Deloitte & Touche

Department of Health and Community Services

Operational Review of Health Labrador Corporation

Results of High-Level Review

Final Report

April 2003

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1. PROCESS UNDERTAKEN

Process Undertaken

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Phase 1: Scoping, Planning & Data Collection

Phase 2: Global High Level Review

Phase 3: Identification of Issues, Improvement Strategies & Preliminary Reporting

Phase 4: Detailed Assessment of Targeted Areas

Phase 5: Development of Final Recommendations and Reporting

- Review of past three fiscal years statistical and utilization data; review of financial data since inception of HLC
- Consultation with the following stakeholder groups: Steering Committee members, HLC Board members, Executive Team, Program/Department Managers and Staff, Physician Leadership, Union Leadership, Aboriginal Community Leaders, Provincial Government Representatives
- Visits to all HLC locations (14 communities)
- Document review
- Internal and external comparative analysis

Process Undertaken

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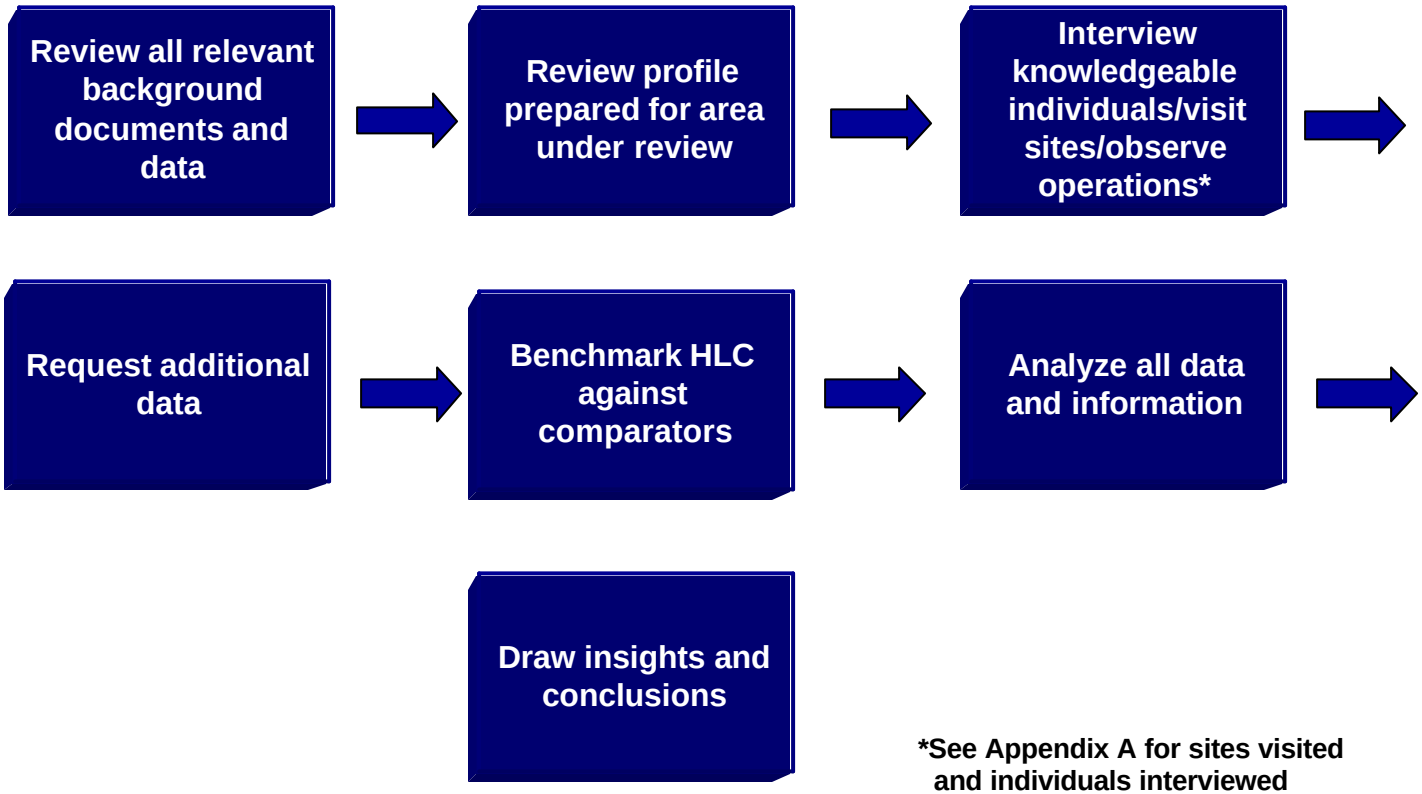
In every area within the scope of our review, we undertook a process that resembled the following:



***See Appendix A for sites visited and individuals interviewed**

Approach to Benchmarking

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- Benchmarking is one of several tools/techniques used to assess the operations of HLC. It supplements insights gained through interviews/site visits/observation and review of documentation/past reviews.
- Two types of benchmarking were undertaken:
  - Internal Comparison: Comparisons within HLC, between locations or trends over time
  - External Comparison: Comparisons with similar organizations or industry standards
- External comparators were selected based on organization size, rural/remote location, similar programs and services, referrals to outside organizations. We compare performance with a group of peers, rather than just one or two.
  - For Acute Care, Admin and Clinical Support services, we compared HLC with 23 organizations across Canada.
    - ✓ 25th percentile used for Administration and Support services; 50th percentile for Clinical Support services, rather than low cost comparator. Thus, we err on the side of achievability. These percentiles are used consistently by Deloitte & Touche in all operational reviews.
    - ✓ For the utilization review, we extracted 15 hospitals from HLC's normal CIHI peer comparison group who were most comparable in terms of volume and profile of clinical activity.
  - For Long-Term Care, HLC was compared with four western Canadian organizations.
  - For Child, Youth and Family Services, the key benchmark comparator was the Technical Working Group Report on Staffing Levels in Child, Youth and Family Services for the Innu Communities of Sheshatshiu and Davis Inlet/Natuashish dated January 17, 2003.

Approach to Benchmarking (cont'd)

- While comparable peers were selected for the benchmarking analysis, there are always variances between organizations. As a result, experience is applied to the benchmark data to reflect environmental considerations within HLC.
- However, the benchmarks do reflect actual staffing levels adopted by peer facilities based on available financial and human resources.
- It should be noted that benchmarks do not necessarily reflect "best practices". In fact, many benchmark organizations would consider themselves to be under-resourced.
- Consistent application of MIS guidelines is always a challenging task. However, at HLC there were several aspects of the MIS trial balance financial and statistical information which created challenges for the benchmarking. For example:
  - Incomplete reporting of statistical data (patient days, workload, etc.)
  - Incomplete capturing and reporting of lieu time
  - Inconsistent assignment of paid hours across the different sites
  - Inconsistent methods of reporting paid hours between different data sources
- Where possible, when reviewing staffing efficiencies, we relied on payroll data, which was closely aligned with management reporting of staffing levels and therefore considered to be most accurate.

Observations

- Management and staff at HLC have been working very hard under difficult conditions. They have been cooperative and helpful throughout this review.
- Despite the challenges, HLC benchmarks quite well against organizations facing fewer challenges.
- Staff at all levels are committed to organization.
- We support continued implementation of the integrated regional approach.

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2. REVIEW OF KEY INDICATORS

Geographic/Demographic Overview

- Labrador's land area represents 61% of the total area represented by the Province of Newfoundland & Labrador.
- The population of Labrador represents 4.6% of the total population of the Province of Newfoundland & Labrador.
- Consequently, the population density is 9 square km per person in Labrador compared to 0.7 square km per person for the entire Province of Newfoundland & Labrador.
- For 8% of Labrador's population, the first learned language (and still understood) is other than English or French. This compares to 1.2% for the entire population of Newfoundland & Labrador.
- 16% of Labrador's population is aboriginal compared to 3% for the entire population of Newfoundland & Labrador.

Labrador represents a huge geographic area to service, with extraordinary travel, language and cultural challenges.

* Data provided by Stats Canada, 2001 Census

Geographic/Demographic Overview

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- Life expectancy at birth is 74.9 years in Labrador compared to 77.2 years for the entire population of Newfoundland & Labrador.
- The death rate for all respiratory diseases is 121.3 per 100,000 population in Labrador compared to 56.9 for the entire population of Newfoundland & Labrador.
- The death rate from all cancers is 212 per 100,000 population in Labrador compared to 194.3 for the entire population of Newfoundland & Labrador.
- The infant mortality rate is 17.3 per 1,000 live births in Labrador compared to 6.6 for the entire population of Newfoundland & Labrador.
- Low birth weight (less than 2,500 grams) represents 6.8% of live births in Labrador compared to 5.8% for the entire population of Newfoundland & Labrador.
- 26.5% of Labrador residents are obese compared to 21.5% for the entire population of Newfoundland & Labrador.

The health needs of the population of Labrador significantly exceed those of other residents in Newfoundland & Labrador, placing tremendous stress on Health Labrador Corporation.

* Data provided by Stats Canada, 2001 Census; more information on the health of aboriginal Labradorians is provided in Appendix B: An Approach to Population Health.

Geographic/Demographic Overview

- The geography and demographics of the population served present great challenges in achieving efficiencies. HLC must contend with lack of critical mass, poor state of some facilities, personal safety considerations, obligations/legislated mandate to provide services to remote communities, cultural impacts associated with diversity of population (e.g. need for/availability of translators impact work flow).
- Other organizations facing similar challenges (e.g. Sioux Lookout and Nunavut) are not "best practice" from an efficiency perspective.
- Questions have been raised concerning appropriateness of utilization of resources (e.g. use of air transport), an issue separate from efficiency. Some activity may be seen as inappropriate by some (e.g. shipping patient out for dental services); HLC is disincented to make some appropriateness decisions (e.g. [a] the cost of transferring many patients to St. John's should be weighed against the cost of bringing specialists into Labrador. In addition to the lower transportation costs, because not all patients who should be transferred actually make the trip, there may be long term health costs that are not considered; [b] CT unit – patients were transferred to St. Anthony at a cost higher than doing in-house; but true costs were in various silos including transportation; hence, no incentive to implement most cost effective solution); and many decisions are based on clinical judgment.

Achieving maximum efficiency is extremely challenging given the geography and demographics of the population served by HLC.

Financial Overview - Revenue

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	Financial Overview - Revenue				
	Operating Fund				
					Variance %
	1999/00 (1)	2000/01 (1)	2001/02 (1)	Projection 2002/03	02/03 vs. 99/00
Operating - DOH&CS	$ 23,695,529	$ 25,855,132	$ 27,397,282	$ 30,061,296	26.9%
Community Services	$ 5,553,520	$ 7,736,559	$ 10,276,637	$ 7,624,919	37.3%
CY&FS Agreement - Innu	$ -	$ -	$ -	$ 2,052,629	100.0%
National Child Benefit	$ 83,890	$ 417,561	$ 736,683	$ 785,051	835.8%
MCP Physicians	$ 3,236,693	$ 3,433,603	$ 4,097,394	$ 4,642,226	43.4%
Air Transport	$ 1,616,774	$ 1,620,470	$ 2,351,338	$ 2,354,133	45.6%
Other	$ 2,319,180	$ 2,917,808	$ 3,453,635	$ 3,625,969	56.3%
Total Revenue	$ 36,505,586	$ 41,981,133	$ 48,312,969	$ 51,146,222	40.1%

(1) Source: Audited financial statements. As of April 99, CYFS became part of HLC; data from prior years is not comparable

- **Revenues have been increasing steadily since 1999/00.**
- **Community Services revenue was inflated in 2000/01 and 2001/02 due to funding for special independent living arrangements.**
- **The drastic increase in air transportation services revenue in 2001/02 was due to an $800,000 grant from the Department of Health and Community Services.**

Financial Overview - Expenses

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	Financial Overview - Expenses				
	Operating Fund				
					Variance %
	1999/00 (1)	2000/01 (1)	2001/02 (1)	Projection 2002/03	02/03 vs. 99/00
Operating and Other	$ 24,564,572	$ 27,888,770	$ 29,317,695	$ 30,966,212	26.1%
Community Services	$ 8,083,699	$ 11,900,745	$ 13,240,700	$ 12,741,092	57.6%
Medical Services	$ 3,539,971	$ 3,805,034	$ 4,539,246	$ 5,034,984	42.2%
Air Transport	$ 2,420,014	$ 2,571,322	$ 2,663,699	$ 2,297,492	-5.1%
Total Shareable Expenses	$ 38,608,256	$ 46,165,871	$ 49,761,340	$ 51,039,779	32.2%
Non-Shareable Expenses	$ 624,557	$ 674,217	$ 463,460	unknown	unknown
(1) Source: Audited financial statements					

- **Expenses have increased steadily since 1999/00.**
- **Growth in total shareable expenses (as a percentage) is significantly less than revenue growth for the same period.**

Financial Overview - Deficits

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Financial Overview - Deficits Operating Fund	1999/00 (1)	2000/01 (1)	2001/02 (1)	Projection 2002/03	
Annual (Deficit) - Community Services	$ (2,446,289)	$ (3,746,625)	$ (2,227,380)	$ (2,278,494)	(3)
Annual (Deficit) - Medical Services	$ (303,278)	$ (371,431)	$ (441,852)	$ (392,759)	
Annual Surplus (Deficit) - Air Transport	$ (803,240)	$ (950,852)	$ (312,361)	$ 56,642	
Annual Surplus - Other	$ 1,450,137	$ 884,170	$ 1,533,222	$ 2,721,054	
Operating Surplus (Deficit) (GAAP)	$ (2,102,670)	$ (4,184,738)	$ (1,448,371)	$ 106,443	(3)
Total (Deficit) (GAAP) (2)	$ (2,727,227)	$ (4,858,955)	$ (1,911,831)	unknown	
Annual Surplus (Deficit) - Operating (DOH&CS)	$ (1,306,512)	$ (3,241,694)	$ (1,144,619)	$ 49,801	
Annual Surplus (Deficit) - Air Transport (DOH&CS)	$ (803,240)	$ (950,852)	$ (312,361)	$ 56,642	
Annual (Deficit) - Capital (DOH&CS)	$ (325,583)	$ (505,049)	$ (338,133)	$ (300,000)	(4)

(1) Source: Audited financial statements
(2) Includes non-shareable items
(3) Includes CYFS Agreement revenue of $2,052,629
(4) Estimated

- **Deficits are not new to HLC.**
- **Community Services, Medical Services and Air Transport have driven the deficits in recent years. Air Transport anticipates a small surplus in 2002/03. Without the CYFS Agreement money, the projected deficit in Community Services for 2002/03 would be $4.3M.**
- **Other areas appear to have recorded significant surpluses in recent years, part of which is attributable to stabilization funding. It is not possible to quantify the surpluses or deficits in these other areas due to the inherent limitations in the allocation process for the provincial operating grant.**
- **Generally Accepted Accounting Principles (GAAP) require adjustments be made for certain timing differences (i.e. accrued severance and vacation pay). DOH&CS only recognizes these expenses as incurred.**

Expenditure Overview – Deficits (GAAP) Since Inception

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	Operating (Deficit)/Surplus Summary (GAAP) (Source: Audited Financial Statements)									
	Total Revenue	(1)	Total Expenses	(1)	Annual Operating Deficit (GAAP)	(1)	Non-Shareable Expenses	Restricted Contributions	Annual Deficit (GAAP)	
Transferred at Inception of Board									$ 339,850	
1995/96	$ 27,302,957		$ 27,502,608		$ (199,651)		$ 1,050,260		$ (1,249,911)	
1996/97	$ 28,518,941		$ 29,536,629		$ (1,017,688)		$ 88,696		$ (1,106,384)	
1997/98	$ 28,235,671		$ 30,062,505		$ (1,826,834)		$ 477,934		$ (2,304,768)	
1998/99	$ 31,821,194	(2)	$ 30,822,349		$ 998,845	(2)	$ 224,949		$ 773,896	(2)
1999/00	$ 36,505,586		$ 38,608,256		$ (2,102,670)		$ 624,557		$ (2,727,227)	
2000/01	$ 41,981,133		$ 46,165,871		$ (4,184,738)		$ 674,217	$ 158,928	$ (4,700,027)	
2001/02	$ 48,312,969		$ 49,761,340		$ (1,448,371)		$ 463,460	$ 23,766	$ (1,888,065)	
Accumulated Deficit					$ (9,781,107)				$ (12,862,636)	
2002/03 (proj.)	$ 51,146,222	(3)	$ 51,039,779		$ 106,443	(3)	unknown	unknown	unknown	
Projected Accumulated Deficit					$ (9,674,664)					

(1) Includes air transport, does not include capital
(2) Incudes special DOH&CS funding of $1,692,000.
(3) Includes CYFS Agreement revenue of $2,052,629.

- **Looking back over the full history of HLC, deficits have been experienced in almost every year.**
- **The exceptions were 1998/99, when HLC received special funding from the DOH&CS and the projection of a modest surplus in 2002/03 (which assumes the retention of over $2M in CYFS Agreement money).**

Expenditure Overview – Deficits (DOH&CS) Since Inception

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	Operating (Deficit)/Surplus Summary (DOH&CS)											
	(Source: Supplementary Financial Information - Audited Financial Statements)											
	Total Revenue	(1)	Total Expenses	(1)	Annual Operating Deficit (DOH&CS)	(1)	Annual Capital Deficit (DOH&CS)		Retroactive Adjustments		Operating Fund Deficit (DOH&CS)	
Transferred at Inception of Board					$ 1,491,962	(4)	$ -	(4)	$ -		$ 1,491,962	(4)
1995/96	$ 27,302,957		$27,511,608		$ (208,651)		$ -	(4)	$ -		$ (208,651)	(4)
1996/97	$ 28,518,941		$29,544,796		$ (1,025,855)		$ (1,692)		$ (129,088)	(4)	$ (1,156,635)	
1997/98	$ 28,235,671		$30,071,337		$ (1,835,666)		$ -		$ -		$ (1,835,666)	
1998/99	$ 31,821,194	(2)	$30,828,802		$ 992,392	(2)	$ -		$ (164,574)	(4)	$ 827,818	
1999/00	$ 36,505,586		$38,615,338		$ (2,109,752)		$ (325,583)		$ -		$ (2,435,335)	
2000/01	$ 41,981,133		$46,173,679		$ (4,192,546)		$ (505,049)		$ -		$ (4,697,595)	
2001/02	$ 48,312,969		$49,769,949		$ (1,456,980)		$ (338,133)		$ -		$ (1,795,113)	
Accumulated Deficit					$ (8,345,096)		$ (1,170,457)		$ (293,662)		$ (9,809,215)	
2002/03 (proj.)	$ 51,146,222	(3)	$51,039,779		$ 106,443	(3)	$ (300,000)		$ -		$ (193,557)	
Projected Accumulated Deficit					$ (8,238,653)		$ (1,470,457)		$ (293,662)		$ (10,002,772)	

(1) Includes air transport, does not include capital
(2) Includes special DOH&CS funding of $1,692,000.
(3) Includes CYFS Agreement revenue of $2,052,629.
(4) Estimated as financial statement disclosure provides insufficient detail.

- **Looking back over the full history of HLC, deficits have been experienced in almost every year.**
- **The exceptions were 1998/99, when HLC received special funding from the DOH&CS and the projection of a modest surplus in 2002/03 (which assumes the retention of over $2M in CYFS Agreement money).**

Expenditure Overview – Understanding the Deficit (GAAP)

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	Summary of Operating Deficits (GAAP) by Selected Program											
	(Source: Audited Financial Statements)											
	Community Services		Medical Services		Air Transport		Surplus Areas			Annual Operating Deficit (GAAP)		
Accumulated (deficit)/surplus	unknown	(4)	$ (553,024)		unknown	(4)	unknown	(4)		$ (3,044,173)		
1998/99 (deficit)	$ (1,422,147)		$ (269,271)		$ (733,058)		$ 3,423,321	(5)		$ 998,845	(5)	
1999/00 (deficit)	$ (2,446,289)	(1)	$ (303,278)		$ (803,240)		$ 1,450,137			$ (2,102,670)		
2000/01 (deficit)	$ (3,746,625)	(1)	$ (371,431)		$ (950,852)		$ 884,170			$ (4,184,738)		
2001/02 (deficit)	$ (2,227,380)	(1)	$ (441,852)		$ (312,361)	(2)	$ 1,533,222			$ (1,448,371)		
Sub-Total	$ (9,842,441)	+	$ (1,938,856)		$ (2,799,511)	+	$ 7,290,850	+		$ (9,781,107)		
2002/03 (as projected by D&T)	$ (2,278,494)	(3)	$ (392,759)		$ 56,642	(2)	$ 2,721,054			$ 106,443	(3)	
Total	$ (12,120,935)	+	$ (2,331,615)		$ (2,742,869)	+	$ 10,011,904	+		$ (9,674,664)		
(1) Includes NCB revenue												
(2) Includes $800,000 grant from DOH&CS												
(3) Includes revenue of $2,052,629 from CYFS Agreement												
(4) Not disclosed separately in audited financial statements.												
(5) Includes $1,692,000 in special deficit funding from DOH&CS.												

- **The primary driver of the deficit has been the provision of Community Services.**
- **Other drivers include the provision of Air Transport and the cost of Medical Services.**
- **It should be noted that these deficits were partially offset by surpluses in other areas. The surpluses are due in part to stabilization funding provided by DOH&CS.**

Expenditure Overview – Understanding the Deficit (DOH&CS)

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	Summary of Operating Deficits (DOH&CS) by Selected Program											
	(Source: Audited Financial Statements)											
	Community Services		Medical Services		Air Transport		Surplus Areas		Annual Operating Deficit (DOH&CS)			
Accumulated (deficit)/surplus	unknown	(4)	$ (553,024)		unknown	(4)	unknown	(4)	$ (1,578,210)			
1998/99 (deficit)	$ (1,422,147)		$ (269,271)		$ (733,058)		$ 3,416,868	(5)	$ 992,392	(5)		
1999/00 (deficit)	$ (2,446,289)	(1)	$ (303,278)		$ (803,240)		$ 1,443,055		$ (2,109,752)			
2000/01 (deficit)	$ (3,746,625)	(1)	$ (371,431)		$ (950,852)		$ 876,362		$ (4,192,546)			
2001/02 (deficit)	$ (2,227,380)	(1)	$ (441,852)		$ (312,361)	(2)	$ 1,524,613		$ (1,456,980)			
Sub-Total	$ (9,842,441)	+	$ (1,938,856)		$ (2,799,511)	+	$ 7,260,898	+	$ (8,345,096)			
2002/03 (proj.)	$ (2,278,494)	(1,3)	$ (392,759)		$ 56,642	(2)	$ 2,721,054		$ 106,443	(3)		
Total	$ (12,120,935)	+	$ (2,331,615)		$ (2,742,869)	+	$ 9,981,952	+	$ (8,238,653)			
(1) Includes NCB revenue												
(2) Includes $800,000 grant from DOH&CS												
(3) Includes revenue of $2,052,629 from CYFS Agreement												
(4) Not disclosed separately in audited financial statements. HLC staff not able to provide detail.												
(5) Includes $1,692,000 in special deficit funding from DOH&CS.												

- **The primary driver of the deficit has been the provision of Community Services.**
- **Other drivers include the provision of Air Transport and the cost of Medical Services.**
- **It should be noted that these deficits were partially offset by surpluses in other areas. The surpluses are due in part to stabilization funding provided by DOH&CS.**

Financial Overview – Stabilization Funding

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Description and Funding Method	HEALTH LABRADOR ACUTE CARE SERVICES	HEALTH LABRADOR AIR SERVICES	HEALTH LABRADOR COMMUNITY HEALTH	HEALTH LABRADOR TOTAL STABILIZATION
1998 - 1999				
- One Time Stabilization Funding (One Time Adjustment)	1,000,000			1,000,000
- Base Home Support, Mental Health and Addictions (Base Adjustment)			150,000	150,000
1999 - 2000				
- Base Stabilization Funding (Base Adjustment)	760,000			760,000
- One Time Stabilization Funding (One Time Adjustment)	590,000			590,000
2000 - 2001				
- Base Stabilization Funding (On Budget Schedule)	590,000			590,000
2001 - 2002				
- Base Stabilization Funding (On Budget Schedule)	300,000			300,000
- Base Inflation Drugs and Med Surg. Supplies (On Budget Schedule)	100,000			100,000
- Air Services Base Stabilization Funding (On Budget Schedule)		800,000		800,000
- Base Stabilization Funding Pending Review (On Budget Schedule)			1,800,000	1,800,000
- One Time Stabilization Pending Review (One Time Adjustment)			200,000	200,000
2002 - 2003				
- Base Funding for Inflation and Growth & Supplies (On Budget Schedule)	147,000			147,000
- Redistribution of 01/02 One Time Stabilization Funding as Base (Adjustment)			200,000	200,000

- **Over the past several years, DOH&CS has provided significant stabilization funding to HLC in the three major service areas shown above.**
- **Without these dollars, HLC's deficits would have been significantly higher than reported on the previous pages.**

Expenditure Overview – Understanding Expenditures in Community Services

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		Expenditure Overview Community Services				
					Variance $	Variance %
	Fiscal 2000 (1)	Fiscal 2001 (1)	Fiscal 2002 (1)	Proj. 2003	2003 vs. 2000	2003 vs. 2000
Community Services - Provincial Plan	$ 5,553,520	$ 7,736,559	$ 10,276,637	$ 7,624,919	$ 2,071,399	37%
CYFS Agreement - Innu	$ -	$ -	$ -	$ 2,052,629	$ 2,052,629	100%
National Child Benefit	$ 83,890	$ 417,561	$ 736,683	$ 785,051	$ 701,161	836%
Community Services Expenses	$ (8,083,699)	$ (11,900,745)	$ (13,240,700)	$ (12,741,092)	$ 4,657,393	58%
Annual (Deficit) - Community Services	$ (2,446,289)	$ (3,746,625)	$ (2,227,380)	$ (2,278,494)	$ (167,795)	-7%
Expenses by Program:						
Addictions	$ 388,274	$ 414,632	$ 403,341	$ 462,053	$ 73,779	19%
Continuing Care	$ 949,160	$ 1,127,502	$ 1,203,650	$ 1,271,165	$ 322,005	34%
Health Promotion	$ 505,005	$ 571,754	$ 676,851	$ 773,379	$ 268,374	53%
Mental Health	$ 565,379	$ 624,855	$ 798,338	$ 764,245	$ 198,866	35%
Child, Youth and Family Services	$ 4,312,779	$ 5,985,356	$ 6,347,587	$ 7,532,707	$ 3,219,928	75%
Family and Rehab Services	$ 1,302,223	$ 1,398,090	$ 1,626,707	$ 1,804,674	$ 502,451	39%
Community Corrections	$ 60,879	$ 102,719	$ 90,691	$ 132,869	$ 71,990	118%
Independent Living Arrangements	$ -	$ 1,675,837	$ 2,093,535	$ -	$ -	0%
	$ 8,083,699	$ 11,900,745	$ 13,240,700	$ 12,741,092	$ 4,657,393	58%
(1)- Source: Audited financial statements						

- **Within Community Services, the largest expenditure area has been and continues to be Child, Youth and Family Services.**
- **Although most areas have experienced steady increases in expenditures, CYFS has experienced particularly high levels of growth year over year.**

Financial Overview – Balance Sheet

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	Financial Overview - Balance Sheet			
	Operating Fund			
				Variance %
	1999/00 (1)	2000/01 (1)	2001/02 (1)	01/02 vs. 99/00
Working Capital Deficit	$ (4,549,646)	$ (9,557,164)	$ (11,625,040)	156%
Bank Overdraft - Net of Restricted Cash	$ (2,020,787)	$ (6,172,330)	$ (8,898,835)	340%
Accumulated Deficit (GAAP)	$ (6,274,544)	$ (10,974,571)	$ (12,862,636)	105%
Accumulated Deficit (DOH&CS)	$ (3,316,507)	$ (8,014,102)	$ (9,809,215)	196%
(1) Source: Audited financial statements				

- **Both the working capital deficit and the bank overdraft have grown at alarming rates since fiscal 2000.**
- **The provincial government has partially guaranteed the operating line.**
- **Significant timing differences in the recognition of certain expense items, as well as other reporting differences, cause a difference between the deficit reported on the audited financial statements and that reported by the government.**

Activity Overview - HLC

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Activity	2000/01	2001/02	2002/03 Proj.	% Change from 2000/01 to 2002/03
Total Patient Days	10,861	8,242	9,216	-15%
Total Cases	2,500	2,415	2,505	0%
Inpatient Weighted Cases	1,659	2,082	1,556	-6%
Total ER Visits	38,781	36,983	??	-5%
Surgical Day Care Visits/ OR Visits	913	1,311	1,003	+10%
Outpatient Visits	20,972	22,153	24,437	+17%
Air Transport – Medevacs to Coast	175	164	173	0%
Public Health	8,740	8,710	8,068	-1%
Mental Health	6,177	5,453	* 6,227	+1%
Addiction Services		** 1,776		-
Total Community Clinic Activity***	42,818	50,382	60,203	+41%

As one would expect, changes in activity level vary across HLC. While inpatient activity has declined, we see a corresponding increase in outpatient activity. Community care volumes have remained constant, as has air transportation activity. Community clinic activity has increased.

* Statistics are coded differently for LHC and CWJMH. This number represents total activity. Statistics for CWJMH are estimates as actual numbers were not available.

** Addiction Services statistics were available for 2001/02 only.

***Estimate - Community clinic activity includes all nursing contact, phlebotomies, vouchers, physician visits, etc. Data not available for Cartwright, Postville and Natuashish.

Activity Overview - LHC

Deloitte & Touche

Activity	2000/01	2001/02	2003/03 Proj.	% Change from 2000/01 to 2002/03
Total Patient Days	6,423	5,861	5,611	-13%
Total Cases	1,742	1,672	1,872	+8%
Inpatient Weighted Cases	1,145	1,016	1,098	-4%
Total ER Visits	20,237	18,148	??	-10%
Surgical Day Care Visits/ OR Visits	515	890	562	+9%
Outpatient Visits	17,232	18,946	20,385	+18%

As we would expect, activity at LHC mirrors total regional activity. The greatest increase in ER visits occurred at LHC.

Activity Overview - CWJMH

Deloitte & Touche

Activity	2000-01	2001-02	2003-03 Proj.	% Change from 2000-01 to 2002-03
Total Patient Days	4,438	2,381	3,605	-19%
Total Cases	758	743	633	-17%
Inpatient Weighted Cases	514	1,066	458	-11%
Total ER Visits	18,544	18,835	??	0%
Surgical Day Care Visits/ OR Visits	398	421	441	+11%
Outpatient Visits	3,740	3,207	4,053	+8%

Activity at CWJMH mirrors regional trends, with greater declines in inpatient volumes and more modest increases in outpatient activity.

Salary/Non-Salary Overview

	1999/00	2000/01	2001/02	2002/03 *	Variance 2002/03 vs. 1999/00 $	%
Salary Expense	$ 25,304,509	$ 29,188,684	$ 32,056,749	$ 34,600,000	$ 9,295,491	37%
Non-Salary Expense	$ 13,303,747	$ 16,977,187	$ 17,704,591	$ 16,693,577	$ 3,389,830	25%
Total expense	$ 38,608,256	$ 46,165,871	$ 49,761,340	$ 51,293,577	$ 12,685,321	33%
Source: Audited Financial Statements						

*** As provided by HLC**

- **As has been the case in most Canadian healthcare organizations, both salary and non-salary costs have increased since 1999/00 (the first year for which comparable data is available).**
- **Most of the salary cost increases can be explained by wage settlements and other agreed increases, the cost of which have been covered by DOH&CS.**

Non-Salary Expense Trends

Non -Salary Expenditures	1999/00	2000/01	2001/02	2002/03	Variance 2002/03 vs. 1999/00 $	Variance 2002/03 vs. 1999/00 %
Supplies						
Plant operation and maintenance	$ 782,417	$ 938,442	$ 943,977	$ 851,693	$ 69,276	9%
Drugs	$ 697,049	$ 853,319	$ 1,151,688	$ 1,152,474	$ 455,425	65%
Medical and surgical	$ 421,755	$ 519,948	$ 447,038	$ 488,018	$ 66,263	16%
Other	$ 1,171,646	$ 1,434,339	$ 1,554,999	$ 1,489,106	$ 317,460	27%
	$ 3,072,867	$ 3,746,048	$ 4,097,702	$ 3,981,290	$ 908,423	30%
Direct client costs						
Continuing care	$ 439,329	$ 558,174	$ 623,055	$ 609,498	$ 170,169	39%
Mental health	$ -	$ -	$ 75,193		$ -	
Child, youth and family services	$ 2,190,216	$ 3,324,710	$ 3,063,938	$ 3,605,657	$ 1,415,441	65%
Family and rehab services	$ 1,302,223	$ 1,398,090	$ 1,606,576	$ 1,805,699	$ 503,476	39%
Community corrections	$ 60,878	$ 93,214	$ 63,199	$ 54,512	$ (6,367)	-10%
Independent living arrangements	$ -	$ 584,802	$ 897,851		$ -	
	$ 3,992,646	$ 5,958,990	$ 6,329,812	$ 6,075,365	$ 2,082,719	52%
Other shareable expenses	$ 4,055,366	$ 4,954,949	$ 4,897,639	$ 4,626,780	$ 571,414	14%
Interest on long-term debt	$ 127,775	$ 127,103	$ 126,266	$ 125,220	$ (2,555)	-2%
Air transportation	$ 2,055,093	$ 2,190,097	$ 2,253,172	$ 1,884,923	$ (170,171)	-8%
	$ 13,303,747	$ 16,977,187	$ 17,704,591	$ 16,693,577	$ 3,389,830	25%

Note: Excludes capital expenses

- **The primary driver of non-salary cost increases has been direct client costs, most notably Child, Youth and Family Services.**
- **As is true of most Canadian healthcare organizations, drug costs have also increased significantly in recent years. In addition, change in HLC accounting policies has resulted in increased revenues and increased expenditures for drugs (previously set off against one another).**
- **These two cost areas represent 75% of total increases over the past four years.**
- **Movement to the new LHC building in 2000/01 may have driven non-salary costs in several areas.**

Staffing Overview

Deloitte & Touche

Job Type	Fiscal 2000/01 FTEs	Fiscal 2001/02 FTEs	Fiscal 2002/03 FTEs	Variance %: 2002/03 vs. 2001/01
Management	53.9	61.6	57.4	+6%
Nursing	132.3	132.3	135.3	+2%
Service	119.2	120.8	124.0	+4%
Administrative	71.4	73.1	70.9	-1%
Technical	21.7	23.2	23.6	+9%
Professional	65.4	71.3	57.4	-12%
Total*	**463.9**	**482.3**	**468.6**	**+1%**

Note: Comparative data unavailable for prior years

- **Salary increases since 2000/01 have not resulted from higher staffing levels.**
- **Overall staffing increases at HLC have been extremely modest.**
- **While professional staff increased significantly in 2001/02, it has since fallen below 2000/01 levels.**
- **Unlike most Canadian healthcare organizations, nursing FTEs have remained constant.**
- **Recent downward trends in management and administration are positive.**
- **There are over 30 positions that are included in the budget, but are not filled. These are not reflected in this analysis.**

* Excludes salaried physicians, totaling approximately 14 over the 3 years

Overtime Overview

Deloitte & Touche

HLC Overtime Trends			
	2000/01	2001/02	2002/03 YTD
Overtime as % of Total Paid Hours	5.0%	4.6%	4.0%
FTEs Paid in Overtime	25.5	23.1	-
FTEs > .5 Paid to Community Health Workers	10.3	8.2	-
Time in Lieu (FTEs)	N/A	18.1	-

Note: Comparative data unavailable for prior years

- On average, over the past few years, overtime hours at HLC represent 4% of total paid hours. This has been going down steadily. It is, however, higher than we normally see (2-3%).
- In some areas, such as community health nurses in Postville, overtime hours represent approximately 50% of total paid hours.
- The vast majority of overtime is paid to community health nurses and maintenance workers in the community clinics. Virtually no overtime is paid in the admin and clinical support areas.
- While overtime continues to represent a significant cost at HLC, it is not driving the increases in salary dollars, as overtime is declining while salary dollars are rising.
- Overtime does, however, represent a management challenge and opportunity for cost savings.
- Time in lieu also represents a significant challenge and an unfunded liability.

High-Level Performance Overview

Deloitte & Touche

- The challenges associated with serving the population of Labrador should not be underestimated.
- Expenditures at HLC have increased consistently and significantly in recent years.
- Increases have not been driven by increases in activity levels. Increases have been experienced in the lower cost outpatient areas, while inpatient activity has been reduced.
- Increases have been driven by increases in salary and non-salary costs.
- Salary increases have not been driven by staffing increases, as staffing levels have remained relatively constant over the past three years.
- Salary increases have not been driven by increases in overtime, as overtime hours have been declining in recent years.
- Salary increases have been driven by wage settlements, which have been covered by DOH&CS funding.
- Non-salary cost increases have been largely driven by direct client costs and increases in drug costs.

HLC's increases in expenditures and resulting deficits are relatively easy to explain. The next question to address is: Are the expenditures reasonable? Related to that question, we must address the following: Are there opportunities to reduce expenditures through improved efficiency? Are there areas where HLC spends less than necessary? Ultimately, we must address the question: Is the funding appropriate for HLC to deliver the current mix of services?

Comments on Past Review

- This operational review does not represent the first review of HLC's operations.
- Reviews were also completed by Delaney in 1998 and Abbott in 2000. Each of these reviews identified a number of opportunities for improved efficiency and cost reduction. While Deloitte & Touche did not complete a detailed assessment of the status of each recommendation, we reviewed analyses prepared by HLC management outlining the status of implementation and reviewed these analyses with senior management of HLC. Management assured the Deloitte & Touche team that the majority of recommendations have been implemented. Both reports were reviewed and considered as part of the current operational review.
- In addition, reviews were completed in various areas within HLC (e.g. lab, pharmacy). Many of the recommendations in these reports have yet to be implemented. They were considered by Deloitte & Touche in the course of this operational review.

Deloitte & Touche

- **REVIEW OF FINDINGS**

A. Corporate Structure and Decision Making

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Observations: Board of Directors

- The Board of Directors includes the Chair and 13 community board members, the CEO and members of the executive leadership team. Board committees included: Executive, Finance and Ethics.
- Board structure and composition are not well defined.
  - Frequency of board/board committee meetings has not been consistent. The requirement for meetings is not defined in the by-laws. HLC was without a functioning Board for approximately one year (2001-02).
  - Appointment of Board members is a government responsibility.
  - Full Board has met 15 times over 3 years; Executive Finance Committee has met 7 times over 3 years.
  - Ethics Committee, recently established, has met on one occasion.
  - The Corporation has not established a Charitable Foundation.
- Board processes are not well defined
  - CEO reports to Board on general and community activities. Board is not well informed relative to quality and risk information. Board is not sufficiently aware of initiatives relative to new operational and capital projects.
  - Board does not have criteria and accountability established for administration of board fund.
  - External reviews have not been consistently presented to or reviewed by the Board.
  - Board assessment process and Board education programs have not been established.
- Planning and policy-setting are not well developed.
  - There is not a Board approved strategic plan.
  - Board policy manual has not been developed.

Board of Directors, Executive Leadership Team, Medical Staff

Summary and Recommendations: Board of Directors

- Structure and composition
  - In addition to Executive/Finance Committee, Board Committees should include Patient Care, Joint Conference, Nominating, Medical Advisory Committee.
  - The Board should establish a liaison committee with the aboriginal community to ensure mutual understanding of service matters, cultural diversity and the devolution process.
  - The Board should create a process to evaluate the feasibility of establishing a charitable foundation to understand if there is potential for expanding fundraising opportunities.
- Board processes
  - Meetings must be held regularly to ensure the business of the Corporation is dealt with in a timely manner; the frequency should be included in the by-laws.
  - Board Chair should lead an annual Board self-assessment process to ensure the Board is functioning effectively.
  - Board education programs should be presented on a regular basis to ensure the Board understands the realities of the organization.
  - Board should require regular reporting from CEO, President of the Medical Staff and members of the executive team on matters relating to care, teaching, research and finances.
  - The Board needs to be inclusive in its strategic planning process.
  - The Board chair should act as mentor to the CEO.
- Planning and policies
  - Board needs to review the corporate by-laws from both a quality/risk and composition perspective.
  - The Board should develop a Board Policy Manual, which should define the governance process, executive limitation and the relationship between the Board and the CEO.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Observations: Executive Leadership Team

- Regional thinking and behaviour is not well developed.
  - Regionalization as a concept is not well established from a structure, process and outcome perspective.
- Leadership processes are improving, with additional work required.
  - Executive Leadership Team meetings were held monthly in 2002 and every 2 weeks in 2001.
  - This team has not established a cost impact analysis process for acquisition of new capital and operating projects.
  - The quality and risk program is in the early stages of development, the communication and reporting process relative to quality and risk are not established.
  - The budget planning, review and accountability has improved over the past year; however, is not inclusive of managers.
  - The team does not appear to be involved in reviewing and developing action plans for external reviews.
  - Team approach to corporate-wide education/training is not based on a learning/needs assessment philosophy.
  - Leadership development is required for the CEO and the full Executive Leadership Team.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Observations: Executive Leadership Team (cont'd)

- According to payroll data for 2001/02, a total of 14.6 FTEs provided General Administration support to HLC. This included 8.15 in the regional executive office and 2.71 in Meditech planning and development. General Admin represents another area where MIS coding is problematic. We are unable to reconcile payroll data with information provided by HLC in profiles and interviews.
- The suggestion below of HLC being overstaffed by 4 FTEs in General Administration may or may not be due to coding differences. These numbers should be reconciled by HLC management.

General Admin

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
Regional (CWJ, LHC, Paddon)	0.46	0.33	-4.0

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Summary and Recommendations: Executive Leadership Team

- Regional structure and programs
  - The regional model structure and process requires realignment to ensure programs are managed from a regional perspective.
  - Prior to filling any vacant position on the Executive Leadership team, the roles and responsibilities of the vacant position should be reviewed. In addition, other management positions including Regional Directors, Managers, Directors of Nursing and the Site Manager (CWJMH) should be reviewed.
  - FTEs within General Admin should be reconciled to determine if staffing reduction opportunities exist.
  - The Executive Leadership team should commit additional resources to the quality improvement and risk management program. The current commitment of a portion of a director's time who has significant other responsibilities is not sufficient to ensure sustainability of a regional quality improvement program.
- Rigourous processes
  - The Executive Leadership team should structure their meetings to ensure their reports are action focused, the quality and risk information are reviewed, external reviews are considered, action plans and accountabilities are established.
  - The Executive Leadership team should consider a policy for cost-impact analysis for new and operating capital initiatives.
  - The budget process should continue to evolve and include managers.
  - The Executive Leadership Team should undertake a learning needs assessment throughout the organization and this effort should include all levels of staff.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Summary and Recommendations: Executive Leadership Team

- Culture of best practices
  - A culture of best practices needs to be given license within HLC and led by the Executive Leadership Team. A Best Practices Committee should be established to identify practices that could be incorporated into the HLC operational environment.
  - The Best Practices Committee should ensure that the Medical Advisory Committee and Pharmacy and Therapeutics Committee are providing leadership for clinical best practices processes. They should, for example, ensure that available protocols are being leveraged.
    - ✓ To illustrate, protocols are now available for many clinical presentations that have evidence to support effectiveness both in terms of improved patient outcome and cost reduction. For example, Community Acquired Pneumonia, Grade I,II,III, IV Cellulites, Deep Vein Thrombosis, Pulmonary Embolism, Asthma, Ectopic Pregnancy, Myocardial Infarction, Ottawa Ankle Rules, Acute Coronary Syndrome, Hypertension and Diabetes, to mention but a few protocols, could be implemented within the HLC clinical environment, especially in the Community Clinics.
  - The Best Practices Committee should also ensure that internal processes are efficient and effective (e.g. turnaround time for xrays). This will require strong medical leadership, implementation of protocols, and learning from others (e.g. Health Care Corporation of St. John's).
  - HLC should participate fully in provincial processes such as the provincial utilization process.
  - As an academic institution, LHC is well positioned to lead a best practice approach. The Regional Director responsible for Community Clinics will be required to take a proactive role to educate the front line workers on the value of best practice management.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Observations: Regional Organizational Structure

- Regional Committees - Regional Management Council, Medical Staff, Pharmacy and Therapeutics, Medical Advisory Committee, Quality Teams, CRMS Steering Committee, Meditech Steering Committee, Community Needs Assessment Steering Committee, Integrated Support Services Management Team, Administrative Policy Committee, Staff Education Committee, Fire Disaster Committees, Professional Practice Committee.
- The current regional structure does not appear to be functioning at a level conducive to addressing the challenges faced by the Corporation.
  - The focus of the organization has been on acute care and crisis intervention.
  - Regional vision not understood from Board to providers of care and services.
  - Some regional directors do not see their leadership role as regional in focus.
  - Minutes for most committees were not available, including MAC, Pharmacy and Therapeutics. Medical Staff Committees and many other committees were institutional and not regional in focus or practice.
  - No evidence of regional clinical practice standards, policies, procedures accountability or quality framework.
  - No regional human resource plan.
  - Communication felt to be deficient at all levels of organization but especially at community level.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Summary and Recommendations: Regional Organizational Structure

- HLC has an unrecognized liability with respect to the health care needs of aboriginals. A strategic plan with an underpinning that is sensitive to population health drivers will require a tri-partite agreement among three groups: aboriginals, government (provincial and federal) and the service provider – HLC. In the initial stages:
  - Establish dialogue between HLC and Aboriginal Health Commissions
  - Develop a working relationship between the provincial and federal health departments and HLC.
- How can the health sector, in this case HLC, whose traditional role is treating the sick, influence the root causes of health and help to reduce inequities in health status among aboriginals? The answer lies in a collaborative effort to renew and reorient the health sector so that it can:
  - take action to meet the emerging challenges in health promotion, injury and disease prevention and health protection, as well as in treatment services;
  - increase the accountability of health services through improved reporting on the quality of health services, and improving access to all needed services;
  - increase our understanding of how the basic determinants of health influence collective and personal well-being;
  - evaluate and identify policy and program strategies that work; and
  - influence sectors outside of health that can significantly affect health status.
- DOH&CS should undertake a population health study of its aboriginal population, mindful of what is happening on the national stage and within aboriginal organizations. The Province should partner with aboriginal populations in this undertaking.

  For more information on the recommended population health approach, see Appendix B.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Summary and Recommendations: Regional Organizational Structure

- Leadership training program must be developed for regional directors in keeping with the priorities needs of the region. These programs should include understanding regional modeling, budgeting, accountability, quality, standards, policies and procedures and IT literacy. Development, implementation and monitoring of the impacts of the training program will require development of a formal process within HLC and strong interfaces with DOH&CS. This formal process should be put in place immediately.
- The Regional Structure and Model for nursing and medical staff, in particular, need to be more sensitive to operational needs. For example, community clinics human resource issues, in particular communication, professional development and policy development require direct management.
- Regional Directors' role, responsibilities and accountability need to be defined and understood.
- The CEO needs to develop a region wide communication strategy to ensure the regional strategic plan, including the vision, mission, values and strategic directions are understood.

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

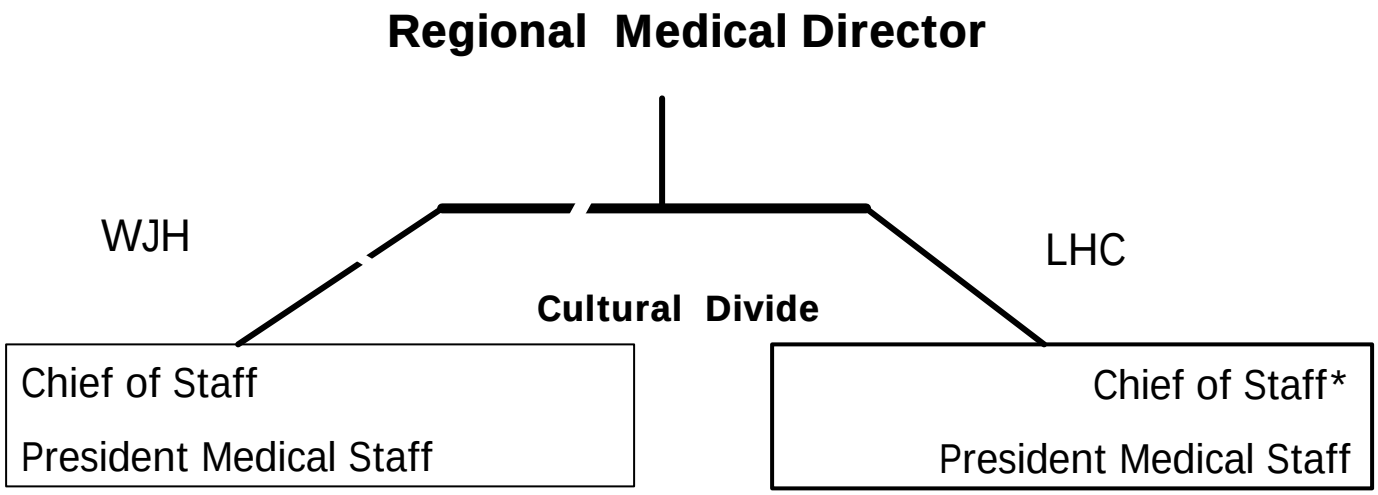
Observations: Medical Staff Structure

- Regional in concept, institutional in practice.
- Bylaws appropriate.
- Chief of Staff and Medical Director LHC are same person. This is a concern, since the Regional Medical Director has a leadership role than cannot be compromised by the needs of one institution. The Director must not only be impartial, but also be seen to be impartial.
- Separate mandates for Medical Staff Organization and Regional Medical Structure.
- Medical Advisory Committee:
  - Mandate not clearly understood by members
  - Has not met in six months
  - Minutes not available
  - Has never met face to face
  - Vision not articulated
  - Should be responsible for leadership in clinical best practice processes (e.g. clinical practice guidelines and care maps)
- Credentialing Committee:
  - Not a formal regional process
  - Process needs to be more inclusive of medical staff and Board
  - No Medical Staff evaluation tool in place

Board of Directors, Executive Leadership Team, Medical Staff

Example of challenges to regionalize Medical Staff structure

Medical Staff Structure



Key message

…

*Regional Medical Director and LHC Chief of Staff are same person

Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Summary and Recommendations: Medical Staff Structure

- Develop governance model where Chief of Staff for LHC (including Paddon Home) and CWJMH are accountable to the Medical Director.
- Professional staff organization structure must be separate and accountable to the medical staff and not the Medical Director. The leader of this body should be elected.
- Consider the option of having both the President of the professional staff organization and the Medical Director as voting members of the Board.
- Regional Credentialing Committee should have representation from both LHC and CWJMH Medical Staff and report to the Board.
- Develop a Regional Medical Human Resource Plan.
- Chief of Staff in each hospital must be accountable for developing and implementing evaluation tool with reporting accountability to Medical Director.
- The Board needs to support the educational interest of its medical staff both as a professional development and a retention and recruitment tool.
- The Board must be more closely involved with quality assurance. Processes must be established to deal with issues, and issues should be dealt with during regular monthly meetings.

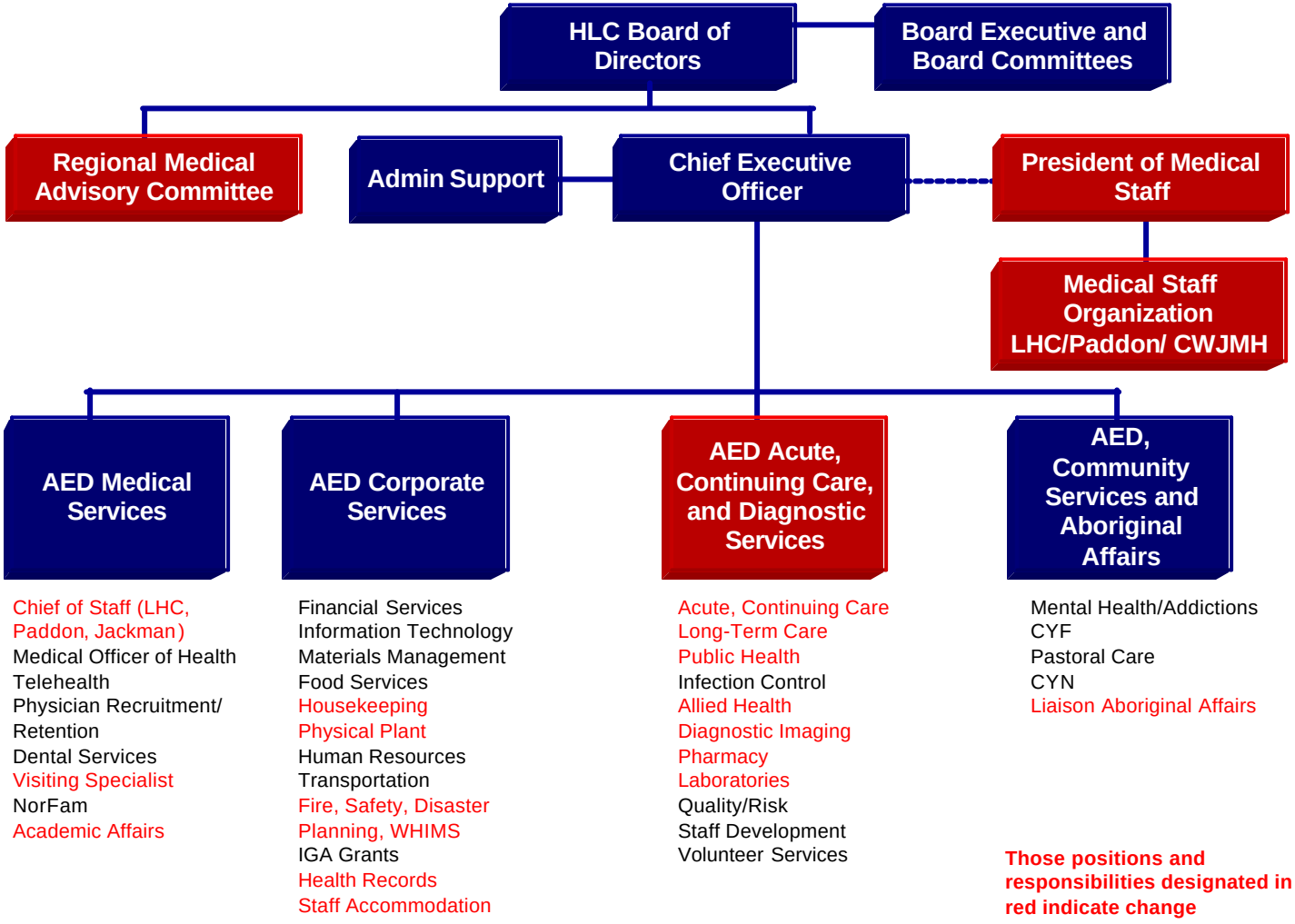
Board of Directors, Executive Leadership Team, Medical Staff

Deloitte & Touche

Summary and Recommendations: Corporate Structure

- We recommend modifications to HLC's corporate structure as shown on the following page. Highlights of the recommendations include:
  - 4 AEDs reporting to the CEO, including an AED of Acute, Continuing Care and Diagnostic Services. Responsibilities of all AEDs will change to differing degrees.
  - A well functioning Regional MAC reporting to the Board of Directors.
  - A restructured medical staff organization.

Proposed Corporate Structure HLC



Those positions and responsibilities designated in red indicate change

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Relationships with Innu, Inuit and Metis Groups

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Overview

- The Labrador **Inuit** Association (LIA) has roughly 4,500 members, representing the entire Inuit population in Labrador; 50% located in Goose Bay; 50% on the north coast.
- Labrador Inuit Health Commission (LIHC) is responsible for the following primary care core programs in coastal communities (excluding Cartwright, Black Tickle):
  - Environmental health
  - Mental health
  - Addictions
  - Community health and communicable disease control
  - Child care/development
  - Home and community care
  - Non-insured health benefits*
- These services were to be provided within a budget of $12.3M in 2001/02, funded by Health Canada. This represents $2,700 per member. Dollars flow directly to LIHC.

* Includes benefits not covered under the provincial medicare program, e.g. drugs, dental, optometry.

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Overview

- The **Innu** population resides in Sheshatshiu (1,400 band members) and Davis Inlet (Natuashish; 700 band members).
- Band-controlled health commissions administer the following programs:
  - Sheshatshiu (2001/02 estimate: $1,690,235)
    - ✓ National Native Alcohol and Drug Program
    - ✓ Brighter Futures
    - ✓ Building Healthy Communities
    - ✓ Canada Pre-natal Nutrition Program
    - ✓ First Nations Home and Community Care
    - ✓ Family Treatment Program
    - ✓ Community Development Staff
    - ✓ Day Program and Youth Outreach
    - ✓ Non-Insured Health Benefits

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Overview

- Davis Inlet (2001/02 estimate: $4,476,398)
  - ✓ Mobile Treatment
  - ✓ National Native Alcohol Drug Abuse Program
  - ✓ Brighter Futures
  - ✓ Canada Pre-natal Nutrition Program
  - ✓ First Nations and Inuit Home and Community Care
  - ✓ Community After Care Programs
  - ✓ Mushuau Innu Participation
  - ✓ Mushuau Innu Healing Coordinator
  - ✓ Community Development Staff
  - ✓ HIV/AIDS Program
  - ✓ White Swan Treatment Centre
  - ✓ Woods Home Treatment Centre
  - ✓ St. Norbert's Treatment Centre
  - ✓ Health Services Program
  - ✓ Non-Insured Health Benefits
  - ✓ Diabetes Initiative
  - ✓ Building Healthy Communities
- Combined Sheshatshiu and Davis Inlet Diabetes Initiative ($92,000)

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Overview

- Child Youth & Family Services Agreement – Federal/Provincial Agreement (INAC) targeting Innu population; HLC designated as Province's agent.
  - ✓ Operational Grant (June 02-March 03) $ 790,000
  - ✓ Maximum Reimbursements for Maintenance* (previously $4.6M) $3,000,000
- If current recoveries from INAC for Innu Child, Youth and Family Services are not maintained by HLC, the projected deficit in Community Services for 2002/03 will likely exceed $4.3M.

* Maintenance outside family home

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Overview

- Labrador **Metis** Nation; 5,000 members: 2,500 members in Goose Bay, 700 members in Cartwright and Black Tickle, 1,800 in southern Labrador (most of which are outside HLC jurisdiction).
- Minimal funding from federal government.

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Observations

- Sharing of vision and information
  - Aboriginal groups want to control their own health and community programs.
  - HLC, Government and Aboriginal groups have not developed a communication framework to ensure mutual understanding of vision.
  - There is a lack of trust between HLC and aboriginal groups.
  - Financial agreements for shared services between HLC, aboriginal provider groups and government are not shared.
- Provision of services
  - There appears to be a duplication of services. For example, community programs such as mental health in two communities are staffed by both HLC and health commissions.
  - As devolution progresses, HLC will likely have to support service delivery, including the provision of back-up services and mentoring.
  - There is a realization by aboriginal leadership that aboriginal groups require professional development before devolution of programs.
  - Stakeholders do not understand each others' challenges in providing services to people in need.
  - There are insufficient numbers of translators at LHC to meet the needs of the aboriginal community.
  - Transportation from the coast to LHC and St. John's is a hardship, particularly for elders. They wish to have more medical services provided in their communities.

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Observations

- Financial matters
  - Non-insured services (e.g. orthodontics) drive significant air transportation costs.
  - Non-insured services are being subsidized indirectly through access to Schedevac flights. HLC is paid $40 by LIHC for flights that cost, on average, $400.
  - Processes are in place to capture amounts claimable under the Federal/Provincial Innu Agreement on Child, Youth and Family Services:
    - ✓ Claims process is cumbersome and still evolving
    - ✓ Reliance on front line workers to use appropriate coding
    - ✓ Amount available for recovery recently reduced by $1.6M effective January 2003 (from $4.6M to $3M)
    - ✓ Current agreement expires March 2003 (renewable)
  - Agreements continue to be negotiated which greatly impact HLC, but over which they have little control.
  - There is an unrecognized liability resulting from poor understanding of population health needs (eg. diabetes, substance abuse, high birth rate).

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

Summary and Recommendations

- Establish planning framework with all stakeholders to identify:
  - Needs of the population
  - Resources required (staff, physical plant)
  - Timetable for devolution
  - Financial impact
- Develop partnerships on the basis of transparency, trust and mutual respect.
- Develop dispute resolution process to address variance in vision, mission and directions.
- Stakeholders must work at understanding each others' cultural uniqueness by using supporting affirmative action programs that would see aboriginal leaders incorporated into the governance structure of HLC, including senior executive.
- Ensure cost recovery opportunities in relation to federal programs for, and agreements with, aboriginals are maximized.

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- **REVIEW OF FINDINGS**
- **Operational Review**

Acute Care

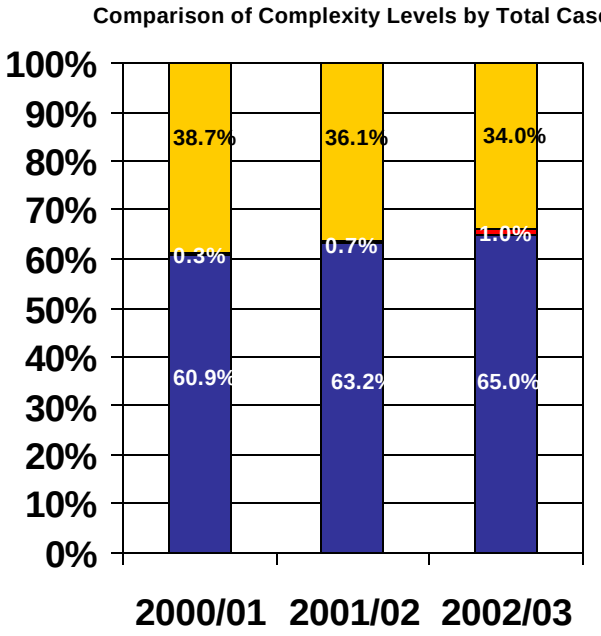
Overview

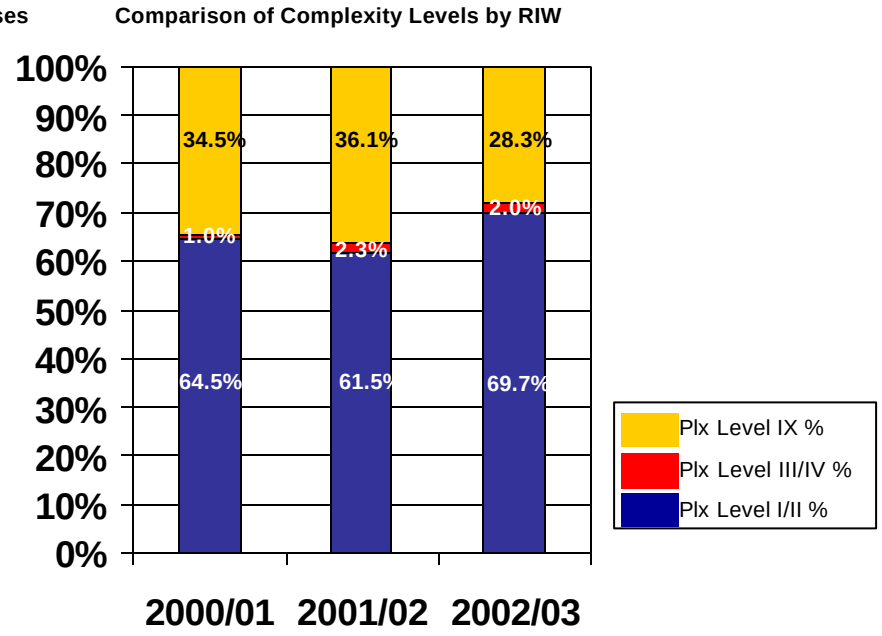
Deloitte & Touche

- Clinical programs at LHC, CWJMH and coastal nursing stations were included in the scope of this review. The findings from the community clinics are included in a separate section of this report.
- In presenting the clinical findings we have reviewed both:
  - clinical utilization – internal analysis of complexity and utilization data and external comparison of utilization data (CMGs, ALOS, ARIW); and
  - clinical staffing – comparative analysis of staffing levels and skill-mix for each acute and ambulatory program with benchmark organizations and experience.
- The data was reviewed to determine if HLC is within expected ranges for similar organizations.

Clinical Findings – Complexity Levels (LHC)

Deloitte & Touche





In looking at the mix of patients at LHC over the three-year period, the overall mix of admitted patients has not changed significantly in terms of volume or complexity. The % of Level III/IV cases is very low, suggesting that all complex cases are referred out of Labrador.

Level I – No co-morbidities; Level II – Co-morbidities related to chronic conditions; Level III – Serious co-morbidities; Level IV – Life-threatening co-morbidities; Level IX – No complexity overlay (OB, Mental Health, LTC) (Source: CIHI)

Clinical Findings – Complexity Levels (LHC)

Deloitte & Touche

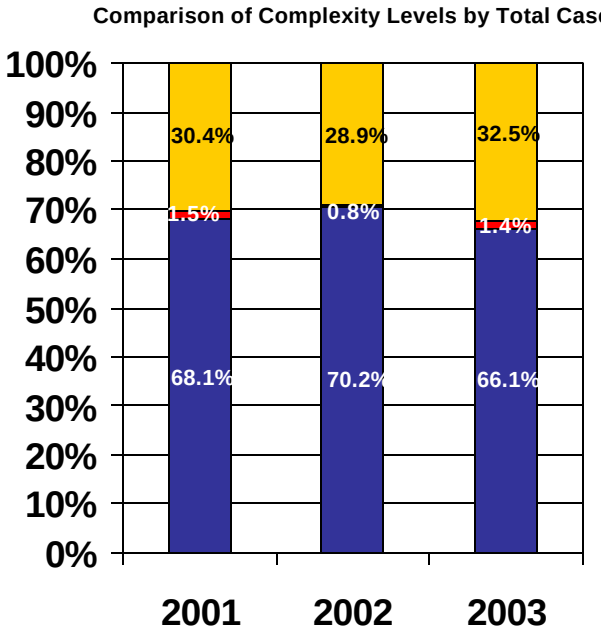
All Levels	Cases	RIW	ARIW	Acute ALOS	Gap to Benchmark (days)
2000/01	594	412.5	0.7	4.0	0.4
2001/02	574	363.0	0.6	3.6	0.4
2002/03	609	366.0	0.6	3.8	0.8
Change 01/03	15	-46.5	-0.1	-0.2	
% Change 01/03	2.5%	-11.3%	-13.5%	-4.0%	

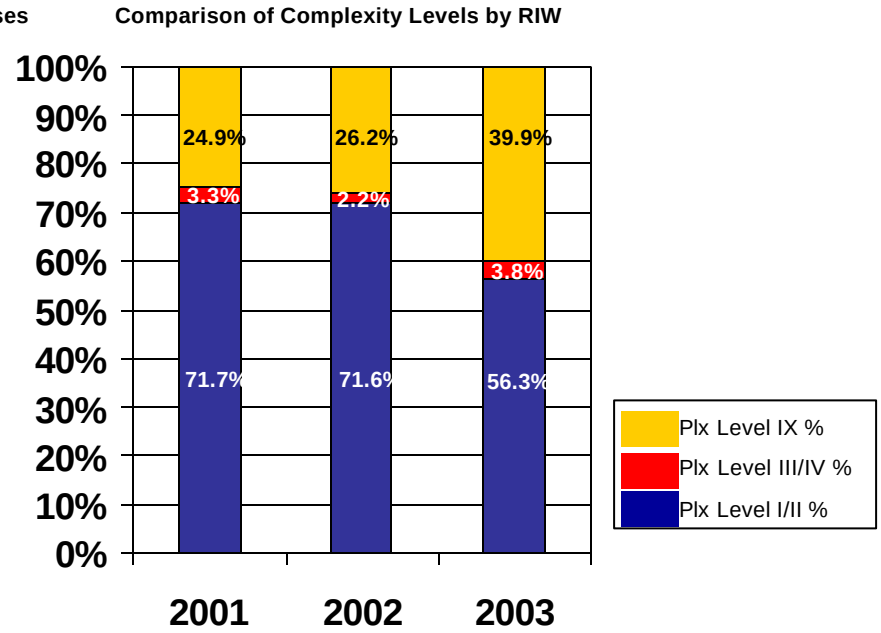
- **There is an inverse relationship between volume and acuity. One would prefer to see the two factors moving in the same direction.**
- **The gap between LHC and benchmark organizations is small (less than 1 day). However, it has increased in the current year and should be monitored to prevent widening of the gap.**

Note: All data is 4 month data, as that was all that was available for LHC for 2003. It is assumed that LOS contains both Acute and ALC days. 2001 data did not differentiate between Acute and ALC. 2002 data did provide a differentiation and, upon review, there was a total of 75 ALC days.

Clinical Findings – Complexity Levels (CWJ)

Deloitte & Touche





In looking at the complexity of patients at CWJMH over the three-year period, the overall mix of admitted patients has not changed significantly in terms of volume. In terms of complexity, there has been an increase in the proportion of level IX patients. As with LHC, the proportion of level III/IV patients is low.

Level I – No co-morbidities; Level II – Co-morbidities related to chronic conditions; Level III – Serious co-morbidities; Level IV – Life-threatening co-morbidities; Level IX – No complexity overlay (OB, Mental Health, LTC) (Source: CIHI)

Clinical Findings – Complexity Levels (CWJ)

Deloitte & Touche

All Levels	Cases	RIW	ARIW	Acute ALOS	Gap to Benchmark
2000/01	477	306.3	0.6	4.8	1.5
2001/02	494	672.9	1.4	3.3	0.0
2002/03	422	305.1	0.7	3.6	0.1
Change 01/03	-55	-1.1	0.1	-1.2	
% Change 01/03	-11.5%	-0.4%	12.6%	-24.9%	

The number of cases is down slightly at CWHMH; current complexity is equal to the level in 2000/01. The ALOS reduction is positive and reflective of effective bed utilization. The organization has done a good job of closing the gap relative to peer organizations.

Note: All data is 8 month data, as that was all that was available for CWJ for 2003. All data is LOS, as there was no differentiation between Acute and ALC days.

Complexity Levels - Summary

Deloitte & Touche

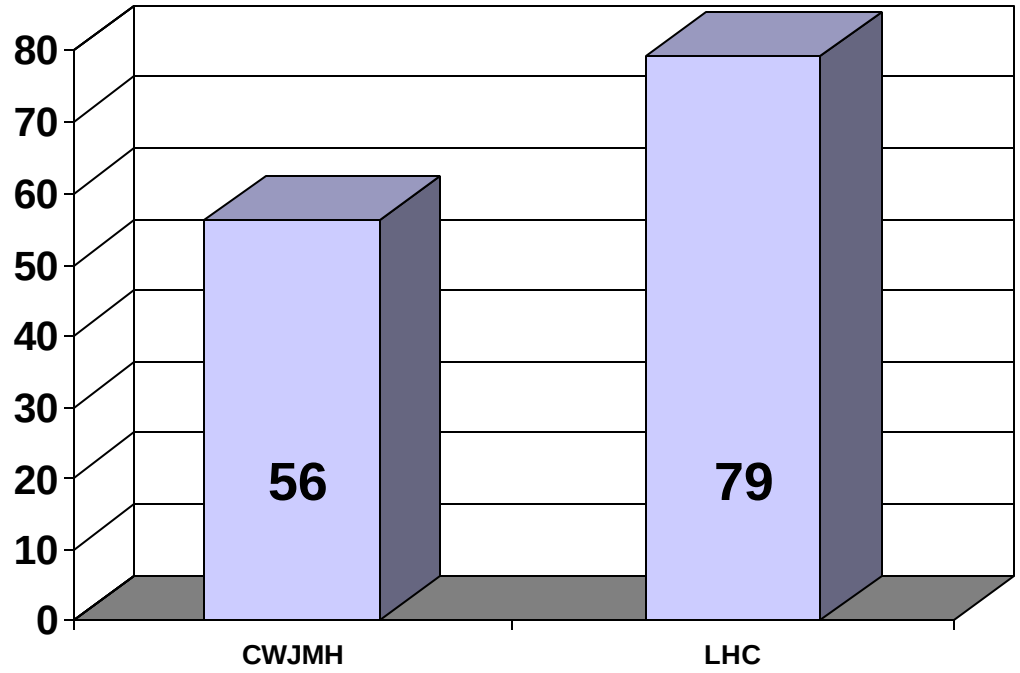
- Volumes and complexity levels have not changed significantly in HLC in the past three years.
- LOS is appropriate for the complexity of patients being served.
- The proportion of admitted Level III/IV patients is below what one would expect. Currently being triaged and transported early.
- Expect increased levels of complexity specifically for the diabetic population:
  - For example, the incidence of Diabetes in the aboriginal population is believed to be close to 50%. Diabetes is the leading risk factor for Ischemic Heart Disease. In addition, a significant number of people with Diabetes will have end organ disease: Renal Failure, Peripheral Vascular Disease and Diabetic Retinopathy. With more than 50% of the population under 25 years of age, the impact of the aboriginal cohort on health care costs will be nothing less than dramatic.

Clinical Findings – External LOS Comparison

- In conducting an external comparison of utilization data, the goal is to identify potential opportunities to improve utilization in relation to peer organizations.
- We conduct an assessment of utilization and potentially "conservable days" opportunities. In doing this, we compare your ALOS by CMG to peer organizations. The analysis is based on the available nine months of data for 2002/03.

Clinical Findings – External LOS Comparison

Potential Conservable Days (Annualized)



The analysis of CWJMH and LHC average length of stay compared to peer organizations suggests there is an opportunity to conserve only 56 days at CWJMH and 79 days at LHC. As these savings are insufficient to reduce beds, there are no potential bed or staff reductions. These findings suggest good bed utilization practices.

Clinical Findings – Staffing Efficiency

- Lack of nursing workload data has limited the ability to conduct a thorough staffing analysis and make substantiated recommendations by unit.
- In addition, in smaller facilities, inefficiencies are often driven by volumes rather than staffing model decisions.
- Opportunities for improvement are based on a qualitative assessment and available data, combined with experience.
- In general, nursing to patient ratios appear to be adequate, given the type of patient population.
- Based on a high-level comparison with other similar organizations (with similar challenges with respect to supports), a small number of opportunities to decrease staffing may exist in selected areas; however, a number of factors need to be considered to implement the opportunities.

Staffing Overview – LHC (Acute Unit)

Deloitte & Touche

- 26-bed inpatient unit; services include obstetrics, medical/surgical, newborn, respite, palliative/respite, gynaecology.
- In 2001/02, there were 6,407 patient days, with a 67% occupancy; 75% of the patient days were medical/surgical; 42% of the patients came from the surrounding area and 58% from coastal communities.
- There were 197 deliveries with a 17% C-Section rate.
- Not all registered nursing staff are cross-trained.
- The FTE complement includes 1 FTE nurse manager, 0.4 FTE head nurse, 10.5 FTE RNs, 7 FTE midwives, 5 FTE LPNs, 2.6 FTE ward clerk.

Position	Day	Evening	Night
Nurse Manager	1		
Head Nurse	0.4		
RNs	3.6	3-2	2
Midwives	2	2-1	1
LPNs	1-2	2-1	1
Ward Clerk	1	1	

Staffing Overview – LHC (OR/PAR/RR/ Day Surgery/Special Procedures)

Deloitte & Touche

- Two operating rooms which operate 5 days per week (0800 to 1300).
- The OR is a 24/7 operation, which performed 940 cases last year (including 133 inpatient, 426 day surgery, and 381 special procedures).
- 70% of the case load is day surgery.
- Staff are cross-trained for all functions.
- Staff are on call after normal working hours.
- Current staffing: 1 FTE nurse manager (who has responsibilities for other clinical areas); 4.0 FTE RNs; 0.8 FTE OR technicians; 0.4 FTE head nurse; 1 FTE medical services assistant.
- With HPPD 8.98, LHC's OR operates with staffing levels slightly higher than benchmarks. However, with geographical challenges, lack of casual staff and the visiting surgeon program, greater efficiencies will be difficult to achieve.

Staffing Overview – LHC (Emergency)

- Emergency is a 24/7 operation, with 1 physician covering each shift and 1 on call from Medevacs.
- Last year (2001/02), there were approximately 18,100 visits to Emergency.
- Staff also do chemotherapy treatments and provide assistance to the Radiology Department.
- No triage coding system is in place.
- Current staff includes: 1 FTE nurse manager (who has other responsibilities at LHC); 10 FTE RNs; 4.2 ward clerks.

Staffing Overview – LHC (Outpatients)

- This is a Monday to Friday (0800 to 1600) operation with a Well Women evening clinic available 7.5 hours per week in the evening.
- Staffing includes: 2 FTE LPNs; clerical support is provided by Health Records.

Staffing Overview – CWJMH (Acute and Long-Term Care)

Deloitte & Touche

- A 20-bed inpatient unit which includes 6 long-term care beds.
- Services provided include: obstetrics; paediatrics; palliative care; special care; and medical/surgical.
- 65 deliveries were performed last year, with a 42% C-Section rate.
- 75% of the caseload was Medical/Surgical.
- Staffing complement includes: 1 FTE nurse manager (who has responsibility for other clinical areas); 10.5 FTE RNs; 5 FTE LPNs; 1 FTE ward clerk; 0.2 FTE recreational therapist.

Position	Day	Evening	Night
Nurse Manager	1		
RNs	3	2	2
LPNs	1-0.33	1	1
Ward Clerk	1		
Recreational Therapist	0.2		

Staffing Overview – CWJMH (Emergency)

Deloitte & Touche

- This is a 24/7 operation with 2,993 visits in 2001/02.
- Activities include minor procedures, phlebotomies, excisional biopsies, IV medication start-ups, and casts.
- Staffing complement includes: 3.65 FTE RNs; 0.5 FTE ward clerk (shared position); 0.5 FTE aide (shared position with inpatient units and OR); 0.5 FTE oncology coordinator; 0.58 FTE RN support for special clinics.

Position	Day	Evening	Night
RNs	2-1	1	1*
Ward Clerk	0.5		

* Coverage provided by the nursing supervisor

Staffing Overview – CWJMH (OR/PAR/RR/Day Surgery/Pre-Op Clinic/OPD

Deloitte & Touche

- This is a 24/7 operation with 890 OR cases and 381 special procedures in 2001/02.
- The staff are all cross-trained, providing coverage in OR/PAR/RR/Day Surgery/Pre-Op Clinic/OPD.
- They also provide some support to the Emergency Department.
- Staffing complement includes: 4.65 FTE RNs; 0.5 FTE LPNs.

Clinical Findings – Staffing Observations

- Directors and managers have identified some challenges in staffing their units cost-effectively:

LHC:

- Availability of skilled staff, including casual staff to meet clinical needs is limited.
- Cross-training of staff at LHC (Acute Care Unit) is minimal.
- Volumes of chemotherapy treatments at LHC have increased by 20% over the past 2 years.
- Medevacs and patient escort requirements are expensive and destabilizing to staff; overtime and time in lieu costs are high.
- Recruitment and retention of nursing staff place extra challenges on older, more experienced staff.
- The Collective Agreement limits the effective management of staff lieu time.
- Clinical pharmacy support is not available to assist staff in clinical decision-making.
- Clinical nutrition support to assist staff in decision-making is minimal.
- Respiratory therapy support is not available to assist staff with clinical decision-making (e.g. ventilator care).

Clinical Findings – Staffing Observations

Deloitte & Touche

CWJMH:

- Availability of skilled staff, including casual staff to meet clinical needs is limited.
- Volumes of chemotherapy treatments at CWJMH have increased by 20% over the past 2 years.
- CWJMH struggles with physical space layout; the acute/LTC unit layout is not conducive to maximum efficiency. There is adequate space, but it is not well designed for its current use.
- The Emergency Department at CWJMH is inadequate for triage patient care space, privacy and efficiency.
- Medevacs and patient escort requirements are expensive and destabilizing to staff; overtime and time in lieu costs are high.
- Recruitment and retention of nursing staff place extra challenges on older, more experienced staff.
- The Collective Agreement limits the effective management of staff lieu time.
- Clinical pharmacy support is not available to assist staff in clinical decision-making.
- Clinical nutrition support to assist staff in decision-making is minimal.
- Respiratory therapy support is not available to assist staff with clinical decision-making (e.g. ventilator care).

Clinical Findings – Staffing Observations (cont'd)

Deloitte & Touche

- Additional challenged:
  - Frustration with the lack of a quality improvement framework, including meaningful outcome indicators.
  - Limited resources for training/education.
  - Inability to utilize the Telehealth Network for clinical consultation, education and administrative meetings.
  - Absence of a workload measurement classification system to support staffing decision-making.
  - Lack of consultation with the introduction of new programs and capital equipment.
  - Lack of involvement in budget process. This area has improved although not at the manager level.
  - There is no regional approach to standards of care, policy and practices.

Clinical Findings – Staffing

Deloitte & Touche

Summary and Recommendations

- Generally, there are only minimal potential savings in the clinical areas, with the potential for additional savings if the medevac program was centralized.

  LHC:

  - The concept of a regional nursing program is not working well. Regional standards, policy and practices along with the quality improvement program are in the early stages of development.
  - When comparing LHC and CWJMH to peers, nursing skill mix of 60% professional, 40% non-professional is appropriate.
  - The obstetrics beds at LHC are staffed almost as a stand-alone facility. Not all of the RN staff are cross-trained. With cross-training the organization should be able to reduce staff on the acute unit by 1.5 to 2.0 FTEs.
  - Improved clinical support from pharmacy, respiratory therapy and clinical nutrition should be considered.

Clinical Findings – Staffing

Deloitte & Touche

Summary and Recommendations

CWJMH

- The concept of a regional nursing program is not working well. Regional standards, policy and practices along with the quality improvement program are in the early stages of development.
- When comparing acute care at CWJMH to benchmark, nursing skill mix of 60% professional, 40% non-professional is appropriate.
- The acute unit at CWJMH is staffed slightly above benchmark; however with the support provided to the Emergency Department and the stress-test lab, further efficiencies will be difficult to achieve.
- The Emergency Department staffing level at CWJMH is lower than benchmark; however additional hours are provided by nursing supervisors and the acute unit.
- The OR staffing level at CWJMH is slightly above benchmarks; however given they operate 24/7, the geographic challenges, visiting specialist program and the inability to recruit casual staff, the opportunity for improved efficiencies is minimal.
- Improved clinical support from pharmacy, respiratory therapy and clinical nutrition should be considered.
- It is recommended that CWJMH (Long-Term Care) should develop a continuing care worker model. The anticipated cost savings when fully implemented will be approximately $20,000 annually.

Clinical – Summary and Recommendations

Deloitte & Touche

- HLC is doing a good job managing utilization.
- Minimal staffing efficiency opportunities exist. The organization should ensure it realizes all potential opportunities.
- Treating more complex patients would reduce air transport costs. Requires analysis of impact of additional scope and volume and required investment.

Workload Indicator	Benchmark	Recommended
LHC		
Acute (HPPD 4.57)	4.57	Reduce 2 RNs
Obstetrics (HPPD 13.93)	10.02	
Emergency/Ambulatory (HPPD .50)	.55	No change
OR/PAR/Day Surgery/Special Procedures (HPPC 8.98)	8.0	No change
CWJMH		
Acute/Long-Term Care (HPPD 5.39)	5.0	No change
Emergency/Ambulatory (HPPV .42)	.45	No change
OR/PAR/Day Surgery/Special Procedures (HPPC 13.69)	8.0	No change
Paddon Home		
(HPPD 3.06)	3.2	No change

* Benchmarks based on experience of Deloitte & Touche team members with organizations similar to LHC, CWJMH and Paddon Home.

There is an opportunity to reduce two FTE RNs at LHC (Acute and Obstetrics). Given low volumes and geographic considerations, further reduction is not recommended.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Administration and Clinical Support

Overview

- The following Administration and Clinical Support Service areas were reviewed in the comparative analysis:
  - Administration: Finance, Human Resources, Systems Support, Housekeeping, Laundry and Linen, Materials Management, Plant Services, Communications, Health Records/Registration and Food Services.
  - Clinical Support:
    - ✓ Allied Health: Physiotherapy and Occupational Therapy
    - ✓ Laboratory
    - ✓ Diagnostic Imaging
    - ✓ Pharmacy
    - ✓ Clinical Education
    - ✓ Nursing Administration
- The following departments were combined for benchmarking purposes, as smaller facilities often have staff who cross departments: Finance and Human Resources; Registration, Health Records and Communications; and Housekeeping and Laundry and Linen.
- 25th percentile benchmarks were used for the Administration areas and 50th percentile for Clinical Support areas.
- Paid hours are used as the basis for FTE calculations; therefore includes overtime and excludes unfilled positions.
- We do not recommend changes if the variance from peers is +/- .5 FTEs or less.

Finance/HR

Deloitte & Touche

Observations

- In 2001/02 a total of 18.4 FTEs provide Finance and HR services to HLC.
- HR FTEs totaled 4.5, including 4.0 at LHC and 0.5 at CWJMH. Two positions are managerial.
- A breakdown of the 13.9 Finance FTEs is provided below. The AED-Corporate Services, and his secretarial support are included in General Administration for benchmarking purposes.

Health Labrador Corporation Financial Services Staffing				
	Regional – LHC	CWJMH	Paddon	Total
Regional Director - Financial Services	1.0			1.0
Budget Analyst	1.0			1.0
Accounts Supervisor		0.4		0.4
Payroll	2.0	0.5		2.5
Accounts Payable	3.0	1.0		4.0
Accounts Receivable	2.0	1.0		3.0
General Ledger	1.0			1.0
Trust Account Clerk			1.0	1.0
Total	**11.0**	**2.9**	**1.0**	**13.9**

Finance/HR

Observations (cont'd)

- Relative to peer organizations, LHC is significantly over-staffed in terms of Finance/HR resources.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.32	0.33	+0.1
LHC	1.17	0.33	-10.4

Deloitte & Touche

Structure, Resources and Location of Accounting Services

- Department structure:
  - Reporting lines are clear and seem appropriate for an organization of this size.
  - The AED – Corporate Services seems to spend a lot of time on financial issues, “in the trenches” performing tasks that normally would be performed by the Regional Director – Financial Services or the Budget Analyst.
  - The Regional Director – Financial Services advises that, while HLC is not currently MIS compliant, she is spending a significant amount of time working with other groups within the organization on MIS compliance issues.
- Number of staff:
  - As indicated previously, benchmarking indicates over-staffing in relation to peers.
  - Remoteness and demographics of coastal communities, combined with a widely dispersed population generally and mandate to provide integrated services, create unique challenges for accounting staff.
  - The early stage of evolution of the group and its systems may limit efficiency in the short term.
  - Unique reporting requirements, primarily related to servicing the aboriginal population, are not faced by other boards and require significant amounts of staff time.
  - Significant amounts of extra work have been undertaken in recent years to develop Meditech financial modules and to get “caught up” on year-end audits.

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Structure, Resources and Location of Accounting Services (cont'd)

- Number of staff (cont'd):
  - Meditech still requires a significant amount of work and further investments of financial resources to reach "best practices".
  - Management feels that the implementation of CRMS will create a significant increase in workload.
  - In fiscal 2000/01, the Budget Analyst position was added, with both HLC management and government apparently agreeing that more effort was required in the key areas of budgeting and internal audit. While not common in other organizations of a similar size, the expense is currently justifiable at HLC due to their unique reporting requirements, the early stage of evolution of the finance group, and the challenges being faced by HLC such as devolution and eventual CRMS implementation.
  - Accounting tasks related to coastal communities, military personnel, retail pharmacy operations, and third party billings for salaried doctors take considerable time and are not adequately reflected in benchmarking numbers.
  - CWJMH staff also relieve the switchboard, thereby interrupting workflow.
- Location of accounting functions:
  - Paddon trust accountant was centralized at one point, but was returned to site after difficulties were encountered.
  - An accounting group of 2.9 FTEs remain at CWJMH. Completing the regionalization of the accounting function by moving these positions to LHC is an option in realizing efficiencies in this function.

Finance/HR

Deloitte & Touche

Qualifications of Accounting Staff

- AED – Corporate Services:
  - An experienced professional accountant
  - Limited experience in healthcare before joining HLC in September 1998
  - By all accounts has advanced HLC greatly during his tenure
  - Committed to organization
- Regional Director – Financial Services:
  - Not a professional accountant or university graduate
  - Experienced in healthcare
  - Long-time accountant for Paddon Home prior to HLC's creation
  - Strong ties to Goose Bay
  - Committed to the organization
- Budget Analyst:
  - Has a commerce degree and is studying for a professional accountancy designation
  - Inexperienced, but very enthusiastic
- Accounting Clerks:
  - Most have joined HLC recently
  - All have some relevant experience prior to joining
  - All have diploma from relevant two year course (or compensating experience)

Finance/HR

Deloitte & Touche

Summary and Recommendations

- In Finance/HR, there appears to be an opportunity to reduce staff by 3.5 FTEs (3 in Finance and 0.5 in HR), though perhaps not all in the short-term – may be achieved through further regionalization and Meditech financial module enhancements.
- Finance staff generally tend to be very dedicated to the organization, but relatively inexperienced in a healthcare environment and may only meet the minimum job qualifications.
- Recruitment and retention of qualified accounting staff at all levels has been a challenge in the past.
- The maintenance of a stable accounting staff is a significant accomplishment for the organization.
- Management feels that accounting staff work very effectively in a unique and challenging environment.
- The continued development and training of existing accounting staff should be a priority.
- Create a strategic plan for financial services.

Systems Support

Observations: Overview

- In 2001/02 3.7 FTEs provided systems support within HLC. An additional 2.71 FTEs were identified as Meditech planning and development resources within General Administration. For purposes of comparing HLC to peer organizations, only the 3.7 core IT FTEs were included.
- HLC has rapidly deployed technology given the start point of limited and dated technology.
- HLC has implemented basic office automation tools and core health systems & technologies.
- Compared to peers, IT resources for ongoing operations are higher than benchmarks. It should be noted that many peer organizations have limited IT support.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
Regional (CWJ, LHC, Paddon) (excl. Meditech)	0.12	0.06	-1.8

- Geographic considerations, the early stage of evolution of regional systems, and the volume of implementation activity justify the variance.

Systems Support

Deloitte & Touche

Observations: Overview

- Users are functioning with basic systems understanding and may not be fully optimizing existing systems capabilities (i.e. Meditech and report writing).
- Centralized management & control have facilitated standards and cost management. IT staff are cross-trained to provide multi-function support.
- Though HLC has not leveraged outsourcing opportunities, the current operations are relatively cost efficient and would not achieve benefits from outsourcing.
- Current technology investments and initiatives are reasonable.

Systems Support

Deloitte & Touche

Observations: Applications

- HLC has implemented core health systems and supporting technologies.
- HLC continues to keep pace with other regions in the Province in implementing core health technologies.
- Meditech needs to be expanded to provide better management of pharmacy, materials and flight requisitions.
- Need for remote deployment of core applications to field to access patient information and results.
- Need for better data access, reporting, business intelligence tools to provide accurate management analysis.
- Opportunity with Meditech to retire the QS1 Pharmacy System and migrate to Meditech.
- Opportunity to leverage imaging to reduce storage needs and create accessibility of patient information.
- The implementation of full PACS would improve speed, access and storage for digital imagery.
- Need for several quick fixes to address Meditech issues (i.e. LIS referred out tests).

Systems Support

Deloitte & Touche

Observations: Infrastructure

- A stable technical environment has been created with minimal downtime.
- Very diverse infrastructure has been created on minimal budget; standards for purchasing should be defined and budget allocated to create a standard technology base to reduce long-term support and acquisition costs.
- Several servers are low grade equipment not meant to support healthcare critical systems.
- HLC is running a dated server architecture - need to migrate to Windows 2000.
- HLC needs redundancy in its core systems, primarily Meditech.
- Due to ground-zero start, a large portion of equipment is expiring at the same time requiring a number of servers and desktops to be replaced over the next two years.
- Need to upgrade and standardize desktops to current technologies to support current applications and support needs. There are too many versions of operating systems and office automation applications to properly support. This should be standardized to two.

Systems Support

Deloitte & Touche

Observations: Communications

- There is a critical need for connectivity for all nursing stations and CYFS to access core applications and collaboration tools.
- CWJMH is running many users over 512kbps. This bandwidth may need to be upgraded to allow for acceptable response time and application access.
- Communications infrastructure that is currently in place may not be able to support 80 new CRMS users and CYFS users.
- Smart Labrador / Telehealth is not properly or fully used due to lack of training, procedures, technical issues and centralized control & management of the technology. As well, funding decision related to the on-going use of this technology are outstanding.
- Investigation and implementation of technology to support data communication via Smart Labrador network could address connectivity needs.

Systems Support

Deloitte & Touche

Observations: IT Organization

- The IT staff are cross-trained to provide multi-function support.
- Centralized management & control have facilitated standards and cost management.
- IT resources appear to be under-staffed and over-challenged given the breath of technologies and volume of projects. As indicated previously, while HLC is over-staffed relative to peers when looking at ongoing IT operations, the volume of activity in the medium-term justifies current staffing levels. Detailed analysis of key upcoming projects, planning/scoping and resourcing needs should be conducted.
- Meditech vendor technical support is poor, placing a larger workload on HLC staff to resolve application issues.
- CRMS may require new support resources within HLC (functional & technical); however the scope & schedule of these implementations will drive resourcing requirements.
- There is a need for education programs for technical support and end users including Meditech, office automation, CRMS, PACS.
- Geography and multi-site model makes comprehensive support difficult.

Systems Support

Deloitte & Touche

Observations: Security and Controls

- Standard security tools have been implemented.
- No major failures or downtimes have been experienced.
- No disaster recovery plan is in place.
- No standards on data retention are established to automate and ensure historic data access.
- Need for defined control reporting to be deployed across the region.
- Need for internal firewall and authentication as CYFS users join the HLC organization and infrastructure.

Systems Support

Deloitte & Touche

Observations: Projects

- Current technology investments and initiatives are reasonable.
- Application deployment placing significant demands on resources.
- Need for Information Technology Strategic Plan.
- Need for dedicated project teams to implement Meditech & CRMS.
- Need to continue deployment of core Meditech applications including Data Repository, Electronic Forms, Pathology, Patient Care System, and Physician Order Management.
- Need for technology education & training development and deployment.
- Need to create communications infrastructure to all sites.
- Need to standardize & upgrade infrastructure, desktop and applications.

Systems Support

Deloitte & Touche

Summary and Recommendations

- Connectivity - There is a critical need to install network connectivity for all nursing stations and CYFS to access core applications and collaboration tools.
- Implementing Systems -
  - Meditech implementation is under-resourced which is slowing implementation. Dedicated project teams should be established to implement Meditech and CRMS independent of other functions and roles.
  - Meditech implementation should continue and be expanded to provide better management of pharmacy, materials and flight requisitions. This will improve control, efficiency and cost management.
  - The Meditech servers are aging and the vendor is phasing out support of the technology. These need to be replaced before critical failure.
  - HLC is behind in the deployment of CRMS and may require an increased investment to catch up.
- It should be noted that, while we strongly support the recommended IT investments, identified savings are not dependent on these investments. The IT investments (e.g. Meditech, PACS) may support additional efficiency opportunities in the future.
- Proper Budgeting - Proper budget has not been allocated for maintenance of technology - only provision for the initial projects. Long-term support and maintenance upgrade budgets need to be defined and funded.
- Leverage Telehealth - Smart Labrador/Telehealth is not properly or fully used due to lack of training, procedures, technical issues and centralized control & management of the technology. A plan to replace or enhance the technology is required.
- Disaster Recover Plan - A disaster recovery plan has not been developed. While basic backup processes are in place, there is need for more comprehensive redundancy, data protection, backup and recovery procedures and tools.

Systems Support

Deloitte & Touche

Summary and Recommendations

- Our specific recommendations (those that can be quantified), combined with necessary planned IT investments, result in the following dollars being required to support IT (note: dollar values provided by HLC management; high priority defined as high benefit, high risk, or short-term funding in place):

	2003/04	2004/05
High Priority		
CRMS Module Implementation	$486,000	$225,000
Mini-PACS Implementation	283,000	-
Meditech Server (Replacement)	150,000	-
	$919,000	**$225,000**
Medium Priority		
Meditech Modules and Enhancements	$1,034,000	$ 462,000
Workstation/Printer Replacements	288,000	261,000
PACS-Computed Radiology	287,000	-
Full PACS LHC/Mini-PACS CWJMH	-	681,000
Network Upgrades	518,000	431,000
Meditech Server	100,000	-
Telehealth Infrastructure	272,000	-
IT Staffing	180,000	180,000
	$2,679,000	**$2,015,000**

Registration/Health Records/Communications

Deloitte & Touche

Observations

- Under a Regional Director located at CWJMH, paid hours in 2001/02 equated to 27.8 FTEs. 2.2 FTE of those hours related to orientation, overtime and sick replacement costs. The remaining 25.4 FTEs include: Regional Director, 10.1 FTE support registration/admitting; 8.04 FTE support health records; 5.45 FTE support switchboard; and 0.8 FTE surgical services clerk.

Breakdown of FTEs		
Position	**LHC**	**CWJMH**
Coders/Transcriptionist	3.0	5.04
Registration/Admitting Clerks	7.4	2.71
Switchboard	2.8	2.65
Surgical Service Clerk		0.8
Regional Director		1.0
Total	**13.2**	**12.2**

- There are two distinct support staff unions – CUPE at CWJMH and NAPE at LHC.
- The program has not been regionalized and there is no involvement with coastal communities or Paddon, except coding and abstracting for four coastal sites who have inpatient beds.
- The director has been visiting LHC every 6 weeks and this is seen to be very positive.
- The quality improvement program for this service is in the early stages of development.

Registration/Health Records/Communications

Deloitte & Touche

Observations

LHC:

- There is centralized registration for physician clinics and visiting specialists.
- There is decentralized registration for Emergency, Surgical Daycare, Laboratory and Radiology.
- Coverage is provided from 0800 to 1600 for Registration. Emergency registration is decentralized. Transcriptionists provide secretarial services for 14 FTE physicians.
- Staff book all visiting specialists' visits.
- Staff provide coverage for OPD Registration/Communications/Admitting and the Surgeon's office.
- Inpatient discharges are 1600.

CWJMH

- There is centralized registration for Emergency/OPD clinics, surgical daycare, minor OR, EKG/EEG.
- The service is decentralized for Laboratory and Radiology.
- Coverage is provided from 0745 to 2245 for Registration. Staff books all visiting specialists' visits.
- Duties include HR/OPD Registration/Communications/Admitting/Surgeon's Office.
- Inpatient discharges are 700.
- Quebec patients from Farmont receive translation services without cost recovery to the cost centre.

Registration/Health Records/Communications

Deloitte & Touche

Observations

- Relative to peer organizations, registration/health records/communications appears over-staffed at HLC.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	1.10	0.71	-4.2
LHC	1.29	0.71	-7.2

- A number of factors indicate that workload is excessive:
  - The backlog of outstanding discharge summaries at LHC is a major concern. This has been identified by the Canadian Council of Health Services Accreditation as a risk issue.
  - There are approximately 3,000 appointments per year for visiting specialists, creating significant workload for staff.
  - High volume of dictation.
  - Physical layout (e.g. two registration desks in outpatient clinic) does not allow for maximum efficiency for physicians' secretaries.

Registration/Health Records/Communications

Deloitte & Touche

Observations

- In addition, the following concerns have been raised with respect to Registration/Health Records/Communications:
  - Health records are not all stored in one location (ie. mental health and community health services are decentralized). Centralization of Health Records is important from a quality and control prospective.
  - The director has minimal involvement in the budget process.
  - There is no specific record for children, youth and families.
  - There is not a Regional Health Records Committee to develop regional standards, policy, practice, and monitor the Quality Improvement Program.

Registration/Health Records/Communications

Deloitte & Touche

Summary and Recommendations

- This is a designated regional service, however not regionalized in practice. It is functioning autonomously at LHC and CWJMH.
- Health records policies and procedures should be developed for health records storage and retention.
- The director should be involved in the budget process.
- Immediate steps should be taken to address the backlog of discharge summaries at LHC.
- The cost centre should receive recovery for out-of-province services, specifically those provided to Farmont.
- The health records quality improvement program should continue to evolve. The quality program should identify and consider best practices which could enhance efficiency and effectiveness.
  - For example, the use of voice recognition software technology has revolutionized the manner in which dictation of medical reports and clinical consults is handled. An opportunity exists to improve the turnaround time of discharge summaries and the dictation of clinical records in the outpatient clinics of both acute care facilities. In addition, it may present an opportunity to further rationalize the number of FTEs dedicated to dictation. Benchmarking the activity in medical records with the practice in other environments, especially where a PACS environment has been introduced, will validate the value of voice recognition software technology as a means to improve efficiency.

Registration/Health Records/Communications

Deloitte & Touche

Summary and Recommendations

- The Regional Director should undertake a review, including:
  - A workload analysis to quantify the following: secretarial support for LHC physicians; regional support for visiting specialists; and regional support for Meditech implementation;
  - Potential for scheduling changes to allow for greater efficiency;
  - Potential to utilize technology enablers for greater efficiency; and
  - Potential for greater efficiency with a redesign of space.
- We recommend a reduction of 2 FTEs within six months, and consideration for further reduction following the review.

Housekeeping/Laundry and Linen

Deloitte & Touche

Observations

- In 2001/02 34.2 FTEs provided housekeeping and laundry services to LHC, CWJMH and Paddon Home, including 16.5 at LHC, 12.6 at CWJMH and 5.1 at Paddon Home (laundry provided by LHC; some housekeeping provided by building maintenance). In the nursing stations, these services are provided by PCAs and maintenance workers. The vast majority of FTEs (27.7) are associated with housekeeping.
- Laundry services were recently rationalized from three locations (LHC, CWJMH and Paddon Home) to two locations (LHC and CWJMH) which resulted in 1.0 FTE reduction.
- Compared to peer organizations, HLC is over-resourced in these areas, most notably at LHC and CWJMH.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ (Hskng, L&L)	1.18	0.81	-3.9
LHC (Hskng, L&L)	1.33	0.81	-6.5
Paddon Housekeeping	0.42	0.31	-0.9

- The results of this comparison must be adjusted to reflect HLC specific requirements (i.e. extra cleaning of staff accommodations and doctors' offices; extra snow removal; some security duties). Thus, HLC would not be able to operate at benchmark levels due to additional duties/workload not seen at peer organizations.

Housekeeping/Laundry and Linen

Deloitte & Touche

Summary and Recommendations

- Due to the unique activities required of HLC housekeeping/laundry and linen staff, we recommend that staffing levels be reduced by 5 FTEs, all in housekeeping services, 3 at LHC, and 2 at CWJMH.

Materials Management

Deloitte & Touche

Observations

- 4.5 FTEs provided materials management services to HLC in 2001/02, including buying, store keeping and stock handling.
- Relative to peers, HLC is appropriately staffed, just slightly over benchmarks at LHC.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.19	0.18	-0.1
LHC	0.24	0.18	-0.8

Materials Management

Deloitte & Touche

Observations

- Significant advances have been made in the materials management area:
  - The Materials Management module of Meditech was implemented in 2000.
  - Supplies have been standardized between sites.
  - The tendering process is now organized by Product Category.
  - The Department has implemented several multi-year supply contracts (e.g. Lab Chemistry Analyzer service contract for annual savings of $5,000; Air Service contract for annual savings of more than $150,000; Insurance contract with REMI (X-Ray Equipment and Sterilizers) with annual savings of 16% of service contract costs).
- Total inventory is valued at $400,000 and annual average inventory turns are 4. The high inventory level reflects a need to reduce shortages.
- Plans are underway to implement electronic requisition and bar coding to improve efficiencies and to eliminate slow moving inventory Items.
- The Regional Director has little input to the budget process. Budget versus actual figures have only recently been made available on a regular basis (monthly).
- HLC goes to public tender for all purchases in excess of $10,000. This policy prevents the Corporation from systematically taking advantage of its best performing suppliers. It can result in the selection of the lowest price, which may also be lowest value.

Materials Management

Deloitte & Touche

Observations

- Customers not satisfied with service:
  - Employees on coast complain of long turnaround time, resulting in high inventory levels
  - No mechanisms in place to track inventory once leaves store room
- Shipping costs from outside suppliers in winter can be prohibitive, so inventory is increased in fall to prevent shortages.
- Shipments of mail, drugs, supplies to and from coastal communities is included in the air transportation contract.

Materials Management

Deloitte & Touche

Summary and Recommendations

- Continue implementation of multi-year contracts (e.g. Ambulance and Security Services at CWJMH and medical gas supplies at LHC and CWJMH). They can significantly reduce the product/service unit price.
- Re-evaluate the public tender policy (to the extent possible under the Public Tender Act).
- No staffing changes are recommended.

Facilities and Plant

Deloitte & Touche

Observations

- **LHC** is a new, modern facility, about twice the size of the Melville Hospital it replaced. Two FTEs were added to the staff complement to cope with added workload. 6 FTEs are responsible for plant and building maintenance.
- Significant challenges associated with the new LHC plant include: the lack of qualified personnel trained to operate in a high tech environment (service contracts = $400,000 per year); and new facility deficiencies (re. floor, windows, humidifiers). Both factors are impacting negatively on maintenance & repair costs.
- The **CWJMH** facility was recently partly refurbished including renovations to patient rooms, medical gas upgrades, and installation of new electric boiler. This facility and equipment are aging and are costly to maintain. 7.4 FTEs are responsible for plant and building maintenance.
- Upgrades are required to bring CWJMH up to standard including electrical service entrances, heating & ventilation replacement. The physical space has significant functional challenges eg triage, workflow, privacy and security.
- A feasibility study was recently undertaken to implement an Energy Retrofit program and additional measures to create a safe and reliable health care environment at CWJMH. Costs are estimated at $1.8M with a 10 year pay-back period.

Facilities and Plant

Observations (cont'd)

- **Paddon Home,** serviced by 6 FTEs in 2001/02, was improved in the past few years with new windows, flooring, fire alarm panels, and HVAC system. However, the facility was not designed for its current use and is not well suited to the provision of long term care. Preliminary discussion underway to add a wing to LHC to replace Paddon Home.
- The **Nursing Stations** are generally in good repair. They are serviced by 14.3 FTEs (in 2001/02) responsible for plant and building maintenance. A few sites (Postville, Rigolet and Black Tickle) require inside/outside renovation for building code upgrades and energy efficiency. HLC is experiencing high travel costs associated with specialized maintenance and repair at nursing stations. Maintenance staff in the remote communities tend to be very versatile, able to handle a variety of situations.

Facilities and Plant

Deloitte & Touche

Observations (cont'd)

- When compared with peer organizations, facilities and plant resources at CWJMH and LHC are high. In addition, resources to support nursing stations are very high relative to similar operations elsewhere.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.69	0.33	-3.9
LHC	0.48	0.33	-1.9

- The high staffing levels at CWJMH may be due to the age and state of the facility, as well as the type of equipment used. For example, 4.25 FTEs are currently required to maintain the boiler 24/7, but the Energy Retrofit Program could allow for a reduction of 2 FTEs.

Facilities and Plant

Deloitte & Touche

Observations (cont'd)

- Nursing station workers perform general building maintenance as well as many duties beyond those performed by traditional maintenance workers, including:
  - Mail retrieval
  - Retrieve staff from airport
  - Clinic security 24/7
  - Assist with lifting patients
  - Maintain external staff housing (will be increasing in future)
- Critical mass limits the opportunity to reduce maintenance resources in coastal communities.
- Concerns associated with plant and building maintenance include:
  - There is currently a focus on corrective rather than preventative maintenance (80/20 versus 20/80).
  - When equipment is purchased, maintenance costs are not usually accounted for in the operating budget.
  - The Regional Director has little input to the budget. While budget versus actual figures are now available electronically, not all managers have access.
  - Training of maintenance workers is minimal.

Facilities and Plant

Deloitte & Touche

Summary and Recommendations

- The skill level of LHC maintenance workers must be improved to allow them to work efficiently with the modern equipment and devices in the facility. This will significantly reduce the need for external expertise and costs of outside contractors and may contribute to staff reductions of up to 2 FTEs in the medium term.
- Before investing an estimated $1.8 M in CWJMH, a needs analysis and role study must be completed. Armed with that information, HLC can make an informed decision regarding upgrading the current building versus construction of a new facility.

Patient/Resident Food Services

Deloitte & Touche

Observations

- Two kitchens operate within HLC, one at LHC and one at CWJMH. Only one cafeteria is currently operating (LHC).
- A total of 22 FTEs provided food services with HLC in 2001/02. The 4.9 FTEs at CWJMH are employed by Aramark.
- Compared to peer organizations, HLC is over-resourced at both LHC and Paddon. The outsourced operation at CWJMH is efficiently run.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.46	0.49	+0.3
LHC	0.74	0.49	-3.2
Paddon	0.95	0.66	-2.6

- At LHC and CWJMH, 1.0 and 0.7 FTEs respectively, accounting clerks handle administrative functions including accounting, bookkeeping, billing, payroll, etc.
- LHC includes 1.5 cafeteria resource.
- The results of this comparison must be adjusted to reflect HLC specific requirements (i.e. off-site food storage for the winter season; off-site delivery of meals at Paddon Home).

Patient/Resident Food Services

Deloitte & Touche

Observations

- The physical plant at Paddon limits the opportunity to optimize efficiency. Food service resources at Paddon are responsible for plating meals, picking up trays, and delivery of nourishments. The supervisor also assists with menu selection.
- In 2001/02, the Paddon Home was not at full capacity due to a staff shortage. It is currently at full capacity and expected to remain so.
- Positive aspects of Food Services include:
  - The Food Operation generates about $100,000 in revenue annually.
  - The contract service provider is improving the operation on an ongoing basis (e.g. implemented Tray Tracker, i.e. Patient likes & dislikes, which has reduced the amount of wasted food).
  - Management provides casual employees with “To Do Lists” and “Quick Reference Guide” in order to make them more efficient.

Patient/Resident Food Services

Deloitte & Touche

Observations

- Concerns regarding Food Services include:
  - Lack of supervision in CWJMH; a clerical resource is providing staff supervision and support.
  - Casual/temporary staff working in multiple departments is of concern from a quality, safety and efficiency perspective.
  - Lack of productivity/workload indicators.
  - The Regional Director has little input to the budget process. Budget versus actual figures have only recently been made available on a regular basis.

Patient/Resident Food Services

Deloitte & Touche

Summary and Recommendations

- Reduce FTEs at LHC by 1.0 after having reduced the casual employees' turnover rate by applying the Collective Agreement more rigorously. An alternative is to examine the feasibility of fully contracting out kitchen/cafeteria services at LHC and Paddon Home.
- Casual staff should be specific to the department, reducing risk and improving efficiency.

Allied Health:
Physiotherapy, Occupational Therapy & Recreation

Deloitte & Touche

Observations

- PT and OT are located at LHC and CWJMH. Recreation is located at Paddon Home. Minimal PT/OT support is provided to Paddon. No support is provided to the coastal communities. The therapists report to a Regional Director located at CWJMH. Each facility has 1 FTE physiotherapist and 1 FTE occupational therapist. At LHC, there is one aide and a .33 FTE clerical. At CWJMH, there is no dedicated clerical support. These numbers, provided by the Regional Director, do not reconcile with total paid hours, which suggests a total of 7.7 FTEs.
- At LHC, 80% of the OT and PT activities are outpatient, 20% inpatient.
- At LHC, the wait list for physiotherapy is 150 clients (3 to 4 months). The urgent wait list is 2 to 3 weeks. The wait list for OT service is 20 clients.
- At CWJMH, 5% of the OT activity is inpatient, 45% outpatient, and 50% schools.
- At CWJMH, the wait list for physiotherapy is 43 clients (7 to 8 weeks). The wait list for OT service is 10 clients and, in addition, there is a wait list for the community school program.

Allied Health:
Physiotherapy, Occupational Therapy & Recreation

Deloitte & Touche

Observations

- Relative to peers, HLC is reasonably staffed overall in terms of allied health. It should be noted that peers do not represent best clinical practice. In fact, many small organizations provide little PT/OT to support acute services, and few support long term care. While Paddon appears to be under-resourced in terms of Recreation, they do receive some PT/OT support as well.

	HPPD	50th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
Physiotherapy			
CWJ	0.31	0.23	-0.9
LHC	0.16	0.23	+0.8
Occupational Therapy			
CWJ	0.10	0.03	-0.7
LHC	0.00	0.03	+0.4
Recreation			
Paddon	0.11	0.26	+1.3

- PT and OT therapists do not have professional practice standards and there is no professional accountability framework.

Allied Health:
Physiotherapy, Occupational Therapy & Recreation

Deloitte & Touche

Summary and Recommendations

- The therapists appear to be functioning well, however they do not have a level of professional accountability.
- Appoint one of the PT/OT therapists as the Regional Practice Leader with specific accountabilities for this role.
- Maintain the current level of staffing overall, recognizing that recruitment and geography are significant challenges. Attempts should be considered to share resources more equitably among sites.
- The work load is heavier at LHC compared to CWJMH; however, both have the same number of FTE therapists. The OT/PT therapist from CWJMH should travel at least monthly to LHC to provide service.

Laboratory

Observations

- Lab services are provided at both LHC and CWJMH. A total of approximately 14 FTEs provided the services in 2001/02 – 8.7 at LHC and 5.3 at CWJMH.
- Relative to peer organizations, CWJMH is appropriately staffed, while LHC appears to be slightly over-staffed.

	HPPD	50th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.57	0.61	+0.4
LHC	0.70	0.61	-1.1

- LHC resources are responsible for providing laboratory services for 9 coastal communities. All specimens need to be processed between 1800 and 2300 hours. Referred in tests represents 1/3 of LHC's workload, compared to only 10% at CWJMH and under 10% at most peer hospitals.
- Laboratory technologists at LHC do all ECGs for the hospital. This is a "drop and go" mandate that interrupts workflow and adds to workload.

Laboratory

Observations

- There are no clerical resources to support the lab workload.
- Internal productivity benchmarking suggests higher levels of productivity at LHC, when all workload is factored in. This results in lower cost/workload unit at LHC.

	LHC	CWJMH
Workload Units (01/02)	856,941	468,209
FTEs	8.7	5.3
Workload Units/FTE	98,499	88,341

Laboratory

Deloitte & Touche

Observations (cont'd)

- There is a lack of standardization of menus, quality assurance protocols and staffing guidelines, creating efficiency opportunities.
- While efficiency opportunities exist, each site has had difficulty moving the agenda forward due to:
  - Leadership - Regional Director does not have a Laboratory background and is seen as not fully understanding the area; physician leadership is unsupportive
  - Institutional cultural diversity between LHC and CWJMH has hindered regionalization
  - Technical infrastructure is inadequate to maximize opportunities
  - Lack of IT support
  - Staffing levels marginally able to cope with current workload, particularly demand from coastal communities
  - Budgeting process does not involve lead techs in meaningful way
  - Year-to-date budget data for managing departments has only recently been made available to managers and is not well understood

Laboratory

Deloitte & Touche

Observations (cont'd)

- Issues of risk and efficiency were raised by lead hand at LHC with Regional Director. A review was ordered. Recommendations have yet to be shared with the Board and senior management.
- The recent Thornhill Report provided a comprehensive overview of lab services. Recommendations have been supported by the Regional Director and both lab lead hands. Key recommendations of Thornhill Report:
  - LIS review required
  - Training required for LIS
  - Requirement for written lab policy
  - Require back-up Chemistry unit for LHC
  - Re-evaluate lab menu - streamline, modify based on evidence
  - CWJMH referred out menu to LHC
  - Re-evaluate scheduling to cope with staff shortages
- Recruitment and retention of technologists is a major concern for Labrador facilities but attention to some of the efficiency and workload issues may address these concerns.
- Physicians are currently resisting using Meditech system due to functionality and user issues.

Laboratory

Deloitte & Touche

Summary and Recommendations

- Maintain current staffing level
  - Transfer non-traditional laboratory duties after 1600 hours at LHC to appropriate department or resource (e.g. ECGs 8-10/day; routine phlebotomy), improving efficiency in lab.
- Opportunity to leverage technology
  - Update Meditech to facilitate transfer of CWJMH referred out tests.
  - Phase in LIS with easy access from physician clinics, ER and clinical areas.
  - Conduct physician Meditech/LIS needs assessment to determine critical success factors for deployment of Meditech system.
- Implement Thornhill Report
  - Regional Manager should take lead to fast track implementation of Thornhill Report.
  - Look to the economy of repatriating work sent to St. Anthony that can be done at HLC as per the Thornhill Report.

Laboratory

Deloitte & Touche

Summary and Recommendations

- Other
  - Formalize association with a consultant pathologist to provide the Regional Manager and Laboratory Department leaders with mentoring and referencing tools. Most appropriate resource may be located in St. Anthony.
  - Need to facilitate improved relationship between laboratories.
  - Revise budget process to encourage involvement of department staff.
  - Review purchasing and utilization of reagents.
  - Develop contingency plan for chemistry analyzer failure at LHC.
  - Develop long-range capital program.

Diagnostic Imaging

Overview

- Diagnostic Imaging services are provided at both CWJMH and LHC, serving very different populations.
- Both the CWJMH and LHC sites function independently with “lead hands” in each department essentially seen as divisional managers. Manpower and equipment needs are site specific.
- A total of 10.5 FTEs provided DI services in 2001/02, 5.4 at CWJMH and 5.1 at LHC.

Diagnostic Imaging

Overview

Diagnostic Imaging Activity		
	LHC	**CWJ**
Regular Radiography		
00/01	5,807	9,498
01/02	5,336	9,961
02/03 (proj.)	7,057	8,302
Ultrasound		
00/01	2,042	2,303
01/02	1,492	2,431
02/03 (proj.)	2,565	2,455
Population Served	15,900	10,600
Regular Radiography/Population (02/03)	**0.44**	**0.78**
Ultrasound/Population (02/03)	**0.16**	**0.23**
FTEs (01/02)	5.1	5.4
Total Tests/FTE (02/03)	1,887	1,992
Total Tests/FTE (01/02)	1,339	2,295

- **Utilization of services at CWJMH is significantly higher than at LHC, despite a younger, non-aboriginal population.**
- **DI resources at CWJMH appear to have been more productive than their counterparts at LHC. However, assuming FTEs have not changed significantly, the gap has closed in 2002/02.**

Diagnostic Imaging

Observations

- Relative to peers, DI services at both sites appear to be under-resourced quite significantly. It should be noted that there is significant variability in performance among peers.

	HPPD	50th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.51	0.68	+1.9
LHC	0.41	0.68	+3.3

- Based on interviews, observations and reviews within HLC, current staffing levels at CWJMH appear adequate. Staffing at LHC is marginal: one illness will result in no coverage after hours.

Diagnostic Imaging

Deloitte & Touche

Observations

- There are no regional menus, policies, or quality assurance program.
- Lack of an in-house radiologist represents a risk area – CT and Ultrasound require the interpretive skills of an appropriately trained clinician. Although it can be argued the emergency CT and Ultrasound can be interpreted for the purposes of excluding life threatening events by an emergency physician who has received training in these modalities, there is no process at HLC to warranty those skills.
- Ultrasound, CT and Mammography have digital information flexibility which would permit the transmission of images for remote reading. The routine modalities like plain X-ray are not digital nor are scanners available.
- Cross-training is critical to the functionality of the department given the difficulty in recruiting and retaining technologists.
- Capital purchases need to be considered in a regional context. Influence of IGA – available only to LHC. Cost impact analysis not a routine exercise for new purchases.
- The Ultrasound machine is old and not functioning at an acceptable level, representing a risk area. The colour probes are faulty thereby significantly limiting the evaluation of high risk conditions such as ectopic pregnancy, ovarian or testicular torsion and other vascular pathology.
- Year-to-date budget data for managing the departments has only recently been made available to managers.

Diagnostic Imaging

Deloitte & Touche

Summary and Recommendations

- Repair the defective wand in the ultrasound machine at LHC. Continuing to operate with the defective wand sub-optimizes some modalities (e.g. colour Doppler function) and presents the potential for techs and readers to miss subtle diagnostic challenges.
- Establish cost impact analysis committee with representation from MAC, Administration and DI Department.
- Address issue of long report cycle for diagnostic imaging:
  - Volume supports resident radiologist
  - Assess probability of recruitment
  - If recruitment efforts fail, reassess relationship with Health Corporation of St. John's, and consider other options (e.g. Gander, St. Anthony)
  - Ultimate goal: PACS environment (available in other regions; Provincial initiative)
    - Risk/quality
    - Cost of film
    - Storage space
- Cross-training CT/US.
- Support efforts to have technologist establish own IV access and inject dye (i.e. multi-tasking which requires cross training), as is common elsewhere. Will require policy adjustment within HLC.
- Establish Quality Assurance Committee.
- Increase staffing levels by 2.0 at LHC.

Pharmacy

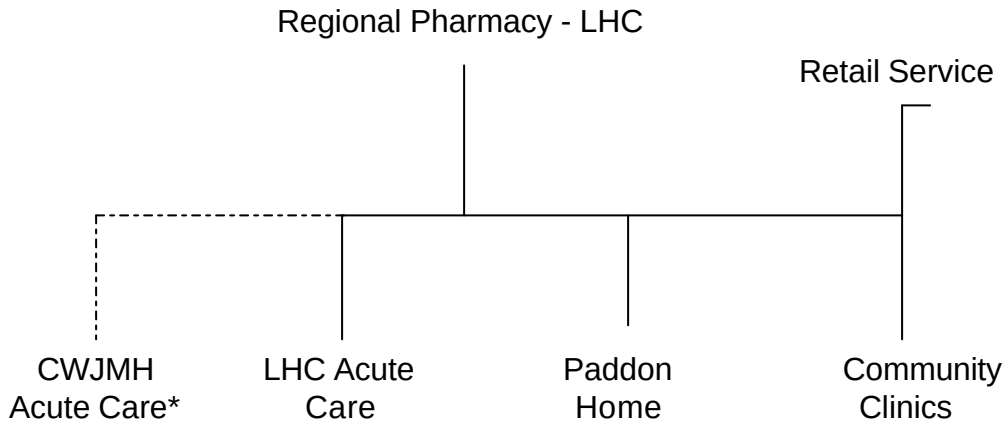
Observations

- Prior to the inception of the HLC Board, the pharmacy department was responsible for provision of pharmaceutical services to Melville Hospital and to 9 nursing stations along coastal Labrador. At that time staffing consisted of 1 pharmacist and 1 pharmacy technician.
- With regionalization, the Department assumed a number of increased responsibilities including:
  - Services to Paddon Home (48 bed regional long term care facility), 30 day carded blisters, P&T representation, etc.
  - Services to Churchill Falls Clinic, formerly serviced from St. Anthony.
  - Preparation of detailed third party invoicing for coastal clinics.
  - Pharmaceutical services to CWJMH, which has not yet been accomplished.
- They currently have 1 staff pharmacist, 2 technicians, and 0.5 admin and 0.5 unit producing pharmacist.
- In 2001/02, total FTEs were 3.4, excluding 1 retail FTE.
- 0.5 Nursing FTE, contract with private pharmacist and cost of inventory for acute and long term care at CWJMH are not included in pharmacy cost centre.
- The current retail operation is in violation of the provincial pharmacy act on two accounts:
  - The re-sale of medications purchased under a group buying arrangement. This was flagged in a previous audit.
  - HLC does not have a retail license under the Pharmacy Act of Newfoundland and Labrador.

Pharmacy

Observations

- The current structure of pharmacy services is shown below.



* CWJMH is a stand-alone unit, not currently under supervision of Regional Pharmacist

Pharmacy

Observations (cont'd)

- Comparison with peer organizations would suggest that Pharmacy services is under-staffed by 1 FTE. However, when the work associated with retail operations and servicing coastal communities is factored in (e.g. packaging and shipping), the gap is larger.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
Regional (CWJ, LHC, Paddon) (excl. 1 FTE retail)	0.11	0.14	+1.0

- The Dalley Report recommends 3 additional FTEs (1 Pharmacist, 1 Technician and 1 Clerical person). The Dalley Report did not capture clinic workload, as data was unreliable at the time. Clerical workload associated with retail portion has increased significantly since Dalley observed activity.

Pharmacy

Deloitte & Touche

Observations (cont'd)

- The following areas within Pharmacy work well:
  - Supply chain (Coast, Paddon Home, Community Clinics) - All chronic medications are provided from LHC to ensure a complete profile, medication interaction checking, duplicate therapy checking while addressing compliance. This initiative was commended by the Newfoundland Pharmaceutical Association in their October 2001 inspection.
  - Reliability and accuracy
  - Profitability of operation
  - Self-supporting
- The following are areas of concern:
  - Unable to provide clinical support to clinicians and nursing staff due to lack of resources. Approximately 98% of pharmacy-related medication errors occur when the pharmacy is short staffed or when increased demand is placed on the department.
  - Regional Pharmacy & Therapeutics Committee (a LHC Committee) is not functioning.
  - Quality assurance, order entry and clinical profiling are not priorities at CWJMH and therefore represent risk areas.
  - Current delivery model at CWJMH is dated and labour intensive. A pharmacist, contracted from the community, is providing support. Unit dosing was recommended in the review but not implemented, representing a risk area.
  - Management overwhelmed by clinical, retail and management duties.
  - Management preoccupied with keeping current resources in a very competitive provincial and national market. To illustrate, the current remuneration scale at HLC is $45,213 - $57,687. This is a seven-step progression where one step equals one year of service. Starting salaries in retail pharmacy in Nova Scotia and Ontario are $55,000 and $65,000 respectively.
  - Cash sales from community retail activity are not included in pharmacy budget.
  - Inventory control is not optimal.

Pharmacy

Deloitte & Touche

Summary and Recommendations

- Evaluate the role of Pharmacy as a clinical support resource and staff accordingly
  - As a regional resource, the pharmacist needs to be available to all sites including community clinics to provide professional support and guidance on quality issues. Dalley Report flagged this as a risk issue.
  - We recommend that staffing be increased by 1 technician, 1 Pharmacist and 0.5 clerical FTE to reflect current workload and incorporation of the CWJMH site which is not currently included in pharmacy workload measurements. Total staff complement recommended: 2.5 FTE unit producing pharmacists, 0.5 FTE pharmacists, 3 FTE technicians and 0.5 FTE clerical. These changes will achieve the following:
    - ✓ Assume regional control and introduce unit dosing to long term care at CWJMH and an appropriate inventory and drug management system appropriate to the acute care side
    - ✓ Free up time of Director currently spent on pharmacy duties to support regional clinical responsibilities (e.g. take a lead role in P&T Committee, provide clinical support to nursing/medical staff)
    - ✓ Pharmacist to undertake regular visits to all sites
    - ✓ Gain better control over retail operation: cash flow, inventory, profit margin
    - ✓ Increase monitoring of drug usage - development of protocols leads to reduced drug costs
    - ✓ Develop and implement a seamless care program for discharged patients
    - ✓ Free up community nurses from routine dispensing duties with the introduction of unit dosing at marginal increase in cost (given unit dose system in place at Paddon)

Pharmacy

Deloitte & Touche

Summary and Recommendations (cont'd)

- To finance the proposed increase in staffing, dispensing fee should be increased to $7.50 from $5.50 (fee has not been adjusted since 1995 and is currently $3.50 below the private retail fee; this must be considered in the context of provincial policy), and 0.5 FTE nursing budget dedicated to pharmacy at CWJMH should be transferred to the pharmacy cost centre. This should represent a cost neutral position with a minimum of $56,000 in revenue from the increased dispensing fee.

- Optimize use of technology
  - Until recently Pharmacy did not have a budget. As it is, the separate home grown accounting system is used for the retail operation only and captures all inventory but not all sales.
  - It is recommended that the Pharmacy Department:
    - Maximize functionality of Meditech module with special emphasis on budgeting and inventory control.
    - Provide professional development opportunity to pharmacy staff to better understand business model.
    - Replace manual drug referencing with electronic drug referencing to improve quality and risk management. This represents significant risk issue. The solution would require a relatively inexpensive piece of software that can be loaded onto a PC or PDA and used as a reference check.

Clinical Education

Observations

- Clinical Education support is minimal for this region. Under the management of a Regional Director, the portfolio includes: staff development, quality and risk management, WHIMS, employee health, infection control, telehealth coordinator, fire safety and disaster planning and accreditation planning.
- With a total of 5.8 FTEs according to 2001/02 payroll, the program has 3 full time staff including the director, with the remainder being filled by temporary positions. The FTE complement includes 1.5 FTEs for the Royal Health Academic Centre. This funding expires March 31, 2003.
- While efficiency benchmarks would suggest the area is adequately staffed, HLC clinical education is responsible for broad range of services not normally associated with that department. (This reflects the MIS coding problems at HLC.) In addition, the requirements for training and staff development are significant for the region and with current allocation of resources it is impossible to meet the needs.

	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.12	0.03	-1.0
LHC	0.00	0.03	+0.4

Clinical Education

Deloitte & Touche

Observations

- The regional director has a broad scope of responsibility.
- The high number of temporary positions creates instability in the department.
- The Telehealth Coordinator position is vacant.
- The Quality Improvement/Risk Management program is in the early stages of development.
- The credentialing process for physicians and other professionals is not working well.
- The integration of community services to HLC has increased workload.
- The move to LHC (September 2000) required a complete review of disaster and fire plans.
- The program does not have an approved budget.

Clinical Education

Deloitte & Touche

Summary and Recommendations

- The program scope for this director is broad and cannot be sustained.
- Some of the responsibilities (ie. fire, safety, disaster planning, employee health, WHIMS), representing approximately 1 FTE, are not being adequately fulfilled and could be realigned to other departments. There is ample capacity within HR and physical plant to handle this additional workload.
- With the shift of responsibilities, current staffing is adequate.
- Consideration should be given to transferring the regional infection control responsibilities to the Manager of Public Health and Continuing Care under the recommended HLC Regional Nursing model. This change would allow for integration of acute and continuing infection control policy and practice within HLC.
- Hire temporary staff as permanent, to allow stability in managing the workload.
- The telehealth coordinator position should be evaluated as part of the recommended telehealth review.
- The regional manager should continue to evolve the regional quality/risk management program.
- There should be a credentialing policy and process for physicians and other professionals, which includes an accountability process to the Board of Directors.

Nursing Administration

Deloitte & Touche

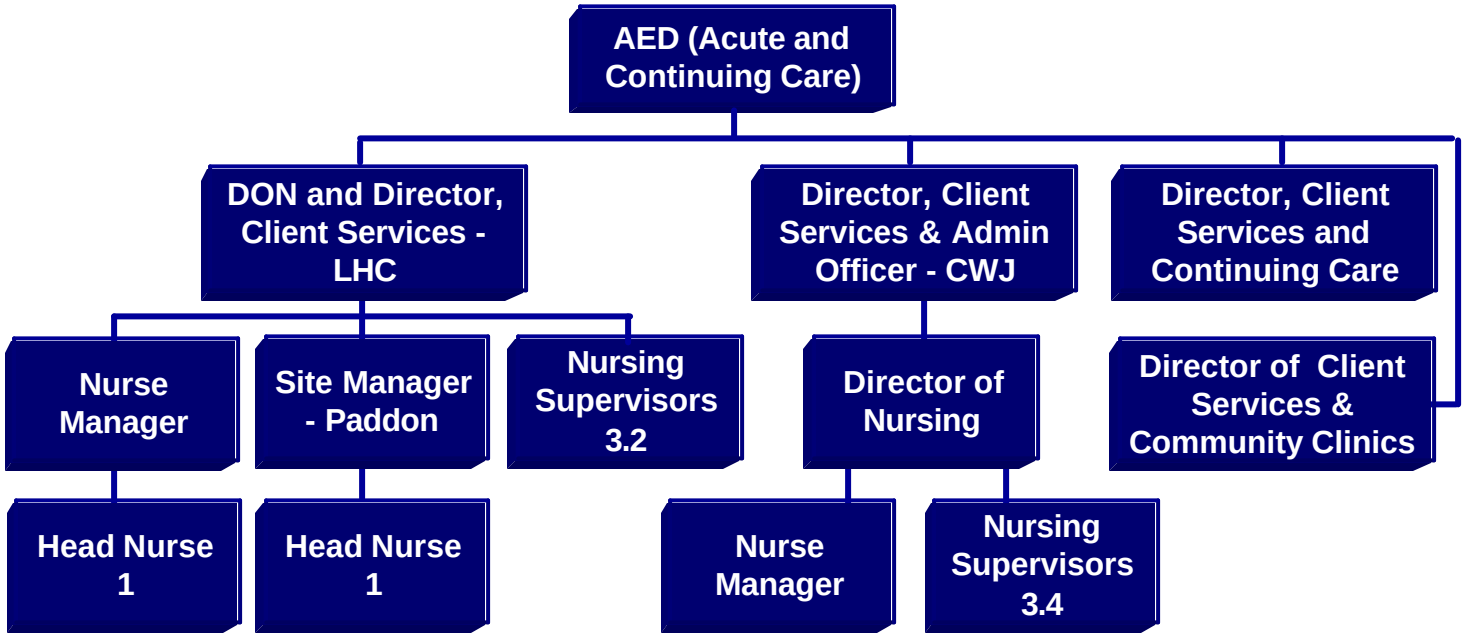
Observations

- At LHC, a Director of Nursing and a Director of Community Clinics report to a member of the Executive Leadership team; at CWJMH a Director of Nursing reports to the same member of the leadership as LHC. Within each facility, there is one manager, and evening, night and weekend supervisors. Paddon has a site administrator who reports to the Director of Nursing at LHC. The acute OR and day surgery areas at LHC have head nurses who are approximately 50% unit producing. There are two regional nursing directors, one for Public Health and the other for Continuing Care. There is no Regional Director of Nursing.
- FTEs in 2001/02 totaled 16.8.

Nursing Administration

Observations (cont'd)

- Current Structure – HLC:



* The Regional Director of Public Health Nursing reports to the AED, Community Services

Nursing Administration

Observations (cont'd)

- LHC and CWJMH function independently of each other.
- Relative to peer organizations, both CWJMH and LHC appear to be over-resourced in terms of Nursing Administration.

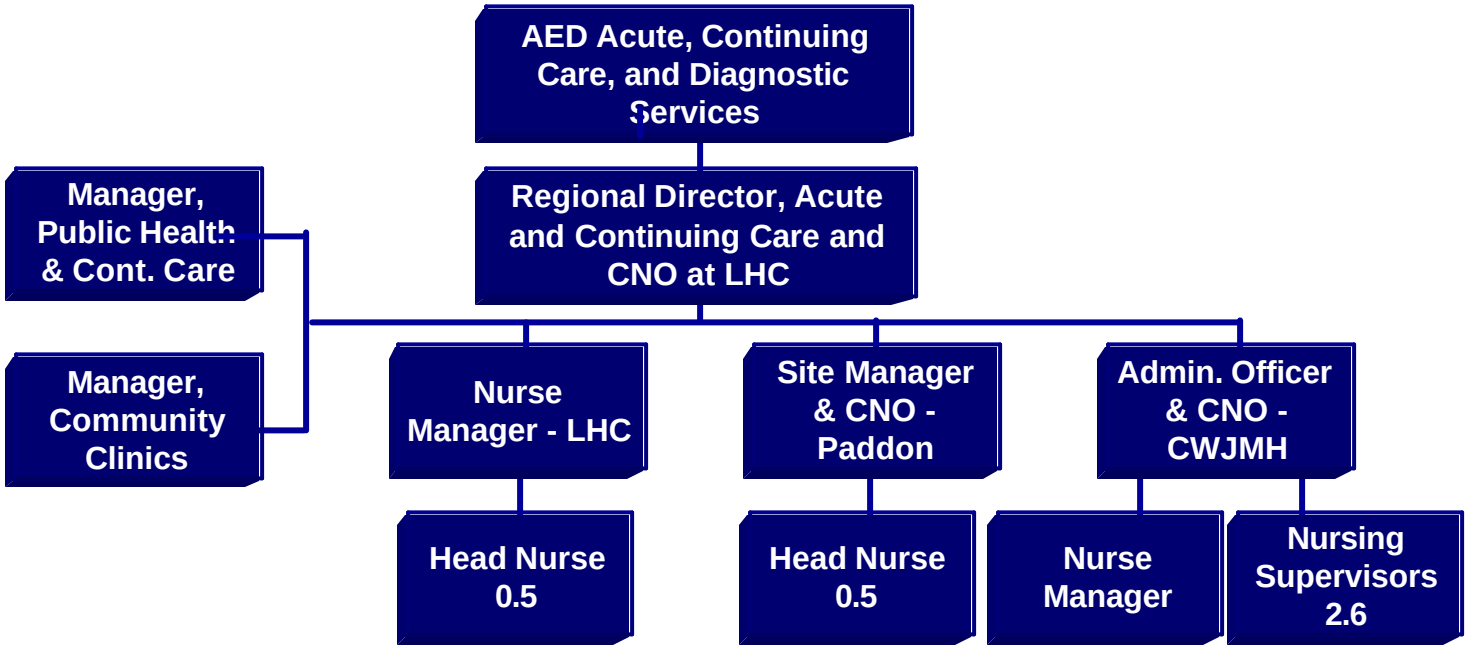
	HPPD	25th Percentile Comparator	Increase/Decrease Required to Match Peer Staffing Levels
CWJ	0.44	0.25	-2.1
LHC	0.48	0.25	-2.9

- Regional nursing standards are in the early stages of development.

Nursing Administration

Summary and Recommendations

- Establish a Regional Director of Nursing role with a mandate and accountability to develop a regional nursing model. This role can be filled within the existing complement. Mentoring will be required. The effectiveness of the new model and the new leadership role should be evaluated within two years.



Nursing Administration

Deloitte & Touche

Summary and Recommendations (cont'd)

- Reduce Nursing Administration by 2 FTEs. Recognizing the geography, impact of Medevacs, and lack of a regional model, further FTE reductions are not appropriate at this time.
- The Nursing Supervisor role is pivotal to the clinical care and administrative functions at both LHC and CWJMH; however, with maturity of the regional model, enhanced training for nursing leaders and RN staff, and a new approach to Medevacs, reductions at the supervisory level could occur. We recommend reduction of 4 FTEs in two years.
- Consider a Facility Manager position at CWJMH that acts as both the Nursing leader and facility manager. This would allow for a nursing leadership position at LHC and CWJMH.

Summary of Admin Support

Deloitte & Touche

Area	HLC HPPD	25th Percentile	Increase/ Decrease	Recommended Change
Finance/HR				
CWJ	0.32	0.33	+0.1	-3.5
LHC	1.17	0.33	-10.4	
Registration/Health Records/ Communication				
CWJ	1.10	0.71	-4.2	-2.0
LHC	1.29	0.71	-7.2	
Housekeeping/Linen & Laundry				
CWJ	1.18	0.81	-3.9	-2.0
LHC	1.33	0.81	-6.5	-3.0
Paddon – Housekeeping	0.42	0.31	-0.9	
Paddon – Linen & Laundry	0.16	0.12	-0.4	
Materials Management				
CWJ	0.19	0.18	-0.1	0.0
LHC	0.24	0.18	-0.8	0.0
Plant				
CWJ	0.69	0.33	-3.9	-2.0
LHC	0.48	0.33	-1.9	Medium term
Patient/Resident Food Services				
CWJ	0.46	0.49	+0.3	0.0
LHC	0.74	0.49	-3.2	-1.0
Paddon	0.95	0.86	-2.6	0.0
Systems Support				
Regional (excl. Meditech)	0.12	0.06	-1.8	0.0
Total Admin Support				**-13.5**

We recommend reductions of administrative support staff by 13.5 FTEs in the short to medium term, assuming the accompanying recommendations are implemented.

Summary of Clinical Support

Deloitte & Touche

Area	HLC HPPD	25th/50th Percentile	Increase/ Decrease	Recommended Change
Laboratory (50th)				
CWJ	0.57	0.61	+0.4	0.0
LHC	0.70	0.61	-1.1	0.0
Diagnostic Imaging (50th)				
CWJ	0.43	0.73	+3.2	0.0
LHC	0.41	0.73	+3.9	+2.0
Physiotherapy (50th)				
CWJ	0.31	0.23	-0.9	0.0
LHC	0.16	0.23	+0.8	0.0
Occupational Therapy (50th)				
CWJ	0.10	0.03	-0.7	0.0
LHC	0.00	0.03	+0.4	0.0
Recreation (50th)				
Paddon	0.11	0.26	+1.3	0.0
Nursing Administration (25th)				
CWJ	0.44	0.25	-0.8	
LHC	0.48	0.25	-5.2	-6.0
Clinical Education (25th)				
CWJ	0.12	0.03	-1.0	0.0
LHC	0.00	0.03	+0.4	0.0
Pharmacy (25th)				
Regional	0.11	0.14	+1.0	+2.5
Total Clinical Support				**-1.5**

With the exception of Nursing Administration, we see no opportunities for efficiency improvements in the clinical support areas. In Diagnostic Imaging and Pharmacy, staffing increases are recommended. This would suggest that HLC is doing a good job managing clinical support resources in a challenging environment.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Air Transport

Air Transport

Deloitte & Touche

Overview

- Air Transport is a program delivered by HLC to provide residents of coastal Labrador, who do not have road access to LHC in Goose Bay, a means of accessing health care programs.
- The following terms define the scope of services included within Air Transport:
  - **Air Ambulance** is a provincial program operated by the Department of Health & Community Services. Access to this service is limited to patients requiring emergency transportation to the most appropriate health facility as determined by the referring and receiving physicians.
  - **Medevac** is a term used to describe the urgent removal of a patient to a site that can provide definitive care. LHC in Goose Bay is the only site operated by HLC that receives medevacs from all communities served by HLC. This includes medevacs that are requested by nurses or doctors who assess patients in their care and are approved by the receiving physician either in Goose Bay or St. John's. A medevac from Goose Bay is generally to a tertiary facility in St. John's.
  - **Schedevac** is a term used to describe the booked patient who uses an aircraft provided by HLC to access HLC services.
  - **RT (Radio/Telephone) Department** is the term used to define the department at HLC that supports the medevac, Schedevac and freight service.
  - **Non-Insured Benefit and Eligibility** refers to services available to aboriginal groups not covered by the provincial health plan but recognized by Federal Agreements.

Air Transport

Deloitte & Touche

Overview

- The volume of air transport activity is provided below.

	Volume of Activity		
	2000/01	**2001/02**	**2002/03 Projected**
Medevacs (flights)			
To coast	175	164	173
To St. John's:			
- CWJMH	79	58	N/A
- LHC	65	129	N/A
Schedevacs (people)			
Patients	unknown	6,200	unknown
Escorts	unknown	2,414	unknown

Air Transport

Observations

2001/02

Revenue	
Work Services Funding	$1,285,485
DOH&CS Revenue	800,000
Other ($40 co-pay & 50/50 agreement)	265,852
	2,351,337
Expenses	
Air Transport Contract	(1,675,156)
Salaries	(410,000)
Diagnostic Services Travel	(259,376)
Medevacs Staff Travel	(262,439)
Ground Transportation	(56,200)
	(2,663,699)
Surplus/(Deficit)	**$ (312,361)**

In 2001/02, Air Transport operated with a deficit in excess of $300,000. A surplus of $56,000 is projected for 2002/03.

Air Transport

Observations

- The following factors are key contributors to the Air Transport deficit:
  - Unpredictability of medevacs (coast and St. John's)
  - Unlimited demand for non-insured transfers (e.g. orthodontics, dental)
  - Lack of resident specialists in Labrador
  - Changes in standards of care (e.g. angioplasty)
  - High client expectations
  - Lack of experienced staff
  - Lack of communication
  - Changing Medical-Legal Environment, resulting in physicians wanting to see the patient

Air Transport

Observations

Key Cost Drivers (2001/02)

Emergent - Medevacs	
Aircraft cost	$ 375,000*
Salaries	410,000
Staff Travel	262,000
Ground Transportation	56,200
	1,103,200
Non-Emergent	
Schedevacs (8,414 patients and escorts)	1,300,699
CT/Mammo	259,800
	1,560,499
Total Expenditures	$2,663,699

Escort Fees - Nurses	$ 96,261
RT (Maintenance)	314,265

Includes Non-Insured, such as: Othodontics/ Dental (600+351)	$190,200
Optometry (1452+)	290,400

* 165 flights X 2.2 hours x $1030/hour = $375,000

Of the $2.6 M spent on Air Transport, $1.1 M relates to emergent activities and is "beyond the control" of HLC. The remaining $1.5M relates to non-emergent activity, including non-insured services.

Air Transport

Observations

- Understanding the Air Transport contract :
  - Valued at $1,675,156 in 2001/02
  - Sole provider – Air Labrador (contract awarded by public tender)
  - $1,030 per hour fixed rate
  - Guaranteed aircraft 24/7 for coastal medevacs
  - Service to 8 out of 10 communities M-F
  - Service to Black Tickle and Cartwright T/F
  - Freight and staff travel
  - 50/50 revenue split on Schedevac hitchhikers only
  - Medevacs done for GRHS region

Air Transport

Deloitte & Touche

Observations

Air Transport Department Activity 2001/02 Cost If No Contract In Place	
Transporting staff and families (705) (352 x $400)	$ 141,000
6,200 Patients (3,100 round trips)	1,240,000
2,414 Escorts (1,207 round trips)	482,800
Total	**$ 1,863,800**
Paid Under Contract	$ 1,675,156
“Saved”	$ 188,644

HLC has negotiated a good contract for air transport, having “saved” $188,000 in 2001/02. In addition, freight and mail are moved at no additional cost. Thus actual “savings” would be significantly higher.

Air Transport

Observations

Comparison of Air Transport Models		
	HLC	Province of Nova Scotia
No. of Patients Moved	178*	608
Cost	$940,000**	$2,000,000
Cost/Patient Moved	$5,281	$3,289

* St. John's only

** Includes cost of aircraft, support costs and HLC FTE estimate; excludes FTE from Healthcare Corporation of St. John's

The provincial model for moving patients to St. John's is very costly relative to the Nova Scotia model.

Air Transport

Deloitte & Touche

Summary and Recommendations

- Improve cost recovery for non-insured services:
  - Define non-insured service
  - Determine number of non-insured clients transported
  - Cost recover at estimated average market price (assume 2,667 round trips at incremental cost of $360 (i.e. $400 less $40 currently recovered), totaling $960,000). We assume a 15% reduction in volumes, totaling potential incremental revenue of $816,000.
- Assess the potential to transfer HLC Medevacs to St. John's to a Provincial jurisdiction:
  - Potential benefits:
    - ✓ Nurses free to float to acute care and maybe community clinics
    - ✓ Standardization of Medevac protocol
    - ✓ More cost efficient based on other provincial experiences
  - Estimated impact:
    - ✓ Nursing FTEs 4 (lieu time + overtime – FTE required for coastal Medevacs)
    - ✓ Physician FTEs .5
    - ✓ Support costs $300,000
- Increase user fees to $80 for all users, including escorts (recognizing that Grenfell must follow suit)
- Some of the changes recommended above may require provincial policy change.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Community Clinics

Overview

- It is difficult to develop an accurate picture of community clinic operations within HLC:
  - Accurate data is unavailable. HLC reported data does not agree with informal data collected by the community clinics. Data inconsistencies relate to FTEs and volume of activity.
  - For purposes of our analysis, we relied on data provided by the Regional Director.

Overview

An overview of the 10 community clinics including population served and staffing complement is provided below. (Data provided by Regional Director.)

Community	Maintenance	RNs (Budgeted FTEs)	PCA	Clerk/Other
Nain Pop'n 1400	4 FT, 5 Casual	3 FT, 1 FT on Education Leave (5)	6 FT, 4 Casual	1 FT Clerk , 1 Supervisor FT, 1 Supervisor Casual
Sheshashiu Pop'n 2140	Leased Space	1 NP, 1 FT, 1 Leave (2)	2 FT, 1 Casual, 1 PT	Paramedics: 1 FT, 1 PT Amb. Attendants: 3 Casuals PCA: 1 FT 1 PT PCA/Amb. Attendant: 1 FT
Black Tickle Pop'n 250	1 FT, 1 LTD	1 FT, 1 Casual (2)	1 FT, 1 Casual	
Cartwright Pop'n 645	1 FT, 1 Casual	2 FT (2)	1 FT, 3 Casual	
Churchill Falls Pop'n 650	Leased Space	1 FT LTD, 2 Temp .5 each (1)	1 FT, 1 Casual	1 FT Physician, 1 FT Typist
Natuashish Pop'n 565	1 FT, 1 PT, 3 Casual	4 FT (3)	1 FT	
Postville Pop'n 255	1 FT, 3 Casual	1 FT, 1 Casual (1)	1 FT, 1 Casual	
Rigolet Pop'n 340	1 FT, 1 Casual	2 FT, 1 Casual (2)	1 FT, 2 Casual	
Hopedale Pop'n 765	1 FT, 2 Casual, 1 PT	2 FT, 1 Casual (2)	1 FT	2 Interpreters Casual (not paid by HLC), 1 Domestic Part time
Makkovik Pop'n 460	1 FT, 1 Casual	2 FT, (2)	1 FT, 1 Casual	1 Interpreter Casual (not paid by HLC)

Overview

- Nain:
  - Only clinic open 18 hours per day - PCA staffing ratio appears high (further study required)
  - No access to air strip after dark - patient medevacs are high or patients are kept due to weather or airstrip access requiring extra staff
  - Population at risk based on historical issues with SA and suicide
  - Difficult to staff – safety issues
  - Staffing levels in maintenance need to be assessed in context of assuring cost recovery for services and space provided to devolved programs
  - Eliminate supervisor role in restructured management
- Sheshashiu:
  - Connected by road to LHC, i.e. not the same role as other clinics
  - No coverage after 1700 hours
  - Population at risk based on historical issues with SA and suicide
  - Prevalence data for diabetes and social problems better defined than other clinics
  - Need to define pre-hospital program and share resources with community clinic
- Black Tickle:
  - Recent reduction of service by HLC plane expected to be problematic
  - Overtime is high due to single nurse, living in clinic and “needy” population
- Cartwright:
  - May soon be **c**onnected by road to LHC - high expectations and new problems
  - Nursing human resources issues are significant
  - Move to external housing will reduce overtime

Overview

Deloitte & Touche

- Churchill Falls:
  - Extremely high utilization rate - significant education investment required
  - Potential for the 1 RN FTE to be supported by a Nurse Practitioner when the current physician leaves
  - Potential to eliminate typist position when physician leaves
- Natuashish:
  - Social problems under-represented due to lack of resident social workers
  - Maintenance costs will increase due to issues around transportation and increased square footage.
  - Staffing levels in maintenance need to be assessed in context of assuring cost recovery for services and space provided to devolved programs
- Postville:
  - Overtime is high due to single nurse
  - Move to external housing will reduce overtime cost
  - Requires 2 FTE RNs
- Rigolet:
  - Staffing parameters, including physician visits, are appropriate
- Hopedale:
  - Large building which serves as a community resource – requires extra maintenance
  - Opportunity to cross-train domestic as PCA
- Makkovik:
  - Potential Nurse Practitioner to also support Churchill Falls

Observations

Deloitte & Touche

Summary of Activity											
	BT	**CWT**	**CHF**	**SESH**	**RIG**	**MAK**	**HDL**	**PSV**	**NAT**	**NAIN**	**Total**
Visits with Nurses	3,537	7,258	3,531	7,425	4,540	4,268	6,261	3,409	4,105	9,960	54,294
Visits with Physicians	340	635	2,154	2,547	413	461	635	306	435	1,235	9,161
Total Visits	3,877	7,893	5,685	9,972	4,953	4,729	6,896	3,715	4,540	11,195	63,455
Population Served	250	645	650	2,140	340	460	765	255	565	1,400	7,470
Visits/Resident	15.5	12.2	8.7	4.7	14.6	10.3	9.0	14.6	8.0	8.0	8.5
Patients/RN/Day	**12.0**	**14.0**	**14.0**	**15.5**	**9.0**	**8.0**	**11.5**	**11.0**	**7.0**	**9.0**	**11.1**
Patients/RN/Regular Clinic Hours	**9.4**	**12.3**	**13.1**	**14.7**	**8.0**	**6.6**	**8.8**	**13.9**	**7.2**	**4.7**	-
Patients/Physician/Day	**18.9**	**21.2**	**8.9**	**18.3**	**18.0**	**14.4**	**17.2**	**16.1**	**9.3**	**12.2**	**19.4**
After Hours Visits	963	647	324	278	364	507	980	808	756	1,552	7,179
Ave. After Hours Visits/Day	2.6	1.7	0.9	0.8	1.0	1.4	2.7	2.2	2.1	4.3	19.7
FTEs to Service (at 4 hrs/visit)	**2.0**	**1.3**	**0.7**	**0.6**	**0.7**	**1.0**	**2.0**	**1.7**	**1.6**	**3.2**	**14.7**

- **Utilization of clinics varies significantly by community. Residents visit 4.7-15.5 times per year.**
- **Productivity of nurses and physicians varies significantly by clinic. During regular hours, nurses service 4.7-14.7 patients/day.**
- **After hours visits vary significantly by clinic. Assuming nurses are paid 4 hours for each visit, 14.7 FTEs of effort are devoted to serving after hours patients.**

Overview

Deloitte & Touche

Summary of Budgeted vs. Actual Staffing			
Position	FTE Budgeted	FTE Actual	Actual vs. Budgeted
Total Reg. Nurse I	13	13.15	+.15
Total Reg. Nurse II	10	7.58	-2.42
Total PCAs	16.5	17.08	+.58
Total Other	5.5	5.62	+.12
Total	45	43.43	-1.57
Overtime FTEs (01/02)			8.2
Time in Lieu (est. 01/02)			6.5 – 9.6

- In total, community clinics are currently operating with 1.57 FTEs less than budgeted; however, the Regional Director reports there will be 7 vacant RN positions by April, 2003.
- An additional 8.2 FTEs were paid in overtime. An additional 6.5 –9.6 FTEs may have been accrued as time in lieu.

Observations

Deloitte & Touche

Community Clinics Paying > 0.5 FTE in Overtime											
Position	**CWT**	**BTL**	**DVS**	**HLP**	**NWR**	**HPD**	**NAI**	**RIG**	**PSV**	**MAK**	**Total**
Community Health Nurse											
01/02	1.1	0.8	1.1	-	-	0.9	1.7	0.6	1.3	0.7	**8.2**
00/01	1.4	1.1	1.7	-	0.6	0.7	2.1	0.5	1.1	1.1	**10.3**

The 8.2 FTEs of overtime are spread across 8 clinics. Any clinic paying for 1 FTE or more could benefit from additional full time resources.

Observations

- There are a number of positive comments to be made concerning community clinics:
  - Physical plants in excellent shape with the exception of Black Tickle and Rigolet.
  - All staff expressed desire to improve delivery of care, level of education and increase participation in decision-making processes.
  - Pharmacy service has improved dramatically over last five years.
- Areas of concern include:
  - Communication - fragmented, inconsistent and uni-directional
  - Devolution - anxiety provoking, poorly understood and potentially destabilizing
  - Physician visits – inadequate number, with exception of Rigolet
  - Lab data - manual and paper-based
  - Supervisor role - concern for all communities; current model is ineffective and requires immediate review
  - Transportation issues in Sango Bay - community dispersed; access to the clinic and airport will be problematic
  - Pharmacy - Pharmacist has never visited the communities; concerns re education, quality control, professional support
  - Maintenance - routine inspection of equipment is lacking; standardization of quality assurance processes is required (represents medical legal liability issue)
  - Medevacs - major cost drivers are lack of experience, airstrip in Nain, CY&FS, and communication.

Observations

Deloitte & Touche

- Areas of concern (cont'd):
  - Human Resources challenges are significant. Aside from the national issues facing nursing (e.g. aging cohort, supply and changing roles), community clinics in Labrador are faced with an immediate need for a minimum of 6-7 nurses (if the expected vacancies occur by April 2003), a non-competitive wage environment compared to other remote nursing environments and other provincial nursing colleagues. Perhaps more importantly, nurses in the nursing stations feel isolated from the HLC family. Physician resources are also challenged in that the number of community visits directly impacts on the number of patients transported from communities, nursing professional developed and overall wellness indicators.
  - Professional development, quality assurance programs, training are significantly challenged, representing risks to HLC.
  - Dental Program is not meeting the needs of the client base in all communities surveyed.
  - Pre-hospital management - lack of training in standardized approach (e.g. collar, backboard) representing risk areas for HLC. Stabilizing, managing and supporting trauma victims or critically ill patients has evolved nationally such that standardized protocols and clinical guidelines have been shown to alter outcome. HLC needs to develop a process to ensure that its staff are trained appropriately for the tasks they are being asked to perform.
  - Stores - unresponsive to unique clinic supply chain problems. Long waits resulting in excessive inventory to compensate

Observations

Deloitte & Touche

- Areas of concern (cont'd)
  - Workload and utilization
    - ✓ Culture of dependency
    - ✓ Remuneration model rewards visits (especially after hours)
    - ✓ Social problems have lead to medical problems
    - ✓ Matching skill set to presenting problem
    - ✓ Staffing levels problematic (single nurse clinics: burnout vs remuneration; impact on Medevacs; recruitment and retention challenges; quality and risk concerns).
  - Training/orientation
    - ✓ Maintenance of competency in CPR, ACLS and TNCC is problematic
    - ✓ Linked to role of supervisor
    - ✓ Professional development and education budget does not address unique needs of the community clinic staff
    - ✓ Telehealth not operationalized
    - ✓ No validation of skill set after orientation occurs.

Summary and Recommendations

Deloitte & Touche

- Address resourcing issues:
  - Budgeted RN FTEs are appropriate, with the exception of Postville, where a second RN is required from a core staffing perspective. No clinic should have less than two nurses, to ensure appropriate coverage.
  - Attempts should be made to improve scheduling in the clinics. Extension of clinic hours to midnight would allow the vast majority of after hours patients to be seen at regular rates of pay. In clinics where more than 1 FTE of overtime is paid, this is a cost effective solution. We recognize that this may impact on job satisfaction given that over-time pay is a significant recruitment and retention incentive.
  - There is an opportunity to introduce more regional behaviour through limited restructuring. There is a need to address the deficits in staffing, professional development, quality assurance, and communication with regional management. A revised administrative structure presents an opportunity to eliminate a supervisory position in Nain.
  - Movement to unit dosing by pharmacy could reduce the staffing complement in Nain by 0.5 FTEs.
  - The role of PCAs is not clear. Further study is required. May present opportunity for improved efficiencies.
  - Appropriateness of maintenance staff in community clinics requires further study.
- Improve communications:
  - Develop communication strategy to incorporate community clinic perspective into overall regional strategic plan.
  - Develop “devolution communication strategy” to allay some of the fears expressed by staff around job security, standards of care and availability of service.
  - Assess IT infrastructure to provide improved communication.

Summary and Recommendations (cont'd)

- Promote integration of community clinics with Aboriginal Health Commissions.
- Review telehealth as a vehicle for delivery of education, clinical care and professional support.
- Develop and implement a standardized pre-hospital program where the basic skills associated with trauma management, Advanced Cardiac Life Support, Pediatric Advanced Life Support and other pre-hospital training courses are integrated and "modified" to meet the needs of community clinic staff. This would involve development of skills and linkages within the clinics.
- Develop an equipment maintenance process, to be implemented by existing workers.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Community Clinics

Overview

- It is difficult to develop an accurate picture of community clinic operations within HLC:
  - Accurate data is unavailable. HLC reported data does not agree with informal data collected by the community clinics. Data inconsistencies relate to FTEs and volume of activity.
  - For purposes of our analysis, we relied on data provided by the Regional Director.

Overview

An overview of the 10 community clinics including population served and staffing complement is provided below. (Data provided by Regional Director.)

Community	Maintenance	RNs (Budgeted FTEs)	PCA	Clerk/Other
Nain Pop'n 1400	4 FT, 5 Casual	3 FT, 1 FT on Education Leave (5)	6 FT, 4 Casual	1 FT Clerk , 1 Supervisor FT, 1 Supervisor Casual
Sheshashiu Pop'n 2140	Leased Space	1 NP, 1 FT, 1 Leave (2)	2 FT, 1 Casual, 1 PT	Paramedics: 1 FT, 1 PT Amb. Attendants: 3 Casuals PCA: 1 FT 1 PT PCA/Amb. Attendant: 1 FT
Black Tickle Pop'n 250	1 FT, 1 LTD	1 FT, 1 Casual (2)	1 FT, 1 Casual	
Cartwright Pop'n 645	1 FT, 1 Casual	2 FT (2)	1 FT, 3 Casual	
Churchill Falls Pop'n 650	Leased Space	1 FT LTD, 2 Temp .5 each (1)	1 FT, 1 Casual	1 FT Physician, 1 FT Typist
Natuashish Pop'n 565	1 FT, 1 PT, 3 Casual	4 FT (3)	1 FT	
Postville Pop'n 255	1 FT, 3 Casual	1 FT, 1 Casual (1)	1 FT, 1 Casual	
Rigolet Pop'n 340	1 FT, 1 Casual	2 FT, 1 Casual (2)	1 FT, 2 Casual	
Hopedale Pop'n 765	1 FT, 2 Casual, 1 PT	2 FT, 1 Casual (2)	1 FT	2 Interpreters Casual (not paid by HLC), 1 Domestic Part time
Makkovik Pop'n 460	1 FT, 1 Casual	2 FT, (2)	1 FT, 1 Casual	1 Interpreter Casual (not paid by HLC)

Overview

- Nain:
  - Only clinic open 18 hours per day - PCA staffing ratio appears high (further study required)
  - No access to air strip after dark - patient medevacs are high or patients are kept due to weather or airstrip access requiring extra staff
  - Population at risk based on historical issues with SA and suicide
  - Difficult to staff – safety issues
  - Staffing levels in maintenance need to be assessed in context of assuring cost recovery for services and space provided to devolved programs
  - Eliminate supervisor role in restructured management
- Sheshashiu:
  - Connected by road to LHC, i.e. not the same role as other clinics
  - No coverage after 1700 hours
  - Population at risk based on historical issues with SA and suicide
  - Prevalence data for diabetes and social problems better defined than other clinics
  - Need to define pre-hospital program and share resources with community clinic
- Black Tickle:
  - Recent reduction of service by HLC plane expected to be problematic
  - Overtime is high due to single nurse, living in clinic and “needy” population
- Cartwright:
  - May soon be **c**onnected by road to LHC - high expectations and new problems
  - Nursing human resources issues are significant
  - Move to external housing will reduce overtime

Overview

- Churchill Falls:
  - Extremely high utilization rate - significant education investment required
  - Potential for the 1 RN FTE to be supported by a Nurse Practitioner when the current physician leaves
  - Potential to eliminate typist position when physician leaves
- Natuashish:
  - Social problems under-represented due to lack of resident social workers
  - Maintenance costs will increase due to issues around transportation and increased square footage.
  - Staffing levels in maintenance need to be assessed in context of assuring cost recovery for services and space provided to devolved programs
- Postville:
  - Overtime is high due to single nurse
  - Move to external housing will reduce overtime cost
  - Requires 2 FTE RNs
- Rigolet:
  - Staffing parameters, including physician visits, are appropriate
- Hopedale:
  - Large building which serves as a community resource – requires extra maintenance
  - Opportunity to cross-train domestic as PCA
- Makkovik:
  - Potential Nurse Practitioner to also support Churchill Falls

Observations

Deloitte & Touche

Summary of Activity											
	BT	CWT	CHF	SESH	RIG	MAK	HDL	PSV	NAT	NAIN	Total
Visits with Nurses	3,537	7,258	3,531	7,425	4,540	4,268	6,261	3,409	4,105	9,960	54,294
Visits with Physicians	340	635	2,154	2,547	413	461	635	306	435	1,235	9,161
Total Visits	3,877	7,893	5,685	9,972	4,953	4,729	6,896	3,715	4,540	11,195	63,455
Population Served	250	645	650	2,140	340	460	765	255	565	1,400	7,470
Visits/Resident	15.5	12.2	8.7	4.7	14.6	10.3	9.0	14.6	8.0	8.0	8.5
Patients/RN/Day	**12.0**	**14.0**	**14.0**	**15.5**	**9.0**	**8.0**	**11.5**	**11.0**	**7.0**	**9.0**	**11.1**
Patients/RN/Regular Clinic Hours	**9.4**	**12.3**	**13.1**	**14.7**	**8.0**	**6.6**	**8.8**	**13.9**	**7.2**	**4.7**	-
Patients/Physician/Day	**18.9**	**21.2**	**8.9**	**18.3**	**18.0**	**14.4**	**17.2**	**16.1**	**9.3**	**12.2**	**19.4**
After Hours Visits	963	647	324	278	364	507	980	808	756	1,552	7,179
Ave. After Hours Visits/Day	2.6	1.7	0.9	0.8	1.0	1.4	2.7	2.2	2.1	4.3	19.7
FTEs to Service (at 4 hrs/visit)	**2.0**	**1.3**	**0.7**	**0.6**	**0.7**	**1.0**	**2.0**	**1.7**	**1.6**	**3.2**	**14.7**

- **Utilization of clinics varies significantly by community. Residents visit 4.7-15.5 times per year.**
- **Productivity of nurses and physicians varies significantly by clinic. During regular hours, nurses service 4.7-14.7 patients/day.**
- **After hours visits vary significantly by clinic. Assuming nurses are paid 4 hours for each visit, 14.7 FTEs of effort are devoted to serving after hours patients.**

Overview

Deloitte & Touche

Summary of Budgeted vs. Actual Staffing			
Position	FTE Budgeted	FTE Actual	Actual vs. Budgeted
Total Reg. Nurse I	13	13.15	+.15
Total Reg. Nurse II	10	7.58	-2.42
Total PCAs	16.5	17.08	+.58
Total Other	5.5	5.62	+.12
Total	45	43.43	-1.57
Overtime FTEs (01/02)			8.2
Time in Lieu (est. 01/02)			6.5 – 9.6

- In total, community clinics are currently operating with 1.57 FTEs less than budgeted; however, the Regional Director reports there will be 7 vacant RN positions by April, 2003.
- An additional 8.2 FTEs were paid in overtime. An additional 6.5 –9.6 FTEs may have been accrued as time in lieu.

Observations

Deloitte & Touche

Community Clinics Paying > 0.5 FTE in Overtime											
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Deloitte & Touche

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Deloitte & Touche

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Summary and Recommendations

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- Develop an equipment maintenance process, to be implemented by existing workers.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Community Services

Community Services includes: Public Health, Mental Health, Health Addictions, Child Youth Network and Pastoral Care, Continuing Care, Family and Rehabilitative Services, Child Care Services, and Community Corrections

Community Services – Public Health

Deloitte & Touche

Observations

- The Regional Director for Public Health is located at LHC and reports to the AED (Acute and Community Care). In addition to responsibilities for Public Health, the Regional Director coordinates the activities of the Northern Labrador Development Team.
- Public Health services are available at LHC, CWJMH, NWR, Cartwright, Black Tickle and Churchill Falls.
- The program provides a range of services, including mandated services (communicable disease control and immunization) as well as preconceptual counselling, childbirth education, healthy beginnings, child health clinics, breastfeeding support, and school health.
- The program is staffed by 7.75 FTE health professionals, supported by 1.5 FTE clerical.
- The demographics for clients seen at LHC have changed as more aboriginal clients are moving between the coastal communities and Happy Valley/Goose Bay. This has occurred without federal funding for programs following the clients.
- Closure of the Happy Valley medical clinic has increased demands at LHC for Public Health Nursing and Continuing Care.

Community Services – Public Health

Deloitte & Touche

Observations (cont'd)

- Several of the Public Health programs are mandated, while others are judged b staff and done on a needs basis.
- Public Health workload has remained steady, decreasing by 1% between 2000/01 and 2002/03..
- The Medical Officer of Health (.5 FTE) and the Communicable Disease Control Nurse for the region are based at LHC.
- The devolution of Community Health Nursing to the Innu Nation and Labrador Health Commission has created confusion and duplication.
- Lack of casual staff makes it difficult to maintain consistent levels of Public Health and Continuing Care.
- CWJMH has a more predictable client base than LHC and appears adequately resourced to meet the priority needs and provide some community programs.
- Public Health does not have quality indicators. Their statistics are comprehensive.

Community Services – Public Health

Deloitte & Touche

Observations (cont'd)

- Implementation of CRMS has been very slow and frustrating for staff. Access to Meditech is seen as an asset to practice, however staff find it challenging to learn two systems.
- Mandated Public Health nursing program needs appear to be met. There has not been a needs assessment process to determine the priority for other programs.
- There are significant gaps in Audiology and Speech Language services.
- The approach to diabetic care is confusing with Public Health Nursing and Continuing Care.
- The increased number of diabetic patients has impacted workload.
- Confusion relative to devolution leads to inefficiencies.
- The regional model is not well integrated resulting in a great deal of confusion and duplication between Public Health Nursing and the aboriginal communities.
- IGA grants have supported a number of initiatives.

Community Services – Public Health

Deloitte & Touche

Recommendations

- This regional program is functioning reasonably well; however, it requires a more integrated approach to service delivery.
- There is a need to develop a regional integrated model of service delivery for Public Health and Continuing Care. The current structure is not conducive to effective planning and management of service delivery.
- One Regional Director should be considered for Public Health and Continuing Care – currently there is one for each program.
- A regional needs assessment should be completed for Public Health, Continuing Care, Mental Health and Addictions to ensure the priority service needs are understood for all of the communities served by HLC.
- Quality indicators for this program should be developed.
- Greater support for the implementation of CRMS should be provided, particularly to the coastal communities.
- Significant gaps in Audiology and Speech Language services should be addressed. The current incumbent is on a one year leave of absence.

Community Services – Mental Health, Addictions, Child Youth Network and Pastoral Care

Deloitte & Touche

This program has a Regional Director located at LHC, and reports to the AED, Community Services.

Mental Health - Observations

- Mental Health is primarily provided at LHC and CWJMH.
- In Churchill Falls, a mental health nurse is employed for ten hours per week; minimal services are provided in Cartwright.
- Clients from the coastal communities fly to LHC for service.
- The program is staffed by 4.5 FTE social workers, 4 FTE psychiatric nurses, and 1.5 FTE clerical. In addition, a mental health nurse is employed to work 10 hours per week in the community of Churchill Falls.
- The program provides mental health – screening, assessment, counselling, follow-up services, clinical care consultation, monitors psychiatric care, administers injectable medication. The service also provides critical incident crisis response, group therapy, and workshops.
- In addition, the service provides placement/financial assessments and facilitates medical transport.
- One social worker works half-time at Paddon Home, the other half at LHC.
- One psychiatric nurse is responsible for the care of 30 residents at Pine Lodge (Level I and II care home).
- IGA grants have supported a number of initiatives.
- Mental Health workload has increased by 1% in 2000/01 to 2002/03.

Community Services – Mental Health, Addictions, Child Youth Network and Pastoral Care

Deloitte & Touche

Mental Health - Recommendations

- This regional program is functioning reasonably well; however, it requires a more integrated approach to service delivery.
- A regional needs assessment should be completed for Mental Health to ensure the priority service needs are understood for all of the communities served by HLC.
- Quality indicators for this program should be developed.

Community Services – Mental Health, Addictions, Child Youth Network and Pastoral Care

Deloitte & Touche

Addictions - Observations

- The Addictions program is staffed by 4 FTE addictions counsellors and one FTE clerical.
- The program provides the following services: detoxification, assessment, referral, outpatient counseling, follow-up care. and impaired driving assessment/treatment.
- The Addictions program does not have quality indicators.
- IGA grants have supported a number of initiatives.

Addictions - Recommendations

- This regional program is functioning reasonably well; however, it requires a more integrated approach to service delivery.
- Quality indicators for this program should be developed.
- A regional needs assessment should be completed for Addictions to ensure the priority service needs are understood for all of the communities served by HLC.

Community Services – Mental Health, Addictions, Child Youth Network and Pastoral Care

Deloitte & Touche

Child Youth Network - Observations

- The Child Youth Network is a 5-site, federally funded program with a $300,000 annual budget. It is a community based initiative, where the manager works with band councils and community groups. This initiative will be reviewed by the federal government in 2004.

Pastoral Care - Observations

- Pastoral Care is a community-provided clergy program at LHC and CWJMH.

Community Services – Continuing Care

Deloitte & Touche

Observations

- Continuing Care is a regional program that provides a range of services, including: financial assessment, assessment and placement, discharge planning, diabetic education, training for personal care attendants, licensing and approval of personal care homes, and coordination of special assistance programs.
- Continuing Care staff are located at LHC, NWR, CWJMH, Churchill Falls, Cartwright, and Black Tickle.
- The program is staffed by a Regional Director, 1 FTE manager, 6.5 FTE health professionals, and 1 FTE clerical.
- Provision for home support is contracted by families directly.
- There does not appear to be a clear understanding of continuing care needs.
- An integrated approach between Public Health and Continuing Care is lacking.

Community Services – Continuing Care

Recommendations

- As mentioned previously, one Regional Director should be considered for Public Health and Continuing Care – currently there is one for each program.
- Quality indicators for this program should be developed.
- A regional needs assessment should be completed for Continuing Care to ensure the priority service needs are understood for all of the communities served by HLC.

Community Services – Family and Rehabilitative Services

Deloitte & Touche

Observations

- The Director (Community Corrections, Child Care Services, Family and Rehabilitative Services) is located at the sub-Regional Office in Labrador City and reports to the AED, Community Services.
- The Family and Rehabilitative Services Program provides services to adults, children, and families with developmental and physical disabilities.
- There are two Family and Rehabilitative Service workers, one located in Wabush and the other in Happy Valley. The heaviest caseloads are in these two locations. Services in Sheshatshiu and the coastal communities are provided by social workers in the CYFS Child Welfare Program.
- Although the social workers provide a range of home support services, conduct investigations under the Neglected Adults Act, and liaise with community boards, such as Family Crisis Shelters, much of their direct service time is spent in the administration of client payments.
- Since December, 2001, new criteria implemented by the Province has restricted approvals in this program to emergency cases only, even if clients meet the pre-existing provincial/regional criteria.

Community Services – Family and Rehabilitative Services

Observations (cont'd)

- Within this service is the Intervention Services Program, comprised of the Community Behavioural Services Program (CBSP) and the Direct Home Services Program (DHSP), both home-based programs that assist parents and caregivers with children and adults having behavioural problems as a result of developmental or cognitive disability.
- The Program Supervisor, Intervention Services, and four Behaviour/Child Management specialists deliver services to Labrador West, Happy Valley/Goose Bay, Sheshatshiu, North West River, and the north coast of Labrador. Staff have degrees in psychology or closely-related disciplines, with many completing Senior Therapist Training for an Autism Pilot Project.
- With funding in December, 2002 from the Province for the position of Program Supervisor, Intervention Services, program supervision is also provided to two designated staff within the Grenfell Region.
- Family and Rehabilitative Services is a very valuable community program that is adequately staffed at this time.

Community Services – Child Care Services

Observations

- The Regional Director (Community Corrections, Child Care Services, Family and Rehabilitative Services) is located in the sub-Regional Office in Labrador City, and reports to the AED, Community Services.
- The major component of this program is the licensing and monitoring of child care services throughout the Region to ensure compliance with the Child Care Services Act and Regulations, as well as providing consultative services and support to licensed child care services. The program also provides families who are financially eligible and who meet the criteria for child care subsidy to obtain licensed child care services for their children.
- Two full-time staff provide this service from the Happy Valley/Goose Bay District Office. The Regional Child Care Consultant position is funded through the National Child Benefit Program, and the Regional Child Care Social Worker position is financed through Early Childhood Development funding.
- Family Child Care is a new program that is still in the developmental stage in Labrador. Currently, applications from families wishing to provide child care in their homes are being assessed by the Regional social worker.

Community Services – Child Care Services

Observations (cont'd)

- The Child Care Consultant is the regional liaison between HLC and the provincial Department of Health and Community Services with respect to the five Family Resource Centres within the Region, and provides consultation services regarding programming.
- As the Family Resource Centres develop, there will be a need for on-site visits, in order that the Centres receive appropriate support and monitoring of their programs. Such visits will have implications for current staffing and financial resources, as child care services are the current priority for the program.

Recommendation

- As the Family Resource Centres play a very valuable supportive role to such programs as Protective Intervention Services, it is recommended that the roles and expectations with respect to HLC's future involvement with the Family Resource Centres be clarified with the Province to ensure an adequate commitment of service by the Child Care Services Consultant.

Community Services – Community Corrections

Observations

- The Regional Director (Community Corrections, Child Care Services, Family and Rehabilitative Services) is located at the sub-Regional Office in Labrador City, and reports to the AED, Community Services.
- The Community Corrections Program provides services to youth between the ages of 12 and 18 who are in conflict with the law.
- With a Community Corrections Consultant in the Happy Valley Regional Office, the program is staffed by three designated full-time staff in Happy Valley and Wabush, and by social workers and community service workers in the coastal communities and Sheshatshiu who provide child welfare services.
- Although there has been a slight decrease in overall statistics, the number of young offenders has increased significantly in Sheshatshiu.
- A new Youth Criminal Justice Act will shortly be promulgated, and its impact is currently being considered by HLC. In future, there may well be greater involvement of staff in delivering community-based programs, including community service for young offenders.

Community Services – Community Corrections

Recommendation

- The current program is functioning well but, with no designated staff in Sheshatshiu, any further rise in the number of young offenders in that community will require a staffing review in this program.
- The position of Community Corrections Consultant is currently funded temporarily by the federal and provincial governments and, as the value of retaining that position is proven, more permanent funding should be explored.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Child, Youth and Family Services Child Welfare Programs

(Child Protective Intervention Services, Youth Services, Adoptions)

Child, Youth and Family Services

Deloitte & Touche

Overview

- The Child, Youth and Family Services Program provides a range of child welfare services to ensure the safety, health and well-being of children, youth, families and communities within the Labrador region.
- Programs of child welfare include legislated protective intervention services for abused or neglected children; protective services to 16 and 17-year old youth on a voluntary basis; supportive services to parents and their children; alternative care placements for children who can no longer live at home; and adoption services.
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Child, Youth and Family Services

Overview (cont'd)

CYFS FTEs										
Position	**HVGB**	**Lab City**	**WAB**	**NAIN**	**MAK**	**HOPE**	**SESH**	**NAT**	**CART**	**Total**
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Program Manager	1		1	1			1			4
Social Worker	4		2	1		1	2	2	1	13
Community Service Worker	1			3	1	1	3	2		11
Clerical	1		1				*2			4
TOTAL	**8**		**4**	**5**	**1**	**2**	**8**	**4**	**1**	**33**

* The duties of one of these two positions is similar to that of a financial assistance clerk.

33 FTEs provide the full range of CYFS child welfare programs throughout the Region, as well as serve clients in the Family and Rehabilitative Services and Community Corrections in Sheshatshiu and the coastal communities where the number of clients in these two programs is too low to designate social workers.

Child, Youth and Family Services

Deloitte & Touche

Observations: CYFS Management

- A committed team of professionals striving to meet the challenges of delivering a complex mix of programs to Labrador communities, while critically lacking an adequate level of staffing.
- Progress being made on enhanced financial and program accountability, as well as staff training initiatives.
- At times, Directors and Program Managers are kept from fully carrying out their own responsibilities by having to cover for staff absent on stress leave, or by having to assist with serious emergency situations where there are insufficient staff in a community to handle the crisis.
- Management support that, at times, is affected by lack of expertise, burn-out, or by a lack of management capability that may not be filled with training.
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Child, Youth and Family Services

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Observations: CYFS Programs

- A range of child welfare services to families, children and youth which are mandated under the relatively-new Child Youth and Family Services Act and the soon-to-be proclaimed Adoption Act.
- Programs being delivered to aboriginal communities struggling against the effects of colonization and assimilation, and which are undergoing high rates of alcoholism, substance abuse, family violence, suicide, and child abuse.
- A high number of aboriginal children placed in care, primarily within the extended family circle.
- An emphasis on maintaining contact between natural parents and their children who are being cared for in white homes, and on providing support to all parents having children in care, as part of the planning process for their childrens' eventual return home.
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Child, Youth and Family Services

Deloitte & Touche

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- Positive team building among HLC community programs resulting in a monthly joint training session with professionals from Mental Health/Addictions, Public Health, Family and Rehabilitative Services, Child Care, and Child Welfare.
- A highly unacceptable situation in the coastal communities and Sheshatshiu where children are at substantial risk because of a critical lack of social workers and community service workers to ensure their personal safety, health and well-being under the Child Youth and Family Services Act.
- The potential exists for past or present clients to take legal action against HLC, alleging failure to protect them from abuse or neglect when they were children.
- No internal evaluation of CYFS programs to assure their effectiveness, their cultural sensitivity, and their ability to protect children and youth.

Child, Youth and Family Services

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- A tireless group of professional social workers who go “above and beyond” in assuming higher caseloads while colleagues leave to assist with emergencies in understaffed communities.
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Child, Youth and Family Services

Deloitte & Touche

HR Issues: Recruitment and Retention

- Recent graduates in social work who lack experience have been targeted to fill vacancies.
- Impediments to recruitment of experienced social workers have been found to be:
  - Unrealistically high caseloads
  - Isolation
  - Security and housing issues
  - Lack of community resources
  - Limited access to quality supervision
  - Limited opportunities for professional development
  - Low rates of compensation for after hours “call-outs”
  - Competition from other Northern employers offering better remuneration packages (see table on following page).
- As experienced staff are essential to meet the challenges of providing child welfare services in the region, recruitment and retention strategies offering attractive incentives, such as sabbaticals and professional development opportunities, should be considered.

Child, Youth and Family Services

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Salary Comparisons* 2002/03				
	Northern Ontario	**Labrador**	**Nunavut**	**Northwest Territories**
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Child, Youth and Family Services

Deloitte & Touche

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- Due to resource restraints, the province can now only provide training related to changes in provincial legislation. Job-specific training is currently provided through the initiatives of a Regional Director, with requests for financial assistance requiring the approval of HLC's Staff Development Committee.
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- There is a serious need for additional training opportunities to strengthen program management and supervisory skills.
- Because staff must be cross-trained in a number of specialized programs and to deliver those programs in the most culturally sensitive way, the current training needs are outstripping HLC's ability to ensure all CYFS staff have the necessary skills and program knowledge.
- There is currently no designated training officer within HLC responsible for assessing and prioritizing the range of training needs, developing course material, nor delivering competency-based training, and specialized courses such as sexual abuse and family violence.
- As additional social workers and community service workers are hired in Labrador, current social development efforts in the coastal communities can be expanded. Workers will require skill training in helping a community identify and assess their concerns; in building relationships within the community; in identifying community strengths; and in enlisting segments of the community in finding solutions.

Child, Youth and Family Services

Deloitte & Touche

Efficiency Review

- Clear internal policies and procedures outline the required management approval for the expenditure of all funds.
- Designated maintenance and operations funding with maximum limits are provided to HLC through the Canada/Newfoundland and Labrador Child and Family Services agreement in effect from June 1, 2002 to March 31, 2003. (The operations funding portion does not cover the actual 2002/03 operating costs in Natuashish and Sheshatshiu.)
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  - The provision of mandated services that are not discretionary under legislation
  - The unpredictability of ascertaining in advance of the budget year, how many children at high risk may come in to care
  - The nature of the special needs of children under protection that must be met by HLC
  - The length of time children in temporary care must remain in other homes before they can return to their families
  - The long-term and increasing cost of children and youth for whom HLC has permanent custody until age 18 or, in approved cases, to 21 years of age

Child, Youth and Family Services

Deloitte & Touche

Efficiency Review (cont'd)

- The extremely high cost of treating troubled children outside the province when such treatment is not available provincially
- The large number of aboriginal children in care who have come from high-risk family situations, accounting for the high maintenance costs needed to provide for their care

- The Child Youth and Family Services Act is a progressive piece of legislation that was not accompanied by the staffing and financial resources needed to cover expanded services and the new emphasis on prevention.
- In general, other provinces have increased resources when new child welfare legislation was proclaimed. British Columbia and Ontario did so, as did Nova Scotia with their new Children and Family Services Act in September 1999. Since then, Nova Scotia has added 163 child welfare positions and over $20 million to agency budgets for child welfare services.
- HLC is significantly under-staffed to meet its mandate, particularly in aboriginal communities, as indicated on the following pages.

Child, Youth and Family Services

Efficiency Review – Current Caseloads

CYFS Caseload (November 2002)	
Clients Receiving Service	**CWLA Cases**
Children in temporary care	28
Children in continuous care	38
Birth parents of children in care, and who are receiving supportive services	51
Children placed with relatives and for whom a child welfare allowance is paid	254
Birth parents of children placed with relatives, and who are receiving service	157
Protection families receiving services to strengthen family life and the care and well-being of their children	238
Youth voluntarily receiving protection services	36
Adoptions	60
Foster Parent/Caregiver Homes	75
Family and Rehabilitative Services (Sheshatshiu and coastal communities)	21
Community Corrections (Sheshatshiu and coastal communities)	75
Total	**1,033**

- **In general, a case is the instance of a family, or an individual child or youth not in the family, or an individual adult, receiving professional guidance from a social worker.**
- **Caseload figures do not represent workload – the amount of time required to perform a specific task. For example, the caseload figure of 238 protection families does not count the 482 children in their homes for whom there are protection concerns requiring the attention of the social worker.**
- **Based on the Technical Working Group Report's* recommendation of a ratio of one team (one social worker and one community service worker) to every 33 cases, the HLC's program is understaffed by one Program Manager, 13 social workers, eight community service workers, and three clerical staff. Current caseload is 79 cases/social worker.**

* The Technical Working Group Report on Staffing Levels in CYFS for the Innu Communities of Sheshatshiu and Davis Inlet/Natuashish dated January 17, 2003.

Child, Youth and Family Services

Deloitte & Touche

Efficiency Review – Proposed Staffing Increases

Position	HVGB		WAB		NAIN		MAK		HOPE		SESH		DVS/NAT		CART		Existing	Proposed Additions	Proposed Total
	E	P	E	P	E	P	E	P	E	P	E	P	E	P	E	P			
Regional Director	1																1		1
Program Manager	1		1		1						1			1			4	1	5
Social Workers	4	1	2		1	2		1	1	1	2	6	2	2	1		13	13	26
Community Services Worker	1				3		1		1	1	3	5	2	2			11	8	19
Clerical	1		1			1		1			2			1			4	3	7
TOTAL	**8**	**1**	**4**	**0**	**5**	**3**	**1**	**2**	**2**	**2**	**8**	**11**	**4**	**6**	**1**	**0**	**33**	**25**	**58**

E = Existing

P = Proposed

With the proposed addition of 13 social workers and 8 community service workers to the Region, a team caseload would average 38.3 cases. Given the small number of social workers and community service workers in each community, that brings HLC as close as possible to the target of one team per 33 cases, as shown on the following page. It is clear that the greatest need is in aboriginal communities.

Child, Youth and Family Services

Deloitte & Touche

Efficiency Review – Proposed Caseloads

New Team Caseloads				
Location	**Caseload**	**Staffing**	**New Caseload Per Team**	**Notes**
Nain	132	3 teams*	44	
Natuashish	174	4 teams	43	
Hopedale	63	2 teams	31	
Makkovik	52	1 team	52	
Cartwright	21	1 social worker	21	Social worker also does screening for mental health and addictions services
Sheshatshiu	338	8 teams	42	
Happy Valley	181	1 team 4 social workers	37	
Wabush	72	2 social workers	36	
Total/Average	**1,033**			

* Each team is composed of a social worker and a community service worker

Applying the Technical Working Group recommendation of one team to 33 cases, these caseload numbers reflect the required number of teams closest to meeting that target.

Child, Youth and Family Services

Deloitte & Touche

Emerging Changes

- Decisions are pending respecting devolution which must be made by other levels of government, and which will affect funding arrangements and the timing and pace of a successful transfer of services to the Innu communities.
- A recruitment campaign by Health Canada's recently-established Labrador Health Secretariat could draw social workers from HLC and exacerbate the current staffing crisis.
- The upcoming implementation of the provincial CRMS system will require training for staff and time for them to become competent in using this data-collecting system.
- The Human Resources and Employment office in Happy Valley/Goose Bay will cease to be a client payment centre for HLC as of April 1, 2004.

Child, Youth and Family Services

Deloitte & Touche

Summary and Recommendations

- Increase staffing to appropriate levels by establishing 25 new positions in the CYFS Child Welfare Program.
- Such new positions would provide one Program Manager, 13 social workers, 8 community social workers, and 3 clerical workers.
- This new staffing complement provides minimal coverage for the current caseload, and does not account for the additional volume of work that will be generated once more social workers and community service workers are in the communities.
- CYFS additional costs (estimated by HLC management) based on 25 positions for the 2003/04 fiscal year are:

Salary costs	$1,582,938
Non-salary costs	703,311
Program costs	788,123
Less: CYFS Agreement Revenue	(428,189)
Net increase in 2003/04	2,646,183
One-time capital costs	1,055,000
Total	**$3,701,183**

Child, Youth and Family Services

Deloitte & Touche

Summary and Recommendations (cont'd)

- Address key HR issues:
  - A Training Officer should be designated from within HLC to undertake a learning needs assessment to identify and prioritize the training requirements of CYFS staff, and to be responsible for the ongoing delivery of orientation and job-specific training throughout the Region.
  - The role of the community service worker should be reviewed to ensure the duties of the position do not include responsibilities that belong solely to the social worker, such as the screening of new referrals. With additional staffing, the community service worker could become more involved in community development tasks, and in activities of a preventive nature that would help to keep children safely in their own homes.
  - Appropriate annual performance appraisal guidelines should be developed for CYFS management and front-line staff with performance appraisals conducted annually.
- Reorganize payment process:
  - Given that Human Resources will no longer be issuing CYFS client payments after April 1, 2004, HLC will need to consider how best to reorganize the entire payment process in such a way that social workers can be relieved of many related administrative tasks.

Deloitte & Touche

- **REVIEW OF FINDINGS**
- **Operational Review**

Child, Youth and Family Services Child Welfare Programs

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Child, Youth and Family Services

Deloitte & Touche

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Child, Youth and Family Services

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Child, Youth and Family Services

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Child, Youth and Family Services

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Efficiency Review (cont'd)

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- **Caseload figures do not represent workload – the amount of time required to perform a specific task. For example, the caseload figure of 238 protection families does not count the 482 children in their homes for whom there are protection concerns requiring the attention of the social worker.**
- **Based on the Technical Working Group Report's* recommendation of a ratio of one team (one social worker and one community service worker) to every 33 cases, the HLC's program is understaffed by one Program Manager, 13 social workers, eight community service workers, and three clerical staff. Current caseload is 79 cases/social worker.**

* The Technical Working Group Report on Staffing Levels in CYFS for the Innu Communities of Sheshatshiu and Davis Inlet/Natuashish dated January 17, 2003.

Child, Youth and Family Services

Deloitte & Touche

Efficiency Review – Proposed Staffing Increases

Position	HVGB		WAB		NAIN		MAK		HOPE		SESH		DVS/NAT		CART		Existing	Proposed Additions	Proposed Total
	E	P	E	P	E	P	E	P	E	P	E	P	E	P	E	P			
Regional Director	1																1		1
Program Manager	1		1		1						1			1			4	1	5
Social Workers	4	1	2		1	2		1	1	1	2	6	2	2	1		13	13	26
Community Services Worker	1				3		1		1	1	3	5	2	2			11	8	19
Clerical	1		1			1		1			2			1			4	3	7
TOTAL	**8**	**1**	**4**	**0**	**5**	**3**	**1**	**2**	**2**	**2**	**8**	**11**	**4**	**6**	**1**	**0**	**33**	**25**	**58**

E = Existing

P = Proposed

With the proposed addition of 13 social workers and 8 community service workers to the Region, a team caseload would average 38.3 cases. Given the small number of social workers and community service workers in each community, that brings HLC as close as possible to the target of one team per 33 cases, as shown on the following page. It is clear that the greatest need is in aboriginal communities.

Child, Youth and Family Services

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Efficiency Review – Proposed Caseloads

New Team Caseloads				
Location	**Caseload**	**Staffing**	**New Caseload Per Team**	**Notes**
Nain	132	3 teams*	44	
Natuashish	174	4 teams	43	
Hopedale	63	2 teams	31	
Makkovik	52	1 team	52	
Cartwright	21	1 social worker	21	Social worker also does screening for mental health and addictions services
Sheshatshiu	338	8 teams	42	
Happy Valley	181	1 team 4 social workers	37	
Wabush	72	2 social workers	36	
Total/Average	**1,033**			

* Each team is composed of a social worker and a community service worker

Applying the Technical Working Group recommendation of one team to 33 cases, these caseload numbers reflect the required number of teams closest to meeting that target.

Child, Youth and Family Services

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Emerging Changes

- Decisions are pending respecting devolution which must be made by other levels of government, and which will affect funding arrangements and the timing and pace of a successful transfer of services to the Innu communities.
- A recruitment campaign by Health Canada's recently-established Labrador Health Secretariat could draw social workers from HLC and exacerbate the current staffing crisis.
- The upcoming implementation of the provincial CRMS system will require training for staff and time for them to become competent in using this data-collecting system.
- The Human Resources and Employment office in Happy Valley/Goose Bay will cease to be a client payment centre for HLC as of April 1, 2004.

Child, Youth and Family Services

Deloitte & Touche

Summary and Recommendations

- Increase staffing to appropriate levels by establishing 25 new positions in the CYFS Child Welfare Program.
- Such new positions would provide one Program Manager, 13 social workers, 8 community social workers, and 3 clerical workers.
- This new staffing complement provides minimal coverage for the current caseload, and does not account for the additional volume of work that will be generated once more social workers and community service workers are in the communities.
- CYFS additional costs (estimated by HLC management) based on 25 positions for the 2003/04 fiscal year are:

Salary costs	$1,582,938
Non-salary costs	703,311
Program costs	788,123
Less: CYFS Agreement Revenue	(428,189)
Net increase in 2003/04	2,646,183
One-time capital costs	1,055,000
Total	**$3,701,183**

Child, Youth and Family Services

Deloitte & Touche

Summary and Recommendations (cont'd)

- Address key HR issues:
  - A Training Officer should be designated from within HLC to undertake a learning needs assessment to identify and prioritize the training requirements of CYFS staff, and to be responsible for the ongoing delivery of orientation and job-specific training throughout the Region.
  - The role of the community service worker should be reviewed to ensure the duties of the position do not include responsibilities that belong solely to the social worker, such as the screening of new referrals. With additional staffing, the community service worker could become more involved in community development tasks, and in activities of a preventive nature that would help to keep children safely in their own homes.
  - Appropriate annual performance appraisal guidelines should be developed for CYFS management and front-line staff with performance appraisals conducted annually.
- Reorganize payment process:
  - Given that Human Resources will no longer be issuing CYFS client payments after April 1, 2004, HLC will need to consider how best to reorganize the entire payment process in such a way that social workers can be relieved of many related administrative tasks.

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- **REVIEW OF FINDINGS**
- **Operational Review**

Long-Term Care

Overview – Harry L. Paddon Home

Deloitte & Touche

- Long term care is provided at Harry L. Paddon and six long-term care beds at CWJMH.
- The six long-term care beds at CWJMH are located on the same floor as the acute unit and the staff are integrated with the acute care staff; direct care is provided by LPNs, supervised by the registered nurses of the acute unit. Review of staffing of these beds was included in our acute care review.
- The 48-bed Paddon Home was opened in 1975 for Level I and Level II seniors. It is currently operating at 80% Level III residents. The Home is divided into two patient care wings, separated by a cafeteria/kitchen, administrative offices, and a lounge. The ALOS is 46.8 months. 70% of the patients require feeding assistance, there is no day program, no protective care space, and the rooms (each with two residents) are very crowded.
- Clinical support from PT/OT/nutrition is minimal. Recreation support is provided.

Overview – Harry L. Paddon Home

Deloitte & Touche

- The complement of Paddon staff is 1 site administrator, 1 head nurse, 7 FTE RNs, 17 FTE RNAs, 2 FTE aides (non-registered caregivers), 2 FTE activation aides, and 1 FTE ward clerk. There are no continuing care workers.

Position	Day	Evening	Night
Head Nurse	1		
RNs	2	1	1
RNAs	9	7-4	3
Aides (non-registered caregivers)	2		
Activation Aides	2		
Clerk	1		

- While staffing levels in 2001/02 at 3.06 HPPD were slightly above peers, they will come into line with the 100% occupancy in 2002/03.

Long-Term Care (Harry L. Paddon Home)

Patient Activity – Harry L. Paddon

	Resident Days	Resident Cases
2000/01	14,176	466
2001/02	13,318	438
2002/03 YTD	12,253	401
Projected 2002/03	16,337	535
% Change 2002/03 to 2000/01	15.2%	14.8%

During 2001/02, the patient days at Harry L. Paddon Home decreased as beds were closed due to staff shortages. In 2002/03, it is projected there will be 100% occupancy.

Summary and Recommendations

Deloitte & Touche

- The Paddon facility, built in the mid 1970s, is not condusive to maximizing efficiency to meet service needs. The rooms, each with two residents, are crowded; the dining room layout will not allow for all residents to be in the area at the same time and maintenance challenges are also significant. The wait list will likely continue to increase.
- The skill-mix is inappropriate for long-term care. The Continuing Care Worker model, used in most provinces across Canada, has not been introduced at Paddon Home. It represents a lower level of care, is safe and effective. The skill-mix should be adjusted over a period of time with the introduction of the continuing care worker role. This would involve initiating a planning process with stakeholders to consider training requirements, transition of staff (particularly LPNs) and, in general terms, to introduce the new role. The cost savings when fully implemented, based on salary ranges for Newfoundland and Labrador, would be approximately $68,000 per year. Given the current gap of 12% between the PCA and LPN salary range, the savings are not significant; however, the concept should be explored, given the LPN skillset could be utilized more effectively in other clinical areas and given the potential for mobility.
- The strategic planning process for HLC should consider the Paddon facility and future plans to address current space issues.
- Quality indicators for long term care have not been developed and should be considered as the regional quality improvement program evolves.
- Clinical support levels for recreation are lower than peers. However, Paddon receives limited PT/OT support as well, not typically provided in peer long-term care facilities. While we are not suggesting that peers represent clinical best practices, they do reflect the current state. We are not recommending increased staffing at Paddon.

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- **REVIEW OF FINDINGS**

C. Accounting and Reporting

Overview

Deloitte & Touche

- Key areas of review included:
  - Financial accounting and reporting processes:
    - ✓ Historical problems/challenges
    - ✓ Timeliness of financial reporting
    - ✓ Adequacy and frequency of reports available to management
    - ✓ Compliance with government reporting requirements
  - Budgeting processes:
    - ✓ Historical problems/challenges
    - ✓ Involvement level of key stakeholders
    - ✓ Compliance with government reporting requirements
  - High level review of internal control systems:
    - ✓ Overall high level review
    - ✓ More focused review in certain key areas such as Child, Youth and Family Services and Air Transportation

Financial Accounting and Reporting Processes

Deloitte & Touche

Observations

- Historical problems/challenges:
  - Quality and timeliness of financial reporting has been a significant issue since HLC's inception in 1994.
  - Early management letters from the board's auditors and an auditor general's report from 1998 identified serious shortfalls in the accounting and reporting systems.
  - Recognizing that the financial systems were inadequate, HLC, in conjunction with the external auditors and DOH&CS, developed a call for proposals in 1997 for a financial information system.
  - Subsequent to the tentative awarding of the contract, the implementation was put on hold pending a group purchase of Meditech modules being negotiated by DOH&CS. This further delayed the implementation of an adequate financial information system.
  - Meditech implementation commenced in fall 1999.
  - HLC management maintains that funding provided to DOH&CS to implement Meditech financial, clinical and medical modules was insufficient, resulting in implementation delays and adding to organizational deficits.
  - Three year-end audits were completed by HLC's external auditors in a 10 month period ending in summer 2002.
  - Executive reporting module in Meditech (ESS) partially operational by fall 2002.
  - Meditech is not yet being fully optimized.

Financial Accounting and Reporting Processes

Deloitte & Touche

Observations (cont'd)

- Timeliness of financial reporting:
  - Board, executive leadership and regional managers have been receiving customized Meditech reports since November 2001. Prior to November 2001, standard Meditech reports were being provided on a periodic basis.
  - ESS now allows management to access current comparative financial, budgetary and FTE information, although implementation was only completed in November 2002.
  - The audit report for 2001/02 was dated July 2002 and was filed on time with DOHCS.
- Adequacy and frequency of reports available to management:
  - ESS allows access to user designed reports at any time.
  - Need for improvement in both the collection and reporting of volume and activity statistics and the capturing and reporting of workload data within clinical and medical modules.
  - Senior management including regional directors generally acknowledge that they now have access to some of the information they need to manage their departments.
  - ESS currently not available to all department heads.
  - Management generally do not yet seem to be making optimal use of the information provided by ESS.
  - Statistical reporting in ESS is not complete.

Financial Accounting and Reporting Processes

Deloitte & Touche

Observations (cont'd)

- Compliance with government (and other) reporting requirements:
  - Monthly MIS data still not being uploaded due to non-compliance of chart of accounts
    - ✓ HLC advises that Meditech module development/implementation and the "catching-up" of year-end audits took precedence over MIS compliance. They further advise that they are currently working towards MIS compliance and anticipate being able to electronically download early in 2003/04.
    - ✓ Our detailed analysis of HLC's MIS trial balances revealed that there is an understanding of reporting requirements, but significant work is required to reach "best practices" in this area. HLC's ability to provide comparable data and make use of peer data is significantly compromised.
  - The adoption of the government's Client Referral Management System (CRMS) will place a further strain on HLC's resources.

Financial Accounting and Reporting Processes

Deloitte & Touche

Summary and Recommendations

- AED too involved in day-to-day operations, not enough time spent on managing resources and strategic planning. This appears to be a function of the early evolution of financial systems and staff development/mentoring requirements.
- Meditech has provided a stable system to build upon.
- Vast improvements in accounting and reporting processes have been realized in last few years.
- Still a long way to go before systems are fully optimized and all reporting obligations are met on a timely basis. Generating adequate reports for external users in a timely manner is still a challenge.
- Senior management continuing to deal with pressure to optimize financial systems and meet reporting obligations.
- Still significant gaps in the budgeting and reporting (primarily to government) processes.
- Adjust MIS chart of accounts to comply with government requirements so that monthly uploads can commence. Improve the capture of statistical data within the medical and clinical modules.

Financial Accounting and Reporting Processes

Deloitte & Touche

Summary and Recommendations (cont'd)

- Complete statistics component of ESS module.
- Begin preparing for deployment and integration of CRMS system, identifying impacts on Finance Department:
  - System integration issues
  - Extra duties (i.e. cheque preparation).
- Carefully review the costs and benefits (i.e. internal control improvements) of any significant information technology investment:
  - Meditech at coastal sites and clinics
  - Internal control enhancements (i.e. Medical Flight Authorization tracking).

Budgeting Processes

Deloitte & Touche

Observations

- Historical problems/challenges:
  - Until fairly recently, only global budgets were prepared.
  - Senior management, including department heads, consistently advise that they have operated without meaningful input into the budget process or adequate access to timely comparative financial reports until very recently. While the AED – Corporate Services, admits that their input into the budget process was very limited prior to 2002/03, he claims to have been providing standard and custom Meditech reports to senior management for some time.
  - Budget analyst position created in 2000/01 to address this gap.
  - Budgets for capital and other projects have not allowed for sufficient implementation, training and maintenance costs.
- Involvement of key stakeholders:
  - 2002/03 detailed budget was initially prepared without significant input from stakeholders.
  - 2002/03 detailed budget was revised in fall 2002 with input from stakeholders.
- Compliance with government reporting requirements:
  - 2002/03 budget was prepared and submitted in accordance with the template provided by DOH&CS. It was not filed electronically.
  - 2002/03 revised draft budget shows a deficit of $2.4M
    - ✓ Actual deficit is projected to be $194,000 for 2002/03.
    - ✓ There are currently over 30 unfilled positions which account for a significant portion of the savings in comparison to budget.
  - 2003/04 budget process had not yet started at the time of the site visit in mid-January 2003. The AED – Corporate Services, advises that the process began in late February 2003.
  - Monthly budget monitoring reports have not been submitted to DOH&CS.

Budgeting Processes

Deloitte & Touche

Summary and Recommendations

- Process still in early stages of development.
- Employee turnover in budget analyst position has delayed the improvements.
- Due to the lack of experience of the budget analyst, there is likely to be a significant learning curve.
- Importance of management involvement in process recognized by senior management.
- Large budgeted deficits continue to be a problem.
- Delays in completing the 2002/03 and commencing the 2003/04 budgeting processes is a significant shortfall.
- Uncertainties such as the ability to retain federal funds recovered in relation to the delivery of certain Child, Youth and Family Services in Innu communities make budgeting in this area challenging.
- The potential impacts of devolution on service delivery and funding are difficult to predict.
- While International Grenfell Association (IGA) grants have been instrumental in a number of research and capital projects undertaken by HLC, their application criteria are limiting and grants awarded have been inconsistent. Therefore, they are difficult to budget for and are not a a substitute for DOH&CS funding.
- Still significant gaps in the budgeting and reporting (primarily to government) processes.
- Complete 2003/04 budget process immediately:
  - Ensure appropriate input from stakeholders.
  - Ensure appropriate level of detail (by month) so that AEDs, regional managers and department heads can use it effectively as a management tool.

Review of Internal Control Systems

Deloitte & Touche

Observations

- Basic controls to ensure the accuracy and completeness of payroll, accounts payable, accounts receivable and other standard systems appear to be in place.
- Significant manual processes, many related to clinic/nursing station activities, allow increased opportunities for error:
  - Medical flight authorizations are issued, tracked and billed manually with limited ability to ensure patient attendance at scheduled appointments.
  - Over-the-counter drug sales at coastal sites not supported by appropriate documentation.
  - Limited segregation of duties at coastal sites.
  - Significant reliance on front-line workers without financial backgrounds or training.
- The high volume of low value payments processed by Community Services (including CYFS and Family Rehabilitation Services), combined with the issuance of cheques by another government department, affords opportunity for error:
  - Vast range of services mandated by provincial legislation.
  - All services approved for payment by HLC (or, in special circumstances, DOH&CS) management and HRE staff prior to cheque being issued.
  - Monthly FACTS report from DOH&CS approved by HLC's Regional Manager prior to payment.

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Summary and Recommendations

- High-level discussions with senior management reveal that basic controls are in place.
- Recent management letters issued by HLC's auditors reveal no significant areas of concern.
- Controls at clinics and nursing stations are not optimal, mainly due to inherent staffing and system limitations.
- There are opportunities for abuse of air transportation, though a system of manual controls attempts to mitigate the risks.
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- Plans are in place to commence an internal audit process as a component of the broader quality control initiatives of the organization. This process will be carried out by the budget analyst.
- While vastly improved, the financial systems are still not optimal.
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Deloitte & Touche

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Summary and Recommendations

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- Recent management letters issued by HLC's auditors reveal no significant areas of concern.
- Controls at clinics and nursing stations are not optimal, mainly due to inherent staffing and system limitations.
- There are opportunities for abuse of air transportation, though a system of manual controls attempts to mitigate the risks.
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- Plans are in place to commence an internal audit process as a component of the broader quality control initiatives of the organization. This process will be carried out by the budget analyst.
- While vastly improved, the financial systems are still not optimal.
- There appears to be a strong commitment to the organization and to the continued improvement of its financial systems.

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4. SUMMARY AND FINANCIAL RECOVERY PLAN

Summary

- The preceding chapters provide detail on strengths and opportunity areas throughout HLC. They also provide a long list of recommended changes in every area of HLC's operations (see Appendix D for a summary of recommendations). We strongly urge HLC Executive Leadership Team to assign accountability for implementation of recommendations in each area and closely monitor progress on a regular basis.
- What are the common threads that cut across the various areas? At the highest level, there are five common themes:
- **Integrated, Regional Model**
  - Today, HLC is not functioning as an integrated, regional organization.
    - ✓ LHC, CWJMH and Paddon function as separate organizations
    - ✓ The Community Clinics do not perceive themselves as being part of a regional structure
    - ✓ There are few regional protocols, standards, quality programs
    - ✓ There is little integration between HLC and aboriginal groups
    - ✓ The integrated, regional model has merit and should be fully implemented and supported
    - ✓ Connectivity, improved communication and education/training are necessary to support regional behaviour

Summary

- Governance and leadership within HLC must be strengthened.
  - ✓ Board composition and processes must be improved
  - ✓ A more streamlined corporate structure should be implemented, with appropriate separation of and accountability for duties
  - ✓ The Executive Leadership Team must function in an executive capacity, leaving day-to-day management and service delivery to managers and staff
  - ✓ Changes are required in the clinical management areas (medical staff organization, nursing administration)
  - ✓ Leadership development and mentoring are paramount
- Quality and risk management concerns exist throughout the organization.
  - ✓ Numerous patient care related risks must be addressed immediately, including:
    - Lack of standardization with respect to triage protocols, clinical practice guidelines, credentialing, equipment servicing, etc.
    - Lack of appropriate clinical support (e.g. reporting of examinations with no radiologist on site, no reference pathologist available as support, lack of clinical pharmacy support)
    - Physical space issues, including the Emergency Department at CWJMH
  - ✓ Regional quality and risk programs must be a priority

Summary

Deloitte & Touche

- **Devolution**
  - Devolution of services to aboriginal groups will have a profound effect on the operations of HLC.
  - The process is currently not well led or managed.
  - HLC and DOH&CS must take a more active role in understanding and influencing the vision for devolution. The relationship with aboriginal groups must be improved.
  - HLC and DOH&CS must come to understand the extent to which they must provide support as services are devolved, and how dollars will follow said support.

- **Efficiency**
  - Maximizing efficiency within HLC is prohibited by lack of critical mass, legislated mandate, physical constraints, and cultural impacts associated with the diversity of the population served.
  - Most areas within HLC operate reasonably efficiently relative to other organizations facing similar challenges. Limited opportunities for efficiency were identified and utilization was found to be appropriate. The Executive Leadership Team must ensure that every opportunity for efficiency identified within this review is realized.
  - Child, Youth and Family Services, which are driven by legislated mandate, are significantly under-staffed.
  - A culture of best practices needs to be given license within HLC and led by the Executive Leadership Team. A Best Practices Committee should be established to identify practices that could be incorporated into the HLC operational environment.

Summary

Information Technology

- While leveraging information technology is a challenge and priority in every organization, it is particularly important in a geography as large and remote as Labrador. Communication must be facilitated by leveraging technology. Coastal connectivity would greatly enhance the possibilities for regional behaviour.
- Sound management decisions require current, accurate information on all aspects of the organization. Completing the Meditech implementation and becoming MIS compliant will represent great strides in this regard.
- Understanding the implications and planning for the Meditech and CRMS implementations are priorities.
- Cost/benefit analyses should drive IT investment decisions.
- HLC must continuously push the limits with respect to how technology can support their regional structure and drive improved efficiency.

Financial Management

- Significant improvements have been made in terms of financial management leadership, budgeting, processes and controls.
- More work needs to be done in areas including budgeting (completing the 2003/04 budget as soon as possible), financial reporting to external parties, and MIS compliance.
- Implementation of the recovery plan, presented on the following pages, represents an opportunity for HLC to improve and stabilize its financial position.

Financial Recovery Plan

Deloitte & Touche

Introduction

- A five-year financial recovery plan was prepared, based on the following information and assumptions:
  - All of the productivity improvements and revenue generation opportunities recommended in this operational review (and summarized on the following pages) are implemented within the recommended timeframes. See Appendix C for implementation plan.
  - It is assumed that CYFS Agreement money will be retained by HLC on a go forward basis. Potential loss of these dollars represents a risk to the organization if they are required to continue providing services but are unable to retain the revenue.
  - It is assumed that increases in fees will result in an estimated 15% reduction in the volume of discretionary transactions.
  - We have been advised by DOH&CS that there may be significant additional cost recoveries available to HLC to cover both the operational and capital costs of providing additional services under a new CYFS Agreement to be negotiated at some future time. Under the current CYFS Agreement, significantly less funds are available. If the additional cost recoveries proposed by DOH&CS are not obtained, HLC's additional funding requirements from DOH&CS will increase significantly.
  - It is assumed that DOH&CS funding will keep pace with inflation and wage settlements, as has been done in the past.
  - It is assumed that surpluses resulting from productivity improvements and increased revenue generated will be used to repay HLC's operating line.

Financial Recovery Plan

Deloitte & Touche

Introduction (continued)

- We have not accounted for any additional staffing requirements associated with CRMS implementation or any other resource-intensive activity.
- For all FTE reductions, It is assumed that total separation costs equal one years salary.
- The projected accumulated operating fund deficit (DOH&CS) as at March, 2003 will be approximately $10M. The net overdraft position at the bank was approximately $9M as at March, 2002. For the purposes of our analysis, this is the balance which is contemplated to be repaid in our recovery plan.
- This analysis is based on a set of assumptions at a point in time and actual results will vary. Among other factors, both known and unknown at this time, the analysis does not contemplate additional costs that may result from such items as devolution and the suggested role study at CWJMH. Some information technology items, such as the telehealth review, IT strategic plan, disaster recovery plan, and maintenance support budget have not been calculated due to the variability in the analysis and implementation costs. The cost of developing technology plans can range from $50,000-$150,000 and the implementation costs of the recommendations are highly variable. The industry standard for maintenance support is 20% per annum of the original software and hardware costs; however, this can vary based on age of technology, custom versus package software, capabilities of the internal support team, etc.
- While we strongly support the recommended IT investments, identified savings are not dependent on these investments. The IT investments (e.g. Meditech, PACS) may support additional efficiency opportunities in the future.

Summary of Revenue Generation Opportunities

Deloitte & Touche

Quantitative Summary of Recommendations			
Area	**Recommended Change**	**$ Impact**	**Timing**
Air Transportation	Cost Recovery for Non-Insured	$816,000	Immediate
Air Transportation	Increase Schedevac Fee to $80*	$87,000	Immediate
Air Transportation	Implement Escort Fee of $80	$82,000	Immediate
Pharmacy	Increase Pharmacy Retail Dispensing Fee to $7.50**	$56,000	Immediate

*With the 15% reduction in total volume, incremental revenue is estimated at $87,000 (3,100 round trips at $40 incremental/trip less 15% reduction in volume).

** Assume no reduction in non-discretionary pharmacy purchases.

Summary of Productivity Improvements

Deloitte & Touche

Quantitative Summary of Recommendations			
Area	**Recommended Change**	**$ Impact**	**Timing**
Acute Care	-2 FTEs	-$100,000	6 months
Long-Term Care			
Paddon	Skill mix change	-$68,000	18 months
CWJMH	Skill mix change	-$20,000	18 months
Administration			
Finance/HR	-3.5 FTEs	-$122,500	6 months
Housekeeping/Linen & Laundry	-5 FTEs	-$175,000	6 months
Plant	-2 FTEs	-$70,000	12 months
Food Services	-1 FTE	-$35,000	6 months
Clinical Support			
Nursing Administration	-2 FTEs	-$140,000	6 months
Nursing Supervisors	-4 FTEs	-$250,000	30 months
Health Records	-2 FTEs	-$70,000	9 months
Laboratory	(Thornhill Report)	-$25,000	Immediately
Air Transportation	Provincial Medevac System	Unknown	Unknown

Summary of Required Additions

Deloitte & Touche

Quantitative Summary of Recommendations			
Area	**Recommended Change**	**$ Impact**	**Timing**
Child, Youth and Family Services			
Salary	+25 FTEs	1,583,000	Immediate
Non-Salary	-	1,063,000	Immediate
Community Clinics	+1 FTE	50,000	Immediate
Diagnostic Imaging	+2 FTEs	80,000	Immediate
Pharmacy	+2.5 FTEs	150,000	Immediate
Child, Youth and Family Services	Capital investment	1,055,000	Immediate
Information Technology			
High Priority	Capital investment	1,144,000	24 months
Medium Priority	Capital investment	4,694,000	24 months

Recovery Plan Model – Annual Surplus Summary

Deloitte & Touche

			Recovery Plan Model				
			Annual Surplus Summary				
	Timing		2003/04	2004/05	2005/06	2006/07	2007/08
Baseline Surplus		(1)	$ 106,443	$ 106,443	$ 106,443	$ 106,443	$ 106,443
Revenue Generation Opportunities							
Cost Recovery for Non-Insured	Immediate	(2)	$ 816,000	$ 816,000	$ 816,000	$ 816,000	$ 816,000
Increase Schedevac Fee to $80.00	Immediate	(2)	$ 87,000	$ 87,000	$ 87,000	$ 87,000	$ 87,000
Implement Escort Fee of $80.00	Immediate	(2)	$ 82,000	$ 82,000	$ 82,000	$ 82,000	$ 82,000
Increase Retail Dispensing Fee to $7.50	Immediate	(2)	$ 56,000	$ 56,000	$ 56,000	$ 56,000	$ 56,000
			$ 1,041,000	$ 1,041,000	$ 1,041,000	$ 1,041,000	$ 1,041,000
Productivity Improvements (Net of Separation Costs)							
Acute Care - 2 FTEs	6 months	(3)	$ -	$ 50,000	$ 100,000	$ 100,000	$ 100,000
Long-Term Care (Skill Mix)	18 months	(4)	$ -	$ 44,000	$ 88,000	$ 88,000	$ 88,000
Finance/HR - 3.5 FTEs	6 months	(3)	$ -	$ 61,250	$ 122,500	$ 122,500	$ 122,500
Housekeeping/Linen & Laundry - 5 FTEs	6 months	(3)	$ -	$ 87,500	$ 175,000	$ 175,000	$ 175,000
Plant - 2 FTEs	12 months	(3)	$ -	$ -	$ 70,000	$ 70,000	$ 70,000
Food Services -1 FTE	6 months	(3)	$ -	$ 17,500	$ 35,000	$ 35,000	$ 35,000
Nursing Administration - 2 FTEs	6 months	(3)	$ -	$ 70,000	$ 140,000	$ 140,000	$ 140,000
Nursing Supervisors - 4 FTEs	30 months	(3)	$ -	$ -	$ -	$ 125,000	$ 250,000
Health Records - 2 FTEs	9 months	(3)	$ -	$ 17,500	$ 70,000	$ 70,000	$ 70,000
Laboratory (Thornhill Report)	Immediate		$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000
Provincial Medevac System	Unknown	(5)	$ -	$ -	$ -	$ -	$ -
			$ 25,000	$ 372,750	$ 825,500	$ 950,500	$ 1,075,500
Total Annual Surplus (Net of Related Costs)			$ 1,172,443	$ 1,520,193	$ 1,972,943	$ 2,097,943	$ 2,222,943

(1) 2002/03 projected operating surplus (net of capital deficit) including revenue of $2,052,629 from CYFS Agreement
(2) Based on 2001/02 usage less 15% reduction in volume (except Pharmacy)
(3) Assumes separation costs equal 1 years salary
(4) Assumed to be accomplished through attrition
(5) Assumes no net benefits to HLC

When isolated from additional required expenditures, there are significant opportunities to generate new revenue and improve productivity.

Recovery Plan Model – Overdraft Repayment Analysis

Deloitte & Touche

		Recovery Plan Model				
		Overdraft Repayment Analysis				
		2003/04	2004/05	2005/06	2006/07	2007/08
Opening Cash/(Overdraft)		$ (9,000,000)	$ (8,322,557)	$ (7,260,105)	$ (5,686,467)	$ (3,901,280)
Borrowing Costs	(1)	(495,000)	(457,741)	(399,306)	(312,756)	(214,570)
Annual Surplus	(2)	$ 1,172,443	$ 1,520,193	$ 1,972,943	$ 2,097,943	$ 2,222,943
Closing Cash/(Overdraft)		$ (8,322,557)	$ (7,260,105)	$ (5,686,467)	$ (3,901,280)	$ (1,892,908)
(1) Assumes annual borrowing costs of 5.5%						
(2) Assumes a single, lump-sum principal repayment on March 31 of each year.						
More frequent payments would reduce interest costs and decrease the time required to repay the loan.						

There are sufficient opportunities in identified revenue generation opportunities and productivity improvements to repay the operating line within 6 years based on a model with no increases in current service levels or the delivery costs, no capital expenditures, no decreases in current funding levels, and HLC retaining all revenue recovered under the CYFS Agreement. Unfortunately, this is not a realistic scenario, so additional funding is required.

Recovery Plan Model – Additional Funding Requirements

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Recovery Plan Model
Additional Funding Requirements

	Timing		2003/04	2004/05	2005/06	2006/07	2007/08
Operational - CYFS							
CYFS +25 FTEs	Immediate	(1)	$ 791,500	$ 1,583,000	$ 1,583,000	$ 1,583,000	$ 1,583,000
CYFS (Non-Salary Costs)	Immediate	(1)	$ 351,500	$ 674,200	$ 645,300	$ 645,300	$ 645,300
CYFS (Incremental Program Costs - Innu and Innuit)	Immediate	(2)	$ 394,000	$ 788,000	$ 788,000	$ 788,000	$ 788,000
Recovery Under Current CYFS Agreement	Immediate	(2)	$ (214,000)	$ (428,000)	$ (428,000)	$ (428,000)	$ (428,000)
Additional Operational Funding Required (under Current CYFS Agreement)		(2)	$ 1,323,000	$ 2,617,200	$ 2,588,300	$ 2,588,300	$ 2,588,300
Proposed Additional Recovery from INAC (per DOH&CS)	Immediate	(2) (4)	$ (878,000)	$ (1,737,900)	$ (1,719,900)	$ (1,719,900)	$ (1,719,900)
Revised Additional Operational Funding Required - CYFS (per DOH&CS)		(2) (4)	$ 445,000	$ 879,300	$ 868,400	$ 868,400	$ 868,400
Operational - Other							
Communitry Clinics +1 FTE	Immediate		$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
Diagnostic Imaging +2 FTEs	Immediate		$ 80,000	$ 80,000	$ 80,000	$ 80,000	$ 80,000
Pharmacy +2.5 FTEs	Immediate		$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000
Additional Operational Funding Required - Other			$ 280,000	$ 280,000	$ 280,000	$ 280,000	$ 280,000
Total Additional Operational Funding Required (per DOH&CS)		(2) (4)	$ 725,000	$ 1,159,300	$ 1,148,400	$ 1,148,400	$ 1,148,400
Capital - CYFS							
CYFS (Staff Housing and Equipment)		(3)	$ 791,300	$ 263,700	unknown	unknown	unknown
Proposed Additional Recovery from INAC (per DOH&CS)		(2) (4)	$ (179,000)	$ (59,600)	unknown	unknown	unknown
Revised Additional Capital Funding Required - CYFS (per DOH&CS)		(2) (4)	$ 612,300	$ 204,100	unknown	unknown	unknown
Capital - Other							
IT - High Priority		(5)	$ 919,000	$ 225,000	unknown	unknown	unknown
IT - Medium Priority		(5)	$ 2,679,000	$ 2,015,000	unknown	unknown	unknown
Additional Capital Funding Required - Other		(5)	$ 3,598,000	$ 2,240,000	unknown	unknown	unknown
Total Additional Capital Funding Required (per DOH&CS)		(4) (5)	$ 4,210,300	$ 2,444,100	unknown	unknown	unknown
Total Additional Funding Required (per DOH&CS)		(2) (4)	$ 4,935,300 +	$ 3,603,400 +	$ 1,148,400 +	$ 1,148,400 +	$ 1,148,400 +

(1) Assumes 50% can be recruited and hired in year 1 and 50% in year 2
(2) Estimated
(3) Assumes 75% of capital expenditures in year 1 and 25% in year 2. Includes $762,500 for new mini homes and furnishings over 2 years.
(4) Assumes DOH&CS is successful in re-negotiating the existing CYFS Agreement to ensure full recovery of all costs of providing relevant services to Innu communities. If the agreement is not re-negotiated, additional funding, primarity from DOH&CS, will be required as follows: 2003/04 - $1,057,000, 2004/05 - $1,797,500, 2005/06 and each year thereafter $1,719,900.
(5) Based on numbers provided by HLC. Does not include cost of putting Meditech at remote sites.

Significant new provincial funding is required at HLC even if we assume the CYFS Agreement with INAC can be renegotiated as proposed by DOH&CS.

Summarizing the Financial Recovery Plan

- As shown on the previous slides, all savings will have been realized before the end of Year 4 (with the final change being the reduction in nursing supervisors in Year 4). Year 5 represents the first year of operation under the new, more efficient model.
- Based on our assumptions and recommendations, there are opportunities to generate surpluses which could be used to repay the existing bank overdraft in just under six years; however, this ignores the significant amounts of additional funding that are required for HLC to meet its mandate.
- The additional funding requirements in the recovery plan model assume that the current CYFS Agreement can be renegotiated to ensure HLC gets full cost recovery on the relevant cost of servicing the Innu communities. This is not consistent with our understanding of similar agreements across Canada that are currently in force. If DOH&CS is not able to revise the current CYFS Agreement, an additional $8.0M in funding will be required, over the next five years, from other sources (primarily DOH&CS) to meet the requirements of the recovery plan model.

Conclusion

- Full implementation of all recommendations contained in this Operational Review will result in HLC improving its processes and performance.
- Achievement of those objectives will require commitment and support from the HLC Board, the Executive Leadership Team, and the Province of Newfoundland and Labrador.

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APPENDIX A: LIST OF INTERVIEWEES

Locations Visited

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- Acute Care & Community Services

LHC - Happy Valley/Goose Bay	CWJM Hospital - Lab City
Nain Nursing Station	Davis Inlet/Natuashish Nursing Station
Hopedale Nursing Station	Makkovik Nursing Station
Postville Nursing Station	Rigolet Nursing Station
Cartwright Nursing Station	Black Tickle Nursing Station
Sheshatshiu Community Clinic	Churchill Falls Community Clinic

- Long-Term Care

  Harry Paddon Nursing Home

  CWJM Hospital

- Child Youth & Family Services Program *

LHC – CYFSP District Office	Responsible for HV/GB & NWR communities
Sheshatshiu – CYFSP District Office	Responsible for Sheshatshiu community
Wabush – CYFSP District Office	Responsible for Wabush, Lab City & Churchill Falls communities
Nain – CYFSP District Office	Responsible for Nain community
Makkovik – CYFSP District Office	Responsible for Makkovik, Rigolet & Postville communities

* Visited 5 out of 8 CYFSP District offices, serving 10 out of 14 communities in Labrador

Individuals Interviewed

Deloitte & Touche

- Steering Committee Members

  Robert Thompson, DM, DOH&CS
  Loretta Chard, ADM, DOH&CS
  Donna Brewer, ADM, Support Services, DOH&CS
  Moira Hennessey, Director, DOH&CS
  Beverly Griffiths, DOH&CS
  John Bennett, ADM, Debt Management and Pensions, Department of Finance
  Brenda Caul, Assistant Secretary (Budgeting), Treasury Board
  Boyd Rowe, CEO, HLC
  Edward Harding, AED, Corporate Services, HLC
  Jim Farrell, Chair of Board, HLC
  Delia Connell, AED, Community Services, HLC
  Dr. Ron Sparkes, DM, DLA
  Sean Dutton, ADM, DLA
  Deanne Chafe, Sectoral Negotiator, DLA
  John Abbott, Associate Administrator, reporting to Minister of Health and Community Services
  (for purposes of the Health Labrador Corporation Operational Review)

Individuals Interviewed (cont'd)

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- HLC Board Members:
  - Mike Barnes
  - Anastasia Qupee
- Aboriginal Leaders
  - Iris Allen, Executive Director - Labrador Inuit Health Commission
  - Peter Penashue, President - Innu Nation
  - Todd Russell, President - Labrador Metis Nation
  - Kathleen Benuen, Health Director – Innu Health Commission
- Union Leaders
  - Darlene Mackey (LHC) and Ross Fry (PH), NAPE (HS)
  - Doreen Mahoney (LW) and Brenda Hay (HV), NLNU
  - Theresa Anderson (LW) – NAPE (LX), Anna Phillipi – CUPE, Pat Joy (LW) - NLNU

Individuals Interviewed (cont'd)

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- Labrador Health Centre - Happy Valley/Goose Bay

  Tracy Duder, RD Dietetics
  James Matthews, Budget Analyst
  Samuel Mansfield, RD, HR
  Kay Goulding, Regional Pharmacist
  Catherine Murray, Director of Nursing
  Corina Price, Head Nurse, OR/RR/PAR/Special Procedures
  Anne-Marie Fequet, Physiotherapy
  Janet Hamel, Food Services Supervisor
  Ian Blake, Maintenance Supervisor
  Amada Winsor, CYFS Program Manager
  Yvonne Power, Chief Technician, DI
  Dr. Narsing Pradhan, Department of Surgery
  Colleen Hanrahan, Health Canada Research Consultant
  Gail Turner, RD, Public Health
  Michelle Kinney, RD, Addictions/Mental Health/Pastoral Care
  Arlene Michelin, Coordinator, Community Youth Network
  Six (6) field workers, Community Youth Network
  Nine (9) physicians as a group
  Focus Group with available social workers and community service workers
  Medical Staff General Forum/Focus Group (8 in attendance)

Individuals Interviewed (cont'd)

Deloitte & Touche

- Labrador Health Centre - Happy Valley/Goose Bay (cont'd)
  - Dr. Michael Jong, AED, Medical Services
  - Marjorie Learning, AED Administrative Services
  - Debbie Pelley, RD, Financial Services
  - Edwin Sharpe, RD, Materials Management & Transportation
  - Wayne Brown, RD, IT
  - Richard Kennedy, RD, F & PO
  - Andrea White, RD, Community Clinics
  - Norma Forsey, RD, Education/Quality/Risk/Infection Control/Employee Health
  - Theresa Dyson, Director, Client Services
  - Jodi Bowles, Occupational Therapy, Allied Health
  - Debbie Fudge, Environmental Services Supervisor
  - Catherine Gray, RD, CYFS/Protective Intervention Services & Adoptions
  - William Attwood, Chief Technician, Laboratory Services
  - Dr. Charlene Fitzgerald, President, Medical Staff
  - Dr. Wieslaw Rawluk, OBS/GYNE
  - Sandra Jesseau, Nurse Manager
  - Lynn Miller, Staff Nurse
  - Suzanne Denty
  - Delisa Barrett, Child Care Services Consultant
  - Sandra Elliott, Community Corrections Consultant
  - Robert Forsey, Emergency Services

Individuals Interviewed (cont'd)

- <u>CWJM Hospital – Labrador City</u>

  Eleanor Fowler, Director of Nursing

  Harold Butt, Environmental Services Supervisor

  Susan Bourgeois, RD, Health Records

  Ozette Simpson, Administrative Coordinator/Regional Director Lab & Diagnostic Services

  Jacqueline Whelan, RD, CYFS/Community Corrections, Family Rehabilitation Services, Child Care Services

  Yvonne Tiller-Edwards, Chief Technician

  Shaun Boozan, Nurse Manager, Acute/Long-Term Care

  Karen Eldem, Physiotherapy

  Martha Richards, Occupational Therapy

  Annette Parsons, Public Health Nurse

  Claudine Kean-Dobbin, Public Health Nurse

  Dr. Chris Whitten, Chief of Staff

  Medical Staff General Forum/Focus Group (4 in attendance)

Individuals Interviewed (cont'd)

- District Office – Wabush
  - Marina Brett, CYFS Program Manager
  - Focus group with available social worker staff
- Others
  - Jim Strong, Director, Financial Services Division, DOH&CS
  - Community Youth Network Staff
  - Michael Fleming, CYFS Program Manager, Nain
  - Tanya Cassell, CYFS Program Manager, Sheshatshiu & David Inlet
  - Crystal Hickey, Program Supervisor, Behaviour Management Services, Wabush
  - Gloria Hall, Social Worker, Nain District Office
  - Christine Broomfield, Community Services Worker, Nain District Office
  - Sandra Dicker, Community Services Worker, Nain District Office
  - Marilyn McCormack, former Director of CYFS
  - Ivy Burt, Director, CYFS, DOH&CS
  - Lynn Vivian-Book, Executive Director of Programs, DOH&CS
  - Bud Avery, Program Manager, EHS Lifeflight
  - BMS (3)
  - Mary Sillet, Social Worker
  - Elizabeth Tuglavina, Community Service Worker, Hopedale District Office
  - Focus group with available workers and community service workers, Sheshatshiu District Office
- Harry L. Paddon Home - Happy Valley/Goose Bay
  - Kimberly White, Facility Manager

Individuals Interviewed (cont'd)

- Nursing Stations

Nain	Patricia Crotty, Supervisor Community Clinics & NIC
	Community Services & Social Workers
Davis Inlet/Natuashish	Delrose Gordon
Hopedale	Ann McElligott, NIC
Makkovik	Donna Arsenault, NIC (Acting)
Postville	Daisy Sacrey, NIC
Rigolet	Patricia Kelsall
Cartwright	Joy Barrett, NIC
Black Tickle	Charles Ash

- Community Clinics

Churchill Falls	Michelle Burt, RN
	Peggy Blair, RN I
	Mr. MacNeil, CEO-CF&LCO
	Dr. Chaudhary
Sheshatsiu/NWR	Dorothy Bragg, NP
	Carolyn Michelin, RNII
	Joan McGee, RN
	Community Services & Social Workers

Individuals Interviewed (cont'd)

- Community Clinics (cont'd)

Nain	Beryl Belbin, Staff Frances Chapman, Staff 1 PCA
Makkovic	Donna Arsenault, NIC Irene Heard, PCA Derek Munton, Regional Nurse Community Health Worker
Postville	Daisy Sacrey, NIC Community Health Worker
Davis Inlet	Delrose Gordon, NIC Frank W. Dicker, Maintenance
Black Tickle	Charles Ash, NIC Kathleen Morris, PCA Pauline Keefe, PCA

Individuals Interviewed (cont'd)

- Community Clinics (cont'd)

Cartwright	Tina Mesher, Regional Nurse Public Health Nurse Social Worker
Hopedale	Ann McElligott, NIC Julie MacIssac, Staff Sarah Jensen, PCA Social Worker Community Health Worker
Rigolet	Laura Kitzke, Regional Nurse

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APPENDIX B: AN APPROACH TO POPULATION HEALTH

Population Health

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The Population of Labrador

- Immediate steps can be taken to quantify certain risk factors recognizing the disparity that exists between the communities of Labrador East and Labrador West. Labrador West has one of the highest incomes per capita in Canada and the population demographics are of interest. The main population is centered in the Labrador City- Wabush area. The median age is marginally greater than main centre of population in Labrador East Happy-Valley Goose Bay (35 versus 33) whereas the median age for the population of Newfoundland and Labrador is 38. The populations of the two main centres are similar with Labrador City at 7,744 and Happy-Valley Goose Bay at 7,970 (Statistics Canada 2001). Labrador City has 215 people over the age of 65 and only 635 above the age of 55 whereas Happy Valley-Goose Bay has 410 people over 65 and 565 over 55 years of age. For a young, affluent population, utilization of health services appears high compared with the remainder of Canada.
- The Labrador Health Centre, located in Happy Valley-Goose Bay, is responsible for the provision of care to the aboriginal population scattered along the coast in sparsely populated communities where the residents are predominantly of Inuit and Innu decent. With 75% of the population in these communities under 25 years of age, the median age of the population of Labrador East is significantly skewed compared to Labrador West. Unlike the remainder of Canada, Labrador has not yet experienced the pressures placed on health care systems by an aging population. Ischemic Heart Disease, Peripheral Vascular Disease, Hypertension and Stroke are yet to demonstrate significant prevalence in these communities. HLC must prepare now for this eventuality as it is unlikely to be shielded from what is a reality in the remainder of Canada.

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An Approach to Population Health

- A population health approach recognizes that any analysis of the health of the population must extend beyond an assessment of traditional health status indicators like death, disease and disability. A population health approach establishes indicators related to mental and social well-being, quality of life, life satisfaction, income, employment and working conditions, education and other factors known to influence health.
- A population health approach means taking action on the complex interactions between factors that contribute to health. It requires:
  - a focus on the root causes of a problem, with evidence to support the strategy to address the problem
  - effort to prevent the problem
  - improving aggregate health status of the whole society, while considering the special needs and vulnerabilities of sub-populations
  - a focus on partnerships and inter-sectoral cooperation
  - finding flexible and multidimensional solutions for complex problems
  - public involvement and community participation

Population Health

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Some Facts

- Canadians with low incomes are more likely than Canadians with high incomes to suffer illnesses and to die early.
  - Only 47% of Canadians in the lowest income level rate their health as excellent or very good, compared to 73% of Canadians in the highest income group.
  - Canadians who live in the poorest neighbourhoods are more likely than residents of the richest neighbourhoods to die at an early age.
  - Children in low-income families and neighbourhoods are at higher risk than children who grow up in families with higher incomes for infant death and low birthweight. They are more likely to experience developmental delays and injuries. The number of young children who lived in low-income families increased from one in five in 1990 to one in four in 1995. These proportions are higher in aboriginal and recently arrived immigrant communities, and in families headed by very young parents and women who are single parents.
- Canada's aboriginal people is at higher risk than the Canadian population as a whole for poor health and early death.
  - Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were still twice as high as among the Canadian population as a whole.
  - Life expectancy is significantly lower among aboriginal people than the overall Canadian population. High rates of suicide and fatal unintentional injuries among First Nations and Inuit young people partly account for this difference.
  - The prevalence of major chronic diseases -- including diabetes, heart problems, cancer, hypertension and arthritis/rheumatism -- is significantly higher in aboriginal communities and appears to be increasing.

Population Health

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Aboriginal Health and Diabetes

- Health Labrador Corporation provides care to 30,000 people, 16% of whom are of aboriginal decent. Currently 50% of the acute care bed population at the Labrador Health Centre is aboriginal. This is an indirect and representative indicator of the level of current resources being devoted to the care of aboriginal people in this very small sector of Canada with an overwhelmingly young population.
- At present, there are approximately 800,000 people in Canada who have been identified as aboriginal. One remarkable feature of this population, as a whole, is its age-distribution, three quarters of which is under twenty-five years of age. This, as well as the increasing availability of Western lifestyle choices to aboriginal Canadians, will increase the number of individuals in this population to the same health pressures other Canadians are experiencing. Canada's aboriginal people are disparate in heritage, lifestyles, and geography. The variable prevalence of diabetes in this population appears to reflect this diversity although it does not disguise the elevated prevalence of diabetes in Canada's aboriginal peoples.
- Diabetes will have a disproportionate impact on not only the well being of aboriginals but also on the cost of providing health care to this group. Advanced age, female sex, urbanized environments, and a number of genetic markers are all associated with a higher prevalence of diabetes in aboriginal populations. There is little evidence to suggest that there will be any attenuation of diabetes as a public health issue in aboriginal Canadians for the foreseeable future. This fact does not seem to be lost on aboriginal leaders, policy makers and researchers. Judging form the volume of information that has been written about this disease in Canada, diabetes appears to be well recognized as an issue of great importance to all Canadians.

Population Health

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Aboriginal Health and Diabetes (cont'd)

- Diabetes is a very costly disease for Western nations. Significant percentages of worldwide health care expenditures are directed towards the care of people with diabetes. In Canada, the importance of diabetes has become more widely recognized, especially in aboriginal peoples. Projects are currently in place and more are being developed to aid in diabetes education, research, and care. However, more work is needed in evaluating the current state of diabetes in the Inuit, Metis, and off-reserve aboriginals. Efforts also need to be directed at screening for and managing the complications of diabetes, including diabetic retinopathy. The impact of diabetes on communities is primarily manifest through its complications. Macrovascular and microvascular complications, such as coronary artery disease, diabetic retinopathy, diabetic nephropathy, and peripheral neuropathy, account for shorter lives and higher morbidity for people with diabetes. In Saskatchewan, aboriginal individuals are 16 times more likely to develop diabetic end-stage renal disease (ESRD) than non-aboriginals. Even when the higher prevalence of diabetes in the aboriginal population was accounted for, the risk of ESRD was still seven-times that of non-aboriginals.
- 1.5 million Canadians have been diagnosed with diabetes; there may be another 750,000 who have yet to be identified. This is particularly significant in the aboriginal community where screening programs are only now becoming common and off-reserve populations remain outside the catchment population for most studies. A more inclusive estimate of the prevalence of diabetes in Canada suggests a crude number of 4% to 6%. Provincially, there are differences in prevalence figures for diabetes. Prevalence estimates range from a low of 2.4% in Alberta to a high of 4.4% in Newfoundland and Labrador. Reasons for these regional differences are presently unknown. The Aboriginal Peoples Survey of 1991, indicated that First Nations people had a rate of diabetes of 6.4% (8.5% on-reserve and 5.3% off-reserve). Metis people reported a rate of 5.5% which, like the First Nations rate, is above the national average of 3.1% for the same time period. Inuit people reported a rate of 1.9%, but data from the 1999 First Nations and Inuit Regional Health Survey show diabetes rates as high as 4% among Inuit people in Labrador.

Population Health

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Aboriginal Health and Diabetes (cont'd)

- Extremely high rates of diabetes have been documented in some specific First Nations communities. For example, in Haida Gwaii, BC, 17% of adults over age 35 have type-2 diabetes, and in Sandy Lake, Ontario it is reported that 26% of its population age 10 and over has type-2 diabetes. The highest rate of diabetes in the world occurs in the Pima tribe in Arizona. There, approximately 65% of adults between the ages of 45 and 74 have diabetes. The Canadian Diabetes Strategy, announced in the 1999 federal budget, created a five year, $115 million strategy to begin to deal with the issue of diabetes. Over the five years, $58 million has been allocated to the Aboriginal Diabetes Initiative (ADI) to begin to address the epidemic of diabetes in aboriginal communities.
- Aboriginal children are also now being diagnosed with type-2 diabetes, a condition that in the past occurred mainly in older persons. It is also important to note that type-2 diabetes is often developed later in life, usually after age 45. Because the aboriginal population is a young population, the rate of diabetes will likely rise in the coming decades as greater numbers of aboriginals will be reaching age 45.
- Diabetes accounts for 2.6% of all deaths in Canada; however, when one considers the association of diabetes with heart disease and cerebrovascular disease, this percentage can be considered an underestimate of the actual magnitude of the effect of diabetes on the health and longevity of Canadians.

Population Health

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Aboriginal Health and Diabetes (cont'd)

- There is evidence to suggest that in aboriginal people the number of deaths related to diabetes is higher than in non-natives with diabetes. Between 1991 and 1996 in British Columbia, Status Indians had a significantly higher number of deaths from diabetes than age-adjusted numbers would have predicted. The Standardized Mortality Ratio (SMR) for men in this population was 1.5 (95% Confidence Interval: 1.0-2.0) and for women it was 2.2 (95% Confidence Interval:1.5-4.5). Status native data from British Columbia has shown that men aged 35 years or older were twice as likely as non-status men to be admitted to hospital for complications of their diabetes. Women older than 35, and pregnant females older than 35 were three-times and two-times more likely, respectively, to be admitted to hospital for diabetes-related illness than non-status women.

Population Health

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Costs Associated with Diabetes

- Diabetes commands a significant percentage of healthcare dollars. Caring for individuals with diabetes costs between 2 to 5 times more than is required for individuals without diabetes. In Canada, $6 billion is spent annually on the management of diabetes and its complications. A recent assessment of the economic impact of diabetes has indicated that 2-3% of health care budgets in all countries worldwide is used to care for people with diabetes.

- Moreover, individuals with diabetes are 25 times more likely to become blind than persons in the general population. As with diabetes, the prevalence of diabetic retinopathy is often elevated in native communities.

- Asymptomatic diabetic retinopathy is prevalent and has a long latent period that precedes vision loss. Fortunately, screening for retinopathy is non-invasive, cost-effective, and highly sensitive and specific. Once detected, diabetic retinopathy is amenable to laser photocoagulation therapy, which has been shown to markedly reduce the risk of severe vision loss from retinal neovascularization and macular edema.

Population Health

Population Health at HLC

- A population health approach focuses on the conditions that underlie health, and then uses what is learned to suggest policies and actions that will improve the well-being of all Canadians. A population health approach uses both short- and long-term strategies to:
  - improve the underlying and interrelated conditions in the environment that enable all Canadians to be healthy; and
  - reduce inequities in the underlying conditions that put some Canadians at a disadvantage for attaining and maintaining optimal health.

- How can the health sector, in this case HLC, whose traditional role is treating the sick, influence the root causes of health and help to reduce inequities in health status among aboriginals? The answer lies in a collaborative effort to renew and reorient the health sector so that it can:
  - take action to meet the emerging challenges in health promotion, injury and disease prevention and health protection, as well as in treatment services;
  - increase the accountability of health services through improved reporting on the quality of health services, and improving access to all needed services;
  - increase our understanding of how the basic determinants of health influence collective and personal well-being;
  - evaluate and identify policy and program strategies that work; and
  - influence sectors outside of health that can significantly affect health status.

Population Health

Population Health at HLC

- In the short term, the Province needs to undertake a population heath study of its aboriginal population, being mindful that the data on population and other demographics are of questionable quality today. In undertaking such a study, the Province should partner with aboriginal populations; this will require gaining the confidence of these populations. Throughout this effort, all parties must be cognizant of the complex relationships between aboriginal peoples and all levels of government.

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APPENDIX C: IMPLEMENTATION PLAN

Implementation Plan

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Introduction

- On the following pages we provide implementation plans for the changes recommended throughout the Operational Review Report that have direct financial implications. Recommendations are categorized as:
  - Revenue Generation Opportunities
  - Productivity Improvements
  - Required Additions
- The implementation plan describes the recommended change, the steps required to realize the opportunity, and the recommended timing.
- It is critical to note that there are many additional recommendations contained in the Operational Review Report which must be addressed by HLC (see Appendix D for a summary). Each section of the report, along with the supporting implementation plan (where it exists), should be provided to the accountable manager. Implementation progress should be tracked by the Executive Leadership Team.

Implementation Plan – Revenue Generation Opportunities

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Area	Recommended Change	Requirements	Timing of Change
Air Transportation	Cost recovery for non-insured services	▪ Establish working committee with aboriginal groups responsible for non-insured services ▪ Define non-insured service ▪ Obtain consensus on process for cost recovery ▪ Develop accounting tool to track activity	Immediate
Air Transportation	▪ Increase Schedevac fee to $80 ▪ Implement escort fee of $80	▪ Work with appropriate provincial government departments and representatives from Grenfell to finalize timing of increase ▪ Communicate planning increases to appropriate parties ▪ Ensure increases are reflected in any forms and systems ▪ Implement change	Immediate
Pharmacy	Increase Pharmacy Retail Dispensing Fee to $7.50	▪ Give notice to Community Clinics of change in dispensing fee ▪ Develop accounting tool to track all cash payments for pharmacy-related recoveries	Immediate

Implementation Plan – Productivity Improvements

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Area	Recommended Change	Requirements	Timing of Change
Acute and Long-Term Care			
Acute Care	Reduce 2 FTEs (Obstetrics)	▪ Develop and implement a cross-training program for all RNs ▪ Reorganize the staffing schedule, as required, to meet the objectives ▪ Update job descriptions for all RNs ▪ Update orientation program for all new RN staff ▪ Review continuing education program to reflect the changing role of RNs ▪ Develop quality indicator to ensure desired outcomes are measured	3-6 months
Long-Term Care	Introduce role of continuing care worker (CCW)	▪ Establish a working group to develop a bridging program for current PCAs interested in achieving CCW status ▪ Working group should include HLC Leadership and Education staff, representatives from DOH&CS, and Community College ▪ Develop a transition plan for RNAs impacted by the change to CCW model ▪ Develop a transition plan for PCAs not involved with transition to CCW model	18-24 months

Implementation Plan – Productivity Improvements

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Area	Recommended Change	Requirements	Timing of Change
Acute and Long-Term Care			
Long-Term Care (cont'd)	Introduce role of continuing care worker (CCW) (cont'd)	▪ Review current job description, work schedules, collective agreements, and other relevant human resource elements to ensure smooth transition ▪ Provide training and support for all staff to ensure understanding of the changes ▪ Develop Quality Indicators to ensure desired outcomes ▪ Establish a working group to develop a Certification Program for the CCW model. The working group should be provincial in scope and inclusive of representatives from DOH&CS, Community Colleges, Home Care Sector, and Long-Term Care Sector.	18-24 months

Implementation Plan – Productivity Improvements

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Area	Recommended Change	Requirements	Timing of Change
Admin and Clinical Support			
Nursing Administration	Reduce 2 FTEs	▪ Develop a transition plan to evolve the regional nursing model, including newly-revised job descriptions, performance standards, timelines, and recruitment of the Regional Nursing Director ▪ Transition plan to include specific timelines, training requirements for all staff impacted by the changes, and quality indicators to ensure desired outcomes are measured ▪ Ensure ongoing continuing education programs reflect the realities of the changing environment	6 months
		▪ Complete an inventory of all functions performed by Nursing Supervisors ▪ Reassign Nursing Supervisors' responsibilities as reasonable, timely and appropriate ▪ Provide training to all staff impacted by the change in Clinical, Support and General Administration areas	36 months

Implementation Plan – Productivity Improvements

Area	Recommended Change	Requirements	Timing of Change
Admin and Clinical Support (cont'd)			
Nursing Administration (cont'd)	Reduce 2 FTEs (cont'd)	▪ Provide training to clinical staff specific to decision-making, empowerment, transfer of functions, staff scheduling, on-call resources, Emergency response procedures, and risk management ▪ Develop a transition plan in keeping with the priority needs of the organization, staff availability, staff readiness, and schedule for training needs	6 months

Implementation Plan – Productivity Improvements

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Area	Recommended Change	Requirements	Timing of Change
Admin and Clinical Support (cont'd)			
Registration/ Health Records/ Communication	Reduce 2 FTEs	▪ Reorganize the work schedule to allow for improved utilization of staff ▪ Ensure appropriate cost recovery for out-of-province services ▪ Undertake a workload analysis to understand the immediate and long-term workload issues ▪ Explore the cost-benefit of utilizing technology enablers ▪ Explore the cost-benefit of space redesign ▪ Review/revise the orientation and training program for all staff ▪ Establish quality indicators to measure outcomes related both to changes and ongoing Departmental activities ▪ Review/revise job descriptions to reflect changes in job responsibility	

Implementation Plan – Productivity Improvements

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Area	Recommended Change	Requirements	Timing of Change
Finance/HR	Reduce 3 FTEs in Finance	▪ Review duties and workload of existing HLC clerks to determine where extra capacity exists	Immediate
		▪ Perform a cost/benefit analysis of maintaining satellite accounting department at CWJMH	Immediate
		▪ Determine if the regionalization of the accounting function should be completed by relocating the remaining positions at CWJMH (and possibly Paddon) to LHC	Immediate
		▪ Consider the impact on future staffing needs of known changes to HLC accounting responsibilities (i.e. CRMS – client payments)	Within 6 months
		▪ Prepare a plan to reduce staff that is mindful of all employee separation costs, employee rights and potential physical space limitations at HLC	Within 6 months

Implementation Plan – Productivity Improvements

Deloitte & Touche

Area	Recommended Change	Requirements	Timing of Change
Finance/HR	Reduce 0.5 FTE in HR (LHC)	▪ Assess current workload with respect to clerk positions ▪ Streamline/automate transactional procedures (e.g. data collection & processing, reporting) ▪ Reassess clerical workload level ▪ Update clerk job descriptions ▪ Provide proper training and support	3-6 months
Housekeeping/ Laundry & Linen	▪ Reduce 2.0 FTEs in Housekeeping (CWJ) ▪ Reduce 3.0 FTEs in Housekeeping (LHC)	▪ Assess current workload with respect to domestic and utility worker positions ▪ Review the nature of tasks to be performed, their duration and frequency ▪ Improve work methods, scheduling & assignment ▪ Reassess the workload level ▪ Update job descriptions ▪ Provide proper training and support	3-6 months

Implementation Plan – Productivity Improvements

Deloitte & Touche

Area	Recommended Change	Requirements	Timing of Change
Plant & Building Maintenance	Reduce 2.0 FTEs in Building Maintenance (LHC)	▪ Assess current workload with respect to trade worker positions ▪ Review the nature of tasks to be performed, their duration and frequency ▪ Improve work methods, scheduling & assignment ▪ Reassess the workload level ▪ Update job descriptions ▪ Provide proper orientation, technical training and support	9-12 months
Patient/Resident Food Services	Reduce 1.0 FTE in Food Services (LHC)	▪ Assess current workload with respect to food service worker positions ▪ Review the nature of tasks to be performed, their duration and frequency ▪ Improve work methods, scheduling & assignment ▪ Reassess the workload level ▪ Update job descriptions ▪ Provide proper training and support ▪ To the extent possible, ensure casual staff are specific to the Department	6-9 months

Implementation Plan – Required Additions

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Area	Recommended Change	Requirements	Timing of Change
Child, Youth and Family Services	Add 25 resources: 1 Program Manager 13 Social Workers 8 Community Service Workers 3 Clerical	▪ Assign internal responsibilities for managing the recruitment and hiring process, and for the acquisition of housing, office space and equipment in the communities ▪ Clearly define the role and responsibilities of the Community Service Worker ▪ Prioritize the phasing-in of new staff by community ▪ Prepare orientation and program familiarization training for all new staff	Immediate
Community Clinics	Add 1 FTE	▪ Conduct staffing review in all community clinics – determine skill mix and experience – minimum of two nurses per clinic ▪ Assess competitive environment ▪ Advertise position ▪ Provide training and support	Immediate
Diagnostic Imaging	Add 2 FTEs at LHC	▪ Conduct staffing review ▪ Determine needs to cross-train ▪ Advertise positions ▪ Assess competitive environment ▪ Provide training and support	Immediate

Implementation Plan – Required Additions

Deloitte & Touche

Area	Recommended Change	Requirements	Timing of Change
Pharmacy	Add 2.5 FTEs at LHC	▪ Develop regional pharmacy strategy ▪ Facilitate development of P&T Committee ▪ Develop clinical pharmacy support structure ▪ Establish new dispensing fee ▪ Provide job description and develop staff evaluation tool ▪ Conduct analysis of remuneration comparison – province/Atlantic competitive environment ▪ Review findings with CEO ▪ Determine level of remuneration for all staff ▪ Advertise new positions ▪ Provide training and support to new and existing staff ▪ Reorganize Pharmacy to better define retail and clinical support role ▪ Validate reorg plan with external reviewer	Immediate
Laboratory		▪ Transfer ER EKG task to ER staff ▪ Realign studies internally	Immediate

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APPENDIX D: SUMMARY OF RECOMMENDATIONS

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CORPORATE STRUCTURE AND DECISION-MAKING

Board of Directors

- Structure and composition:
  - In addition to Executive/Finance Committee, Board Committees should include Patient Care, Joint Conference, Nominating, Medical Advisory Committee.
  - Composition of the Board should include key stakeholders with guaranteed representation from the aboriginal community.
  - The Board should establish a liaison committee with the aboriginal community to ensure mutual understanding of service matters, cultural diversity and the devolution process.
  - The Board should create a process to evaluate the feasibility of establishing a charitable foundation to understand if there is potential for expanding fundraising opportunities.
- Board processes:
  - Meetings must be held regularly to ensure the business of the Corporation is dealt with in a timely manner; the frequency should be included in the by-laws.
  - Board Chair should lead an annual Board self-assessment process to ensure the Board is functioning effectively.
  - Board education programs should be presented on a regular basis to ensure the Board understands the realities of the organization.
  - Board should require regular reporting from CEO, President of the Medical Staff and members of the executive team on matters relating to care, teaching, research and finances.
  - The Board needs to be inclusive in its strategic planning process.
  - The Board chair should act as mentor to the CEO.
- Planning and policies:
  - Board needs to review the corporate by-laws from both a quality/risk and composition perspective.
  - The Board should develop a Board Policy Manual, which should define the governance process, executive limitation and the relationship between the Board and the CEO.

Executive Leadership Team

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- Regional structure and programs:
  - The regional model structure and process requires realignment to ensure programs are managed from a regional perspective.
  - Prior to filling any vacant position on the Executive Leadership team, the roles and responsibilities of the vacant position should be reviewed. In addition, other management positions including Regional Directors, Managers, Directors of Nursing and the Site Manager (CWJMH) should be reviewed.
  - FTEs within General Admin should be reconciled to determine if staffing reduction opportunities exist.
  - The Executive Leadership team should commit additional resources to the quality improvement and risk management program. The current commitment of a portion of a director's time who has significant other responsibilities is not sufficient to ensure sustainability of a regional quality improvement program.
- Rigourous processes:
  - The Executive Leadership team should structure their meetings to ensure their reports are action focused, the quality and risk information are reviewed, external reviews are considered, action plans and accountabilities are established.
  - The Executive Leadership team should consider a policy for cost-impact analysis for new and operating capital initiatives.
  - The budget process should continue to evolve and include managers.
  - The Executive Leadership Team should undertake a learning needs assessment throughout the organization and this effort should include all levels of staff.

Executive Leadership Team (cont'd)

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- Culture of best practices:
  - A culture of best practices needs to be given license within HLC and led by the Executive Leadership Team. A Best Practices Committee should be established to identify practices that could be incorporated into the HLC operational environment.
  - The Best Practices Committee should ensure that the Medical Advisory Committee and Pharmacy and Therapeutics Committee are providing leadership for clinical best practices processes. They should, for example, ensure that available protocols are being leveraged.
    - ✓ To illustrate, protocols are now available for many clinical presentations that have evidence to support effectiveness both in terms of improved patient outcome and cost reduction. For example, Community Acquired Pneumonia, Grade I,II,III, IV Cellulites, Deep Vein Thrombosis, Pulmonary Embolism, Asthma, Ecoptic Pregnancy, Myocardial Infarction, Ottawa Ankle Rules, Acute Coronary Syndrome, Hypertension and Diabetes, to mention but a few protocols, could be implemented within the HLC clinical environment, especially in the Community Clinics.
  - As an academic institution, LHC is well positioned to lead a best practice approach. The Regional Director responsible for Community Clinics will be required to take a proactive role to educate the front line workers on the value of best practice management.

Regional Organizational Structure

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- HLC has an unrecognized liability with respect to the health care needs of aboriginals. A strategic plan with an underpinning that is sensitive to population health drivers will require a tri-partite agreement among three groups: aboriginals, government (provincial and federal) and the service provider – HLC. In the initial stages:
  - Establish dialogue between HLC and Aboriginal Health Commissions
  - Develop a working relationship between the provincial and federal health departments and HLC.
- How can the health sector, in this case HLC, whose traditional role is treating the sick, influence the root causes of health and help to reduce inequities in health status among aboriginals? The answer lies in a collaborative effort to renew and reorient the health sector so that it can:
  - take action to meet the emerging challenges in health promotion, injury and disease prevention and health protection, as well as in treatment services;
  - increase the accountability of health services through improved reporting on the quality of health services, and improving access to all needed services;
  - increase our understanding of how the basic determinants of health influence collective and personal well-being;
  - evaluate and identify policy and program strategies that work; and
  - influence sectors outside of health that can significantly affect health status.

  For more information on the recommended population health approach, see Appendix B.

Regional Organizational Structure (cont'd)

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- Leadership training program must be developed for regional directors in keeping with the priorities needs of the region. These programs should include understanding regional modeling, budgeting, accountability, quality, standards, policies and procedures and IT literacy.
- The Regional Structure and Model for nursing and medical staff, in particular, need to be more sensitive to operational needs. For example, community clinics human resource issues, in particular communication, professional development and policy development require direct management.
- Regional Directors' role, responsibilities and accountability need to be defined and understood.
- The CEO needs to develop a region wide communication strategy to ensure the regional strategic plan, including the vision, mission, values and strategic directions are understood.

Medical Staff

- Develop governance model where Chief of Staff for LHC (including Paddon Home) and CWJMH are accountable to the Medical Director.
- Professional staff organization structure must be separate and accountable to the medical staff and not the Medical Director. The leader of this body should be elected.
- Both the President of the professional staff organization and the Medical Director should be voting members of the Board.
- Regional Credentialing Committee should have representation from both LHC and CWJMH Medical Staff and report to the Board.
- Develop a Regional Medical Human Resource Plan.
- Chief of Staff in each hospital must be accountable for developing and implementing evaluation tool with reporting accountability to Medical Director.
- The Board needs to support the educational interest of its medical staff both as a professional development and a retention and recruitment tool.

Corporate Structure

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- We recommend modifications to HLC's corporate structure as shown on the following page. Highlights of the recommendations include:
  - 4 AEDs reporting to the CEO, including an AED of Acute, Continuing Care and Diagnostic Services. Responsibilities of all AEDs will change to differing degrees.
  - A well functioning Regional MAC reporting to the Board of Directors.
  - A restructured medical staff organization.

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ACUTE AND LONG-TERM CARE (INCLUDING COMMUNITY CLINICS)

Clinical Findings – Staffing

- Generally, there are only minimal potential savings in the clinical areas, with the potential for additional savings if the medevac program was centralized.

  LHC:

  - The concept of a regional nursing program is not working well. Regional standards, policy and practices along with the quality improvement program are in the early stages of development.
  - When comparing LHC and CWJMH to peers, skill mix of 60% professional, 40% non-professional is appropriate.
  - The obstetrics beds at LHC are staffed almost as a stand-alone facility. Not all of the RN staff are cross-trained. With cross-training the organization should be able to reduce staff on the acute unit by 1.5 to 2.0 FTEs.
  - Improved clinical support from pharmacy, respiratory therapy and clinical nutrition should be considered.

Clinical Findings – Staffing (cont'd)

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CWJMH

- The concept of a regional nursing program is not working well. Regional standards, policy and practices along with the quality improvement program are in the early stages of development.
- When comparing acute care at CWJMH to benchmark, skill mix of 60% professional, 40% non-professional is appropriate.
- The acute unit at CWJMH is staffed slightly above benchmark; however with the support provided to the Emergency Department and the stress-test lab, further efficiencies will be difficult to achieve.
- The Emergency Department staffing level at CWJMH is lower than benchmark; however additional hours are provided by nursing supervisors and the acute unit.
- The OR staffing level at CWJMH is slightly above benchmarks; however given they operate 24/7, the geographic challenges, visiting specialist program and the inability to recruit casual staff, the opportunity for improved efficiencies is minimal.
- Improved clinical support from pharmacy, respiratory therapy and clinical nutrition should be considered.
- It is recommended that CWJMH (Long-Term Care) should develop a continuing care worker model. The anticipated cost savings when fully implemented will be approximately $20,000 annually.

Clinical Findings

- HLC is doing a good job managing utilization.
- Minimal staffing efficiency opportunities exist. The organization should ensure it realizes all potential opportunities.
- Treating more complex patients would reduce air transport costs. Requires analysis of impact of additional scope and volume and required investment.

Workload Indicator	Benchmark	Recommended
LHC		
Acute (HPPD 4.57)	4.57	
Obstetrics (HPPD 13.93)	10.02	Reduce 2 RNs
Emergency/Ambulatory (HPPD .50)	.55	No change
OR/PAR/Day Surgery/Special Procedures (HPPC 8.98)	8.0	No change
CWJMH		
Acute/Long-Term Care (HPPD 5.39)	5.0	No change
Emergency/Ambulatory (HPPV .42)	.45	No change
OR/PAR/Day Surgery/Special Procedures (HPPC 13.69)	8.0	No change
Paddon Home		
(HPPD 3.06)	3.2	No change

There is an opportunity to reduce two FTE RNs at LHC (Acute and Obstetrics). Given low volumes and geographic considerations, further reduction is not recommended.

Community Clinics

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- Address resourcing issues:
  - Budgeted RN FTEs are appropriate, with the exception of Postville, where a second RN is required. No clinic should have less than two nurses, to ensure appropriate coverage.
  - Attempts should be made to improve scheduling in the clinics. Extension of clinic hours to midnight would allow the vast majority of after hours patients to be seen at regular rates of pay. In clinics where more than 1 FTE of overtime is paid, this is a cost effective solution. We recognize that this may impact on job satisfaction given that over-time pay is a significant recruitment and retention incentive.
  - There is an opportunity to introduce more regional behaviour through limited restructuring. There is a need to address the deficits in staffing, professional development, quality assurance, and communication with regional management. A revised administrative structure presents an opportunity to eliminate a supervisory position in Nain.
  - Movement to unit dosing by pharmacy could reduce the staffing complement in Nain by 0.5 FTEs.
  - The role of PCAs is not clear. Further study is required. May present opportunity for improved efficiencies.
  - Appropriateness of maintenance staff in community clinics requires further study.

Community Clinics (cont'd)

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- Improve communications:
  - Develop communication strategy to incorporate community clinic perspective into overall regional strategic plan.
  - Develop "devolution communication strategy" to allay some of the fears expressed by staff around job security, standards of care and availability of service.
  - Assess IT infrastructure to provide improved communication.
- Promote integration of community clinics with Aboriginal Health Commissions.
- Review telehealth as a vehicle for delivery of education, clinical care and professional support.
- Develop and implement a standardized pre-hospital program where the basic skills associated with trauma management, Advanced Cardiac Life Support, Pediatric Advanced Life Support and other pre-hospital training courses are integrated and "modified" to meet the needs of community clinic staff.
- Develop an equipment maintenance process, to be implemented by existing workers.

Long-Term Care

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- The Paddon facility, built in the mid 1970s, is not condusive to maximizing efficiency to meet service needs. The rooms, each with two residents, are crowded; the dining room layout will not allow for all residents to be in the area at the same time and maintenance challenges are also significant. The wait list will likely continue to increase.
- The skill-mix is inappropriate for long-term care. The Continuing Care Worker model, used in most provinces across Canada, has not been introduced at Paddon Home. The skill-mix should be adjusted over a period of time with the introduction of the continuing care worker role. This would involve initiating a planning process with stakeholders to consider training requirements, transition of staff (particularly LPNs) and, in general terms, to introduce the new role. The cost savings when fully implemented, based on salary ranges for Newfoundland and Labrador, would be approximately $68,000 per year. Given the current gap of 12% between the PCA and LPN salary range, the savings are not significant; however, the concept should be explored, given the LPN skillset could be utilized more effectively in other clinical areas and given the potential for mobility.
- The strategic planning process for HLC should consider the Paddon facility and future plans to address current space issues.
- Quality indicators for long term care have not been developed and should be considered as the regional quality improvement program evolves.
- Clinical support levels for recreation are lower than peers. However, Paddon receives limited PT/OT support as well, not typically provided in peer long-term care facilities. While we are not suggesting that peers represent clinical best practices, they do reflect the current state. We are not recommending increased staffing at Paddon.

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ADMINISTRATION AND CLINICAL SUPPORT

Finance/HR

- In Finance/HR, there appears to be an opportunity to reduce staff by 3.5 FTEs (3 in Finance and 0.5 in HR), though perhaps not all in the short-term – may be achieved through further regionalization and Meditech financial module enhancements.
- Finance staff generally tend to be very dedicated to the organization, but relatively inexperienced in a healthcare environment and may only meet the minimum job qualifications.
- Recruitment and retention of qualified accounting staff at all levels has been a challenge in the past.
- The maintenance of a stable accounting staff is a significant accomplishment for the organization.
- Management feels that accounting staff work very effectively in a unique and challenging environment.
- The continued development and training of existing accounting staff should be a priority.
- Create a strategic plan for financial services.

Systems Support

- Connectivity - There is a critical need to install network connectivity for all nursing stations and CYFS to access core applications and collaboration tools.
- Implementing Systems -
  - Meditech implementation is under-resourced which is slowing implementation. Dedicated project teams should be established to implement Meditech and CRMS independent of other functions and roles.
  - Meditech implementation should continue and be expanded to provide better management of pharmacy, materials and flight requisitions. This will improve control, efficiency and cost management.
  - The Meditech servers are aging and the vendor is phasing out support of the technology. These need to be replaced before critical failure.
  - HLC is behind in the deployment of CRMS and may require an increased investment to catch up.
- Proper Budgeting - Proper budget has not been allocated for maintenance of technology - only provision for the initial projects. Long-term support and maintenance upgrade budgets need to be defined and funded.
- Leverage Telehealth - Smart Labrador/Telehealth is not properly or fully used due to lack of training, procedures, technical issues and centralized control & management of the technology. A plan to replace or enhance the technology is required.
- Disaster Recover Plan - A disaster recovery plan has not been developed. While basic backup processes are in place, there is need for more comprehensive redundancy, data protection, backup and recovery procedures and tools.

Systems Support (cont'd)

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- Our specific recommendations (those that can be quantified), combined with necessary planned IT investments, result in the following dollars being required to support IT (note: dollar values provided by HLC management):

	2003/04	2004/05
High Priority		
CRMS Module Implementation	$486,000	$225,000
Mini-PACS Implementation	283,000	-
Meditech Server (Replacement)	150,000	-
	$919,000	**$225,000**
Medium Priority		
Meditech Modules and Enhancements	$1,034,000	$ 462,000
Workstation/Printer Replacements	288,000	261,000
PACS-Computed Radiology	287,000	-
Full PACS LHC/Mini-PACS CWJMH	-	681,000
Network Upgrades	518,000	431,000
Meditech Server	100,000	-
Telehealth Infrastructure	272,000	-
IT Staffing	180,000	180,000
	$2,679,000	**$2,015,000**

Registration/Health Records/Communications

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- This is a designated regional service, however not regionalized in practice. It is functioning autonomously at LHC and CWJMH.
- Health records policies and procedures should be developed for health records storage and retention.
- The director should be involved in the budget process.
- Immediate steps should be taken to address the backlog of discharge summaries at LHC.
- The cost centre should receive recovery for out-of-province services, specifically those provided to Farmont.
- The health records quality improvement program should continue to evolve. The quality program should identify and consider best practices which could enhance efficiency and effectiveness.
  - For example, the use of voice recognition software technology has revolutionized the manner in which dictation of medical reports and clinical consults is handled. An opportunity exists to improve the turnaround time of discharge summaries and the dictation of clinical records in the outpatient clinics of both acute care facilities. In addition, it may present an opportunity to further rationalize the number of FTEs dedicated to dictation. Benchmarking the activity in medical records with the practice in other environments, especially where a PACS environment has been introduced, will validate the value of voice recognition software technology as a means to improve efficiency.

Registration/Health Records/Communications (cont'd)

Deloitte & Touche

- The Regional Director should undertake a review, including:
  - A workload analysis to quantify the following: secretarial support for LHC physicians; regional support for visiting specialists; and regional support for Meditech implementation;
  - Potential for scheduling changes to allow for greater efficiency;
  - Potential to utilize technology enablers for greater efficiency; and
  - Potential for greater efficiency with a redesign of space.
- We recommend a reduction of 2 FTEs within six months, and consideration for further reduction following the review.

Housekeeping/Laundry and Linen

- Staffing levels can be reduced by 5 FTEs, all in housekeeping services, 3 at LHC, and 2 at CWJMH.

Materials Management

- Continue implementation of multi-year contracts (e.g. Ambulance and Security Services at CWJMH and medical gas supplies at LHC and CWJMH). They can significantly reduce the product/service unit price.
- Re-evaluate the public tender policy (to the extent possible under the Public Tender Act).
- No staffing changes are recommended.

Facilities and Plant

- The skill level of LHC maintenance workers must be improved to allow them to work efficiently with the modern equipment and devices in the facility. This will significantly reduce the need for external expertise and costs of outside contractors and may contribute to staff reductions of up to 2 FTEs in the medium term.
- Before investing an estimated $1.8 M in CWJMH, a needs analysis and role study must be completed. Armed with that information, HLC can make an informed decision regarding upgrading the current building versus construction of a new facility.

Patient/Resident Food Services

- Reduce FTEs at LHC by 1.0 after having reduced the casual employees' turnover rate by applying the Collective Agreement more rigorously. An alternative is to examine the feasibility of fully contracting out kitchen/cafeteria services at LHC and Paddon Home.
- Casual staff should be specific to the department, reducing risk and improving efficiency.

Allied Health:
Physiotherapy, Occupational Therapy & Recreation

- The therapists appear to be functioning well, however they do not have a level of professional accountability.
- Appoint one of the PT/OT therapists as the Regional Practice Leader with specific accountabilities for this role.
- Maintain the current level of staffing overall, recognizing that recruitment and geography are significant challenges. Attempts should be considered to share resources more equitably among sites.
- The work load is heavier at LHC compared to CWJMH; however, both have the same number of FTE therapists. The OT/PT therapist from CWJMH should travel at least monthly to LHC to provide service.

Laboratory

Deloitte & Touche

- Maintain current staffing level
  - Transfer non-traditional laboratory duties after 1600 hours at LHC to appropriate department or resource (e.g. ECGs 8-10/day; routine phlebotomy), improving efficiency in lab.
- Opportunity to leverage technology
  - Update Meditech to facilitate transfer of CWJMH referred out tests.
  - Phase in LIS with easy access from physician clinics, ER and clinical areas.
  - Conduct physician Meditech/LIS needs assessment to determine critical success factors for deployment of Meditech system.
- Implement Thornhill Report
  - Regional Manager should take lead to fast track implementation of Thornhill Report.
  - Look to the economy of repatriating work sent to St. Anthony that can be done at HLC as per the Thornhill Report.

Laboratory

Deloitte & Touche

- Other:
  - Formalize association with a consultant pathologist to provide the Regional Manager and Laboratory Department leaders with mentoring and referencing tools. Most appropriate resource may be located in St. Anthony.
  - Need to facilitate improved relationship between laboratories.
  - Revise budget process to encourage involvement of department staff.
  - Review purchasing and utilization of reagents.
  - Develop contingency plan for chemistry analyzer failure at LHC.
  - Develop long-range capital program.

Diagnostic Imaging

- Repair ultrasound machine at LHC.
- Establish cost impact analysis committee with representation from MAC, Administration and DI Department.
- Address issue of long report cycle for diagnostic imaging:
  - Volume supports resident radiologist
  - Assess probability of recruitment
  - If recruitment efforts fail, reassess relationship with Health Corporation of St. John's, and consider other options (e.g. Gander, St. Anthony)
  - Ultimate goal: PACS environment (available in other regions; Provincial initiative)
    - Risk/quality
    - Cost of film
    - Storage space
- Cross-training CT/US.
- Support efforts to have technologist establish own IV access, as is common elsewhere.
- Establish Quality Assurance Committee.
- Increase staffing levels by 2.0 at LHC.

Pharmacy

- Evaluate the role of Pharmacy as a clinical support resource and staff accordingly
  - As a regional resource, the pharmacist needs to be available to all sites including community clinics to provide professional support and guidance on quality issues. Dalley Report flagged this as a risk issue.
  - We recommend that staffing be increased by 1 technician, 1 Pharmacist and 0.5 clerical FTE to reflect current workload and incorporation of the CWJMH site which is not currently included in pharmacy workload measurements. Total staff complement recommended: 2.5 FTE unit producing pharmacists, 0.5 FTE pharmacists, 3 FTE technicians and 0.5 FTE clerical. These changes will achieve the following:
    - ✓ Assume regional control and introduce unit dosing to long term care at CWJMH and an appropriate inventory and drug management system appropriate to the acute care side
    - ✓ Free up time of Director currently spent on pharmacy duties to support regional clinical responsibilities (e.g. take a lead role in P&T Committee, provide clinical support to nursing/medical staff)
    - ✓ Pharmacist to undertake regular visits to all sites
    - ✓ Gain better control over retail operation: cash flow, inventory, profit margin
    - ✓ Increase monitoring of drug usage - development of protocols leads to reduced drug costs
    - ✓ Develop and implement a seamless care program for discharged patients
    - ✓ Free up community nurses from routine dispensing duties with the introduction of unit dosing at marginal increase in cost (given unit dose system in place at Paddon)

Pharmacy (cont'd)

Deloitte & Touche

- To finance the proposed increase in staffing, dispensing fee should be increased to $7.50 from $5.50 (fee has not been adjusted since 1995 and is currently $3.50 below the private retail fee), and 0.5 FTE nursing budget dedicated to pharmacy at CWJMH should be transferred to the pharmacy cost centre. This should represent a cost neutral position with a minimum of $56,000 in revenue from the increased dispensing fee.

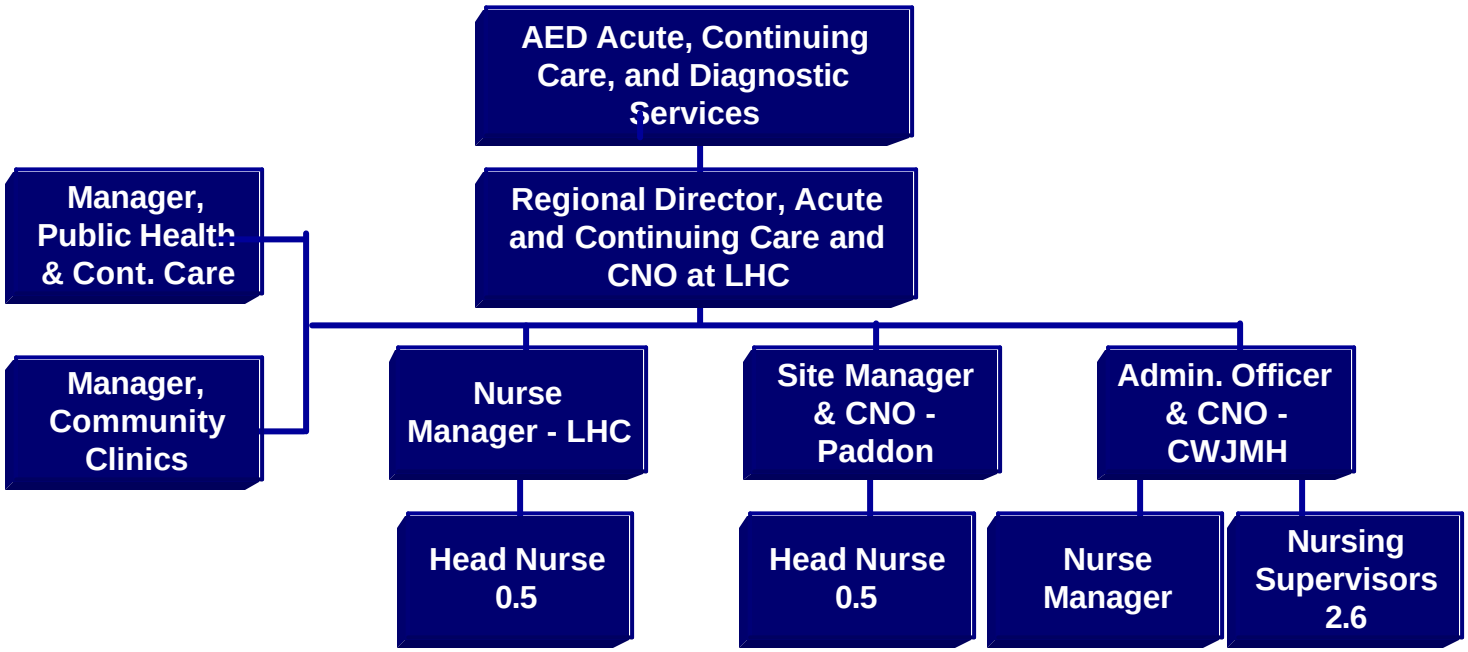
- Optimize use of technology
  - Until recently Pharmacy did not have a budget. As it is, the separate home grown accounting system is used for the retail operation only and captures all inventory but not all sales.
  - It is recommended that the Pharmacy Department:
    - Maximize functionality of Meditech module with special emphasis on budgeting and inventory control.
    - Provide professional development opportunity to pharmacy staff to better understand business model.
    - Replace manual drug referencing with electronic drug referencing to improve quality and risk management. This represents significant risk issue.

Clinical Education

- The program scope for this director is broad and cannot be sustained.
- Some of the responsibilities (ie. fire, safety, disaster planning, employee health, WHIMS), representing approximately 1 FTE, are not being adequately fulfilled and could be realigned to other departments. There is ample capacity within HR and physical plant to handle this additional workload.
- With the shift of responsibilities, current staffing is adequate.
- Consideration should be given to transferring the regional infection control responsibilities to Public Health.
- Hire temporary staff as permanent, to allow stability in managing the workload.
- The telehealth coordinator position should be evaluated as part of the recommended telehealth review.
- The regional manager should continue to evolve the regional quality/risk management program.
- There should be a credentialing policy and process for physicians and other professionals.

Nursing Administration

- Establish a Regional Director of Nursing role with a mandate and accountability to develop a regional nursing model. This can be filled within the existing complement.



Nursing Administration (cont'd)

Deloitte & Touche

- Reduce Nursing Administration by 2 FTEs. Recognizing the geography, impact of Medevacs, and lack of a regional model, further FTE reductions are not appropriate at this time.
- The Nursing Supervisor role is pivotal to the clinical care and administrative functions at both LHC and CWJMH; however, with maturity of the regional model, enhanced training for nursing leaders and RN staff, and a new approach to Medevacs, reductions at the supervisory level could occur. We recommend reduction of 4 FTEs in two years.
- Consider a Facility Manager position at CWJMH that acts as both the Nursing leader and facility manager. This would allow for a nursing leadership position at LHC and CWJMH.

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COMMUNITY SERVICES

Community Services – Public Health

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- This regional program is functioning reasonably well; however, it requires a more integrated approach to service delivery.
- There is a need to develop a regional integrated model of service delivery for Public Health and Continuing Care. The current structure is not conducive to effective planning and management of service delivery.
- One Regional Director should be considered for Public Health and Continuing Care – currently there is one for each program.
- A regional needs assessment should be completed for Public Health, Continuing Care, Mental Health and Addictions to ensure the priority service needs are understood for all of the communities served by HLC.
- Quality indicators for this program should be developed.
- Greater support for the implementation of CRMS should be provided, particularly to the coastal communities.
- Significant gaps in Audiology and Speech Language services should be addressed. The current incumbent is on a one year leave of absence.

Community Services – Mental Health

- This regional program is functioning reasonably well; however, it requires a more integrated approach to service delivery.
- A regional needs assessment should be completed for Mental Health to ensure the priority service needs are understood for all of the communities served by HLC.
- Quality indicators for this program should be developed.

Community Services – Addictions

- This regional program is functioning reasonably well; however, it requires a more integrated approach to service delivery.
- Quality indicators for this program should be developed.
- A regional needs assessment should be completed for Addictions to ensure the priority service needs are understood for all of the communities served by HLC.

Community Services – Continuing Care

- As mentioned previously, one Regional Director should be considered for Public Health and Continuing Care – currently there is one for each program.
- Quality indicators for this program should be developed.
- A regional needs assessment should be completed for Continuing Care to ensure the priority service needs are understood for all of the communities served by HLC.

Community Services – Child Care Services

- As the Family Resource Centres play a very valuable supportive role to such programs as Protective Intervention Services, it is recommended that the roles and expectations with respect to HLC's future involvement with the Family Resource Centres be clarified with the Province to ensure an adequate commitment of service by the Child Care Services Consultant.

Community Services – Community Corrections

- The current program is functioning well but, with no designated staff in Sheshatshiu, any further rise in the number of young offenders in that community will require a staffing review in this program.
- The position of Community Corrections Consultant is currently funded temporarily by the federal and provincial governments and, as the value of retaining that position is proven, more permanent funding should be explored.

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CHILD, YOUTH AND FAMILY SERVICES

Child, Youth and Family Services

Deloitte & Touche

- Increase staffing to appropriate levels by establishing 25 new positions in the CYFS Child Welfare Program.
- Such new positions would provide one Program Manager, 13 social workers, 8 community social workers, and 3 clerical workers.
- This new staffing complement provides minimal coverage for the current caseload, and does not account for the additional volume of work that will be generated once more social workers and community service workers are in the communities.
- CYFS additional costs (estimated by HLC management) based on 25 positions for the 2003/04 fiscal year are:

Salary costs	$1,582,938
Non-salary costs	703,311
Program costs	788,123
Less: CYFS Agreement Revenue	(428,189)
Net increase in 2003/04	2,646,183
One-time capital costs	1,055,000
Total	**$3,701,183**

Child, Youth and Family Services (cont'd)

Deloitte & Touche

- Address key HR issues:
  - A Training Officer should be designated from within HLC to undertake a learning needs assessment to identify and prioritize the training requirements of CYFS staff, and to be responsible for the ongoing delivery of orientation and job-specific training throughout the Region.
  - The role of the community service worker should be reviewed to ensure the duties of the position do not include responsibilities that belong solely to the social worker, such as the screening of new referrals. With additional staffing, the community service worker could become more involved in community development tasks, and in activities of a preventive nature that would help to keep children safely in their own homes.
  - Appropriate annual performance appraisal guidelines should be developed for CYFS management and front-line staff with performance appraisals conducted annually.
- Reorganize payment process:
  - Given that Human Resources will no longer be issuing CYFS client payments after April 1, 2004, HLC will need to consider how best to reorganize the entire payment process in such a way that social workers can be relieved of many related administrative tasks.

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AIR TRANSPORT

Air Transport

Deloitte & Touche

- Improve cost recovery for non-insured services:
  - Define non-insured service
  - Determine number of non-insured clients transported
  - Cost recover at contract fixed cost
    - ✓ Estimated minimum revenue - $1.2M (represents incremental revenue to HLC of $960,000)
- Assess the potential to transfer HLC Medevacs to St. John's to a Provincial jurisdiction:
  - Potential benefits:
    - ✓ Nurses free to float to acute care and maybe community clinics
    - ✓ Standardization of Medevac protocol
    - ✓ More cost efficient based on other provincial experiences
  - Estimated impact:
    - ✓ Nursing FTEs 4 (lieu time + overtime – FTE required for coastal Medevacs)
    - ✓ Physician FTEs .5
    - ✓ Support costs $300,000
- Increase user fees to $80 for all users, including escorts

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RELATIONSHIPS WITH ABORIGINAL GROUPS

Relationships with Innu, Inuit and Metis Groups

Deloitte & Touche

- Establish planning framework with all stakeholders to identify:
  - Needs of the population
  - Resources required (staff, physical plant)
  - Timetable for devolution
  - Financial impact
- Develop partnerships on the basis of transparency, trust and mutual respect.
- Develop dispute resolution process to address variance in vision, mission and directions.
- Stakeholders must work at understanding each others' cultural uniqueness by using supporting affirmative action programs that would see aboriginal leaders incorporated into the governance structure of HLC, including senior executive.
- Ensure cost recovery opportunities in relation to federal programs for, and agreements with, aboriginals are maximized.

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ACCOUNTING AND REPORTING

Financial Accounting and Reporting Processes

Deloitte & Touche

- AED too involved in day-to-day operations, not enough time spent on managing resources and strategic planning. This appears to be a function of the early evolution of financial systems and staff development/mentoring requirements.
- Meditech has provided a stable system to build upon.
- Vast improvements in accounting and reporting processes have been realized in last few years.
- Still a long way to go before systems are fully optimized and all reporting obligations are met on a timely basis. Generating adequate reports for external users in a timely manner is still a challenge.
- Senior management continuing to deal with pressure to optimize financial systems and meet reporting obligations.
- Still significant gaps in the budgeting and reporting (primarily to government) processes.
- Adjust MIS chart of accounts to comply with government requirements so that monthly uploads can commence. Improve the capture of statistical data within the medical and clinical modules.

Financial Accounting and Reporting Processes (cont'd)

Deloitte & Touche

- Complete statistics component of ESS module.
- Begin preparing for deployment and integration of CRMS system, identifying impacts on Finance Department:
  - System integration issues
  - Extra duties (i.e. cheque preparation).
- Carefully review the costs and benefits (i.e. internal control improvements) of any significant information technology investment:
  - Meditech at coastal sites and clinics
  - Internal control enhancements (i.e. Medical Flight Authorization tracking).

Budgeting Processes

Deloitte & Touche

- Process still in early stages of development.
- Employee turnover in budget analyst position has delayed the improvements.
- Due to the lack of experience of the budget analyst, there is likely to be a significant learning curve.
- Importance of management involvement in process recognized by senior management.
- Large budgeted deficits continue to be a problem.
- Delays in completing the 2002/03 and commencing the 2003/04 budgeting processes is a significant shortfall.
- Uncertainties such as the ability to retain federal funds recovered in relation to the delivery of certain Child, Youth and Family Services in Innu communities make budgeting in this area challenging.
- The potential impacts of devolution on service delivery and funding are difficult to predict.
- While International Grenfel Association (IGA) grants have been instrumental in a number of research and capital projects undertaken by HLC, their application criteria are limiting and grants awarded have been inconsistent. Therefore, they are difficult to budget for and are not a a substitute for DOH&CS funding.
- Still significant gaps in the budgeting and reporting (primarily to government) processes.
- Complete 2003/04 budget process immediately:
  - Ensure appropriate input from stakeholders.
  - Ensure appropriate level of detail (by month) so that AEDs, regional managers and department heads can use it effectively as a management tool.

Review of Internal Control Systems

Deloitte & Touche

- High-level discussions with senior management reveal that basic controls are in place.
- Recent management letters issued by HLC's auditors reveal no significant areas of concern.
- Controls at clinics and nursing stations are not optimal, mainly due to inherent staffing and system limitations.
- There are opportunities for abuse of air transportation, though a system of manual controls attempts to mitigate the risks.
- There are risks associated with payments made to clients under Community Services, mainly due to the nature, scope and volume of the services. The CRMS implementation may address some of these issues.
- Plans are in place to commence an internal audit process as a component of the broader quality control initiatives of the organization. This process will be carried out by the budget analyst.
- While vastly improved, the financial systems are still not optimal.
- There appears to be a strong commitment to the organization and to the continued improvement of its financial systems.