this situation is resolved. A complete and current medical record is an essential tool for ensuring continuity of patient care and the issue should not be ignored any longer. The RMAC should clearly communicate the expectation to the Medical Staff that medical records must be completed in a timely fashion. Failure to do should result in penalties including but not limited to suspension of privileges and reporting to the Newfoundland Medical Board. It should be noted that draft policies and changes to the medical staff rules and regulations to promote more prompt completion of charts are being developed. However, the issue is clearly not the presence of an appropriate regulation, but the will to require and enforce safe practices by the medical staff in the region.

The RMAC should ensure the development of an appropriate and relevant Medical Quality Improvement Program for WHCC.

The Corporation has a Quality Council in place and has made numerous requests to RMAC for representation from the Medical Staff on the Council. The minutes of the RMAC first record this request in February 2003. In March 2004 the RMAC minutes indicate that no practicing physician has agreed. The degree of effort that the RMAC has put into the recruitment of a physician for the Quality Council is not recorded but it is difficult to accept that there are no physicians within the Corporation willing to participate in such an important corporate endeavor.

The RMAC should ensure that an appropriate and relevant Medical Quality Improvement Program is developed and that expectations are communicated to the Medical Staff Departments regarding their participation in such a Program. The RMAC should develop a mechanism to receive relevant and timely Reports about the Medical Staff Quality Initiatives on a regular basis.

Recommendations:

It is recommended that:

(55) The RMAC Chair and the VP Medical Services should develop and implement an appropriate and relevant Medical Quality Improvement Program.

(56) The RMAC should suspend the privileges of Medical Staff that do not complete medical records in a timely fashion.

(57) The RMAC should appoint an appropriate member of the Medical staff to participate in the Corporate Quality Council.

3.5.6 RMAC Effectiveness

3.5.6.1 Policy Development

The RMAC must formalize the process for development of policies. Some policies are just not optional and the Chair of RMAC and the VP Medical Services must be more proactive in educating the members of RMAC about their role in policy development and ensuring that RMAC deals appropriately with its obligations in this regard.

The process for development of Medical Staff policies is unclear. Policy suggestions are brought forward to the MAC by Discipline Chiefs or Chiefs of Staff. Some examples include policies related to chart completion, on call coverage, credentials, patient referral and the use of oxytocin. Background documentation about the rationale for the policy and the content and application of the policy is scant. There is insufficient leadership at the MAC to adequately champion policies that must be developed and enforced. The credentials policy is the most blatant example.

The smaller sites within WHCC are experiencing difficulty referring patients to appropriate specialists and finding a physician who will accept the transfer of patients.

Another good example however is the issue of the referral process. The smaller sites within the Corporation are experiencing difficulty finding a physician who will accept the transfer of patients or assisting with the referral of the patient to an appropriate specialist. The RMAC minutes of February 18, 2004 highlighted this issue. In particular the Chief of Family Medicine identified that the problem had been brought to his attention on two separate occasions by nursing staff of the Sir Thomas Roddick Hospital.

The RMAC minutes of November 2003 indicated that "it was the general consensus that for the most part specialists accept

responsibility for care of the patient and ensure appropriate referral to another …. It was suggested that the transferring physician ensure they receive confirmation of acceptance from the receiving physician. It was also felt that individual physicians should be approached regarding treatment provided in the two cases identified."

There was no assignment of responsibility to follow up on this item nor was there any attempt to ensure that a clear policy was put in place to manage the transfer of patients nor was there any responsibility accepted by the RMAC to communicate their expectations to the Medical Staff.

A policy and process for transfer of patients within the various facilities of the Corporation must be established.

A policy and process for transfer of patients within the various facilities of the Corporation must be established and communicated clearly to all Medical Staff and Nursing staff. There must be delineation of responsibilities of the physician transferring the patient as well as the physician receiving the patient. The process must be sufficiently robust so that patients are not compromised.

Recommendations:

It is recommended that:

(58) The RMAC Chair and VP Medical Services should formalize the process for development of medical care and medical staff policies.

(59) The RMAC should establish a policy and process for transfer of patients between and within the various facilities of the Corporation.

3.5.7 Physician Human Resource Planning and Impact Analysis

The latest Physician Resource Plan was developed in 2000. It identifies the current complement of Physicians in each discipline, impending retirements and recommendations for future requirements. There is no indication of impact analysis for any of the new recruits or replacements for retirement at this time but this impact analysis will obviously be needed before any firm commitments are made.

The medical manpower plan is currently outdated.

The VP Medical Services and the RMAC should review the manpower plan on annual basis. The Plan is currently outdated. The Physician Resource requirements and financial impact should be clearly identified. The resource requirements will be affected by a variety of factors including population demographics and disease profile, physician lifestyle

expectations, compensation models for physicians and other things. The factors affecting physician resource requirements should be identified and considered as the Plan is being developed.

There is some concern about the manner in which the need for new physicians is identified. As an example The RMAC approved the recruitment of a 3rd ENT specialist against the recommendation of the Discipline Chief in ENT as noted from the minutes of RMAC dated January 2003. While this may be the correct decision there should be some population-based data, workload data or lifestyle basis that gives support to the decision. None of this evidence was clearly presented to the RMAC and so the full rationale for the decision is not evident.

The VP Medical Services should ensure that appropriate impact analysis is completed for all new and replacement physicians in advance of any firm commitment and that the resources are available to accommodate these physicians.

Also, there are examples of requests from individual physicians being presented directly to the RMAC without first being considered by chief of discipline and/or the chief of staff. Requests for actions by the RMAC from individual or groups of members of the medical staff should, in all cases, be first considered and then presented by a chief of discipline and/or the chief of staff.

The RMAC should insist that all requests for resource expenditure that are brought before them are thoroughly assessed before presentation and that the request is one that is a high priority need for the Corporation.

There are a number of physicians who were sponsored for training on the basis that they return to the Corporation. The Corporation should take a serious look at its contracts with trainees to ensure that the right incentives/disincentives are in place to ensure the obligations are fulfilled. Additionally the Corporation should ensure that a mechanism is in place to maintain contact with sponsored physicians to develop the relationship and provide the assurances of ongoing support.

When considering the Corporation's manpower requirements, the RMAC must also consider the impact of the salaried versus fee-for service compensation structure for physicians. There is a generally held view among many of the physician leaders that the salaried physician's performance in terms of volume of patients seen, willingness to engage in on-call schedules is less than that of fee-for service colleagues in

geographic locations where there are sufficient numbers of patients to support a fee-for-service practice.

There are no performance agreements between the Corporation and salaried physicians that clearly define performance expectations.

There are no performance agreements between the Corporation and salaried physicians that clearly define performance expectations. If such performance agreements exist at the provincial level, the Corporation states that it has no knowledge of them. There is therefore a significant variation in practice capacity for some physician that may significantly impact the number of physicians required to meet the needs of a large population. There is also some belief that waiting list have grown when specialist have changed status fro fee-for-service to salary.

The Corporation should undertake to understand whether differences exist in both quality and volume of service between salaried and fee-for-service physicians. Service agreements should be developed with all salaried physicians and the comparative information along with other relevant data should be used to inform the discussions.

Recommendations:

It is recommended that:

(60) The VP Medical Services and the RMAC should review the medical manpower plan on annual basis.

(61) The VP Medical Services should ensure that appropriate impact analysis is completed for all new and replacement physicians.

(62) The VP Medical Services should maintain contact with sponsored physicians and ensure that obligations are fulfilled.

(63) The VP Medical Services should develop and negotiate service agreements with all salaried physicians.

3.5.8 Medical Departments/Clinical Disciplines

The Clinical Organization is outlined in the Bylaws in Section 16.1. There are nine (9) Regional Clinical Disciplines including Anaesthesia, Family Practice, Medicine, Obstetrics and Gynecology, Paediatrics, Pathology and Laboratory Medicine, Psychiatry, Diagnostic Imaging, Surgery. Within each Discipline there may be a number of Divisions.

3.5.8.1 Meetings of the Disciplines

Most Disciplines appear to be meeting on a regular basis with varying success in terms of attendance by members. Attendance at meetings is an important vehicle for exchange of information, dealing with issues around professional practice, resource utilization, professional development, future planning for the Discipline and other matters. All members have a contribution to make to the discussions and should be actively encouraged to attend meetings and a minimum number of attendances should be mandatory for retention of privileges.

Recommendation:

It is recommended that:

(64) The Chiefs of Discipline should ensure that Physicians' attendance at Meetings of the Discipline is a part of annual performance assessment before re-appointment.

3.5.8.2 Role of Chiefs of Disciplines

Important outstanding issues that are not being adequately addressed by the Discipline Chiefs.

The roles of the Discipline Chiefs are outlined in the Bylaws although it is not evident from discussions at the RMAC as previously noted, that the Chiefs fully understand their role. It is clear however that many of the Chiefs are not acting on their responsibilities in an appropriate manner. This issue has also been highlighted elsewhere. There are many outstanding issues that are not being adequately addressed by the Discipline Chiefs. In discussions with the Chiefs and also from review of the RMAC minutes some of these issues include:

- Long standing conflict within disciplines such that the membership is dysfunctional. Some examples identified were Anaesthesia, Paediatrics and Surgery
- Failure to coordinate leaves of absence (RMAC Minutes, October 2003)
- Physician- On-Call responsibilities (RMAC Minutes, September 2003)
- Manpower Planning and Impact analysis
- Discipline of membership for inappropriate use of resources including but not limited to family practitioners and surgeons
- Professional development requirements

There are significant structural deficits with respect to the roles, responsibilities and behaviours of Discipline Chiefs:

- Beyond what is articulated in the Bylaws regarding role, there are no job descriptions for the positions of Discipline Chief in WHCC.
- The Corporation does not negotiate performance expectations with each Discipline Chief
- The Corporation does not execute a contract with each Discipline Chief
- The Corporation, through its RMAC, does not evaluate the performance of each Discipline Chief annually

The RMAC Chair should re-enforce the role of the Discipline Chief, ensure that each Chief understands the role and is prepared accept the responsibilities and that each Chief is given adequate education and support to assume the assigned responsibilities and manage the issues.

Recommendations:

It is recommended that:

(65) The VP Medical Services should develop job descriptions for the role of Discipline Chief.

(66) The VP Medical Services should negotiate contracts and performance expectations with each Discipline Chief.

(67) The RMAC Chair supported by the VP Medical Services should evaluate the performance of each Discipline Chief annually.

3.6 Nursing Management

Health care organizations are "held together, glued together, enabled to function….by the nurses".

Health care organizations are "held together, glued together, enabled to function….by the nurses."[27] Nurses who practice at Western Health Care Corporation are challenged to engage in the complexities and excitement of patient care delivery in the 21st century. WHCC nurses are key in creating the vision of a community of excellence and achieving the organization's vision and strategic direction.

[27] Thomas, Lewis. "The Youngest Science" as cited by Needleman, et al in "Nurse-Staffing levels and the Quality of Care in Hospitals", New England Journal of Medicine, Volume 346, No. 22. Page 1715. May 30, 2002.

3.6.1 The Role of Nursing within the Corporation

There is a general concern regarding the role of nursing within the organization and that the current management structure does not provide for an adequate voice for nursing within senior management. Much of the literature today emphasizes that nursing, and ultimately the quality of patient care, is strongly influenced by the chief nursing officer (CNO) position, its role within the organization and the leadership capabilities of the incumbent.

3.6.1.1 Role of the Chief Nursing Officer

The current approach to nursing leadership is diminishing the importance of nursing within the organization.

Within the current structure at WHCC, the role of the Chief Nursing Officer (CNO) rotates periodically between VPs with nursing designations. These individuals also have other, continuing operational responsibilities. This is a less than ideal situation. This approach to nursing leadership is diminishing the importance of nursing within the organization. It is a temporary responsibility and it is secondary to the person's continuing set of responsibilities:

- There will likely be inconsistencies in the execution of the role
- The role will not be of primary importance to the incumbent
- There is no continuing champion for nursing within the Corporation

There should be a permanent position of Chief Nursing Officer.

Ideally, there should be a permanent position of Chief Nursing Officer for the region without additional operational responsibilities. Minimally, the responsibilities of CNO should be a permanent responsibility of one individual.

The CNO should play a key role in planning and delivering services in support of the WHCC's fundamental commitment to the quality of patient care. Reporting to the CEO, the CNO would be a member of the Senior Management Team, working closely and collaboratively with the Vice-Presidents, and the Chief of Staff.

With a strong focus on quality improvement, the CNO should, first and foremost, be an advocate for nursing practice. The CNO should provide significant and continuing leadership in the challenging and exciting task of planning, implementing and evaluating region-wide services and programs. This role could also oversee a broad range of key strategic areas related to nursing: Professional Practice, Quality Improvement,

Accreditation, Ethics, Clinical Education, and Research. The role of CNO is generally expected to bring to bear on corporate planning, the knowledge of best nursing practice and the experience of the region's dedicated nursing staff and managers.

This is a demanding role particularly within a regional structure and consideration should be given to a role separate from any operational responsibilities. Such a role could be more active in promoting the nursing professional practice model of shared/self governance.

Recommendation:

It is recommended that:

(68) The Chief Executive Officer (CEO) should create a non-rotating Chief Nursing Officer (CNO) position separate from the role of Vice-President.

3.6.1.2 Regional Director of Nursing Practice

In recognition of the deficits in the current approach to nursing leadership and in an effort to support and advance the role of nursing professional practice, a Regional Director position was created and reports to the rotating CNO position. This is an important role to support the development of consistent policies and practices across the region. Distances make it difficult for one individual to provide direct support, but use of various communication media are in place and should be continued.

3.6.1.3 Education and Specialty Roles

Apart from the role of Regional Director of Nursing Practice there are few clinical education/resource supports for nursing. Education is a centralized function and provides support for organization wide training such as orientation. Although the Education Department is responsible for ensuring nursing staff maintain their competency, it relies heavily on the Directors of Nursing for input into the necessary content and timing of training. There is a perception among Directors of Nursing that it is very difficult to get expertise for updating and/or maintaining clinical competency particularly in specialized areas.

There is a need to introduce advanced practice nursing roles to the region to support clinical competence in the delivery of patient care and to maintain best practice. It is suggested

initially that the region re-instate the Clinical Nurse Specialist role for LTC. More discussion is provided in a following section on long term care.

Recommendation:

It is recommended that:

(69) The CNO should add advanced practice and/or education roles at WHCC to support best practice nursing care in the region.

3.6.2 Nursing Organization Structure

3.6.2.1 Roles & Titles

The role of Director of Nursing appears at all sites across the region. At all sites except in Corner Brook these roles also have responsibility for site coordination. Their title does not accurately reflect their responsibilities. It is also unusual to see the title of Director of Nursing. In many organizations this role/title no longer exist. It is suggested that consideration be given to a change of title that more accurately reflects the important role these individuals have in the delivery of service at their sites and within the region. Something like Director of Patient or Resident Care would be more appropriate.

The role of Assistant Director of Nursing within WHCC is that of a front-line patient care manager. They generally have responsibility for at least 2 patient care units or areas. They have responsibility for approximately 70-110 staff. This is not an unusual span of control and is seen in other organizations. However, we have concern regarding the lack of education and/or advanced practice nursing roles to support nurse managers and staff. And again, the title for this position does not accurately reflect its responsibilities or role within the organization. Consideration should be given to changing the title to one such as Patient Care Manager that more appropriately reflects their role.

Recommendation:

It is recommended that:

(70) The CEO should change the titles of the nursing administrative roles to better reflect the work content of these positions.

3.6.2.2 Nursing Advisory Councils and Team Structures

Within WHCC there is a regional and local nursing advisory council structure. These councils are designed to develop, implement, monitor, and evaluate nursing professional standards and practices. The membership of the Regional Nursing Advisory Council (RNAC) includes Directors of Nursing from all sites, the Regional Director of Professional Practice, and representatives from other corporate advisory councils and clinical support teams. This Council provides oversight, leadership and direction in the development of nursing clinical policies and procedures. There is a need to involve more front-line staff on this council and there is a move toward using this structure as part of process for strengthening the approach to shared governance.

The Local Nursing Advisory Councils (LNAC) provide the opportunity for front-line staff to contribute to the development of nursing policies and standards and to participate in the implementation of regional practices. The Director of Nursing for each site is the liaison between the Regional and Local councils.

Both the Local and Regional Councils meet 8 times per year. With improved electronic and other mechanisms for communication, it is suggested that meeting frequency be reviewed. The Regional Council should be able to fulfill its role of oversight and direction with quarterly meetings.

The structure of regional and local councils is seen in other regional jurisdictions and should enable the organization to advance the practice of nursing within the corporation.

Recommendation:

It is recommended that:

(71) The Chief Nursing Officer should streamline the operations of the Regional Nursing Advisory Council and ensure appropriate representation of front-line nursing staff on this council.

The Role of Program Teams and Site Performance Improvement Teams and their relationship to Nursing Councils is unclear.

In addition to Nursing Advisory Councils the corporation also has two team structures that are involved in the development of policies and procedures. There are Program Teams (e.g. Long Term Care) and Site Performance Improvement Teams (SPIT). These teams meet frequently. As a result, Nursing Directors and Regional Directors and staff representatives are involved in a large number of meetings.

There is also a lack of clarity about each group's role in the development of policies and procedures, the appropriate communication processes and the approval process. This is resulting in poor communication, apparent duplication of work and a significant amount of frustration among the staff.

Policy & procedure development and approval process a problem.

The process for policy development is a significant problem for the region because of the lack of clarity in roles and who is doing what. Approval processes appear to be cumbersome.

It also appears that all policies have to go to senior management for approval. This adds another layer and creates delay. A recent example is of 51 policies from one program that had to go to the senior team. Often staff are already doing an activity before approvals are obtained or they are waiting too long before implementing appropriate changes in practice.

Recommendations:

It is recommended that:

(72) The CEO should review the management and committee structures to ensure clarity of roles and to reduce the number of meetings.

(73) The CEO should develop structures and processes that improve the timeliness of policy approvals.

4.0 Programs & Services

Western Health Care Corporation operates nine facilities in six communities and 22 medical clinics.

Western Health Care Corporation operates nine facilities in six communities and 22 medical clinics. The nine facilities include two hospitals: Western Memorial Regional Hospital in Corner Brook, and Sir Thomas Roddick Hospital in Stephenville; four health centres: Calder Health Centre in Burgeo, Bonne Bay Health Centre in Norris Point, Rufus Guinchard Health Centre in Port Saunders, and the Dr. Charles Legrow Health Centre in Channel-Port Aux Basques; and two long term care centres: Bay St. George Long Term Care Centre in Stephenville Crossing and Corner Brook Long Term Care, which includes the Dr. J.I. O'Connell Centre and the Interfaith Home for Seniors in Corner Brook and the 5th and 6th floor of Western Memorial Regional Hospital. Together, these facilities provide approximately 266 acute care beds, and 441 long-term care beds[28]. Seventy percent of the acute care beds are located at Western Memorial Regional Hospital, and the other thirty percent are located across five facilities.

WHCC Activity Volumes for 2002/03.

During 2002/03, in WHCC facilities, there were:

- 9,348 admissions to acute care,
- 137 long-term admissions to long-term care,
- 79,769 visits to the Emergency and outpatient clinics,
- 12,937 OR and procedure room visits, and
- 629 births.

The twenty two medical clinics are located within 6 districts of the region: South West Coast (3), Bay St. George (5), Bonne Bay (5), Deer Lake/White Bay South (4), Burgeo (4), and Corner Brook (1).

The focus of this section of the report is analysis of utilization of WHCC hospital services by the residents of the region, and identification of opportunities to find efficiencies that will allow the Corporation to best meet the needs of the population within the available resources.

Data Sources

To support the analysis of utilization of hospital services, we obtained Canadian Institute for Health Information (CIHI) discharge abstract database (DAD) data from the

[28] As of March 31, 2004 as confirmed by hospital staff on October 19, 2004.

Newfoundland and Labrador Centre for Health Information (NLCHI). This data included all inpatient and same day surgery (SDS) separations from Newfoundland and Labrador acute care hospitals during fiscal year 2001/02 (which was the most current year for which complete provincial data was available to the project).[29]

The NLCHI edited the data (including geographic assignment, based on patient residence) and then forwarded the edited dataset to CIHI for application of updated Case Mix Group (CMG) and Resource Intensity Weight (RIW) assignments. The data was grouped using the CMG 2003, using revised ICD-10 translations and the revised grade list diagnoses. The CMG 2003 and RIW 2003 assignments were used so that the data would be compatible with data available to the consultants from the annual CIHI/HayGroup Benchmarking Analysis of Canadian Hospitals. The updated assignments also minimized the potential impact of previously identified ICD-10 to ICD-9 code translation errors and reduced the impact of the "upcoding" of grade list diagnoses in the comparative data from Ontario.

Program Assignment

All of the acute care data was assigned to a "program cluster category" (PCC) to support program-based analysis. The PCCs are similar to the major clinical category groupings of CMGs used by CIHI, but are subdivided by medicine and surgery. PCCs were used instead of doctor service categories to overcome the limitations of variation in doctor service assignment across organizations and jurisdictions.

Exhibit 4.1 shows the program cluster categories and the total distribution of 2001/02 inpatient and SDS activity in the hospitals operated by the Corporation. In 2001/02 the average length of stay for inpatients overall was 7.9 days. 6.3% of inpatient days were reported as "alternate level of care" (ALC), or patients who no longer required acute care and were awaiting placement elsewhere.

[29] More current data was available for discharges from WHCC facilities, but consistently grouped and edited data for the entire province was only available for 2001/02 at the time of the review.

Exhibit 4.1
2001/02 Inpatient Activity in WHCC Hospitals by Program

H&CS - Western					
Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
Cardiology	1,217	10,424	8.6	6.3%	1
Psychiatry	647	8,282	12.8	7.0%	52
General Surgery	895	8,282	9.3	4.6%	634
General Medicine	689	8,006	11.6	13.7%	6
Pulmonary	731	6,135	8.4	9.1%	0
Gastro/Hepatobiliary	896	4,617	5.2	2.6%	424
Trauma	437	3,647	8.3	8.8%	28
Neurology	376	3,500	9.3	18.1%	0
Obstetrics	1,005	3,475	3.5	0.2%	15
Orthopaedics	450	3,100	6.9	4.7%	308
Oncology	276	2,914	10.6	3.8%	30
Urology	435	2,502	5.8	3.0%	162
Neonatology	707	2,311	3.3	0.8%	0
Vascular Surgery	108	1,961	18.2	7.6%	16
Endocrinology	222	1,939	8.7	0.5%	1
Gynaecology	429	1,906	4.4	0.0%	891
Nephrology	110	1,253	11.4	10.2%	14
Haematology	101	698	6.9	0.0%	2
Cardio/ Thoracic	39	615	15.8	3.6%	1
Rehabilitation	30	594	19.8	4.4%	0
Otolaryngology	286	488	1.7	0.0%	177
Rheumatology	48	409	8.5	32.3%	0
Dermatology	39	236	6.1	0.0%	55
Plastic Surgery	30	162	5.4	0.0%	8
Ophthalmology	53	132	2.5	0.0%	467
Not Generally Hosp.	35	111	3.2	0.0%	51
Neurosurgery	5	88	17.6	0.0%	48
Dental/Oral Surgery	1	7	7.0	0.0%	304
Ungroupable	1	3	3.0	0.0%	0
Grand Total	10,298	77,797	7.6	6.6%	3,695

4.1 Populations' Utilization of Programs & Services

The analyses of utilization of programs and services are based on the assignment of patients to geographic areas according to their place of residence, not the location of the hospital that provided their care. Utilization data organized in this manner can be used to assess the rates of use of hospital services by the populations of different geographic communities, and to identify patterns of reliance on individual hospitals.

4.1.1 Program/Service Population Utilization Rates

The basic measure of utilization of acute care services used for this project is the number of hospital separations (both inpatient and day surgery) per 10,000 population used by the residents of a geographic area. The rates are "age/gender standardized", meaning that they are adjusted to reflect the age

and gender composition of the population. This allows comparisons of rates across regions that may have very different demographic structures. This is necessary because the elderly rely much more on acute care hospital services and a region with a higher percent of elderly residents will have much higher crude rates of use of hospital services. Standardization removes the impact of the differences in distribution of residents by age, and allows more direct comparison of the propensity of populations to use acute care hospitals for their health care.

Standardized utilization rates are compared across regions to help identify populations for which there may be opportunities to modify their patterns of reliance on hospitals or for which increased investments in non-hospital health services may be required.

The initial assumption when comparing utilization rates is that after standardization, all other factors being equal, all communities should have similar utilization rates, which reflect the natural burden of illness and injury, and the services that hospitals provide to treat these illnesses and injuries.

When a community is identified with high utilization, it may reflect:

- Unnecessary over-servicing of population (i.e. capacity for acute care greater than need for acute care).
- Necessary response to poor health status of population (i.e. a burden of illness greater than would be expected, given the population demographics, due to factors such as environmental challenges, lifestyles, or poor socio-economic status).
- Lack of availability of alternative non-hospital health care providers (i.e. the hospital plays a broader role in the provision of primary or long-term care because of inadequate capacity of these services in the community).
- Geographic impacts, where the threshold for admission to (and discharge from) a hospital in a region with a widely distributed population may be very different from the threshold in a densely populated urban area.

Low utilization may reflect:

- Under-servicing of a population (i.e. insufficient capacity to respond to population need).

- Appropriate response to population with good health status (and less need for care).
- Reduced reliance on hospital care because of enhanced availability of primary and community care.

4.1.2 Demographic Profile of Population in Region

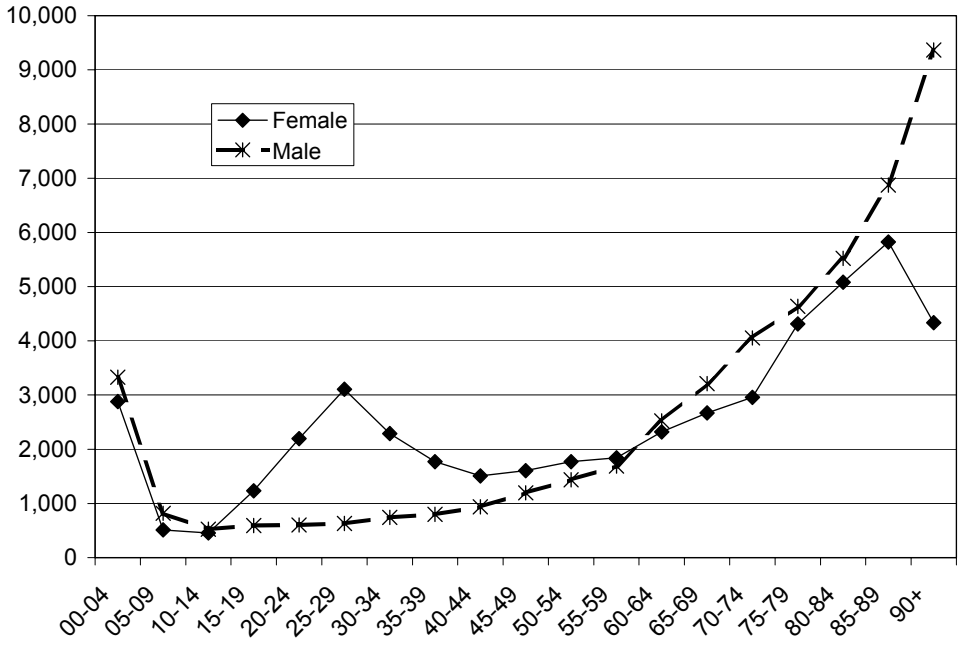
Exhibit 4.2 shows the distribution of the 2001 populations of each Newfoundland and Labrador health region by gender and age. The Western region has a slightly higher than average proportion of the population who are over 60 years old.

Exhibit 4.2
Distribution of Newfoundland and Labrador Population by Age/Gender Group (2001) by Health Board

Age/ Gender Group		H&CS - St. Johns	H&CS - Eastern	H&CS - Central	H&CS - Western	Hlth Labrador Corp	Grenfell RHSB	Nfld & Lab
Female	0 to 19	22,316	13,219	11,786	9,742	3,819	2,056	62,938
	20 to 44	38,206	19,249	17,645	14,577	4,924	3,140	97,741
	45 to 59	19,307	12,860	11,427	9,625	2,456	1,774	57,449
	60 to 74	9,489	6,930	6,602	5,375	596	894	29,886
	75 Plus	5,871	4,256	3,480	2,609	168	409	16,793
	Total	95,189	56,514	50,940	41,928	11,963	8,273	264,807
Male	0 to 19	23,206	14,082	12,445	10,310	3,843	2,223	66,109
	20 to 44	36,045	19,229	17,595	13,698	4,851	3,225	94,643
	45 to 59	18,454	13,013	11,322	9,491	2,741	1,705	56,726
	60 to 74	8,353	6,761	6,625	5,224	722	1,026	28,711
	75 Plus	3,097	2,914	2,662	1,859	120	338	10,990
	Total	89,155	55,999	50,649	40,582	12,277	8,517	257,179
Total	0 to 19	45,522	27,301	24,231	20,052	7,662	4,279	129,047
	20 to 44	74,251	38,478	35,240	28,275	9,775	6,365	192,384
	45 to 59	37,761	25,873	22,749	19,116	5,197	3,479	114,175
	60 to 74	17,842	13,691	13,227	10,599	1,318	1,920	58,597
	75 Plus	8,968	7,170	6,142	4,468	288	747	27,783
	Total	184,344	112,513	101,589	82,510	24,240	16,790	521,986
% Distribution	0 to 19	24.7%	24.3%	23.9%	24.3%	31.6%	25.5%	24.7%
	20 to 44	40.3%	34.2%	34.7%	34.3%	40.3%	37.9%	36.9%
	45 to 59	20.5%	23.0%	22.4%	23.2%	21.4%	20.7%	21.9%
	60 to 74	9.7%	12.2%	13.0%	12.8%	5.4%	11.4%	11.2%
	75 Plus	4.9%	6.4%	6.0%	5.4%	1.2%	4.4%	5.3%

Exhibit 4.3 shows the relationship between age and gender and use of acute care hospital services for Western region residents in 2001/02. Below the age of 60 years old, there are more hospital separations per population for females than males, because of hospital-based obstetrical and gynaecological services. Over the age of 60 years old, males (on average) use more hospital acute care. The steep slope of both the female and male curves between 55 and 85 years old reflects the dramatic increase in use of acute care associated with increased age.

Exhibit 4.3
2001/02 Utilization of Acute Care (IP & SDS)
by Age and Gender, per 10,000 Population – Western Region Residents



The Western region had a dependency ratio (the ratio of the children and elderly population to the working age population) in 2001 of 42.8, higher than the Newfoundland and Labrador provincial average of 40.6.

52.4% of the Western region population is considered to live in an urban centre, the highest percentage of any of the health regions outside St. John's.

12.5% of Western region residents report their self-rated health status as fair or poor, similar results as for the rest of the province.

Rates of asthma (6.0%) and diabetes (5.1%) are below the provincial average.

The average personal income for Western residents in 2000 was $19,981, approximately the same as the average income in the other regions outside St. John's, but almost $7,000 below the St. John's average income. 23.3% of WHCC residents are considered to be low income, a higher percentage than in the other large health regions in the province.

4.1.3 Small Area Variation Analyses

Small area variation analyses are comparisons of rates of utilization of health care services by populations. Health services researchers (notably Dr. Jack Wennberg, with his

comparisons of use of health care services in Boston and New Haven) have used these analyses to help understand the factors that influence use of health care services and to help inform development of health care policy.

Exhibit 4.4 shows the age/gender-standardized rate of use of acute care services (measured as inpatient and SDS separations per 10,000 population) for the residents of each of the Newfoundland and Labrador health regions in 2001/02. Utilization rates are shown for all hospital programs combined and for individual programs. Use of hospital services is attributed to the region where the patient lives, not the region where they were hospitalized. Thus, if a resident of the Western region were hospitalized in St. John's, their utilization would contribute to the Western region utilization rate. Within each program area, the utilization for the region with the highest utilization is shown in bold.

The lowest rate of use of acute care hospital services in Newfoundland and Labrador is 1,713 separations per 10,000 population by the residents of the Eastern health region. The highest rate of use of acute care hospital services in Newfoundland and Labrador is 2,673 separations per 10,000 population by the residents of the Grenfell health region.

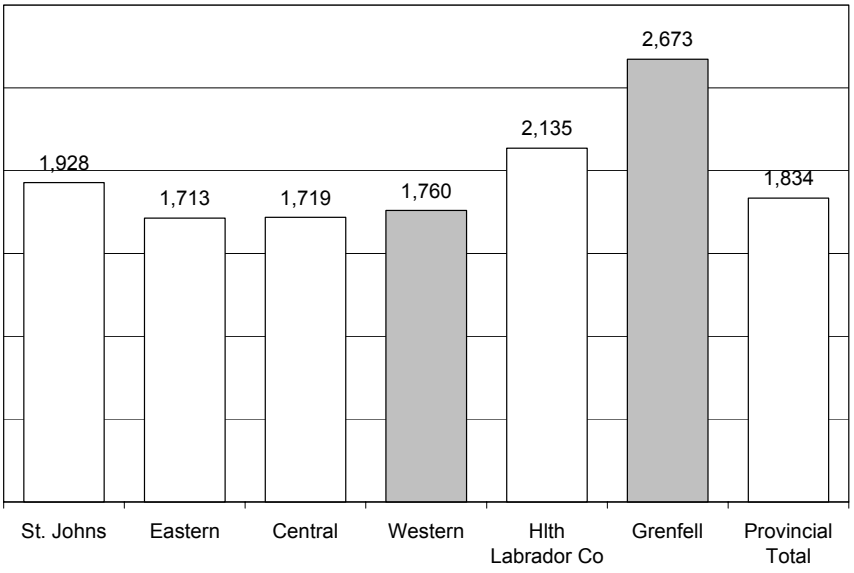
Exhibit 4.4
Age/Gender Standardized Rate of Use of Acute Care
(IP & SDS Separations per 10,000 Population)
by Program by Residents of Health Regions (2001/02)

Program Cluster	St. Johns	Eastern	Central	Western	Hlth Labrador Co	Grenfell	Provincial Total	Western % over Avg
Orthopaedics	80.2	66.0	105.2	87.9	81.5	**139.3**	85.2	3%
Neurology	28.1	31.9	41.1	44.8	51.8	**75.6**	37.0	21%
Neurosurgery	17.6	17.9	**20.8**	10.1	12.5	16.5	16.9	-40%
Rheumatology	4.3	4.1	6.9	5.7	**9.7**	8.7	5.4	5%
Dermatology	10.5	6.3	8.5	11.7	6.9	**13.7**	9.3	26%
Trauma	42.5	37.6	44.6	54.9	77.0	**79.5**	46.8	17%
Urology	173.2	144.8	150.7	87.6	114.5	**178.9**	145.4	-40%
Nephrology	10.8	9.8	10.7	**15.1**	10.7	11.2	11.4	32%
Gynaecology	71.4	95.0	114.7	**159.4**	100.5	150.9	101.5	57%
Obstetrics	119.8	105.6	117.6	140.5	157.8	117.4	120.4	17%
Neonatology	95.2	80.3	83.8	**95.6**	90.6	87.2	89.6	7%
Otolaryngology	87.3	78.7	59.6	59.2	**92.7**	74.7	75.7	-22%
Dental/Oral Surgery	54.8	**66.0**	36.9	38.3	45.7	56.6	50.6	-24%
Cardiology	82.7	115.0	150.5	135.9	162.5	**265.8**	121.8	11%
Cardio/ Thoracic	**41.8**	30.5	27.0	24.9	25.0	31.0	32.2	-23%
Pulmonary	65.9	74.4	84.2	82.7	**140.2**	131.8	78.5	5%
Oncology	**62.1**	50.9	42.8	44.5	52.8	44.2	51.6	-14%
Haematology	17.5	14.4	13.5	12.3	20.6	**21.5**	15.4	-20%
Endocrinology	25.0	21.8	21.7	28.4	39.0	**48.0**	25.2	12%
Psychiatry	82.1	43.2	62.6	**87.2**	76.3	62.0	69.5	25%
Ophthalmology	**72.3**	47.7	58.5	61.6	71.6	52.9	60.7	1%
Gastro/Hepatobiliary	309.2	248.3	148.1	162.8	301.8	**525.7**	243.6	-33%
General Surgery	224.9	199.3	200.0	189.8	210.3	**250.0**	207.1	-8%
General Medicine	74.0	71.6	76.4	80.2	116.6	**148.0**	78.7	2%
Vascular Surgery	16.3	17.4	**19.2**	15.5	16.9	15.9	17.1	-9%
Plastic Surgery	**13.6**	8.2	5.3	6.6	7.9	4.4	9.1	-27%
Rehabilitation	0.1	1.4	0.7	**3.5**	0.0	1.3	1.1	211%
Not Generally Hosp.	44.4	25.0	6.7	12.7	41.4	**57.9**	27.3	-54%
Ungroupable	0.6	0.1	0.2	0.1	0.3	**1.9**	0.4	-66%
Total	1,927.9	1,713.2	1,718.6	1,759.7	2,135.2	**2,672.5**	1,834.5	-4%

Utilization of acute hospitals by the Western region population is 4% below provincial average, third lowest of the six regions.

The overall utilization rates are shown in graph format in Exhibit 4.5.

Exhibit 4.5
2001/02 Age/Gender Standardized Rate of Use of Acute Care
(IP & SDS Separations per 10,000 Population)
by Residents of Health Regions



We obtained 2001/02 acute care utilization rate data from Ontario to compare with the Newfoundland and Labrador utilization rates. Regions served primarily by academic health science centres usually have the lowest utilization rates[30]. This is attributed to the greater availability of primary and community care, and hospital-based ambulatory care, usually found in the urban centres in which academic health science centres are located, and the greater adherence to principles of evidence-based medical utilization in an academic environment. Thus, the Toronto utilization rates were selected to demonstrate the minimum potential utilization in an urban centre.

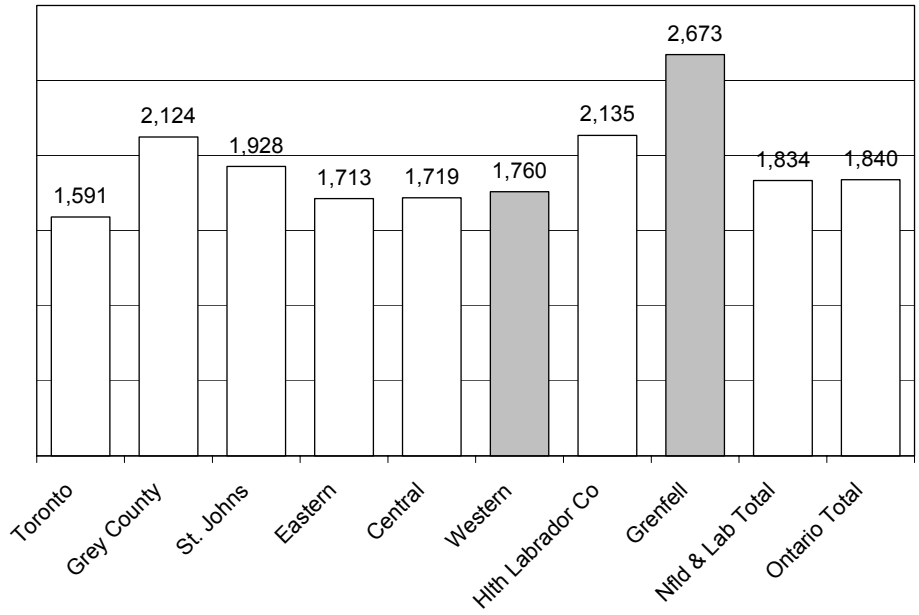
A second Ontario region, the county of Grey, was selected based on its' population (89,000 people) and its' geography (a medium sized community hospital serving a largely rural population). While the population is similar in size to the population of the Western region, it is much larger than the population of the Grenfell region, and the Grey county

[30] The St. John's region is one of the few exceptions in Canada to this pattern. The populations in three other health regions in Newfoundland and Labrador (including the Western health region population) have lower acute care utilization rates than St. John's. This anomaly was previously identified in a review of hospital services provided by the Health Care Corporation of St. John's.

population is much less geographically dispersed than either the Western or Grenfell region populations.

Exhibit 4.6 shows that the overall utilization rate of acute care in Ontario is slightly higher than the overall rate for Newfoundland and Labrador.

Exhibit 4.6
2001/02 Age/Gender Standardized Hospital Utilization per 10,000 Population for Nfld & Lab and Selected Ontario Regions



As expected, the utilization rate for Toronto is lower than that in any of the Newfoundland and Labrador health regions, but the Grey county utilization rate is higher than the utilization rate in all of the Newfoundland and Labrador health regions except Health Labrador Corporation and the Grenfell region.

Exhibit 4.4 (shown previously) showed that the utilization of hospital services by the Western region population was more than 20% above the provincial average for the following programs:

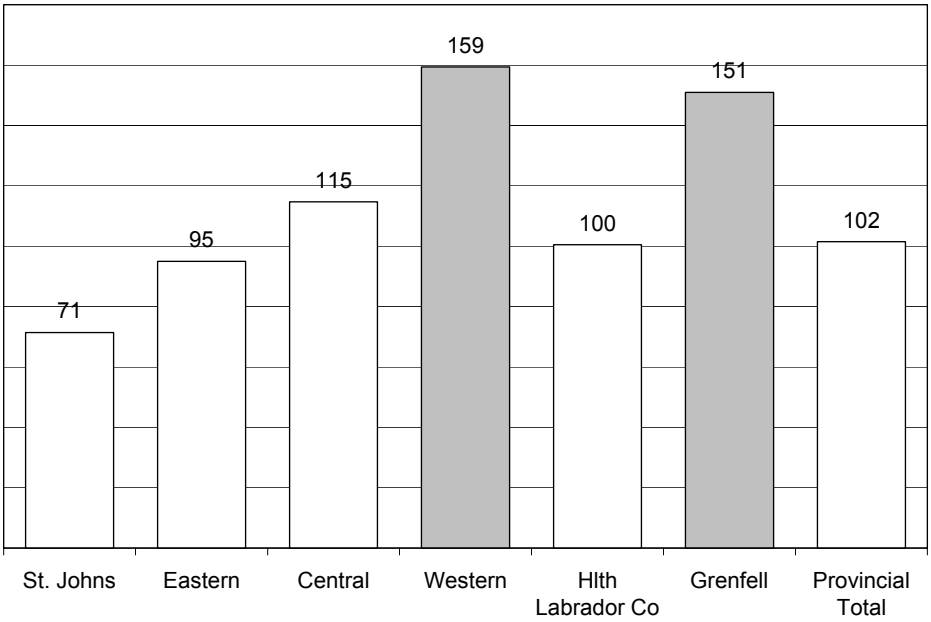
- Neurology (21% above provincial average)
- Dermatology (26% above)
- Nephrology (32% above, highest in province)
- Gynaecology (57% above, highest in province)
- Psychiatry (25% above, highest in province)

Utilization of hospital services by Western region residents was more than 20% below the provincial average for:

- Neurosurgery (40% below, lowest in province)
- Urology (40% below, lowest in province)
- Otolaryngology (22% below, lowest in province)
- Dental/Oral Surgery (24% below)
- Cardio-Thoracic Surgery (23% below, lowest in province)
- Gastro-Hepatobiliary (33% below)
- Plastic Surgery (27% below)

Exhibit 4.7 shows the rates of acute care hospital separations for gynaecology. Utilization by both Grenfell region and Western region residents is 50% above the provincial average and more than double the rate for St. John's residents. The recent CIHI report, "2004 Health Indicators" showed that the rate of surgery for hysterectomy for Western region residents was one of the highest in Canada.

Exhibit 4.7
2001/02 Age/Gender Standardized Hospital Utilization per 10,000 Population – Gynaecology



4.1.4 Analysis of Avoidable Hospitalization Conditions

Health services researchers have identified a set of hospitalization conditions that can be considered to be potentially avoidable, because early and consistent access to good primary care can prevent the condition or can manage

the condition and reduce the severity of impact such that hospitalization is unlikely (or infrequent). The conditions considered to be potentially avoidable hospitalization conditions are:

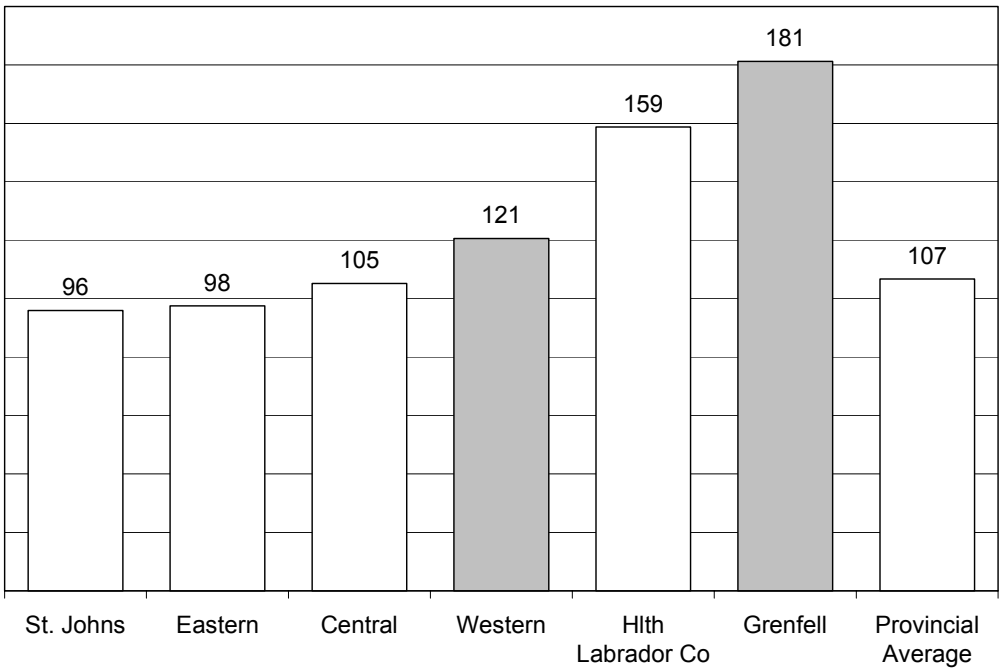
- Pneumonia
- Congestive Heart Failure
- Asthma
- Cellulitis
- Ulcer
- Pyleonephritis
- Diabetes
- Ruptured Appendix
- Hypertension
- Hypokalemia
- Immunizable Conditions
- Gangrene

Rate of avoidable hospitalizations for Western region residents is 20% higher than the rates for St. John's and Eastern region residents.

High rates of admissions for these conditions may signify the need to enhance the primary care system.

Exhibit 4.8 shows the 2001/02 rates of inpatient admission (per 10,000 population) for avoidable hospitalization conditions for the Newfoundland and Labrador health regions.

Exhibit 4.8
Avoidable Hospitalization Condition Inpatient Admissions per 10,000 Age/Gender Standardized Population (2001/02)



The highest rate of admission for potentially avoidable hospitalization conditions is for Grenfell region residents. The Western region rate is 20% higher than the rates for St. John's and Eastern region residents.

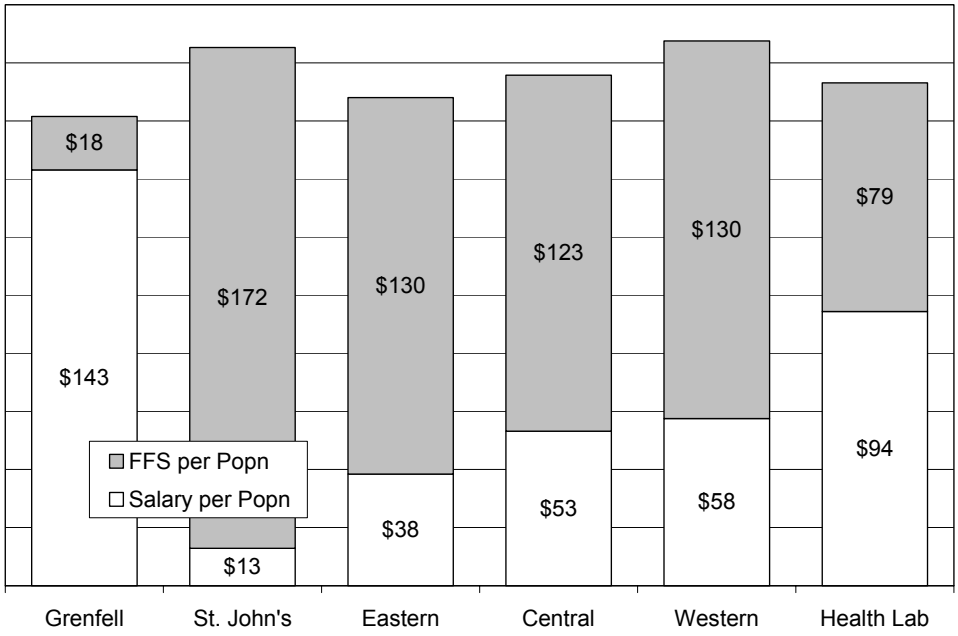
To assess the relative capacity of the primary care system in each region, we obtained physician payment data (both salary and fee-for-service) for primary care physicians located in each health region. The payment data was to be a surrogate for measures of distribution of primary care physician FTEs, since the FTE data was not available. Salary data was available for 2001/02. Fee-for-service data was not available for 2001/02 but the Department of Health provided fee-for-service payment data by health region for 2003/04.

Exhibit 4.9 shows the range of primary care physician payments per population by health region. While the range of per capita primary care physician payments is narrow, the highest per capita payment is in the Western region, and the lowest in Grenfell region.[31] This would suggest, the Western

[31] Because the FFS data is more current than the salary data, it is inflated relative to the salary data. Use of un-inflated 2001/02 FFS data (not available) would further reduce the variation in payments between regions and bring Western closer to the Grenfell payment per population number.

Region has access to and uses primary medical care comparably to other regions in the province.

Exhibit 4.9
Primary Care Physician Payments per Population
(Salary [2001/02] and Fee For Service [2003/04])



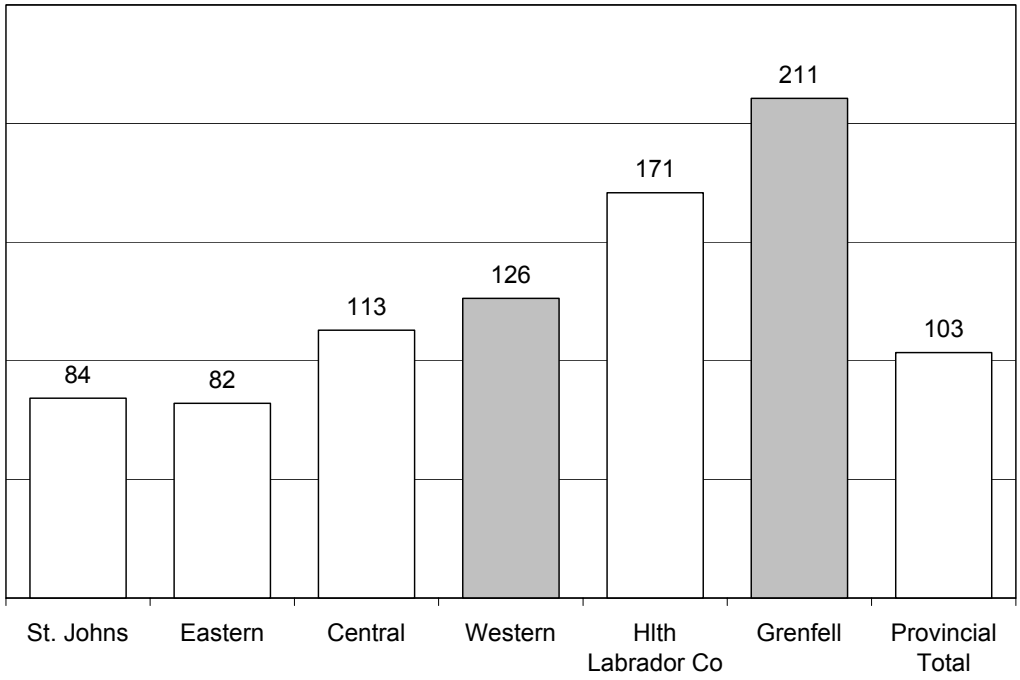
4.1.5 Analysis of 'MNRH' Admissions

CIHI identifies a subset of Case Mix Groups (CMGs) as "May Not Require Hospitalization" (MNRH). These are CMGs where, based on experience across Canada, CIHI's physician advisors have determined that care can usually (but not always) be provided on an ambulatory basis. High MNRH rates may indicate opportunities to expand day care surgery and/or ambulatory clinics.

The rate of MNRH admissions for the population of the Western Region is 20% above the provincial average.

Exhibit 4.10 shows the age/gender-standardized rate of MNRH admissions per 10,000 population for the residents of each Newfoundland and Labrador health region. The Western MNRH rate is the 3rd highest, 20% above the provincial average. Internal WHCC reports show that 10.5% of inpatient cases are considered to be MNRH cases. Interviewees reported, and it was confirmed by concurrent review data and provincial bed studies, that it was not unusual for patients to be admitted solely to access diagnostic services and thereby bypass the ambulatory waiting list.

Exhibit 4.10
MNRH Inpatient Cases per 10,000 Population by Region (2001/02)



4.1.6 Opportunities to Reduce Inpatient/SDS Hospital Use

We believe that it should be possible for the WHCC to reduce admission of avoidable hospitalization condition patients and MNRH patients to the provincial average rate (107 AHC admissions and 103 MNRH admissions per 10,000 population). The availability of primary medical care, measured in terms of payments per population, is highest in the province. The planned provincial primary care renewal initiatives (as will be implemented in Bonne Bay as part of the federally funded pilot projects) should further support reduce reliance on inpatient hospital care.

The impact of reduction of MNRH rates is incorporated later in this report in the identification of opportunities to shift from inpatient to ambulatory care in the clinical efficiency analysis.

If the WHCC rate of admission of potentially avoidable hospitalization conditions was reduced from 126 to 103 admissions per 10,000 population, 116 annual admissions could be avoided at an annual direct cost saving of $337,000.

Exhibit 4.11
Calculation of Potential Direct Savings from Reduction in WHCC Potentially Avoidable Hospitalizations

WHCC AHC Utilization	Acute Care Utilization Rate	Estimated Cases
Current	121	998
Target	107	883
Change	- 14	- 116
Average RIW per Case Saved		1.19
Weighted Case Reduction		- 137
Direct Cost per Weighted Case		$ 2,450
Estimated Direct Savings		-$ 336,781

Both Grenfell and WHCC have utilization rates for gynaecology services (50% higher than in other regions in Newfoundland and Labrador and at least 30% higher than the next highest region). The recent CIHI Health Care in Canada publication reported that the hysterectomy rate in the Western region was 632 cases per 100,000 population, 63% higher than the national average rate. The Medical Advisory Committees in both regions should coordinate reviews of the appropriateness of utilization of acute care gynaecology services and opportunities to change practices through expanded use of standardized protocols. If gynaecology utilization rates were reduced to a rate 25% above the provincial average, there would be a reduction in direct costs for WHCC of $213,000 and a reduction in direct cost for GRHSB of $33,000.

Exhibit 4.12
Calculation of Potential Direct Savings from Reduction in WHCC Gynaecology Utilization

WHCC Gynaecology Utilization	Acute Care Utilization Rate	Estimated Cases
Current	159	1,312
Target	128	1,056
Change	- 31	- 256
Average RIW per Case Saved		0.34
Weighted Case Reduction		- 87
Direct Cost per Weighted Case		$ 2,450
Estimated Direct Savings		-$ 213,066

Recommendations:

It is recommended that:

(74) The WHCC Board should establish a target rate for admission of potentially avoidable hospitalization conditions of 103 admissions per 10,000 population.

(75) The WHCC MAC should coordinate a review of appropriateness of acute care gynaecology services and expand the use of standardized protocols.

4.2 Population Dependence on Regions' Programs

4.2.1 Market Share of Services Used by Populations in Region

90% of all of the acute care inpatient hospitalizations for Western region residents in 2001/02 were provided by hospitals located within the region.

Exhibit 4.13 shows the percent of total acute care inpatient hospitalizations for the residents of the Western health region provided by hospitals located in the Grenfell, Western, or St. John's health regions. The percentages are based on 2001/02 data and are shown by program area for primary, secondary, and tertiary/quaternary hospitalizations.[32]

[32] Inpatient cases have been categorized as primary, secondary, or tertiary/quaternary, using the HayGroup Level of Care methodology. Cases are assigned to a level of care based on their CMG, Plx level, and patient age. The level of care is established based on factors such as average case cost, the number of hospitals that are capable of providing the care, and the distance that patients travel to access the care.

Exhibit 4.13
Percent of Inpatient Hospitalizations of WHCC Residents Provided by Hospitals in Grenfell, Western, and St. John's Regions (2001/02)

Program Cluster	% Cases Treated in Grenfell Region Hospitals				% Cases Treated in Western Region Hospitals				% Cases Treated in St. John's Region Hospitals			
	Prim.	Sec.	Tert./ Quat.	All	Prim.	Sec.	Tert./ Quat.	All	Prim.	Sec.	Tert./ Quat.	All
Cardiology	0%	0%	0%	0%	98%	90%	67%	95%	1%	10%	33%	4%
Obstetrics	0%	1%	0%	1%	97%	91%	0%	95%	2%	8%	0%	3%
General Surgery	2%	1%	1%	1%	94%	90%	73%	90%	3%	9%	26%	8%
Gastro/Hepatobiliary	1%	0%	0%	1%	96%	89%	0%	95%	2%	9%	100%	3%
Neonatology	0%	0%	0%	0%	97%	60%	11%	93%	2%	40%	89%	7%
Pulmonary	0%	0%	0%	0%	98%	98%	100%	98%	1%	2%	0%	1%
Psychiatry	0%	0%	0%	0%	98%	88%	83%	91%	2%	12%	13%	8%
General Medicine	0%	0%	0%	0%	98%	95%	83%	97%	1%	5%	17%	3%
Urology	0%	1%	0%	0%	95%	71%	25%	87%	3%	20%	75%	9%
Orthopaedics	0%	1%	0%	1%	97%	91%	76%	90%	3%	7%	24%	9%
Trauma	2%	0%	0%	0%	94%	89%	63%	88%	2%	9%	27%	9%
Gynaecology	0%	1%	0%	0%	96%	92%	60%	94%	3%	7%	40%	5%
Neurology	2%	0%	0%	1%	93%	93%	67%	93%	4%	7%	17%	6%
Oncology	0%	1%	0%	1%	0%	80%	30%	76%	0%	19%	70%	23%
Otolaryngology	0%	0%	0%	0%	94%	81%	55%	87%	5%	19%	45%	12%
Endocrinology	1%	0%	0%	0%	94%	68%	100%	90%	3%	32%	0%	8%
Cardio/ Thoracic	0%	0%	0%	0%	0%	64%	10%	17%	0%	36%	90%	83%
Vascular Surgery	0%	0%	0%	0%	0%	89%	80%	86%	0%	11%	17%	13%
Nephrology	0%	0%	0%	0%	98%	76%	100%	89%	2%	22%	0%	10%
Haematology	0%	0%	0%	0%	98%	88%	0%	94%	2%	12%	0%	6%
Ophthalmology	0%	0%	0%	0%	100%	66%	33%	65%	0%	34%	67%	34%
Rheumatology	0%	0%	0%	0%	100%	80%	100%	84%	0%	20%	0%	16%
Not Generally Hosp.	0%	0%	0%	0%	0%	71%	0%	71%	0%	29%	0%	29%
Plastic Surgery	0%	0%	0%	0%	0%	73%	25%	67%	0%	27%	75%	31%
Dermatology	0%	0%	0%	0%	0%	87%	100%	88%	0%	13%	0%	13%
Neurosurgery	0%	14%	0%	3%	0%	57%	3%	13%	0%	29%	97%	84%
Rehabilitation	0%	0%	0%	0%	0%	100%	100%	100%	0%	0%	0%	0%
Ungroupable	0%	0%	0%	0%	0%	100%	0%	100%	0%	0%	0%	0%
Dental/Oral Surgery	0%	0%	0%	0%	0%	100%	0%	100%	0%	0%	0%	0%
Grand Total	1%	0%	0%	0%	97%	87%	43%	90%	2%	12%	55%	9%

90% of all of the acute care inpatient hospitalizations for Western region residents in 2001/02 were provided by hospitals located within the region. St. John's hospitals provided a further 9% of the total inpatient hospitalizations of Western region residents. This "market share" varied by level of care:

- 97% of Primary level hospitalizations of Western region residents were provided in WHCC hospitals (2% in St. John's)
- 87% of Secondary level hospitalizations of Western region residents were provided in WHCC hospitals (12% in St. John's)

- 43% of Tertiary/ Quaternary level hospitalizations of Western region residents were provided in WHCC hospitals (55% in St. John's hospitals)

The WHCC hospital market share of inpatient hospitalizations ranged from a low of 13% for neurosurgery and 17% for cardio-thoracic, to more than 95% for pulmonary and general medicine.

4.2.2 Referral of Patients to Centres Outside Region

Exhibit 4.14 shows the number of residents of the Western region who were hospitalized as inpatients in hospitals outside the Western region in 2001/02, by program. The table is sorted by descending volume of patients. The largest numbers of residents leaving the region for inpatient care were cardio/thoracic, general surgery, and oncology patients hospitalized in St. John's hospitals.

Exhibit 4.14
Volume of Western Region Residents Hospitalized as Inpatients in Other Health Regions by Program (2001/02)

Program	Admissions in Other Regions		
	St. John's	Other	Total
Cardio/ Thoracic	179	0	179
General Surgery	77	17	94
Oncology	80	4	84
Urology	44	16	60
Psychiatry	56	3	59
Trauma	40	14	54
Cardiology	46	8	54
Neonatology	48	5	53
Orthopaedics	39	6	45
Obstetrics	34	8	42
Gastro/Hepatobiliary	23	17	40
Otolaryngology	37	1	38
Neurosurgery	32	1	33
Neurology	22	5	27
Endocrinology	19	6	25
Ophthalmology	25	0	25
Gynaecology	21	3	24
General Medicine	17	2	19
Vascular Surgery	16	1	17
Pulmonary	9	5	14
Not Generally Hosp.	13	0	13
Nephrology	12	1	13
Plastic Surgery	13	0	13
Rheumatology	8	0	8
Haematology	6	0	6
Dermatology	5	0	5
Grand Total	921	123	1,044

4.2.3 Use of Services by Patients from Outside Region

In 2001/02 there were 531 non-residents of the Western health region admitted as inpatients in WHCC hospitals. Half (279) of these inpatients were residents of the Grenfell region, 194 were Central region residents, and 58 came from elsewhere.

The highest volume programs for non-residents were cardiology, gastro/hepatobiliary, orthopaedics, and trauma.

Exhibit 4.15
Inpatient Hospitalizations of Non-Residents by Program (2001/02)

Program	Patients from Other Regions			
	Grenfell	Central	Other	Total
Cardiology	49	6	13	68
Gastro/Hepatobiliary	41	7	3	51
Orthopaedics	14	23	6	43
Trauma	15	20	7	42
Obstetrics	8	28	1	37
General Surgery	11	24	0	35
Neonatology	9	24	1	34
General Medicine	17	11	6	34
Pulmonary	20	7	3	30
Psychiatry	21	3	5	29
Urology	21	0	3	24
Gynaecology	10	11	0	21
Otolaryngology	6	13	2	21
Neurology	9	5	2	16
Oncology	2	5	2	9
Endocrinology	4	1	1	6
Vascular Surgery	4	1	0	5
Nephrology	4	0	1	5
Rheumatology	2	3	0	5
Dermatology	3	1	0	4
Ophthalmology	2	1	1	4
Haematology	2	0	1	3
Cardio/ Thoracic	2	0	0	2
Not Generally Hosp.	2	0	0	2
Plastic Surgery	1	0	0	1
Grand Total	279	194	58	531

4.3 Review of Hospital Activity

Exhibit 4.16 shows the 2001/02 inpatient and SDS activity volume for the hospitals within WHCC. The average inpatient length of stay for the hospitals in the region was 7.6 days. 71% of inpatient admissions, 73% of inpatient days, and 60% of SDS cases were provided in Corner Brook. In 2001/02, ALC days were under-reported at 6.6% of total inpatient days.

Exhibit 4.16
Western HCC Hospital Activity in 2001/02[33]

Hospital	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
Western Memorial, Corner Brook	7,357	57,607	7.8	5.3%	2,235
Sir Thomas Roddick Hospital	1,573	11,397	7.2	10.2%	1,196
Charles L. Legrow HC	662	3,932	5.9	7.1%	264
Bonne Bay HC, Norris Point	189	2,201	11.6	20.5%	0
R Guinchard HCC, Port Saunder	401	1,852	4.6	8.2%	0
Calder Health Centre, Burgeo	112	804	7.2	9.5%	0
Grand Total	10,294	77,793	7.6	6.6%	3,695

The 2001/02 activity volume for each of the WHCC hospitals is shown in Exhibits 4.17 through 4.22.

Exhibit 4.17
WHCC Hospital Activity – Western Memorial, Corner Brook (2001/02)

Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
General Surgery	711	7,445	10.5	5.1%	338
Psychiatry	482	6,895	14.3	4.6%	52
Cardiology	699	6,457	9.2	2.8%	1
General Medicine	374	4,319	11.5	11.8%	5
Pulmonary	410	3,703	9.0	7.9%	0
Trauma	389	3,445	8.9	9.1%	24
Gastro/Hepatobiliary	563	3,170	5.6	3.8%	15
Orthopaedics	404	2,829	7.0	4.3%	289
Obstetrics	781	2,784	3.6	0.0%	13
Neurology	250	2,429	9.7	18.1%	0
Oncology	202	2,090	10.3	1.2%	12
Urology	340	2,024	6.0	2.3%	84
Neonatology	571	1,892	3.3	0.3%	0
Vascular Surgery	88	1,826	20.8	7.6%	11
Gynaecology	374	1,746	4.7	0.0%	582
Endocrinology	131	1,173	9.0	0.0%	0
Nephrology	83	1,116	13.4	11.5%	14
Cardio/ Thoracic	38	599	15.8	3.7%	1
Haematology	65	498	7.7	0.0%	0
Otolaryngology	261	414	1.6	0.0%	155
Rheumatology	35	205	5.9	0.0%	0
Plastic Surgery	25	149	6.0	0.0%	5
Dermatology	22	133	6.0	0.0%	8
Neurosurgery	5	88	17.6	0.0%	47
Ophthalmology	31	88	2.8	0.0%	298
Not Generally Hosp.	19	53	2.8	0.0%	1
Rehabilitation	3	30	10.0	0.0%	0
Dental/Oral Surgery	1	7	7.0	0.0%	280
Grand Total	7,357	57,607	7.8	5.3%	2,235

[33] In 2001/02 ambulatory surgery (SDS) cases at Western Memorial were under-reported.

Exhibit 4.18
WHCC Hospital Activity – Sir Thomas Roddick Hospital (2001/02)

Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
General Medicine	148	2,010	13.6	20.2%	1
Cardiology	212	1,803	8.5	14.0%	0
Pulmonary	169	1,472	8.7	5.2%	0
General Surgery	174	791	4.5	0.0%	218
Psychiatry	89	772	8.7	0.4%	0
Gastro/Hepatobiliary	128	745	5.8	0.0%	320
Obstetrics	179	589	3.3	1.2%	1
Neurology	44	517	11.8	30.2%	0
Endocrinology	37	442	11.9	2.3%	1
Oncology	32	401	12.5	7.5%	16
Neonatology	112	359	3.2	3.3%	0
Urology	55	337	6.1	8.9%	49
Rehabilitation	11	267	24.3	9.7%	0
Rheumatology	3	158	52.7	83.5%	0
Gynaecology	47	146	3.1	0.0%	299
Orthopaedics	19	146	7.7	16.4%	11
Trauma	20	105	5.3	0.0%	3
Haematology	17	96	5.6	0.0%	2
Dermatology	6	53	8.8	0.0%	31
Ophthalmology	22	44	2.0	0.0%	164
Nephrology	8	34	4.3	0.0%	0
Otolaryngology	10	33	3.3	0.0%	5
Vascular Surgery	14	32	2.3	0.0%	4
Cardio/ Thoracic	1	16	16.0	0.0%	0
Plastic Surgery	5	13	2.6	0.0%	3
Not Generally Hosp.	10	13	1.3	0.0%	43
Ungroupable	1	3	3.0	0.0%	0
Dental/Oral Surgery	0	0			24
Neurosurgery	0	0			1
Grand Total	1,573	11,397	7.2	10.2%	1,196

Exhibit 4.19
WHCC Hospital Activity – Charles L. LeGrow HC (2001/02)

Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
Cardiology	138	1,013	7.3	1.8%	0
Pulmonary	63	572	9.1	32.5%	0
General Medicine	63	431	6.8	4.4%	0
Gastro/Hepatobiliary	100	319	3.2	0.0%	89
Rehabilitation	13	275	21.2	0.0%	0
Neurology	35	271	7.7	14.0%	0
Endocrinology	25	160	6.4	0.0%	0
Oncology	22	140	6.4	0.0%	2
Psychiatry	29	127	4.4	7.9%	0
Haematology	15	98	6.5	0.0%	0
Obstetrics	39	92	2.4	0.0%	1
Urology	19	89	4.7	0.0%	29
Trauma	17	74	4.4	13.5%	1
Neonatology	23	59	2.6	0.0%	0
Nephrology	11	48	4.4	0.0%	0
Orthopaedics	14	47	3.4	0.0%	8
General Surgery	9	37	4.1	0.0%	78
Otolaryngology	8	21	2.6	0.0%	17
Rheumatology	3	13	4.3	0.0%	0
Vascular Surgery	3	12	4.0	0.0%	1
Gynaecology	7	12	1.7	0.0%	10
Dermatology	2	12	6.0	0.0%	16
Not Generally Hosp.	4	10	2.5	0.0%	7
Ophthalmology	0	0			5
Grand Total	662	3,932	5.9	7.1%	264

Exhibit 4.20
WHCC Hospital Activity – Bonne Bay HC, Norris Point (2001/02)

Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
General Medicine	41	654	16.0	1.4%	0
Cardiology	41	505	12.3	36.4%	0
Psychiatry	9	320	35.6	77.5%	0
Neurology	13	160	12.3	0.0%	0
Pulmonary	23	122	5.3	0.0%	0
Vascular Surgery	2	89	44.5	12.4%	0
Oncology	4	74	18.5	0.0%	0
Gastro/Hepatobiliary	18	57	3.2	0.0%	0
Endocrinology	8	35	4.4	0.0%	0
Orthopaedics	4	33	8.3	0.0%	0
Not Generally Hosp.	1	31	31.0	0.0%	0
Nephrology	3	29	9.7	0.0%	0
Rehabilitation	3	22	7.3	0.0%	0
Dermatology	4	20	5.0	0.0%	0
Rheumatology	3	13	4.3	0.0%	0
Otolaryngology	4	12	3.0	0.0%	0
Trauma	2	10	5.0	0.0%	0
Urology	3	6	2.0	0.0%	0
Obstetrics	2	6	3.0	0.0%	0
Haematology	1	3	3.0	0.0%	0
Grand Total	189	2,201	11.6	20.5%	0

Exhibit 4.21
WHCC Hospital Activity – R. Guinchard HCC, Port Saunders (2001/02)

Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
Cardiology	105	528	5.0	3.4%	0
General Medicine	45	345	7.7	38.8%	0
Pulmonary	56	215	3.8	0.0%	0
Gastro/Hepatobiliary	68	189	2.8	0.0%	0
Psychiatry	31	149	4.8	0.0%	0
Oncology	14	118	8.4	0.0%	0
Neurology	24	91	3.8	0.0%	0
Endocrinology	14	86	6.1	0.0%	0
Orthopaedics	7	41	5.9	0.0%	0
Urology	14	29	2.1	0.0%	0
Rheumatology	4	20	5.0	0.0%	0
Dermatology	4	14	3.5	0.0%	0
Trauma	9	13	1.4	0.0%	0
Otolaryngology	2	5	2.5	0.0%	0
Nephrology	1	4	4.0	0.0%	0
Vascular Surgery	1	2	2.0	0.0%	0
Gynaecology	1	2	2.0	0.0%	0
Neonatology	1	1	1.0	0.0%	0
Grand Total	401	1,852	4.6	8.2%	0

Exhibit 4.22
WHCC Hospital Activity – Calder Health Centre, Burgeo (2001/02)

Program Cluster	IP Cases	IP Days	Avg. LOS	% ALC	SDS Cases
General Medicine	18	247	13.7	8.1%	0
Gastro/Hepatobiliary	19	137	7.2	0.0%	0
Cardiology	22	118	5.4	0.0%	0
Oncology	2	91	45.5	61.5%	0
Pulmonary	10	51	5.1	0.0%	0
Endocrinology	7	43	6.1	0.0%	0
Neurology	10	32	3.2	0.0%	0
Nephrology	4	22	5.5	0.0%	0
Psychiatry	7	19	2.7	0.0%	0
Urology	4	17	4.3	0.0%	0
General Surgery	1	9	9.0	0.0%	0
Not Generally Hosp.	1	4	4.0	0.0%	0
Orthopaedics	2	4	2.0	0.0%	0
Dermatology	1	4	4.0	0.0%	0
Otolaryngology	1	3	3.0	0.0%	0
Haematology	3	3	1.0	0.0%	0
Grand Total	112	804	7.2	9.5%	0

4.3.1 Beds and Occupancy by Site

The majority of the acute care beds, and the greatest challenge with excessive occupancy of medical beds, is at the Western Memorial Regional Hospital in Corner Brook. For 2003/04, the overall occupancy of acute care beds (excluding nursery) by site was:

- WMRH – 96%
- STRH – 84%
- CLLHC – 80%
- BBH – 56%
- RGHC – 68%
- CHC – 57%

Exhibit 4.23 shows the trend for acute care beds (excluding bassinets) and occupancy by service at WMRH. The reported bed numbers are the actual beds available, taking into account seasonal reductions in staffed beds. Overall occupancy in 2003/04 was 93%[34], with medical service occupancy of 126%. The medical service occupancy has been above 115% for each of the past 6 years.

[34] The occupancy excludes 8 ICU beds and 12 ALC beds.

Exhibit 4.23
Western Memorial Hospital Beds and Occupancy by Service[35]

Service	1998/99		1999/00		2000/01		2001/02		2002/03		2003/04	
	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.	Beds	% Occ.
Medicine	52	132%	54	124%	52	124%	60	116%	56	129%	58	126%
Surgery	75	69%	77	66%	66	75%	56	83%	55	80%	54	79%
Obstetrics	19	45%	18	47%	11	63%	11	69%	11	57%	9	68%
Paediatrics	16	67%	16	68%	13	70%	12	79%	12	68%	12	62%
Psychiatry	23	82%	23	72%	21	73%	21	75%	21	82%	21	88%
Palliation	-		-		-		-		9	40%	8	44%
Total (excl. ICU & 12 bed ALC unit)	184	86%	188	82%	163	89%	159	93%	164	92%	162	93%

In 2002/03, surgical service occupancy was 79% and psychiatry service occupancy was 88%.

4.3.2 Level of Care by Site

Exhibit 4.24 shows the distribution of inpatient cases hospitalized in WHCC hospitals by level of care. Over half of WHCC hospital inpatients (60.5%) were primary level patients. Less than t 3% of WHCC hospital inpatients were tertiary/quaternary patients.

Exhibit 4.24
Distribution of WHCC Hospital
Inpatients by Level of Care by Hospital (2001/02)

Hospital	% Distribution of Inpatient Cases by Level of Care		
	Primary	Secondary	Tertiary/ Quaternary
Bonne Bay HC, Norris Point	63.5%	36.5%	0.0%
Calder Health Centre, Burgeo	70.5%	29.5%	0.0%
Charles L. Legrow HC	66.8%	33.1%	0.2%
R Guinchard HCC, Port Saunder	69.8%	30.2%	0.0%
Sir Thomas Roddick Hospital	64.0%	34.8%	1.1%
Western Memorial, Corner Brook	58.5%	38.0%	3.4%
Western Total	60.5%	36.8%	2.6%

Exhibit 4.25 shows similar information expressed in terms of inpatient weighted cases. This shows the approximate allocation of inpatient costs by level of care. 51% of WHCC

[35] Occupancy data from WMRH Occupancy Rate by Service Report, generated June 26, 2003.

inpatient resources were used for secondary patients, 38% for primary patients, and 11% for tertiary/quaternary patients.

Exhibit 4.25
Distribution of WHCC Hospital Inpatient Weighted Cases by Level of Care by Hospital (2001/02)

Hospital	% Distribution of Inpatient RIW Weighted Cases by Level of Care		
	Primary	Secondary	Tertiary/ Quaternary
Western Memorial, Corner Brook	34.8%	51.2%	14.0%
Sir Thomas Roddick Hospital	46.3%	49.6%	4.0%
Charles L. Legrow HC	50.2%	49.0%	0.8%
R Guinchard HCC, Port Saunder	57.6%	42.4%	0.0%
Bonne Bay HC, Norris Point	41.4%	58.6%	0.0%
Calder Health Centre, Burgeo	53.8%	46.2%	0.0%
Western Total	38.1%	50.8%	11.1%

4.3.3 Admission Entry Code by Site

Exhibit 4.26 shows the distribution of inpatient admissions in WHCC hospitals in 2001/02 by source of entry. 39% of the admissions were direct admissions (i.e. admissions from home). One half of the inpatients were admitted via the emergency department.

Exhibit 4.26
Distribution of Inpatient Admissions by Entry Code (2001/02)

Hospital	Entry Code					Total IP Cases
	Direct	ED	From Clinic	From Day Surg	New born	
Bonne Bay HC, Norris Point	48%	43%	8%	0%	0%	189
Calder Health Centre, Burgeo	18%	78%	4%	0%	0%	112
Charles L. Legrow HC	39%	58%	0%	0%	3%	662
R Guinchard HCC, Port Saunder	26%	59%	15%	0%	0%	401
Sir Thomas Roddick Hospital	23%	62%	6%	1%	7%	1,573
Western Memorial, Corner Brook	43%	46%	2%	1%	7%	7,357
Grand Total	39%	50%	3%	1%	7%	10,294

4.3.4 ICU Cases & Days by Site

CIHI inpatient discharge records include identification of hours and days of care spent in a "special care unit" (SCU). SCUs include neonatal intensive care units, ICUs, and CCUs.

Exhibit 4.27 shows the volume of SCU cases and days in 2001/02 for all Newfoundland and Labrador hospitals that reported any SCU activity.

Exhibit 4.27
SCU Activity in Newfoundland and Labrador Hospitals in 2001/02

Hospital	SCU Cases	SCU Days	ALOS in SCU	% of Cases with SCU	% of Days in SCU
Health Sciences Centre, St. John's	2,447	14,766	6.0	11.2%	6.6%
Janeway Child Health Centre, St. John's	410	6,514	15.9	7.8%	24.0%
Western Memorial, Corner Brook	611	3,165	5.2	8.3%	5.5%
James Paton Memorial Hospital, Gander	405	2,964	7.3	11.2%	11.0%
Central Newfoundland Regional Health Centre	536	2,544	4.7	11.3%	7.3%
Carbonear General Hospital	405	1,413	3.5	14.3%	6.2%
Curtis Memorial St. Anthony	424	1,051	2.5	18.2%	7.2%
Dr. G. B. Cross Memorial Hospital, Clarenville	158	668	4.2	12.0%	8.2%
Burin Peninsula Health Care Centre	138	469	3.4	12.1%	6.8%
Sir Thomas Roddick Hospital	183	360	2.0	11.6%	3.2%
Charles L. Legrow HC	84	174	2.1	12.7%	4.4%
Labrador HC, Happy Valley-Goose Bay	55	142	2.6	3.3%	2.2%
Captain Wm Jackman Memorial Hospital	63	141	2.2	8.5%	5.5%
Notre Dame Bay Memorial HC, Twillingate	1	2	1.8	0.2%	0.0%

In the Western region, SCU care was provided at Western Memorial, Sir Thomas Roddick, and Charles LeGrow.

Exhibit 4.28 shows the distribution of SCU days in WHCC hospitals by program area. 40% of all SCU days are for cardiology and 30% of cardiology inpatients have at least one day of stay in an SCU bed. Two thirds of cardio-thoracic patients spend time in SCU and their average SCU stay is 11.9 days (approximately 50% of their total stay).

Exhibit 4.28
Distribution of Western Region SCU Activity by Program (2001/02)

Program	SCU Cases	SCU Days	ALOS in SCU	% of Cases w/ SCU	% of Days in SCU
Cardiology	359	1,478	4.1	29.5%	14.2%
General Surgery	111	616	5.5	12.4%	7.4%
Cardio/ Thoracic	26	310	11.9	66.7%	50.5%
Pulmonary	60	304	5.1	8.2%	5.0%
Vascular Surgery	46	241	5.2	42.6%	12.3%
Trauma	50	200	4.0	11.4%	5.5%
Gastro/Hepatobiliary	34	105	3.1	3.8%	2.3%
Nephrology	21	94	4.5	19.1%	7.5%
Neurology	34	76	2.2	9.0%	2.2%
General Medicine	31	72	2.3	4.5%	0.9%
Oncology	14	43	3.1	5.1%	1.5%
Psychiatry	31	32	1.0	4.8%	0.4%
Gynaecology	5	27	5.5	1.2%	1.4%
Endocrinology	14	26	1.9	6.3%	1.4%
Neonatology	7	17	2.4	1.0%	0.7%
Orthopaedics	11	16	1.4	2.4%	0.5%
Haematology	4	12	2.9	4.0%	1.7%
Urology	7	8	1.2	1.6%	0.3%
Rheumatology	1	6	5.8	2.1%	1.4%
Obstetrics	5	5	0.9	0.5%	0.1%
Dermatology	2	4	2.2	5.1%	1.8%
Plastic Surgery	2	4	2.0	6.7%	2.5%
Rehabilitation	1	2	1.7	3.3%	0.3%
Neurosurgery	1	1	1.2	20.0%	1.4%
Dental/Oral Surgery	0	0		0.0%	0.0%
Otolaryngology	1	0	0.0	0.3%	0.0%
Not Generally Hosp.	0	0		0.0%	0.0%
Ungroupable	0	0		0.0%	0.0%
Ophthalmology	0	0		0.0%	0.0%
Grand Total	878	3,699	4.2	8.5%	4.8%

4.3.5 Discharge Destinations and ALC Days

Combining ALC day data with discharge disposition records can assist in identification of barriers to access of post-acute care. CIHI records require that patients who will be discharged or transferred to a health care facility (or home with home support) have a record of this post-acute care on their acute care discharge abstract. If large volumes of ALC days are recorded for patients discharged to a particular discharge disposition, then this may indicate that either lack of capacity or processing delays are causing patients to be backlogged in acute care. Because ALC status was underreported in 2001/02, the analyses of CIHI data will not identify the absolute volume of discharge delays, but the data

can be used to identify the placement options that are most associated with delays. For fiscal year 2002/03 reported ALC days for WHCC increased to 10.5% of all days, and to 16.3% of all days in 2003/04.

Exhibit 4.29 shows the distribution of Western Region residents who were hospitalized in 2001/02 by discharge disposition and the ALC activity associated with each placement option.

Exhibit 4.29
Distribution of 2001/02 Inpatient Cases for Western Region Residents (Excluding Stillbirths) by Discharge Disposition, with Associated ALC Activity

Discharge Disposition	IP Cases	% of IP Cases	Total IP Days	Avg. LOS	ALC Cases	% ALC Cases	ALC Days	% of All ALC Days	% of Stay as ALC	ALC LOS per ALC Case
Died	401	3.8%	8,104	20.2	14	3.5%	509	9.8%	6.3%	36.4
Home	9,099	85.1%	58,942	6.5	64	0.7%	1,529	29.3%	2.6%	23.9
Home with Support	309	2.9%	4,206	13.6	10	3.2%	99	1.9%	2.4%	9.9
Signed Out	74	0.7%	232	3.1	0	0.0%	0	0.0%	0.0%	
Xfr to LTC facility	212	2.0%	8,103	38.2	63	29.7%	2,953	56.7%	36.4%	46.9
Xfr to Other	24	0.2%	265	11.0	2	8.3%	39	0.7%	14.7%	19.5
Xfr to Other IP facility	573	5.4%	6,564	11.5	6	1.0%	83	1.6%	1.3%	13.8
Grand Total	10,692	100.0%	86,416	8.1	159	1.5%	5,212	100.0%	6.0%	32.8

85.1% of hospitalized Western region residents were discharged home with no documented home support and a further 2.9% were discharged home with home support. 5.4% of hospitalized residents were transferred to another (acute) inpatient facility.

While only 2.0% of inpatients were discharged to long-term care, these patients accounted for 56.7% of all ALC days. Almost 30% of patients discharged to long-term care were designated as ALC in acute care, and these patients waited an average of 47 days in acute care before moving to long-term care.

Less than 1% of the patients discharged home spent any time as ALC, but the patients who were ALC spent more than 3 weeks waiting for discharge, and accounted for 30% of the total ALC days for region residents.

The 5,212 reported ALC days were 6% of total inpatient days and are equivalent to 14.3 beds (at 100% occupancy). Use of acute care beds for patients waiting for placement contributed to high occupancy rates, particularly for medical beds in

Corner Brook. Exhibit 4.30 shows discharge disposition and ALC information for patients discharged from Western Memorial Hospital in 2001/02. Enhanced access to long-term care and home support would reduce ALC levels and reduce occupancy rates to more reasonable levels.

Exhibit 4.30
Distribution of 2001/02 Western Memorial Hospital Inpatient Cases (Excluding Stillbirths) by Discharge Disposition, with Associated ALC Activity

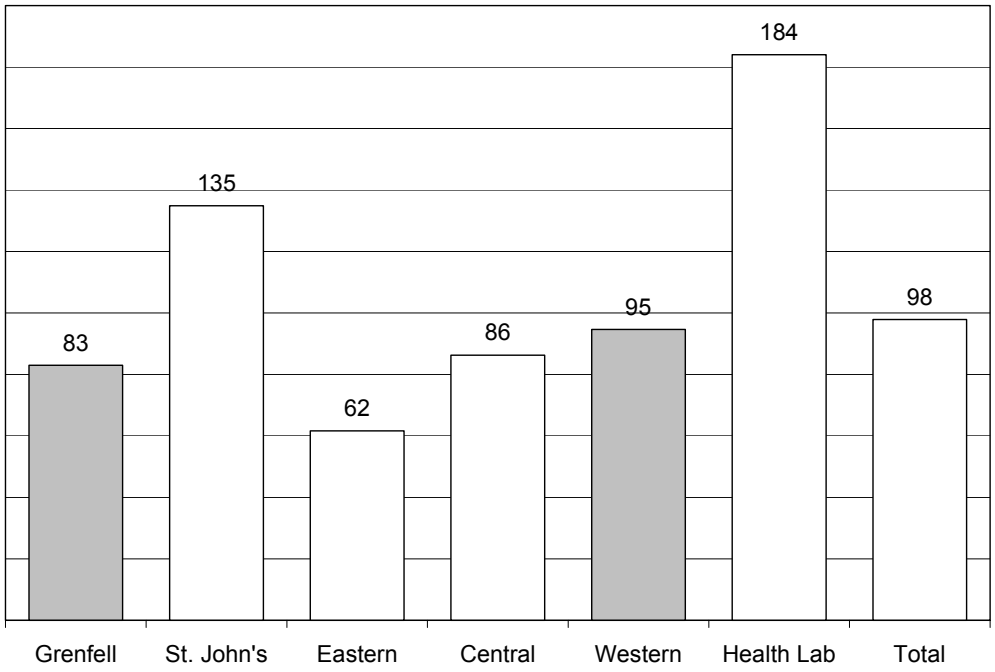
Discharge Disposition	IP Cases	% of IP Cases	Total IP Days	Avg. LOS	ALC Cases	% ALC Cases	ALC Days	% of All ALC Days	% of Stay as ALC	ALC LOS per ALC Case
Died	211	2.9%	4,923	23.3	7	3.3%	270	8.9%	5.5%	38.6
Home	6,399	87.0%	39,415	6.2	30	0.5%	825	27.1%	2.1%	27.5
Home with Support	222	3.0%	3,116	14.0	7	3.2%	84	2.8%	2.7%	12.0
Signed Out	54	0.7%	136	2.5	0	0.0%	0	0.0%	0.0%	
Xfr to LTC facility	147	2.0%	5,662	38.5	39	26.5%	1,797	59.0%	31.7%	46.1
Xfr to Other	19	0.3%	275	14.5	1	5.3%	53	1.7%	19.3%	53.0
Xfr to Other IP facility	305	4.1%	4,080	13.4	3	1.0%	16	0.5%	0.4%	5.3
Grand Total	7,357	100.0%	57,607	7.8	87	1.2%	3,045	100.0%	5.3%	35.0

The Western region is just below the provincial average in LTC beds/1000 population over 75.

Exhibit 4.31 shows the number of long-term care beds per 1,000 population over 75 years old for each health region. Health Labrador Corporation has almost double the provincial average rate of long-term care beds. The Western region is just below the provincial average, and Grenfell is 15% below the provincial average.

The consultants were told that construction of a new (replacement) long-term care facility is planned for WHCC. Given that delays in access to long-term care beds is the greatest cause of ALC days, rapid approval and availability of the new facility will support achievement of the goal of reduced ALC utilization.

Exhibit 4.31
Long-Term Care Beds per Population Over 75 Years Old



4.3.6 Quality of Care

While administrative data collection standards, such as the MIS Guidelines and the CIHI DAD, have been established to support monitoring of utilization and efficiency, there are few widely available and standardized measures of quality of care (particularly outcomes). Some utilization measures that have been previously identified (such as length of stay, mortality rate, and ALC rate) can also be considered measures of quality. The CIHI "Health Indicators, 2004" included some measures of the quality of care provided for Western region residents:

- The in-hospital 30-day stroke mortality rate for WHCC was 18.7%, the lowest in the province.
- The asthma readmission rate was 5.5%, just higher than the provincial average rate of 5.4%.
- The pneumonia readmission rate was 3.8%, the highest in the province.
- The rate of hospitalization for pneumonia and influenza was 1,060 cases per 100,000 population, significantly higher than the national rate of 768 cases.
- The rate of hospitalization for hip fracture was 590 cases per 100,000 population, the highest in the province, but

not significantly different from the national average rate of 554.

- There were 0.7 in-hospital hip fractures per 1,000 population, higher than the provincial rate of 0.5, but lower than the national rate of 0.9.
- The caesarean section rate for WHCC mothers was 26.6%, the same as the provincial average rate, but higher than the national rate of 22.5%.
- Only 12.3% of mothers with a previous caesarean section had a subsequent vaginal delivery, compared with 26.7% nationally.
- The rates of hip and knee replacement for WHCC residents were the highest in the province (49.4 hip replacements and 56.9 knee replacements per 100,000 population), but below the national averages (56.9 hips and 70.5 knees).
- Hysterectomy rates for WHCC residents were the highest in the province (632 per 1,000 population), and among the highest of any communities in the country (the national average was 389).

Bypass surgery rates (135.6 cases per 100,000) were lower than the provincial average (149.4), but 40% above the national average (95.1).

5.0 Clinical Efficiency Analysis

Clinical efficiency analysis refers to the examination of opportunities to reduce use of inpatient days through a shift from inpatient to ambulatory surgery or through reduced length of stay. There are often variations between hospitals (or regions) in use of ambulatory care and variations in lengths of stay for apparently similar patients. Identifying these variations (and sharing the information with clinical staff) is an important step in reducing the variation and reducing the total cost of inpatient care.

Exhibit 5.1 shows the characteristics of inpatient hospital stays for the residents of Newfoundland and Labrador, sorted by their region of residence. Residents of St. John's have the longest average acute care hospital stays (1 day longer than the provincial average). Residents of Grenfell region have the second lowest acute care hospital stays (2 days below the provincial average). The short average LOS for Grenfell residents is partially due to admissions of short stay patients who would either not be treated in a hospital in other regions or would be treated on an ambulatory basis. The average acute care hospital stay for Western region residents is 0.2 days longer than the provincial average.

Exhibit 5.1
Average Length of Stay by Region of Patient Residence (2001/02)

Patient Residence	IP Cases	IP Days	Avg. Total LOS	ALC Days	% ALC	Avg. Acute LOS
Unknown, Out of Province	881	4,744	5.4	27	0.6%	5.4
Grenfell RHSB	3,068	18,129	5.9	184	1.0%	5.8
H&CS - Central	12,707	92,919	7.3	4,541	4.9%	7.0
H&CS - Eastern	11,554	95,074	8.2	6,240	6.6%	7.7
H&CS - St. Johns	18,325	163,044	8.9	11,725	7.2%	8.3
H&CS - Western	10,697	86,421	8.1	5,212	6.0%	7.6
Hlth Labrador Co	3,071	14,616	4.8	200	1.4%	4.7
Grand Total	60,303	474,947	7.9	28,129	5.9%	7.4

5.1.1 Clinical Efficiency Methodology

For the purposes of the best practice review, we have used targets for clinical efficiency based on demonstrated performance of other Canadian hospitals. In addition to the Newfoundland and Labrador CIHI data provided by the NLCHI, CIHI data for hospitals in other provinces, as reported

by peer hospitals to the annual CIHI/HayGroup benchmarking study, has been included.

Targets for use of ambulatory surgery and length of stay were developed for each hospital based on peer hospital performance for individual CMGs, age groups (and, initially, case complexity levels[36]). Targets were only applied where at least one hospital had at least 30 cases in a fiscal year in the CMG/age group category.

5.1.2 Peer Groups

The consultants identified (and the Steering Committee confirmed) groups of comparator hospitals for each hospital included in the study. Peer hospitals were selected based on size, clinical activity and geography from Newfoundland & Labrador peers and from participants in the CIHI/HayGroup annual benchmarking study. The peer groups are shown in the following exhibits:

[36] Initial analyses were based on establishment of targets for individual CMG, patient age, and complexity ("Plx") combinations. Feedback from the project steering committee indicated that the co-morbidity diagnoses that determine CIHI complexity levels are likely under-reported in Western and Grenfell region hospitals. As a result the complexity (Plx) levels were ignored, and targets were established based only on CMG and patient age.

Exhibit 5.2
Western Memorial Hospital Peer Group

Western Memorial	
James Paton Memorial Hospital, Gander	
Central Nfld Regional Health Centre, Grand Falls	
Carbonear General, Carbonear	
Rouge Valley Health Centre	Ajax & Pickering
Fraser Health Region	Burnaby
Grey Bruce Health Services	Owen Sound (Regional)
Guelph General	
Soldiers' Memorial	
Chinook Health Region	Lethbridge Regional
Fraser Health Region	Langley
Fraser Health Region	MSA Hospital
Niagara Health System	Niagara General
Niagara Health System	St. Catharines General
St. Mary's General	
St. Thomas Elgin	
Cambridge Memorial	
Brant CHCS	Brantford General
Miramichi Reg. Hosp.	
Interior Health Authority	Royal Inland
Interior Health Authority	Vernon Jubilee
Interior Health Authority	Penticton Regional

Exhibit 5.3
Roddick Hospital Peer Group

Roddick	
Curtis Memorial	
Dr. GB Cross Memorial	
Burin Peninsula Health Centre	
Lakeridge Health	Port Perry
Lakeridge Health	Bowmanville
Fraser Health Region	Eagle Ridge
Fraser Health Region	Ridge Meadows
Grey Bruce Health Services	Meaford General
South East Regional	Sackville
Northern Lights	
Fraser Health Region	Delta
Niagara Health System	Douglas Memorial
Stanton Territorial H.	
Vancouver Coastal	Powell River
Vancouver Coastal	St. Mary's
Interior Health Authority	Kootenay Boundary
Interior Health Authority	East Kootenay Regional
Interior Health Authority	Shuswap Lake
Interior Health Authority	Kootenay Lake Reg H
Interior Health Authority	South Okanagan Gen H
Interior Health Authority	Boundary

Exhibit 5.4
LeGrow Peer Group

LeGrow HC	
Lakeridge Health	Uxbridge Cottage
Lakeridge Health	Port Perry
Grey Bruce Health Services	Centre Grey General
Grey Bruce Health Services	Meaford General
Grey Bruce Health Services	Saugeen Memoria
South East Regional	Sackville
Chinook Health Region	Taber
Chinook Health Region	Cardston
Chinook Health Region	Crowsnest Pass
Chinook Health Region	Fort Macleod
Chinook Health Region	Border Counties
Chinook Health Region	Pincher Creek
Chinook Health Region	Raymond
Fraser Health Region	Mission
Niagara Health System	Douglas Memorial
Vancouver Coastal	Powell River
Vancouver Coastal	Squamish General
Vancouver Coastal	St. Mary's
Interior Health Authority	Cariboo Memorial
Interior Health Authority	1 Mile House Gen.H
Interior Health Authority	Creston Valley Hospital
Interior Health Authority	Fernie District Hospital
Interior Health Authority	Queen Victoria
Interior Health Authority	Lillooet District H
Interior Health Authority	Arrow Lkes

Exhibit 5.5
Calder, Bonne Bay, Guinchard Peer Group

Calder HC	
Bonne Bay HC	
Guinchard HC	
Dr. Walter Templemen Health Centre	
Fogo Island Hospital	
Connaigre Peninsula Health Centre	
Chinook Health Region	Coaldale
Fraser Health Region	Fraser Canyon
Niagara Health System	Niagara on Lake
Brant CHCS	Willet Hospital
Vancouver Coastal	Bella Coola
Vancouver Coastal	R.W. Large
Interior Health Authority	Golden & District Gen H
Interior Health Authority	Nicola Valley General
Interior Health Authority	Invermere & District H
Interior Health Authority	Princeton General

5.1.3 "Best Quartile" Targets

For each peer group, the "best quartile" target for use of ambulatory surgery and the "best quartile" target for length of

stay was calculated for each possible CMG and patient age combination.

The "best quartile" target for ambulatory surgery in a CMG-patient age cell is the percent use of ambulatory surgery where one quarter of the hospitals (with at least 30 cases) in the peer group had a higher percent use of ambulatory surgery, and three quarters of the hospitals had a lower percent use of ambulatory surgery. The impact of the application of the ambulatory surgery targets is used to simulate the reduction of MNRH admissions (presented previously in section 4.1.5).

The "best quartile" target for length of stay in a CMG-patient age cell is the length of stay (for Typical and Outlier cases, including all ALC days) where one quarter of the hospitals (with at least 30 cases) in the peer group had a shorter LOS and three quarters of the hospitals had a longer LOS.

The "best quartile" targets for length of stay were calculated after application of the "best quartile" targets for ambulatory surgery. A hospital may have a low average LOS for a CMG because patients who would be treated on an ambulatory basis in other hospitals get admitted as inpatients for 1 or 2 days. The inclusion of these very short stay cases reduces the average length of stay, and could cause the hospital to look very efficient (based on average LOS) when in fact they have opportunities to further reduce use of inpatient beds. To avoid this we simulate the achievement of "best quartile" ambulatory performance for each hospital (and remove short stay inpatient cases that could have been treated on an ambulatory basis) before calculating the target length of stay.

For a hospital that has aggressively shifted inpatient surgery to ambulatory surgery, this adjustment will have little impact. However, for a hospital that has not shifted inpatient surgery to ambulatory surgery, the adjustment will remove a large number of 1 or 2 day stay cases, and establish a new, longer, average length of stay that gets used with the assessment of length of stay reduction opportunities.

For some CMG-patient age combinations no hospital exceeded the minimum annual volume requirement of 30 cases, so no target was established. Death, transfer, and sign-out cases (and their associated days) are excluded from the clinical efficiency analysis.

5.1.4 Clinical Efficiency Analysis Results

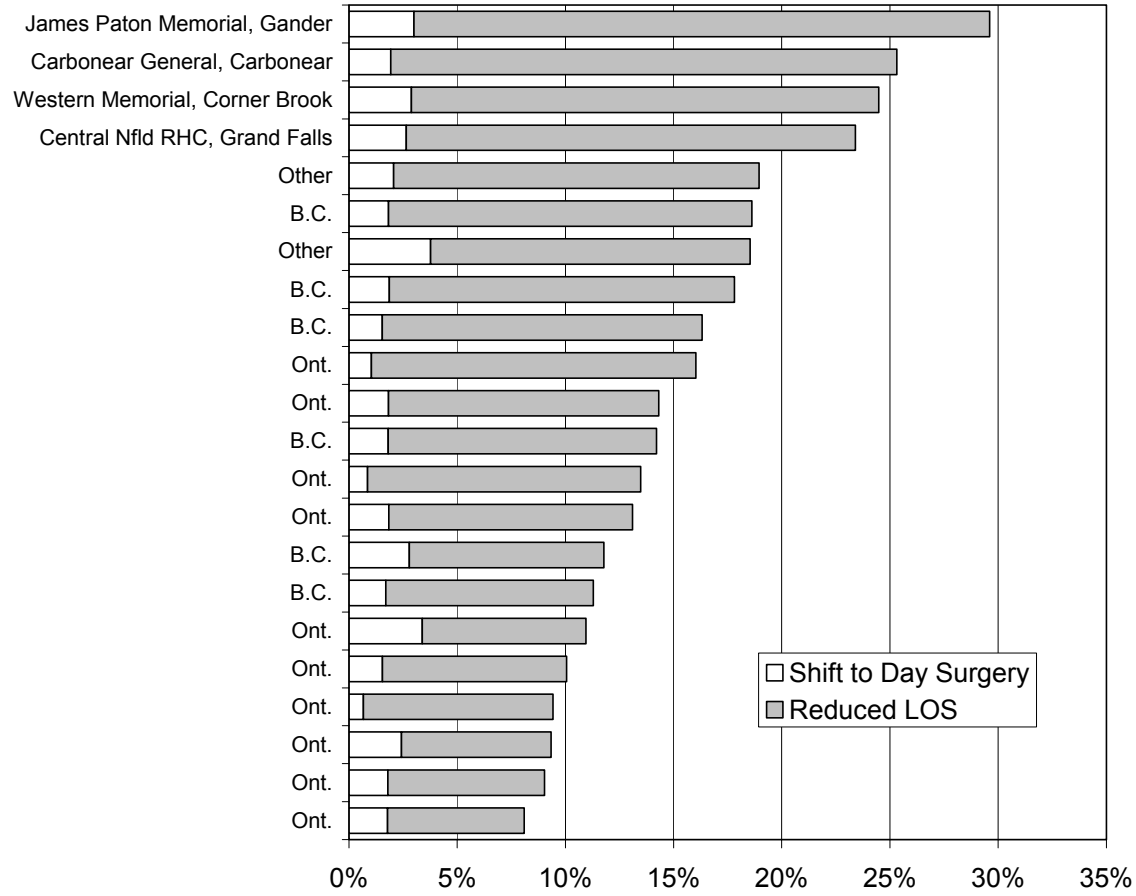
At best quartile performance WMRH would have saved 24.5% of its 2001/02 inpatient days.

The analysis results shown in the following charts show what percent of actual total inpatient days would be saved if each hospital achieved the "best quartile" targets for ambulatory surgery and length of stay for every CMG-patient age combination. The hospitals with the smaller estimated savings opportunities are those whose patterns of practice are already close to the "best quartile" performance levels and who would be considered to be relatively clinically efficient. The hospitals with the larger estimated savings opportunities are those who would be considered to be clinically inefficient. No one hospital is likely to be able to achieve the "best quartile" targets across the board, so even the most efficient hospital will have some further savings opportunities identified through this analysis.

Exhibit 5.6 shows the results of the clinical efficiency analysis for Western Memorial Hospital. The most efficient of the peer hospitals would save 8.1% of total inpatient days at the "best quartile" targets. Western Memorial would save 24.5% of 2001/02 inpatient days.[37]

[37] Opportunities to reduce use of inpatient days are expressed as a percent of the total actual inpatient days at each site in 2001/02, but the opportunities are calculated using targets applied to only typical and outlier cases (i.e., no opportunities are calculated for deaths, transfers, or sign/outs).

Exhibit 5.6
Percent of Current Days Saved at "Best Quartile" Targets for Western Memorial (2001/02)



At best quartile performance STRH would have saved 18.9% of its 2001/02 inpatient days.

Exhibit 5.7 shows the results of the clinical efficiency analysis for Sir Thomas Roddick Hospital. The most efficient of the peer hospitals would save 4.2% of total inpatient days at the "best quartile" targets. Sir Thomas Roddick would save 18.9% of 2001/02 inpatient days.

Exhibit 5.7
Percent of Current Days Saved at "Best Quartile" Targets
for Sir Thomas Roddick Hospital (2001/02)

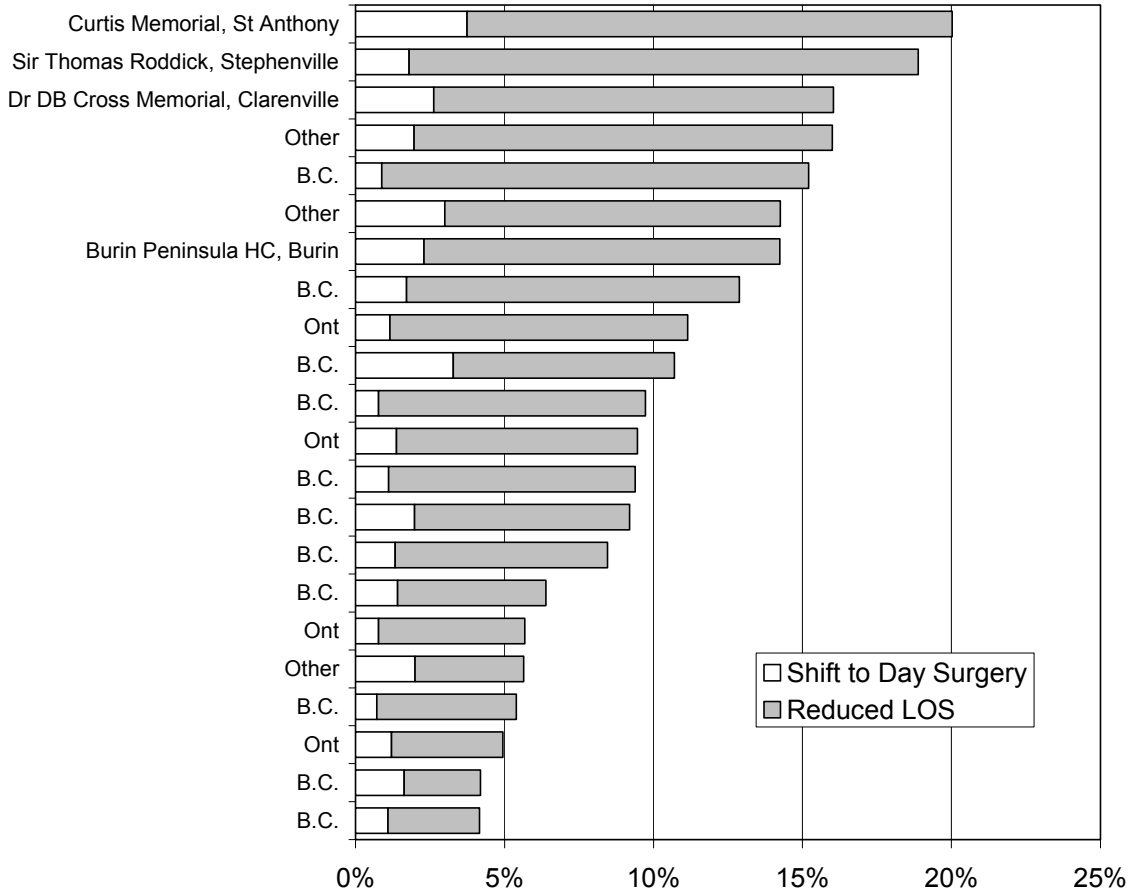


Exhibit 5.8 shows the results of the clinical efficiency analysis for Charles LeGrow Hospital. The most efficient of the peer hospitals would save 3.0% of total inpatient days at the "best quartile" targets. Charles LeGrow would save 11.6% of 2001/02 inpatient days.

Exhibit 5.8
Percent of Current Days Saved at "Best Quartile" Targets for Charles LeGrow (2001/02)

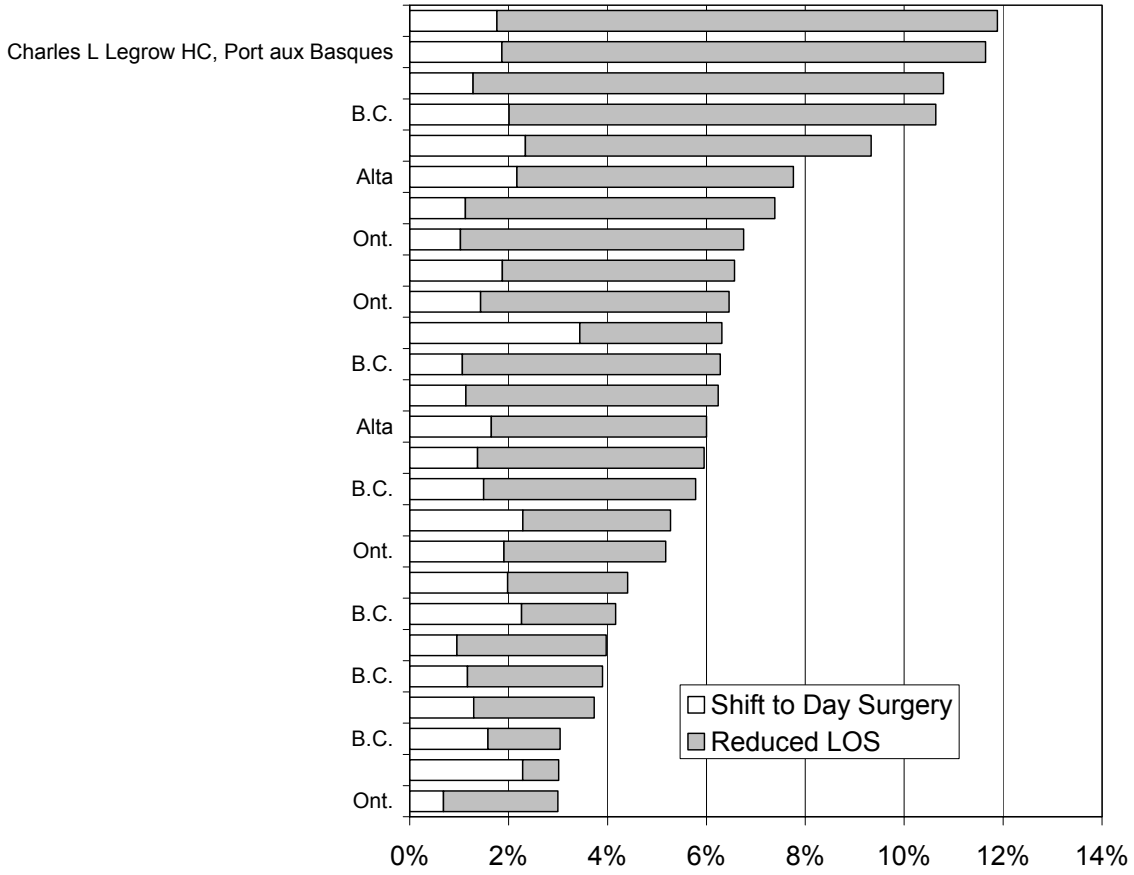
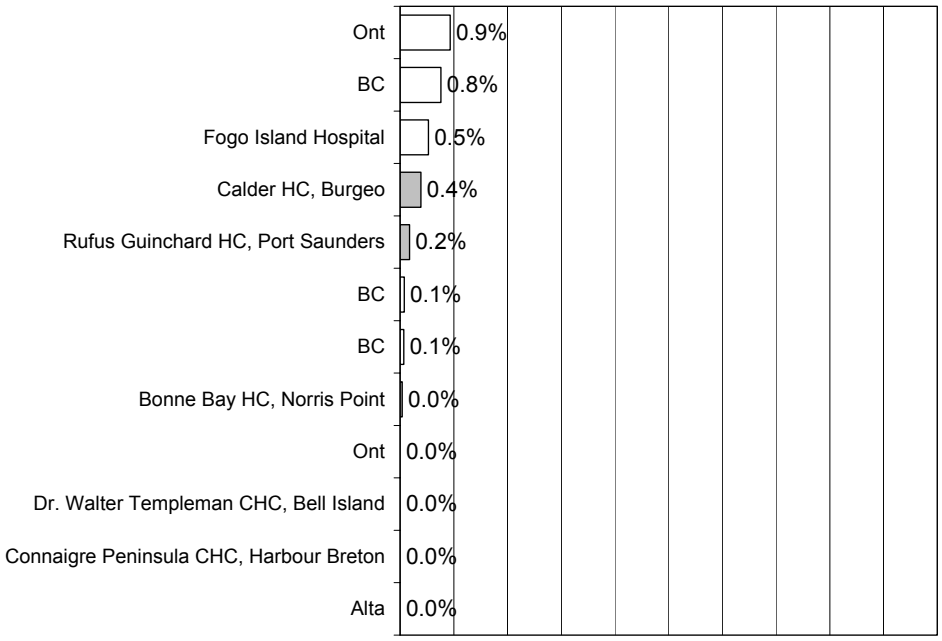


Exhibit 5.9 shows the results of the clinical efficiency analysis for Calder, Rufus Guinchard, and Bonne Bay health centres. The hospitals in this peer group are generally too small to have enough annual cases in the CMG-patient age combinations to exceed the minimum volume requirement to be considered for target setting.[38]

[38] The minimum volume threshold was reduced from 30 to 15 cases in a CMG-patient age cell for this peer group.

Exhibit 5.9
Percent of Current Days Saved at "Best Quartile" Targets for Calder, Rufus Guinchard, and Bonne Bay Health Centres (2001/02)



5.1.5 Inpatient Day Reduction Targets

It is generally not considered feasible to achieve "best quartile" targets across the board. Instead we have assumed that the study hospitals should be able to improve their clinical efficiency to the median level achieved in their peer group. The resulting clinical efficiency targets for each study hospital are:

- Western Memorial Hospital – estimated opportunity at "best quartile" performance was 24.5%. Median opportunity of peer group was 14.3%. If Western Memorial operated at the median performance level of the peer group it could save 10.2% of 2001/02 inpatient days.
- Sir Thomas Roddick Hospital – estimated opportunity at "best quartile" performance was 18.9%. Median opportunity of peer group was 9.6%. If Sir Thomas Roddick operated at the median performance level of the peer group it could save 9.3% of 2001/02 inpatient days.
- Charles LeGrow Hospital – estimated opportunity at "best quartile" performance was 11.6%. Median opportunity of peer group was 6.1%. If Charles LeGrow operated at the median performance level of the peer group it could save 5.5% of 2001/02 inpatient days.

The Clinical Efficiency Target for WMRH is Reduced to Reflect Impact on Non-Reported Ambulatory Surgery Data.

In 2001/02 (the year for which the clinical efficiency analysis data is available) some ambulatory procedures performed at Western Memorial Hospital were not abstracted and reported to CIHI. This means that the actual percent use of ambulatory surgery for some CMGs may be under-represented in the data. To adjust for this missing data we have reduced the magnitude of the overall inpatient day reduction target to 9.1%,[39] reflecting an assumed percent use of ambulatory surgery in 2001/02 at WMRH equal to the median percent use of ambulatory surgery in the peer group.

5.1.6 Ambulatory Surgery Opportunities by CMG

The following tables show the individual CMGs at each hospital that were identified as having the greatest opportunity to reduce inpatient days by shifting inpatient cases to ambulatory procedure. The opportunities for WMRH are based on the reported 2001/02 data. If all ambulatory procedures had been abstracted and reported to CIHI in 2001/02, apparent WMRH opportunities would be reduced. This has been taken into account through reduction of the overall WMRH target for reduction in inpatient days.

[39] The calculated opportunity to reduce use of inpatient days at Western Memorial based on best quartile ambulatory procedure targets was 2.9%. The median opportunity in the peer hospitals from ambulatory procedure targets was 1.8%. To account for the under-reporting of SDS cases at Western Memorial in 2001/02, the overall target was reduced by 1.1% (from 10.2% to 9.1%), the difference between the WMRH 2.9% and the peer 1.8%.

Exhibit 5.10
Top 15 CMGs for Opportunity to Shift Inpatient Cases to Ambulatory Procedures – Western Memorial (2001/02)

Case Mix Group		IP Cases	SDS Cases	% SDS	Cases to SDS	Resulting % SDS	Days to Save
294	Esoph/Gastro/Misc Digest Dis	309	9	2.8%	108	36.9%	204
579	Maj Ut/Adnexal Proc No Malig	233	54	18.8%	66	41.8%	190
93	Tonsill/Adenoidectomy (MNRH)	128	44	25.6%	122	96.2%	122
317	Laparoscopic Cholecystectomy	133	32	19.4%	95	77.2%	120
512	Oth Transureth Proc/Bx(MNRH)	78	0	0.0%	48	61.5%	99
536	Urinary Obstruction (MNRH)	78	0	0.0%	40	51.3%	79
269	Bilateral Hernia Procedures	72	54	42.9%	46	79.5%	69
375	Minor Upper Extremity Proc	40	27	40.3%	33	89.3%	58
581	Gyn Reconstructive Procedures	67	1	1.5%	17	26.5%	43
617	Abortive Outcome With D&C	26	10	27.8%	24	94.0%	38
483	Diabetes	79	0	0.0%	13	16.5%	36
329	Biliary Tract Disease	44	0	0.0%	17	38.6%	34
696	Upper Extremity Fractures	30	4	11.8%	25	85.3%	33
281	G.I. Hemorrhage	55	1	1.8%	14	26.8%	30
271	Unilateral Hernia Proc (MNRH)	27	41	60.3%	21	90.5%	28
297	Other G.I. Diagnoses	39	2	4.9%	15	41.5%	25
All Other CMGS		5,919	1,956	24.8%	301	28.7%	455
Total		7,357	2,235	23.3%	1,004	33.8%	1,663

Exhibit 5.11
Top 15 CMGs for Opportunity to Shift Inpatient Cases to Ambulatory Procedures – Sir Thomas Roddick (2001/02)

Case Mix Group		IP Cases	SDS Cases	% SDS	Cases to SDS	Resulting % SDS	Days to Save
536	Urinary Obstruction (MNRH)	30	3	9.1%	20	69.6%	34
266	Anus & Stomal Proc (MNRH)	19	19	50.0%	17	93.8%	30
317	Laparoscopic Cholecystectomy	49	11	18.3%	27	64.2%	27
893	Vein Ligation & Strip (MNRH)	10	3	23.1%	10	100.0%	15
617	Abortive Outcome With D&C	10	1	9.1%	9	90.4%	13
297	Other G.I. Diagnoses	15	80	84.2%	7	91.1%	13
269	Bilateral Hernia Procedures	10	26	72.2%	6	87.7%	9
529	Lower Urinary Tract Infection	20	0	0.0%	3	15.0%	8
55	Lens Insertion (MNRH)	6	117	95.1%	6	100.0%	8
587	Misc Gyn Procedures (MNRH)	8	217	96.4%	6	99.2%	6
704	Red Blood Cell Disorders	14	2	12.5%	3	29.4%	6
57	Other Ophthalmic Proc (MNRH)	4	23	85.2%	4	100.0%	6
851	Oth Factors Cause Hospitaliz	42	1	2.3%	5	14.0%	5
281	G.I. Hemorrhage	13	5	27.8%	2	40.5%	5
294	Esoph/Gastro/Misc Digest Dis	52	221	81.0%	2	81.7%	4
425	Skin Grf/Wnd Db (Ex Ulc/Cell)	5	3	37.5%	3	80.7%	4
All Other CMGS		1,266	464	26.8%	8	27.3%	12
Total		1,573	1,196	43.2%	137	48.1%	205

For Charles LeGrow, the total estimated opportunity to shift inpatient cases to ambulatory procedure in 2001/02 was 48 cases (based on "best quartile" targets). 28 cases were in CMG 294 Esophagitis/Gastro-Enteritis/Miscellaneous Digestive Disease, 7 in CMG 536 Urinary Obstruction (MRH) and 4 each in CMG 529 Lower Urinary Tract Infection and CMG 586 Tubal Interruption (MNRH).

5.1.7 Total Inpatient Day Reduction Opportunities by CMG

In 2001/02, the WMRH "typical" case length of stay was 21.9% above the CIHI expected LOS for similar patients.

The following tables show the individual CMGs at each hospital that were identified as having the greatest opportunity to reduce inpatient days, primarily by shortening length of stay (based on "best quartile" targets).

In 2001/02, the Western Memorial Regional Hospital "typical" case length of stay was 21.9% above the CIHI expected LOS for the combinations of CMGs, patient age, and patient complexity, of WMRH inpatients. If the proposed reductions in inpatient days (9.1% of total days) were achieved only by reducing the LOS for "typical" patients, the WMRH average LOS for these typical patients would be 101% of the CIHI expected LOS. For internal LOS monitoring and management purposes, WMRH should target to achieve the CIHI ELOS performance level.

Exhibit 5.12
Top 15 CMGs for Opportunity to Reduce Inpatient Days – Western Memorial (2001/02)

CMG #	CMG Name	2001/02 Actual				Impact of Best Quartile Targets					
		IP Cases	IP Days	LOS	SDS Cases	IP Cases	IP Days	LOS	SDS Cases	Days to	% Days to Save
294	Esoph/Gastro/Misc Digest Dis	309	1,623	5.3	9	201	820	4.1	117	803	49.5%
579	Maj Ut/Adnexal Proc No Malig	233	1,067	4.6	54	167	559	3.4	120	508	47.6%
140	Chr Obstructive Pulmonary Dis	59	1,084	18.4	0	59	601	10.2	0	483	44.6%
792	Adjustment Disorders(MNRH)	65	661	10.2	0	65	228	3.5	0	433	65.5%
662	Femur/Pelvis Proc For Trauma	52	955	18.4	0	52	530	10.2	0	425	44.5%
611	Vaginal Delivery	335	1,113	3.3	0	335	692	2.1	0	421	37.8%
213	Uns Angina No Cath/Spec Cond	140	1,436	10.3	0	140	1,028	7.3	0	408	28.4%
483	Diabetes	79	723	9.2	0	66	318	4.8	13	405	56.1%
13	Spec Cerebrovasc Disord(xTIA)	79	1,070	13.5	0	79	712	9.0	0	358	33.5%
648	Neo,Wt>2500G,Normal Newborn	375	1,028	2.7	0	355	709	2.0	20	319	31.0%
766	Depress Mood Dis No ECT/Ax3	80	1,608	20.1	0	80	1,298	16.2	0	310	19.3%
842	Signs & Symptoms	16	441	27.6	0	16	142	8.9	0	299	67.9%
208	AMI No Card Cath No Spec Cond	122	1,223	10.0	0	122	926	7.6	0	297	24.3%
764	Depress Mood Disord With ECT	9	460	51.1	49	9	165	18.3	49	295	64.2%
237	Arrhythmia	80	591	7.4	0	80	305	3.8	0	286	48.4%
Grand Total (All CMGs)		7,357	57,607	7.8	2,235	6,353	43,503	6.8	3,239	14,104	24.5%

In 2001/02, the STRH "typical" case length of stay was 21.9% above the CIHI expected LOS for similar patients.

In 2001/02, the Sir Thomas Roddick Hospital "typical" case length of stay was 21.9% above the CIHI expected LOS for the combinations of CMGs, patient age, and patient complexity, of Sir Thomas Roddick inpatients. If the proposed reductions in inpatient days (9.3% of total days) were achieved only by reducing the LOS for "typical" patients, the Sir Thomas Roddick Hospital average LOS for these typical patients would be 97% of the CIHI expected LOS. For internal LOS monitoring and management purposes, WMRH should target to achieve the CIHI ELOS performance level.

Exhibit 5.13
Top 15 CMGs for Opportunity to Reduce Inpatient Days – Sir Thomas Roddick (2001/02)

CMG #	CMG Name	2001/02 Actual				Impact of Best Quartile Targets					
		IP Cases	IP Days	LOS	SDS Cases	IP Cases	IP Days	LOS	SDS Cases	Days to Save	% Days to Save
222	Heart Failure	42	552	13.1	0	42	319	7.6	0	233	42.1%
14	TIA & Precerebral Occlusions	4	188	47.0	0	4	11	2.7	0	177	94.2%
847	Other Specified Aftercare	53	1,170	22.1	0	53	1,004	19.0	0	166	14.1%
213	Uns Angina No Cath/Spec Cond	34	315	9.3	0	34	152	4.5	0	163	51.6%
143	Simple Pneumonia & Pleurisy	46	441	9.6	0	46	294	6.5	0	147	33.3%
485	Nutrit/Misc Metabolic Disord	12	169	14.1	1	11	49	4.4	2	120	70.9%
142	Chronic Bronchitis	47	426	9.1	0	47	319	6.8	0	107	25.1%
294	Esoph/Gastro/Misc Digest Dis	52	262	5.0	221	50	179	3.6	223	83	31.6%
611	Vaginal Delivery	73	236	3.2	0	73	154	2.1	0	82	34.8%
237	Arrhythmia	41	197	4.8	0	41	117	2.9	0	80	40.5%
483	Diabetes	25	273	10.9	0	25	197	7.9	0	76	27.8%
648	Neo,Wt>2500G,Normal Newborn	77	228	3.0	0	77	156	2.0	0	72	31.4%
242	Chest Pain	18	74	4.1	0	18	29	1.6	0	45	61.4%
317	Laparoscopic Cholecystectomy	49	94	1.9	11	22	52	2.4	38	42	44.4%
792	Adjustment Disorders(MNRH)	17	100	5.9	0	17	62	3.7	0	38	37.6%
Grand Total (All CMGs)		1,573	11,397	7.2	1,196	1,436	9,244	6.4	1,333	2,153	18.9%

In 2001/02, the Charles L LeGrow Hospital "typical" case length of stay was 5.7% above the CIHI expected LOS for the combinations of CMGs, patient age, and patient complexity, of Charles L LeGrow inpatients. If the proposed reductions in inpatient days (5.5% of total days) were achieved only by reducing the LOS for "typical" patients, the Charles L LeGrow Hospital average LOS for these typical patients would be 95% of the CIHI expected LOS. For internal LOS monitoring and management purposes, Charles L LeGrow Hospital should target to achieve the CIHI ELOS performance level.

Exhibit 5.14
Top 15 CMGs for Opportunity to Reduce Inpatient Days – Charles L LeGrow (2001/02)

CMG #	CMG Name	2001/02 Actual				Impact of Best Quartile Targets					
		IP Cases	IP Days	LOS	SDS Cases	IP Cases	IP Days	LOS	SDS Cases	Days to Save	% Days to Save
143	Simple Pneumonia & Pleurisy	22	283	12.9	0	22	111	5.1	0	172	60.6%
294	Esoph/Gastro/Misc Digest Dis	57	149	2.6	48	29	84	2.9	76	65	43.6%
13	Spec Cerebrovasc Disord(xTIA)	22	226	10.3	0	22	179	8.1	0	47	20.7%
483	Diabetes	23	156	6.8	0	23	109	4.8	0	47	29.9%
213	Uns Angina No Cath/Spec Cond	39	217	5.6	0	39	171	4.4	0	46	21.3%
142	Chronic Bronchitis	10	84	8.4	0	10	71	7.1	0	13	15.9%
536	Urinary Obstruction (MNRH)	10	38	3.8	2	3	26	8.7	9	12	31.6%
529	Lower Urinary Tract Infection	7	22	3.1	3	3	13	4.3	7	9	40.9%
813	Drug Reaction	4	12	3.0	0	4	5	1.3	0	7	58.3%
611	Vaginal Delivery	16	39	2.4	0	16	32	2.0	0	7	17.9%
604	Caesarean Delivery	4	20	5.0	0	4	14	3.6	0	6	28.0%
646	Neo,Wt>2500G,Caesarean Delivr	5	21	4.2	0	5	16	3.2	0	5	24.5%
586	Tubal Interruption (MNRH)	4	4	1.0	0	0	0		4	4	100.0%
22	Seizure And Headache	7	20	2.9	0	7	16	2.3	0	4	18.9%
648	Neo,Wt>2500G,Normal Newborn	17	37	2.2	0	17	34	2.0	0	3	8.1%
Grand Total		662	3,932	5.9	264	614	3,474	5.7	312	458	11.6%

5.1.8 Estimated Potential Cost Savings From Clinical Efficiencies

The previously presented analyses show the estimated percent of inpatient days that could be saved through improved clinical efficiency. The targets have been established by applying the "best quartile" targets at the CMG-patient age level to all of the hospitals in a peer group, and then using the median performance level in the peer group to create a target for reduction in use of inpatient days for the study hospitals.

Percent targets for reduction in use of inpatient days do not translate into the same percent targets for reduction in costs. Cost savings estimates will be lower because:

- Not all costs will be reduced when inpatient days are eliminated. Some fixed costs cannot be reduced (particularly in small facilities) or will not change unless entire nursing units can be closed.
- Clinical efficiency savings target elimination of lower cost days at the end of a patient's stay or the shift of minor surgical procedures to SDS (which may eliminate a day or two of inpatient care, but won't impact the surgical costs).

To model the potential cost savings impact of the proposed targets for reduction of inpatient days, we have used the CIHI RIW components to calculate the marginal impact of reduction of days at the end of an inpatient stay. For shifts from inpatient surgery to SDS, we have eliminated the "typical" inpatient RIW and added the corresponding DPG RIW for the procedure.

For length of stay reductions, we assume that the first days saved will be ALC days, and use the CIHI "low severity" per diem RIW to estimate the impact of removal of these days. If the days to save are greater than the reported ALC days, we assume that the savings associated with elimination of these additional days will be based on the CIHI "routine/ancillary" (R/A) per diem weight for the CMG. These estimates are used to calculate a hospital-specific estimated RIW reduction per inpatient day saved and apply an estimated cost saving target per RIW (based on actual direct cost per RIW values from peer hospitals[40]) to generate a direct cost savings figure.

Exhibit 5.15 shows the results of this cost saving analysis for the three Western region hospitals to which clinical efficiency

[40] Data was not available to support the calculation of actual WHCC hospital-specific direct cost per RIW weighted case values.

targets have been applied. While the overall target for reduction of inpatient days is 8.9% of total days, we estimate that the corresponding reduction in direct costs would be only 5.6% of total direct costs or $1.68 million.

Exhibit 5.15
Estimated Direct Cost Savings from Clinical Efficiencies (2001/02)

Region	Hospital	Actual IP Days	Actual Total RIW	% Days to Save @ Tgt	Estimated IP Day Savings	RIW Red'n per Day Saved	Est. Direct Savings per RIW	Direct Cost Savings	% RIW Red'n
Western	Western Memorial	57,607	9,698	9.1%	5,242	0.107	$ 2,450	$ 1,374,252	5.8%
	Sir Thomas Roddick	11,397	1,917	9.3%	1,060	0.095	$ 2,450	$ 246,697	5.3%
	Charles L LeGrow	3,932	648	5.5%	216	0.108	$ 2,450	$ 57,222	3.6%
Total		72,936	12,263	8.9%	6,518	0.105	$ 2,450	$ 1,678,171	5.6%

While the analysis of clinical efficiency savings opportunities has been based on 2001/02 data (the most recent year for which comprehensive provincial data is available), CIHI length of stay performance is available for more recent years. The CIHI length of stay performance is calculated only on the basis of "typical" patients (patients who are not outliers and complete a full course of treatment in the acute care hospital) and excludes reported ALC days, and so is not directly comparable to the LOS performance calculations and targets used in this review. However, it does provide an indication of whether the length of stay performance has improved or deteriorated since 2001/02. Exhibit 5.16 shows the CIHI expected length of stay (ELOS) performance for Western Memorial, Sir Thomas Roddick, and Charles L LeGrow hospitals.

Exhibit 5.16
CIHI Typical Case ELOS Performance
for Largest WHCC Hospitals from 2001/02 to 2003/04 (YTD)

Western Memorial							
Year	Typical Cases	Typical Days	Expected Days	Actual LOS	Expected LOS	Actual - Expected LOS	ELOS Performance
2001/02	5,999	30,026	24,855	5.01	4.14	0.86	120.8%
2002/03	5,487	28,002	21,837	5.10	3.98	1.12	128.2%
2003/04*	4,057	21,638	16,549	5.33	4.08	1.25	130.8%
Sir Thomas Roddick							
Year	Typical Cases	Typical Days	Expected Days	Actual LOS	Expected LOS	Actual - Expected LOS	ELOS Performance
2001/02	1,242	6,184	5,217	4.98	4.20	0.78	118.5%
2002/03	1,059	5,324	4,384	5.03	4.14	0.89	121.4%
2003/04*	777	4,223	3,291	5.44	4.23	1.20	128.3%
Charles L LeGrow							
Year	Typical Cases	Typical Days	Expected Days	Actual LOS	Expected LOS	Actual - Expected LOS	ELOS Performance
2001/02	493	2,218	2,117	4.50	4.29	0.20	104.8%
2002/03	543	2,307	2,474	4.25	4.56	-0.31	93.3%
2003/04*	419	1,915	1,931	4.57	4.61	-0.04	99.2%

* 2003/04 data is for April to December year-to-date.

The WMRH LOS performance has deteriorated by almost 50% from 20.8% above the expected in 2001/02 to 30.8% above the expected in 2003/04.

In 2001/02, WMRH's actual typical LOS was 20.8% above expected. The WMRH LOS performance has deteriorated in subsequent years and was 30.8% above expected in 2003/04. This means that there may now be greater opportunities to reduce use of inpatient days (and to generate clinical efficiency savings) than there were in 2001/02.

The STRH LOS performance has also deteriorated since 2001/02.

The Charles L LeGrow LOS performance has improved since 2001/02, meaning that much of the calculated clinical efficiency savings for this hospital may have already been achieved.

5.1.9 Estimated Timing of Savings

We estimate that 25% of estimated direct cost savings from clinical efficiency opportunities could be achieved in the first year of implementation, 50% in the second year, and the remaining 25% in the third year.

Exhibit 5.17
Estimated Clinical Efficiency Direct Cost Savings by Year

Region	Direct Cost Savings	Year 1	Year 2	Year 3
Western HCC	$ 1,678,148	$ 419,537	$ 839,074	$ 419,537
Total Annual Savings in Year		$ 419,537	$ 1,258,611	$ 1,678,148

Recommendation:

It is recommended that:

(76) The WHCC Board should establish a target for reduction of use of inpatient days based on the results of the clinical efficiency analyses conducted during the Best Practices Review.