A Report To The Honorable Gary Mar
Alberta Minister Of Health and Wellness

Review Of Quality Care and Access To Health Services Within The Chinook Regional Health Authority: Fort Macleod, Pincher Creek and Coaldale

Observations, Issues, and Recommendations

Mr. Jim Saunders
Dr. Donna Radmanovich
March 24, 2003

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Terms Of Reference

In a letter to Mr. Jim Saunders from Mr. Gary Mar, dated February 13, 2003, Mr. Jim Saunders and Dr. Donna Radmanovich were requested to conduct a special review of the Chinook Regional Health Authority to study the provision of quality care and access to health services in Fort Macleod, Pincher Creek, and Coaldale. The scope of the project was to determine a go forward plan that is acceptable to local physicians and community leaders.

Summary of Primary Issues

The Chinook Health Region (CHR) is in the process of implementing their approved 2002/03 Business Plan. The CHR Plan calls for a number of changes including where, what, and how some health services are provided to the residents of Fort Macleod, Pincher Creek, and Coaldale. The CHR is very proud of their Health Plan and is confident that it will result in operating cost reductions, improved quality of care and service, and the continuation of reasonable access to the continuum of health services.

Some members of these communities, some physicians, and some staff do not support these changes. Some believe that the changes are unreasonable reductions in access and quality of health services in their communities. Some also believe that the CHR has a long-term strategy to shut down the hospitals in their communities. Some indicated that they do not trust the CHR. Some members of the communities do not seem to understand and/or accept the CHR vision, and are frustrated with what they believe to be a lack of communication from the CHR, and a lack of opportunity to provide meaningful input to the planning for health services in their communities.
The CHR Plan is very broad and comprehensive. The majority of the Plan seems to be well supported and appears to be quite acceptable to most stakeholders and communities. It is the planning and consultation process leading up to the approval of the CHR Health Plan that seems to be causing most of the tension. The CHR did not feel that they had the

latitude to share their draft plans with the communities prior to the Minister approving their plan. However, it is noteworthy that, even considering these communication and related concerns, it is only select changes, in selected communities that are being challenged at this time.

The CHR is anxious to proceed with their plan. The communities are emotional and are resisting some of the proposed changes. The working relationships are somewhat strained between the communities and the CHR Board and Senior Management at this time. However, the issues are considered to be resolvable.

The core issues relate to a lack of communication and commitment to plan and work together. The CHR and each of the communities visited have contributed in various ways to the breakdown in current relationships.

A successful go-forward strategy and plan will require both the CHR and the community leaders in Fort Macleod, Pincher Creek, and Coaldale to respect the importance and accountabilities of their respective roles. Each group will need to commit to working together in a constructive partnership. Each will have to bury the hatchet, talk through the issues, and find reasonable ways to develop new planning strategies. Once agreement is reached, it will be important that all commitments are honored and that all parties publicly support the decision-making process and all actions resulting from it.

Clearly, the issues contributing to the current relationships have developed over time and each of these stakeholders must be held accountable to some degree for the current status. All parties must also work together to develop strategies to enable mutually beneficial and constructive partnerships between the CHR and all of the communities they serve.

It must be accepted that the CHR does have the authority and the accountability to make the final decisions related the planning and provision of health services in the communities within their region. However, it will serve the best interest of everyone involved if there was an opportunity for the key stakeholders to have meaningful input into the health service planning process prior to the finalization of key service decisions.

Data Collection

The primary sources of information collected were: personal, group and telephone interviews with the Board and Senior Management of the Chinook Health Region (CHR) and community representatives, municipal leaders and physicians from Fort Macleod, Pincher Creek, and Coaldale. In addition, information related to policy, statistics, standards, staffing, quality assurance, and finance were provided by the CHR and Alberta Health and Wellness.

1. The Position of The Chinook Health Region

A non-judgmental interpretation of information provided to the consultants by the Board and Senior Management of CHR.

- The Board and Senior Management are very proud of their Business Plan, their approach to care, and their regional, health-system strategy. They believe their Plan is strategic, efficient, and safe in every respect and that, once implemented, will result in improved health outcomes, improved quality, sustained access, better coordination and integration of services, and improved communication among physicians and multidisciplinary team members.

- The 2002/03 Chinook Health Region (CHR) Business and Health Plan has been approved by the Minister and has since been strongly supported by senior staff in Alberta Health & Wellness, including the previous Deputy Minister of AHW.

- The CHR is facing an operating budget deficit in 2002/03 of $8 – 13 million. The potential for an even larger deficit in 2003/04 is a major challenge if funding is not increased substantially this year. It is essential that CHR find acceptable and realistic strategies to balance their operating budget. The CHR Plan projects a significant reduction in operating costs for the CHR. The Board and Senior Management are firmly committed to their Plan and believe it will enable the CHR to meet both the service and the fiscal expectations of AH&W.

- The CHR has taken an evidence-based approach to the design of their health plan, and to their proposed changes to access, locations of services, acute and continuing care beds, community services, and to their service delivery options. They have studied their utilization experiences throughout their region and have benchmarked their performance against peer providers both within, and outside, of Alberta.

- The CHR believe they have communicated effectively with all of their communities, have involved key stakeholders from the communities in the planning processes leading up to the approval of the 2002/03 Health Plan, and have continued communicating regularly with them throughout this past year.

- They believe that they have negotiated and reached formal agreements with their communities related to the health service changes proposed for their communities. They are disappointed that some of the communities continue to publicly voice concerns and a lack of support for the service changes.

- The CHR does not support changing their Health Plan in any discernable way. They are very concerned that any add-on, or reinstatement, of any service change or bed allocation they have forecast in their current Health Plan will result in an immediate demand by their other communities to reinstate any and all health services and beds which may have been changed in the recent past, or are currently proposed for change in the future.

2. The Position of The Fort Macleod, Pincher Creek and Coaldale Communities

A non-judgmental interpretation of information provided to the consultants by community representatives.

- Representatives interviewed in each community expressed a general lack of support for some parts of the CHR Health Plan. In turn, many of those interviewed expressed a lack of support for, and trust in, the CHR Board and Senior Management.

- Representatives from all three communities indicated that they did not understand the CHR Health Plan, how it was developed, who was involved in developing it, or the rationale and reasons for the proposed changes to the beds and services in their communities. They see the rural communities as victims of the CHR health care change strategy.

- They do not feel that they were invited to participate in any meaningful ways in the development of the CHR Health Plan. They agree that the CHR did tell them about their plans, but only after the plans had been finalized. They do not feel they were invited to participate in the evaluation of alternative strategies that could be considered which would both safeguard their communities as well as meet the obligations of the CHR. They regard the CHR communication as notices of top-down decisions, and not as community consultation.

- The community representatives do not understand the definitions used by the CHR to describe the different levels of inpatient hospital and continuing care. CHR terms such as: observation beds, swing beds, community support beds, enhanced lodge beds, designated assisted living beds, and continuing care beds are confusing to the community. They do not understand the differences in staffing and are not convinced that the new types of beds and services being proposed in their communities will meet their needs safely.

- In general, the community representatives do not seem to understand how the health system links together, and how the CHR is able to assure reasonable access to a comprehensive safety net of regional health services across the continuum of care.

- Many representatives indicated that they do not understand why the health services are changing, or what is happening to the money that is saved as a result of what they consider to be service reductions. They believe that the CHR is proceeding with a centralist strategy favoring the Lethbridge Regional Hospital by moving most hospital services into Lethbridge, and forcing the rural population to travel unreasonable distances to access health services.

- They are concerned that the Regional Hospital is already overcapacity. Waiting times in emergency and for diagnostic tests and elective surgery are felt to be too long now. They are concerned that the regional hospital will not be able to cope

with the increase in volumes brought about by the service changes in the rural communities. Further, they do not understand why more services, vs. less, could not be done in the rural hospitals. They believe that the rural hospitals could relieve the workload on the regional hospital, and could do it less expensively. They cite Calgary as an RHA who they believe supports a rural health strategy.

- Some representatives expressed the suspicion that the CHR strategy is to continue to downgrade the health services in their communities and to eventually close their hospitals completely. They quote comments going back as far as 1994 that were made by board members and management staff in various settings that, in their perception, confirms the CHR goal to close the rural hospitals.

- In general, the communities seem to fear the long-term impact of what they consider to be reductions in access to health services in their communities and the resulting impact on their community infrastructure. They fear that deterioration in locally available health services will weaken their local economies and create job loss and problems with retention and recruitment of physicians and health care staff in their communities.

3. Summary of Proposed Changes Included in the CHR Health Plan To Coaldale, Fort Macleod, and Pincher Creek

This section will summarize the current and proposed health services in each of the communities. The shaded areas represent proposed service changes.

3.1 Coaldale

Service Comparisons[1]

	Current	Projected
Hospital beds:		
Acute care beds	0	0
Swing beds	7	0
Surgery	0	0
Maternity	0	0
Emergency/Urgent[2]	ER	UT
Lab/x-ray	24 hours	daytime M-F[3]
Continuing care:		
• Traditional nursing home	44	41
• Designated assisted living (DAL)	0	0
• Enhanced lodge (EL)	20	20
• Community support beds (CSB)	0	3[4]

Five general practitioners/family physicians practice in Coaldale, four have admitting privileges in the Lethbridge Regional Hospital (the physician without privileges does not have them by choice).

Inpatient Statistics for 2001-2002

- 202 admissions - 201 adult, 1 paediatric
- 71.8 % of patients were 65 years of age and older
- Average length of stay was 10.8 days

[1] Shaded areas represent service changes.
[2] Urgent treatment is provision of urgent physician care service to address urgent, but not emergency or critical care needs (i.e., after hours basic care)
[3] The RHA has allocated specific funding for lab and x-ray. This will support daytime lab and x-ray, and possibly some on call..
[4] Community support beds are available for stays of up to 2 months to provide respite, convalescence, palliation or infirmary. They are for patients who require more support than can be provided at home but less than is required in acute care or traditional nursing homes although for infirmary care the patient must be in a facility that has 24 hour RN service.

- Top diagnostic groups (accounting for 36.6% of admissions): malignant neoplasms, bronchitis, pneumonia, other abdomen/pelvis symptoms, pancreatic disease, gastrointestinal hemorrhage, general symptoms and fractures.

Impact on Quality of Care In Coaldale

The changes being proposed should not lead to any reduction in the quality of care that can be provided to the residents of Coaldale and surrounding area.

Emergency and inpatient services are located approximately 12 minutes away at the Lethbridge Regional Hospital, a facility with specialty support and advanced diagnostic services. Some of those patients who now use swing beds may be able to be cared for in the community support beds.

3.2 Fort Macleod

Service Comparisons

	Current	Projected
Hospitals beds:		
• Acute care beds	12	5 observation[5]
• Swing beds	0	0
• Surgery	yes	0
• Maternity	yes[6]	0
Emergency/Urgent	ER	ER
Lab/X-ray	24 hr	24 hr
Continuing care:		
• Traditional nursing home	50	50
• DAL	0	0
• EL	0	0
• CSB	0	3
Renal dialysis	yes	yes
Special Development Unit	25 Persons with developmental disabilities	

Physician Services

- Enhanced primary care: The Walker Clinic and the CHR are negotiating a joint venture that would see co-location of the physicians, 24 hour emergency, lab and x-ray, rehabilitation services, home care, community mental health, public health and renal dialysis at the Health Centre. The physicians have received funding

[5] Observation beds are located on stretchers in the emergency department and will provide care to patients who require hospitalization of less than 48 hours.

[6] 35 deliveries in 2001-02

from POSP for implementation of electronic medical records and have also requested funding from the MSDIF for 2 advanced practice nurses.

- Fort Macleod has/will lose 3 physicians this year leaving two in the community. One physician cited closure of hospital beds as the reason for his departure. Personal/family circumstances are believed to have had a greater role in the decision of the other two physicians to leave. Physician recruitment is underway and prospects look very favorable to replace these physicians.

Inpatient Statistics for 2001-2002

- 609 admissions
- Inpatient occupancy 88.7%
- 43.7% of patients were 65 years of age and older
- Average length of stay 6.4 days
- Top diagnostic groups for adults (accounting for 32.1% of adult admissions): Encounter for other and unspecified procedures and aftercare, heart failure, pneumonia, other abdomen/pelvis, diabetes mellitus, respiratory system and other chest symptoms, bronchitis, acute MI, cellulites.
- 25 procedures: 3 tonsillectomies, 1 peritonsillar incision and drainage, 1 varicose vein ligation and stripping, 6 appendectomies, 2 hemorrhoidectomies, 10 hernia repairs, and 2 tubal ligations.
- 31 paediatric admissions - top diagnostic groups: acute upper respiratory tract infection (5), pneumonia (5), acute laryngitis/tracheitis (4) fluid and electrolyte imbalance (2), asthma (2) and other respiratory system diseases (2). The average length of stay was 1.7 days.

Impact on Quality of Care In Fort Macleod

It is unlikely that the proposed service changes will affect the quality of care provided in Fort Macleod. On the one hand, co-location of the health providers, multi-disciplinary teams, electronic medical records and other changes being proposed to primary care should result in improved care. Maintenance of 24-hour emergency services and the availability of acute inpatient beds in Claresholm (21 minutes) Pincher Creek (31 minutes) and Lethbridge (30 minutes) should prevent any deterioration in the quality of care.

On the other hand, use of stretchers as observation beds and potential problems in physician recruitment could have a negative impact on quality of care. Use of stretchers in the emergency room as observation beds can decrease privacy and patient comfort. Inability to provide significant inpatient care, perform minor procedures and deliver pregnant women, could adversely affect physician recruitment to Fort Macleod. Although community leaders believe this is likely, experts within the Region believe the advantages gained from the changes to community primary care will exceed the disadvantages of primary care physicians being unable to practice their full scope of practice within Fort Macleod.

3.3 Pincher Creek

Service Comparisons

	Current	Projected
Hospitals beds:		
• Acute care beds	16	16
• Swing beds	0	0
• Surgery	yes	yes
• Maternity	yes[7]	yes
Emergency/Urgent	ER	ER
Lab/x-ray	24 hr.	24 hr
Continuing care:		
• Traditional nursing home	31	3
• DAL	0	50
• EL	0	0
• CSB	0	5

Physician Services:

- There is a 10 physician general practice/family medicine group practice in Pincher Creek; some of the physicians have extra training and expertise in "specialized areas. The group have submitted a number of proposals for primary care reform – to the Capacity Building Fund, the Medical Services Delivery Innovation Fund and the federal government aboriginal funding envelope. These proposals support multi-disciplinary, team-based, disease management approaches in primary care.
- The physicians are also working with the CHR to develop an APP and a community Health Center.

Changes to Long Term Care

The CHR's model for continuing care is premised on a "Wellness/Independence" model of care. It is based on an extensive review of the types of care required by seniors and consists of 20% continuing care facility beds, 40% designated assisted living beds and 40% enhanced lodge beds ("20-40-40). Prior to adopting this approach the CHR visited assisted living facilities in Calgary, Edmonton and Morinville.

In October 2002 twenty-eight of the 31 long term care beds in the Pincher Creek facility were closed and a 50 bed designated living (DAL) facility, Vista Village, opened.

[7] 83 deliveries in 2001-02

DAL clients

Clients are:

- 18 years of age or older
- have complex medical needs but are medically stable and do not require 24 hour onsite RN services
- may require injection or PRN meds
- may have mild to moderate dementia but pose minimal risk of elopement and are not harmful to themselves or others
- may have unmanaged incontinence and require complete feeding, mechanical lifts

Vista Village staffing model:

	Days	Evenings	Nights
RN	1 @7.75 hours	1 @ 4 hours plus on call	On call
LPN	1	1	1
PCA	3 @12 hours 1 @ 7.75 hours 1 @ 6 hours	1@ 7.75 hours 1 @ 4 hours	3 @ 12 hours

- The CHR staffing standard for Continuing Care is 3.2 paid hours per resident day.
- The staffing in the Pincher Creek facility was 3.93 paid hours per resident day (higher because of the loss of economies of scale from operating two small separate units)
- The direct care staffing in Vista Village is 3.198 hours per resident day
- In addition to the nursing and personal care staff, Vista Village has the following staff who regularly assist with portering and meals:
    - 1 FTE therapy aide
    - 1 clerk
    - 1 manager
- Many of the DAL staff were previously employed in the hospital long term care unit.
- The CHR has the potential to add staff if required

No patients have been admitted to the three remaining facility beds; there are 4 empty beds in the DAL, and no Pincher Creek residents on the wait list for continuing care. To date, there have been no admissions to the community support beds.

Transition

Multi-disciplinary assessments of all patients were done prior to patient transfer to the DAL. Planning for the move began in June 2002; the move occurred over a 2 week period in October 2002. Although the Pincher Creek long term care facility patients included 11 Fs and 3Gs, only one resident was assessed as possibly inappropriate for

DAL. This person was transferred to the Geriatric Assessment Rehabilitation Unit, redesignated palliative and subsequently died in that unit.

The transfer to DAL was not without problems. There were issues with pharmaceuticals (felt to have been in large measure related to the contract for pharmacy services), inadequate numbers of staffing, security, and cleanliness. These concerns appear to have been addressed. Residents are settling in, additional staff have been hired, pharmacy services have been improved and Pincher Creek physicians are satisfied with the level of care that is being provided to their patients.

Quality Assurance and Evaluation

Quality assurance and evaluation activities include but are not limited to:

- The Good Samaritan Society (GSS) regularly measures and monitors quality and risk indicators (e.g., patient satisfaction, complaints, medication errors, infection and adverse events)

- The CHR service agreement with GSS requires Quarterly Monitoring reports

- The CHR will also use quality indicator reports generated from MDS-H.C. Although access to these reports is currently limited, the RHA plans to have these available electronically by November 2003. See attachment 1

- A "Vista Village Review Project" has been initiated. This includes review an analysis of:

    - MDS-H.C. quality Indicator reports from … assessments completed on each Continuing Care client prior to the move to … DAL, 3 months post move and 6 months post move

    - Physician visits, hospital visits, adverse events, deaths and other data

- The CHR is working with Drs. Stephen Lewis and Colleen Maxwell on a two year research project that will evaluate the care and patient outcomes in the various CHR living options.

- Client drug use is currently reviewed annually and as needed by the RN case manager, in consultation with the community pharmacist and physician. In 2003 – 2004 the CHR will explore the merits of implementing a Structured Medication Review process that integrates peer support, community pharmacists, case managers and physicians.

Impact on Quality of Care In Pincher Creek

Experts within the Seniors' Health Program, senior CHR clinical leaders and the Pincher Creek physicians are solid supporters of the assisted living concept and express the belief that substitution of DAL beds for facility beds will improve the quality of life for seniors who can no longer be cared for at home but do not require 24 hour nursing care.

All those interviewed referred to the difficult transition but see that time as "growing pains" which have largely abated. In the words of a Pincher Creek physician with patients in Vista Village, "Patients are doing remarkably well, better than in the facility." There is anecdotal evidence as well that several residents, particularly those with dementia, have experienced marked improvement in their functional status.

The ability of DAL placement to meet the needs of patients with high personal care needs (e.g., those in whom skin integrity is an issue) has been questioned by non-CHR interviewees, however, CHR clinical leaders believe care to these patients will not be compromised.

In summary, in the opinion of these reviewers, there is potential for the quality of seniors' care to improve as a result of this initiative. However, because of the novelty of the approach, lack of provincial standards for supportive living, community concern and the information that can be learned and applied to other regions, we recommend that the substitution of facility beds with DAL beds be monitored to assess the impacts on quality of care and health outcomes. The GSS and the CHR have a number of initiatives already in place to do this. AHW should work with the region to ensure the evaluation plan meets provincial as well as regional needs.

4. Evaluation of The Impact on Quality of Care Resulting From the 2002/03 CHR Business and Health Plan

Dr. Radmanovich assessed the impact on the quality of care resulting from the changes to the Community Health Center concept in the CHR rural communities. She reviewed the proposed delivery models, access standards, admission criteria, multidisciplinary staffing levels, physician support, DAL quality assurance plans, and the transition process that accompanied the transfer of Pincher Creek patients from the long term care facility to designated assisted living.

Dr. Radmanovich concluded that there is no evidence to indicate that the quality of care for the populations currently served in Fort Macleod, Pincher Creek, or Coaldale will be adversely compromised by the proposed CHR changes. Dr. Radmanovich stresses that it is essential that there be an ongoing monitoring of standards, quality, impact on patients and families, and the access to physicians, staff, facilities and medical technology.

National and international quality benchmarks must continue to be monitored.

This analysis indicates that the CHR Health Plan does not pose a threat of reducing the quality of care for the residents of the CHR communities. Nor is there any indication that the plan would reduce the quality of care or service below acceptable Alberta, national or international standards.

However fairly or unfairly the findings may seem, the expectations of the community related to how they define quality of care must also be taken into consideration when evaluating the success of any Alberta regional health authority. Consumer satisfaction and confidence are important factors to be seriously considered in both the evaluation of quality of care, and quality of health services. At this time, the consumers in the communities where the health services were reviewed believe that the CHR Health Plan will negatively impact their quality of care and/or service. It is in this area where both the threats and the opportunities are apparent for the development of a new and positive working relationship between the CHR and the communities. The CHR will need to market their Health Plan. A balance between the CHR definition of quality of care and service, and the consumer's definition, is required.

5. Evaluation of the Functionality of the CHR 2002/03 Business and Health Plan

Note of qualification: The consultants did not review the 2002/03 Health Plan in great detail and are not in a position to substantively evaluate, or comment on, the service or financial projections made in it. The comments noted in this section relate to the perceived functionality and viability of the Plan in the opinion of the consultants.

- The consultants consider the CHR 2002/03 Health Plan to be creative, innovative, and progressive. The Plan is based on well-researched operating strategies and demonstrates an understanding and commitment to a health system approach for the delivery of regional health care programs and services.

- The coordinated regional network of multidisciplinary services proposed in the core Plan appears to be realistic and functional. The theory behind the flow of health care patients/residents/clients from rural to regional health centers is well thought out.

- The CHR proposal to convert selected rural hospitals into "one stop shopping" Community Health Centers (CHC) with: 24/7 Emergency Services, laboratory and x-ray services, rehabilitation services, specialized programs and services (e.g. renal dialysis); and custom mixes of different numbers and types of acute, holding and continuing care inpatient beds, is considered a progressive strategy specially when (as CHR proposes) they are co-located with on-site physician offices, home care, community mental health, and other related health services and staff. The full spectrum of health service staff from the CHR with the physicians in the CHCs will promote new opportunities for improved communication, coordination of care, highly functioning multidisciplinary teams and the implementation of health promotion and chronic disease management programs.

- The quality of care is considered to be within all standards from a safety perspective, but some proposed changes are perceived to result in less than satisfactory quality from a consumer standpoint.

- The communities of Fort Macleod, Pincher Creek, or Coaldale do not support some parts of the CHR vision and proposals for service changes within their communities. There is open opposition to some parts of the CHR Plan in the communities, and the Plan does not have the full confidence of the municipal leaders, MLAs, some physicians and some staff.

The CHR Plan is very broad and comprehensive. The majority of the Plan seems to be quite well supported and appears to be acceptable to most stakeholders and communities. It is only selected changes, in selected communities that are being challenged at this time.

On the one hand, the CHR Plan is innovative and does appear to maintain quality and reasonable access. On the other hand, it is evident that there are some changes proposed in the plan that are not supported by either the communities or some of the physician groups.

The functionality of the CHR Health Service Plan is difficult to assess. Functionality is a relative term. No matter how rational a strategy and plan may appear to a health service provider and to health care policy makers, governors and managers, a health program must also be understood by both the consumers and the CHR.

The CHR does understand the key reasons for the targeted lack of support for some parts of their Plan. In turn, they do have good evidence to disagree and argue that the opposition to the Plan is not rational. Even so, the CHR cannot afford to ignore the reality of the impact that this vocal opposition can have on the successful implementation of their plans. Equally, from accountability perspective back to the public, they cannot avoid the need to openly work through a transparent process in an attempt to resolve the known concerns prior to aggressively moving forward to implement them.

It is concluded that the CHR Health Plan is functional from a design perspective. However, the consultation and planning process leading up to the approval of the plan, the communication and marketing of the plan, and the strategy to implement the plan are issues that must be addressed.

5. Recommendations

1. **That the CHR delay, until May 01, 2003, the activation of any significant initiatives included in their Health Plan that have not already been implemented in Coaldale, Pincher Creek and Fort Macleod.**

   This short delay in the implementation of those changes that have not already been initiated should be used to evaluate, understand and rebuild the relationship between the CHR and each of the communities.

   This recommendation for a delayed implementation may need to be further evaluated for practical reasons. It was recently reported by the CHR that the Coaldale Health Center has indicated their willingness and are prepared to proceed on April 01, and that Pincher Creek has essentially completed their proposed changes. Further, it may be impossible to staff the acute care beds in Fort Macleod for the Month of April even if the decision was made to try to keep them open for that extra month.

   The important point in this recommendation is that the CHR does need to initiate discussions with the physicians and community leaders as soon as possible and does need to talk to them about the plans, impacts, and alternative opportunities the catchment population will have to maintain reasonable access to quality health care services.

   The proposed delay from April 01 to May 01, 2003 may result in some additional costs for the CHR, and a higher-than-planned operating budget deficit for 2003/04. If the CHR does experience additional costs then it is further recommended that CHR submit a detailed cost and impact analysis of this delay to AHW, and that AHW consider a one-time grant to cover the costs of this delay.

2. **That the CHR develop, either internally or through a communication consultant, a clear and consumer-friendly summary of the CHR vision for the health system within the Chinook RHA and a strategic marketing plan to explain it to the communities.**

   Included in this information should be the process by which the rural communities can be assured of both quality of care, and reasonable access to the full continuum of care and services. Assurance of long-term sustainability will be important.

   The communication summary should highlight how the CHR health system is organized, and how the CHR plans to continue to serve the needs of the rural communities. Standards of care need to be defined. Rationale for strategic directions needs to be explained. Financial issues, challenges, and an explanation

of the alternate use of any health care funding that is withdrawn from a community needs to be shared in some form with the communities.

Where possible, the communication strategy should include a description of the standards of access to services in their communities, and within the greater CHR. Where possible, the rural communities need to be reassured that there are no plans to close their local hospitals in the future. Where this reassurance is not possible, the communities should be educated well in advance about the factors that could influence this type of decision.

3. **That the CHR initiate discussions as soon as reasonably possible with the MLAs, Mayors, Reeves and medical staffs, in Pincher Creek, Fort Macleod, and Coaldale, to begin a renewed consultation process, and to develop a go-forward planning process that all parties can commit to.**

   The first phase of the consultative process needs to be initiated as quickly as possible to demonstrate both a commitment to action by the CHR, as well as to expedite the timely implementation of the resulting action plans.

   It is important that the trust and respect for the important roles that both the CHR and the communities play in the health system be restored. Mutual respect, open communication and meaningful stakeholder participation in the CHR planning processes are required for the health system to function effectively.

   The CHR does have both the authority and the accountability to provide the leadership for the operation of the health system in their defined area. However, they are not the only group who could have, and can, initiated positive discussions to improve the relationship between the CHR and the communities. Effective communication and the ability to develop successful strategies to work together will require effort from all of groups including the CHR, physicians, community leaders and MLAs.

   The issues contributing to the current state of relationships have developed over time and each of these stakeholders must be held accountable to some degree for the current status, and for the development of acceptable solutions to bring about a constructive partnership.

4. **As one strategy within the go-forward plan, that the CHR plan a regional consultation workshop to take place in April. An experienced facilitator is recommended to assist with the planning, organization and conduct of the workshop.**

   The agenda for the workshop should be planned with the input of local MLAs, community leaders, physicians, and currently established health service planning committees.

   The workshop should include discussion about alternate models that could be designed to facilitate an ongoing planning, consultation and communication process. The objectives should include:

   a) A commitment to work together constructively,

   b) Clarification of the roles, responsibilities, authorities, and expectations (related to the health system) of the CHR Board, CHR Senior Management, physicians, community leaders, MLAs, and any established health service planning committees,
   c) Agreement on a strategy and series of processes that will allow meaningful community and physician input into CHR strategic directions and annual operating plans before they are finalized, and

   d) Agreement on the creation of, and terms of reference for, some form of CHR-sanctioned community advisory committee. Options could include the formation of Community Health Council(s), the recognition of existing community health committees/groups, or some new alternative.

5. **That AHW support the strategies proposed by the CHR to expand the concept of primary health care, and the development of Community Health Centers in Pincher Creek and Fort Macleod. Further, that all outstanding applications for financial assistance to achieve these changes be expedited wherever possible.**

   Currently the physicians in both Pincher Creek and Fort Macleod have submitted proposals to the MSDIF. Pincher Creek has submitted a proposal for funding through the Capacity Building Fund grant process.

   The CHR must move to a position where they can make firm commitments to the physicians and to the communities to move forward in a timely manner with the changes proposed in the CHR Health Plan. They need to demonstrate timely action and follow-through on their promises and commitments.

The CHR proposal to invite the community physicians in Fort Macleod and Pincher Creek to move into the local hospitals is fully supported. CHR requires grant approvals or special financial support to underwrite the cost of required renovations, as well as to purchase, or supplement the purchase price of, the private office buildings currently owned by the physicians in these centers.

6. **That AHW expedite the conclusion of negotiations with the Alberta Medical Association and the community physicians in Pincher Creek and Fort Macleod to move those physicians who agree, into an alternate payment plan (APP).**

   The physicians are concerned with the restrictive limit of only three years of primary health care and APP funding. Further information and reassurance to the physicians from AHW and the CHR about the risks inherent in the primary health care, community health center, and APP funding would be helpful.

7. **That AHW support and approve the recently submitted proposal by the CHR for a special one-time grant of $1 million to fund the renovation and other transition costs related to the implementation of the primary health care and community health center model in Fort Macleod, and the relocation of the Fort Macleod physicians into the hospital.**

8. **That the proposed changes to the use of hospital space, hospital beds, and continuing care beds in Fort Macleod be revised as follows:**

   A) **Move the physicians, public health offices, and mental health offices into the hospital as soon as possible. Keep the Home Care offices there also.**

   B) **Develop additional clinic space in the hospital to accommodate other outpatient and outreach programs such as Chronic Disease Management etc.**

   C) **Open 5 to 6 new Observation Beds in the Emergency area of the hospital.**

      The CHR should consult with, and obtain the input from, the Fort Macleod physicians about the final number of beds, admission criteria, and staffing plan prior to the approval of these plans.

      If space permits, CHR should consider the use of regular hospital beds in the Observation Unit as opposed to stretchers,

D) Based on the proposed function and staffing for the Observation Unit, a 24 – 48 hour guideline for length of stay is supported. Within this guideline, and within the medical limits established by staffing levels, staff training, and back-up services, the admitting physician must have the responsibility to authorize patient length of stay on the unit, patient discharge requirements, and if and when a transfer to an acute care hospital is warranted. The physicians must then be accountable back to the CHR for the decisions they make.

Admissions to the Observation Beds should be approved by the admitting physician in consultation with the Charge Nurse to assure adequate staffing for both the numbers and complexity of patients. Patient admissions and transfers to acute care hospitals should be within the framework of the Emergency Critical Care Program of the CHR.

E) Do not open the 3 Community Support Beds (CSBs) currently proposed to be located in the Extendicare facility.

F) Open 3 to 4 new Infirmary Beds in the Special Development Unit (SDU) in the hospital.

The CHR, with input from the local physicians, will need to define the final number of Infirmary beds, use of the beds, staffing levels, etc. Given the defined purpose of the beds, staffing levels and training, and level of backup services in the hospital, the admitting physician, in consultation with the Charge Nurse, will determine patient-specific length of stay, discharge plan, and/or transfer plan to an acute care hospital.

G) Convert one of the existing 50 nursing home beds into a respite bed.

H) Close the current 12 acute care beds.

The combination of Infirmary and Observation Beds in the hospital, combined with reasonable access to alternate acute care beds within a 30-minute drive is reasonable and is considered safe by all measures and all standards.

I) CHR, with input from the local physicians, must continue to monitor the quality and utilization of all types of beds in Fort Macleod on an ongoing basis.

If a change in the number and/or type of health care beds in the community is warranted, then a plan should be developed with the input of local physicians and the community health service planning body prior to implementing the changes.

J) Maintain the current Emergency, laboratory and x-ray services 24 hours per day, 7 days per week.

K) CHR should get actively involved in the negotiation process with AHW, AMA and others to expedite the negotiations related to Fort Macleod physicians APP agreements, purchase of the medical office building, and the relocation of the physicians into the hospital.

9. That the proposed changes to the use of hospital space, hospital beds, and continuing care beds in Pincher Creek be revised as follows:

A) Move the physicians, public health offices, home care, and mental health offices into the hospital as soon as possible.

Capital/renovation funding will be required. The most appropriate source is through the Capacity Building Fund if the Pincher Creek proposal is approved. Alternatively, an application will need to be made to Alberta Infrastructure,

B) Develop additional clinic space in the hospital to accommodate other outpatient and outreach programs.

C) Maintain the current three (3) nursing home beds in the Pincher Creek Hospital. Upgrade and renovate these resident rooms and the surrounding areas to meet continuing care/long term care standards.

The previous accommodation for 31 long term care beds was changed to 50 Assisted Living Beds and 5 Community Support Beds off site from the hospital, and 3 Nursing Home Beds in the hospital. This is a gain of 27 beds. There seems to consensus that the quality of care has not decreased, and actually may have increased for many long-term care residents as a result of the change in accommodation. The fact that there have been no admissions to the 3 nursing home beds since they opened would indicate that an increase in the number of nursing home beds is not required at this time.

D) CHR, with input from the local physicians, must continue to monitor the quality and utilization of all types of beds in Pincher Creek on an ongoing basis.

If a change in the number and/or type of health care beds in the community is warranted, then a plan should be developed with the input of local physicians and the community health service planning body prior to implementing the changes.

E) CHR should get actively involved in the negotiation process with AHW, AMA and others to expedite the negotiations related to Pincher Creek physicians APP agreements, purchase of the medical office building, and the relocation of the physicians into the hospital.

If the physicians do move into the hospital there will be insufficient room for the potential construction of new lodge beds in the hospital. An alternate strategy for the new lodge beds would be an expansion to the Good Samaritan facility.

10. That the CHR provide the following information and support to the Coaldale Health Center (CHC):

Note: The enthusiasm of the Coaldale Health Center Board, Management and physicians is recognized. They have a number of creative ideas and they need to be encouraged and supported by the CHR. However, the 12-minute driving time from Coaldale to Lethbridge is a significant factor when considering the CHR requirements to maximize quality, critical mass and efficiency of core health services. Alternatively, that same short driving time that is reducing the incentive for the CHR to unnecessarily duplicate health services in Coaldale, is also the greatest incentive for the CHR to use this facility in the future for short or long term service relief capacity. The CHC facility is a strategic alternative for the CHR.

The following action is recommended:

A) CHR Board and Senior Management to meet with CHC to discuss their expectations and their respective future visions of the CHC.

It is noteworthy that the CHC did submit their operating plan to the CHR and that it was this plan that was approved by the CHR,

B) CHR to provide the Coaldale Health Center (CHC) with their annual and multi-year expectations related to: corporate policies, operating and capital budget, quality of care, access, service and other performance standards. Once agreement is reached, the CHR should delegate the full operating authority for the CHC to the CHC, including the ability of the CHC Board to establish priorities and to reallocate funds as they deem necessary as long as it is within the policy and performance agreements approved by the CHR Board.

C) CHR to provide additional background information to CHC to support the rationale for the 30% reduction in the CHC operating funds.

D) **CHR to provide a one-time grant to CHC of $150,000 to cover CHC transition costs to convert from their previous role to the new role. Further, if CHC projects that they may incur severance costs as a result of the transition to their new role, that they seek the prior approval from the CHR for full reimbursement of these costs.**

E) **CHR and AHW to support and assist the Coaldale Board, management, and medical staff in investigating alternate uses for that facility, and alternate revenue generating opportunities.**

F) **As and when appropriate, CHR to consider negotiating additional operating contracts with CHC for the use of any unused bed and operating room capacity in the CHC.**

   Such capacity could be used to augment the capacity of the Regional Hospital as required and/or when it may be more cost effective for the CHR to use the CHC facility than their other options.

In closing

Sincere appreciation is extended to all participants and contributors to this review. The information shared, the level of cooperation and the constructive nature of the all discussions were sincerely appreciated.

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