

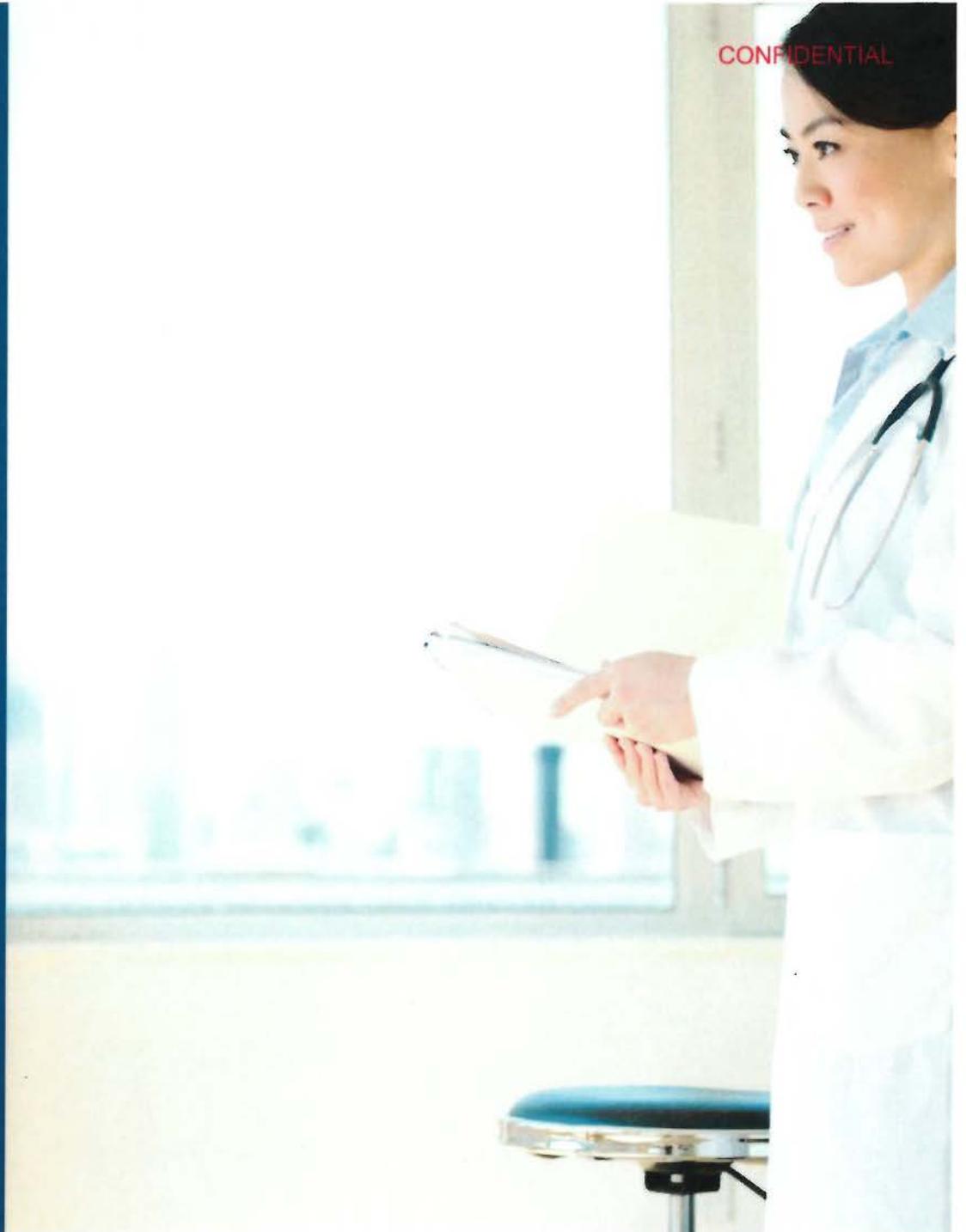


Health System Sustainability & Innovation Review: Phase 1 Report

Manitoba Health, Seniors and Active Living and
Manitoba Finance

January 31, 2017

CONFIDENTIAL



Notice

This report (the "Report") by KPMG LLP ("KPMG") is provided to Manitoba Health Seniors and Active Living (MHSAL or the 'Department') represented by Manitoba Finance ("Manitoba") pursuant to the consulting service agreement dated November 3, 2016 to conduct an independent Health Sustainability and Innovation Review (the "Review") of the Department, the Regional Health Authorities (RHAs), and other provincial healthcare organizations.

If this Report is received by anyone other than Manitoba, the recipient is placed on notice that the attached Report has been prepared solely for Manitoba for its own internal use and this Report and its contents may not be shared with or disclosed to anyone by the recipient without the express written consent of KPMG and Manitoba. KPMG does not accept any liability or responsibility to any third party who may use or place reliance on our Report.

Our scope was limited to a review and observations over a relatively short timeframe. The intention of the Phase 1 Report is to provide a scoping document for identifying potential areas of opportunities, of which select opportunities would be further investigated through work plan development in Phase 2. The procedures we performed were limited in nature and extent, and those procedures will not necessarily disclose all matters about departmental functions, policies and operations, or reveal errors in the underlying information.

Our procedures consisted of inquiry, observation, comparison and analysis of Manitoba-provided information. In addition, we considered leading practices. Readers are cautioned that the potential cost improvements outlined in this Report are order of magnitude estimates only. Actual results achieved as a result of implementing opportunities are dependent upon Manitoba and department actions and variations may be material.

The procedures we performed do not constitute an audit, examination or review in accordance with standards established by the Chartered Professional Accountants of Canada and we have not otherwise verified the information we obtained or presented in this Report. We express no opinion or any form of assurance on the information presented in our Report, and make no representations concerning its accuracy or completeness. We also express no opinion or any form of assurance on potential cost improvements that Manitoba may realize should it decide to implement the recommendations contained within this Report. Manitoba is responsible for the decisions to implement any recommendations and for considering their impact. Implementation of these recommendations will require Manitoba to plan and test any changes to ensure that Manitoba will realize satisfactory results.



Process & Delivery

Process and Delivery refers to the resourcing of the Province as related to staffing, organizational design and structure, as well as workload capacity, skills training processes, and other facets of the Province's workforce.

The following themes were identified in consultations and document reviews:

Operating agreements and service delivery frameworks/practices codify independence and autonomy of regions and sites, instead of encouraging performance as part of a province-wide system.

- There is appetite for greater administrative standardization of provincial services such as Human Resources, Supply Chain (e.g., pharmaceuticals), support functions, Lean management, ICT, real estate and facilities management, clinical engineering, medical device reprocessing, and analytics. Outsourcing could be considered for shared services, while balancing the need for strategic, rather than transactional, relationships with the business.
- A lack of coordination between regions, programs, and sites have contributed to high transport costs within WRHA and across Manitoba. It is noted that there is no contract for air transport services, despite a spend estimated at \$70M+ in the North; it is understood that there is a proposal to MHSAL to submit a formal RFP.
- There are jurisdictional gaps with respect to Indigenous populations, reflecting stakeholder observations on disparity in health status and increased healthcare utilization. Jurisdictional gaps include lack of primary care, which impacts chronic disease prevention and management. There are promising practices, such as *Blurring the Lines* in Southern Health-Sante Sud, which has built relationships with First Nations reserves and the First Nations and Inuit Health Branch to successfully address immediate and long-term needs impacting health equity.
- Different standards of integration create confusion and contribute to higher costs of delivery and administration.

Incremental design and development of the healthcare system has resulted in a highly complex and siloed delivery environment.

- Until recently, there has been no master plan or provincial clinical services plan that outlines where and how services are delivered to reduce duplication and improve clinical outcomes (e.g., through the creation of Centres of Excellence). The public and healthcare providers/administrators who participated in the *Have Your Say* survey also noted that the provision of appropriate services is an opportunity for improvement.
- Navigating across the continuum of care was recognized as a challenge by providers, patients, families and caregivers, due to the siloed delivery environment. There is health inequity (particularly related to social determinants of health and indigenous communities) in Manitoba. Opportunities to integrate health and social care, such as building on successes with Early Intervention, were identified as critical to supporting population health.
- The current model restricts the development of alternate delivery models that emphasize community or preventative care or strategies to pursue integrated delivery with alternate cost structures.

Technical & Allocative Efficiencies

We followed a comprehensive approach based on the measurement criteria set out in the Health Fiscal Performance Review Framework to identify immediate (2017/18), tactical / operational opportunities and medium-term transformation opportunities required to ensure sustainability. Each of the potential key areas of opportunities will be qualified as technical or allocative efficiency.

Lens	Examples	Criteria	Improvement Category	Timelines
Technical Efficiency <i>'doing things the right way'</i>	Potential areas of opportunity for 2017/18 <ul style="list-style-type: none"> Tactical cost reduction programs in larger hospitals via opportunities identified through benchmarking. Consolidation of procurement functions and transformation of Supply Chain. Improved drugs procurement. 	Economy & Efficiency	Immediately Implementable <i>High impact cost management opportunities realized in-year.</i>	2017/18
			In-Depth Analysis: <i>Tactical cross-cutting programs across health system.</i>	2018/19+
Allocative Efficiency <i>'doing the right things'</i>	Areas of potential opportunities in 2017/18 to realize significant savings in a 3-4 year fiscal year timeframe <ul style="list-style-type: none"> Reallocation of funding. Clinical support services in relation to consolidation/ outsourcing. 	Effectiveness	In-Depth Analysis: Strategic Re-design <i>Re-design models of care/service reconfiguration.</i>	1+ Years
			In-Depth Analysis: Strategic Partnerships <i>Working with others to deliver existing and new services differently.</i>	1+ Years

Area of Opportunity #1: Strategic System Realignment



Description

The information contained in this section is directional and is subject to revision based on detailed analysis of foundational legislative and legal frameworks. It also would be subject to completion of detailed planning and financial analysis recommended for Phase II of the HSIR.

When compared to other jurisdictions, both within Canada and globally, Manitoba has one of the most complex healthcare systems for a population of its size. It is characterized by a large number of independent organizations with overlapping jurisdictional responsibility that have limited accountability for delivery and outcomes as part of an integrated system. Governance is fragmented in part due to the large number of independent boards of directors focused on the leadership and stewardship of each organization as a separate entity.

Regionalization has not been effective at delivering all of the benefits envisioned with its introduction in 1997. Established with the intention of creating a more direct level of community accountability for healthcare service delivery, the actions to implement this concept reinforced the growth and development of separate healthcare delivery organizations instead of contributing to the development of a stable system that delivers ensure high quality services in all areas of the Province.

The capacity of the Province's regional health authorities is widely varied. Steps to reduce the number of regions have resulted in some improvements in delivery management capacity but there are critical gaps in capability especially for specialized expertise to oversee clinical service delivery and provide advanced management functions like capital planning or medical device reprocessing. This is particularly true for Interlake-Eastern RHA and the Northern RHA. The capability of individual regions was to be augmented through the shared Regional Health Authorities of Manitoba (RHAM) but this organization has not been effective in leveraging the combined capacity of the system. The recent decision to shut down RHAM operations reinforces this point.

Unfortunately, the steps necessary to effectively consolidate the regions and rationalize governance, management and service delivery structures were not well executed or remain unfinished. Similarly, actions like the consolidation of imaging and testing services through Diagnostics Services Manitoba or the integration of health ICT investments through eHealth Manitoba have not fully achieved intended outcomes because of barriers to complete service integration.

Organizations like CancerCare Manitoba or the Addictions Foundation of Manitoba operate independently within the public system. While these organizations have achieved some clinical service proficiency, they also create significant challenges to service integration because of conflicts between their mandates and those of other organizations in the system. There is not clear evidence that these organizations are more effective at delivering key management services despite leadership claims that they have more cost effective or sustainable operations.

The realities of this organizational complexity contribute to ineffectiveness and inefficiencies in the current system.

Area of Opportunity #1: Strategic System Realignment



Description (Cont.)

The lack of effective integration is particularly true for Winnipeg and the WRHA. Established by the consolidation of the WRHA and the Winnipeg Community and Long Term Care Authority, it is widely acknowledged that the WRHA has never fully integrated as a region. This is in part a result of the 1994 *Faith Based Healthcare Agreement* that reinforced the independent nature of hospitals operated by the Province's major religious groups. This agreement – originally conceived to ensure that these groups could have input on spiritual and community needs as part of health authority system – was operationalized to ensure the autonomous nature of these facilities within the WRHA through a series of operating agreements. Even for sites that have “devolved” their governance to the WRHA as an organization, the principles of independence and autonomy have a significant impact on day-to-day service delivery.

The Province has continued to evolve the WRHA's role in the healthcare system through a series of incremental changes to its mandate. These changes significantly increased the role of the WRHA as a funding organization alongside of its healthcare delivery responsibilities. This has contributed to further imbalance in the system as the WRHA's resources often exceed those of the department. This factor has created significant confusion throughout the system about the role of MHSAL and the WRHA, and in the case of many organizations, significant mistrust of the WRHA because it operates both as a funder and service delivery organization.

MHSAL's capability to provide meaningful oversight and coordination has been eroded by these changes over time. The initial transition of core functions to regional delivery resulted in a significant capability and experience gap at the time of regionalization. Subsequent changes to the department have restored some of this capability but there continues to be limited departmental strength in many fundamental areas including policy development, service planning, delivery oversight and funding.

MHSAL retains a significant number of health care delivery functions that are not consistent with the role of a government department in most high performing health systems. Retaining these functions within the department complicates service integration and misaligns policy, planning, oversight, commissioning and delivery roles.

Stakeholders universally confirmed that the structure of the system is a significant barrier to achieving short-term performance gains and longer-term system sustainability.

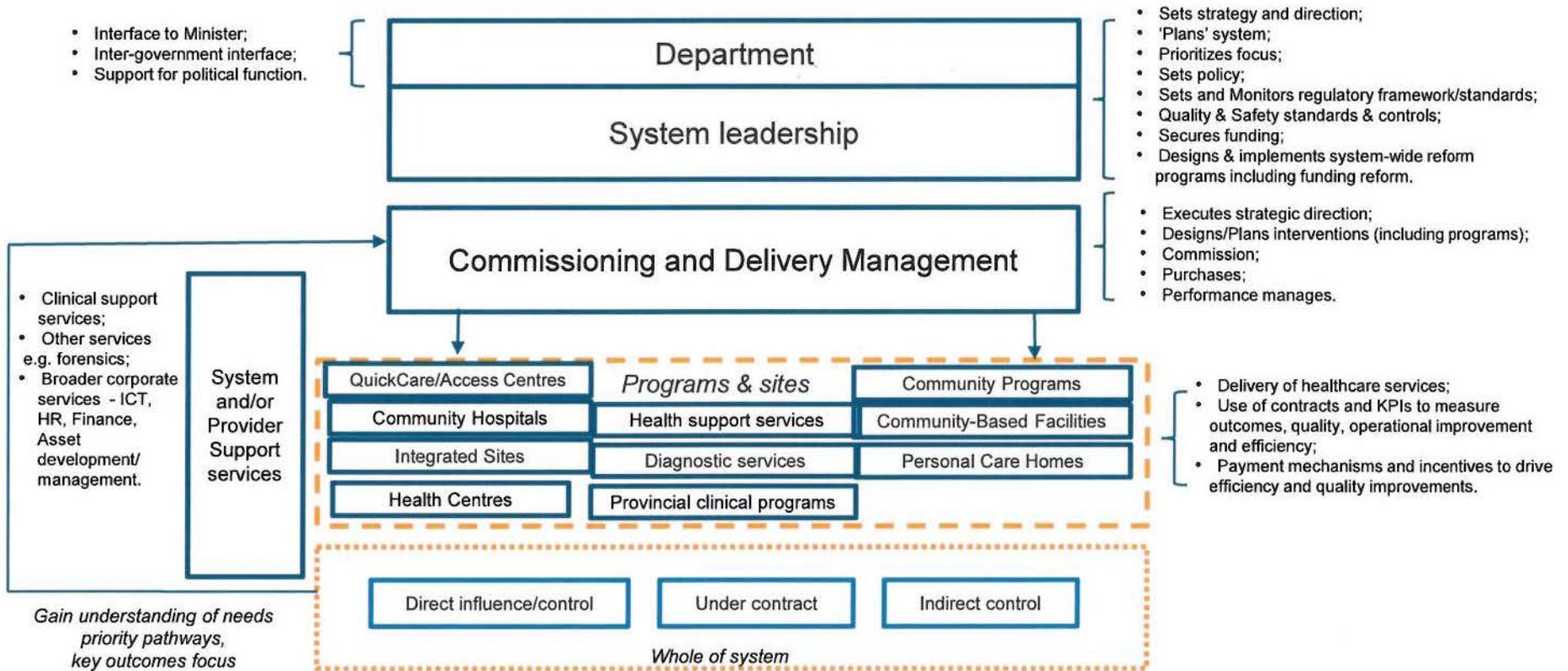
Other jurisdictions such as Ontario and BC have recognized the importance of structural realignment to bend the curve of long-term healthcare costs. Similarly, high-performing systems in many countries around the world have taken steps to streamline organizational complexity and improve system accountability as an early step in their strategic sustainability plans. They have recognized that failure to address system structure is a major risk area.

The next page seeks to align the roles of MHSAL, RHAs, and Providers with high-performing health systems.

Area of Opportunity #1: Strategic System Realignment



Analysis & Observations



Performance Management and Accountability Framework across the provincial system

Area of Opportunity #1: Strategic System Realignment



Description (Cont.)

Given the complexity of Manitoba's environment, a significant realignment is required to simplify the system and strengthen accountability for performance.

KPMG recommends this opportunity as a fundamental enabling condition of long-term system change.

This opportunity area will contribute direct savings through elimination of overlapping governance, leadership, management and delivery functions between all regions and healthcare delivery organizations in the Province.

More important however are the significant efficiency, agility and performance management gains that will be created through a realigned system as well as strengthened capacity of MHSAL to provide strong leadership and oversight to the entire provincial system.

A system realignment is a critical enabler of the Province's ability to realize savings in all opportunity areas identified in this review.

Actions for this opportunity area include:

- Development of a final recommendation for a sustainable health care system for Manitoba including the role of the Department, Regions and health care delivery organizations that incorporates tactical realignment opportunities that can be implemented on a near-term basis.
- Considerations to reduce the overall number of Health Care Delivery Organizations in the system.
- Specific recommendations on the alignment of CancerCare Manitoba, Addictions Foundation of Manitoba, Diagnostics Services Manitoba and eHealth Manitoba within the proposed system structure.
- Development of a high-level realignment road map to guide the transition from current environment to the future state.
- Recommendations about the best approach to activate the system realignment process with emphasis on enabling the Government to establish clear direction and activate the realignment roadmap over a three-year period.
- Recommendations about the governance, structure and resource requirements for a Transformation Management Office to be located within MHSAL to guide the realignment process with a combination of internal and external resources.

Area of Opportunity #1: Strategic System Realignment



Analysis & Observations

A process was developed to assess the impacts of realigning Manitoba's health system to each of the three reference models outlined in the following pages with the objective of improving overall system performance and sustainability:

- Potential actions required for realignment of the current Manitoba system have been identified by strategic lever:
 - People and organizational structure;
 - Process and delivery;
 - Information Technology;
 - Regulation and Policy;
 - Governance.
- Sensitive/strategic change opportunities are identified for each alternative.
- The potential impact of the organizational capacity of MHSAL, WRHA and Other Health System Entities is assessed for each alternative.
- The potential impact of each alternative is evaluated against the review criteria:
 - Alignment;
 - Economy;
 - Effectiveness;
 - Efficiency;
 - Implementation/transition risk;
 - Capacity and capability of the health system to execute and sustain the required changes.
- Key reflections about system structure and design going forward are provided in the next section for consideration at this stage in the process.

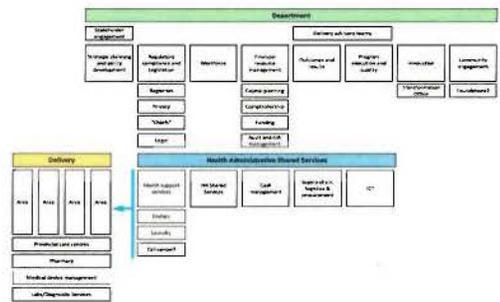
Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

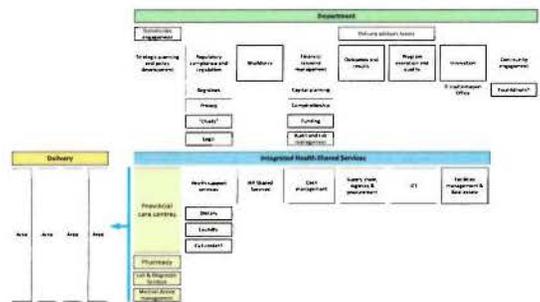
Three reference models have been developed to structure the analysis of reference jurisdictions and to assess the impact of potential changes to Manitoba's health system.

These models are based on the principles of high-performing health systems. Each model separates the role of the Department, Healthcare Delivery Organizations, and Shared Services Organizations as set out below.

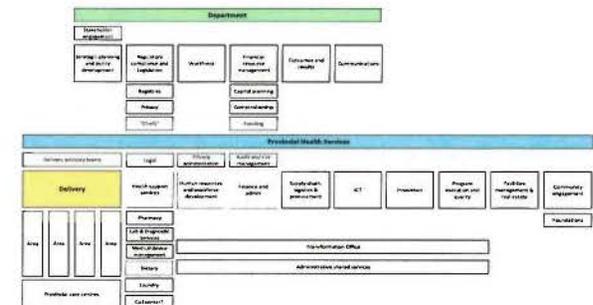
The models represent an increasing level of integration of healthcare delivery and alignment of governance.



Health Shared Services Organization



Integrated Health Services Organization



Provincial Health Services Organization

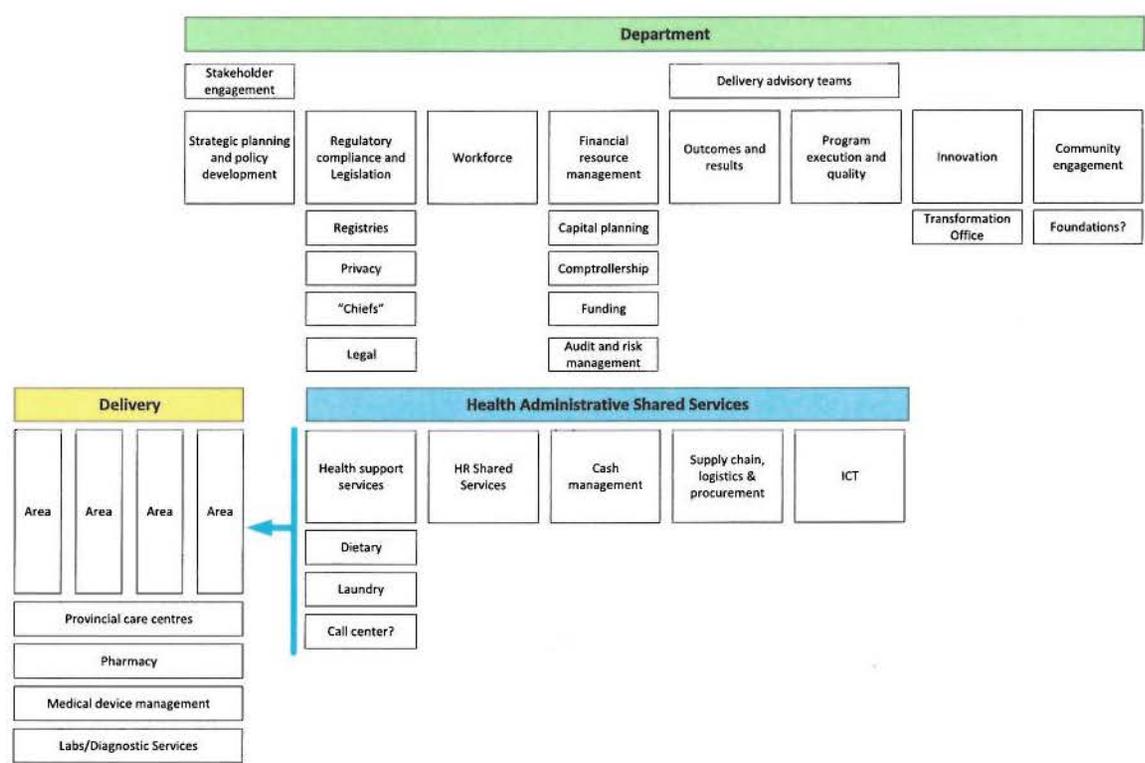


Area of Opportunity #1: Strategic System Realignment



Analysis & Observations (Cont.)

Reference Model: Health Administrative Shared Services



Key Design Principles

- Establish jurisdiction wide focus on planning, funding and performance.
- Focus healthcare delivery with area or specialty basis.
- Integrate common administrative services to achieve scale and capacity.

Role of Department

- Centralize critical policy, planning, workforce development, funding, compliance and outcomes management processes.
- Coordination of program execution and outcomes.
- Manage and monitor system performance through funding agreements.

Role of Delivery Organizations

- Execute service delivery mandate with independent governance and leadership.
- Retain local administrative services and transformation management capability.

Role of Shared Services Organization

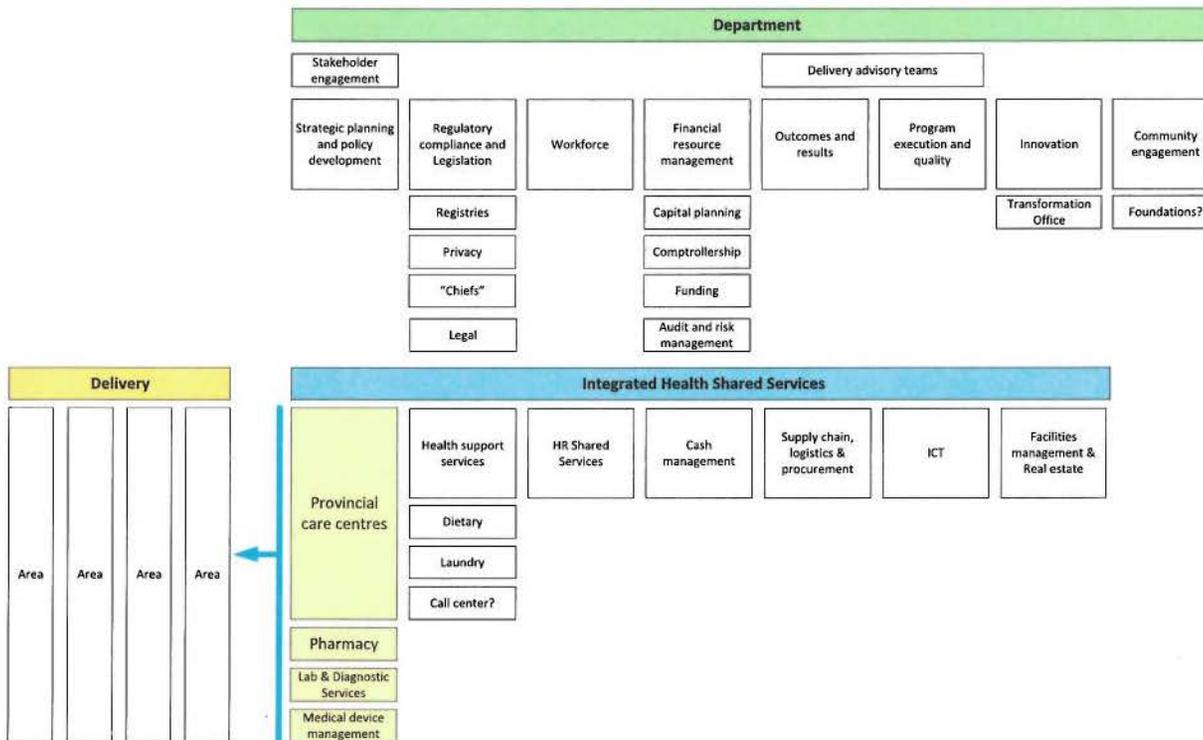
- Integrate and support delivery organizations as service provider.
- Managed with shared governance and SLA/KPIs.

Reference Jurisdictions:
Saskatchewan 3S, B.C. PHSA

Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

Reference Model: Integrated Health Shared Services



Key Design Principles

- Establish jurisdiction wide focus on planning, funding and performance.
- Focus healthcare delivery into areas.
- Integrate jurisdiction wide health delivery services to achieve scale and capacity.

Role of Department

- Centralize critical policy, planning, workforce development, funding, compliance and outcomes management processes.
- Coordination of program execution and outcomes.
- Manage and monitor system performance through funding agreements.

Role of Delivery Organizations

- Execute service delivery mandate with independent governance and leadership.
- Retain local administrative services and transformation management capability.

Role of Shared Services Organization

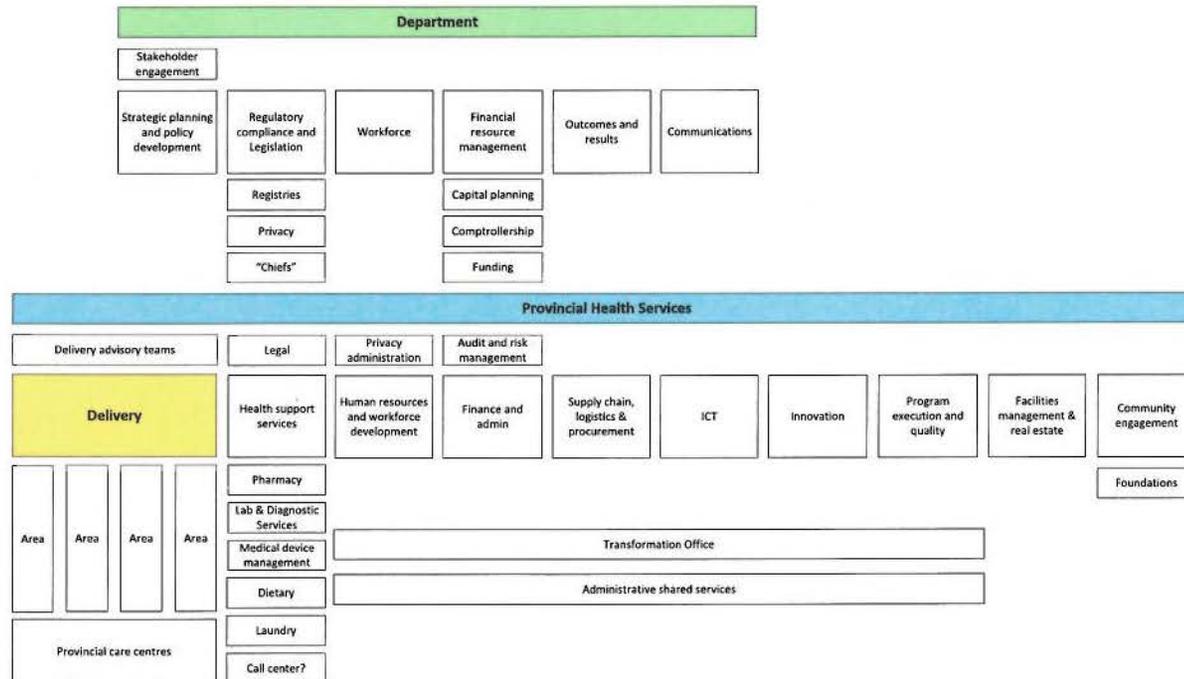
- Integrate and support delivery organizations as service provider.
- Consolidate and integrate whole jurisdiction services and provincial care programs/sites.
- Managed with shared governance and SLA/KPIs.

Reference Jurisdictions:
Thedacare

Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

Reference Model: Provincial Health Services Organization



Key Design Principles

- Establish jurisdictional focus on planning, funding, compliance and outcomes reporting.
- Establish corporate delivery organization with mandate to integrate all health, administration/support and transformation services at the jurisdictional level.
- Eliminate redundant and competing governance.

Role of Department

- Centralize critical policy, planning, workforce development, funding, and compliance and outcomes reporting processes.
- Manage and monitor system performance through funding agreements.

Role of Shared Services Organization

- Execute service delivery mandate with independent governance and leadership.
- Integrate all delivery, administrative services and transformation management processes.
- Consolidate and integrate all healthcare delivery programs.
- Consolidate all community engagement and foundation activities.
- Single integrated governance structure.

Reference jurisdictions:
 Northern Territory, Alberta Health Services, NHS England
 LHINs (Ontario), PHSA (B.C.)

Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

Based on the Current State assessment, the capability of Manitoba's health care system is in the early stages of operational maturity (see below). This is a significant factor to consider in realignment initiative.

Re-design of any system requires careful consideration to ensure that the implemented changes will actually achieve the intended outcomes. Lessons learned from other jurisdictions underscore the critical nature of this point with respect to health system change. Programs that do not plan for the development of capability and capacity in a structured way often achieve sub-optimal results.

Relative comparison of organizational maturity by lever



Criteria	MHSAL	WRHA	Other MB Health System Entities
People & Organizational Structure	Level 1 Initial 	Level 1 Initial 	Level 1 Initial 
Process & Delivery	Level 1 Initial 	Level 1 Initial 	Level 1 Initial 
Information Technology	Level 1 Initial 	Level 2 Managed 	Level 1 Initial 
Regulation & Policy	Level 1 Initial 	Level 1 Initial 	Level 1 Initial 
Governance	Level 1 Initial 	Level 1 Initial 	Level 2 Managed 
Overall Rating	Level 1 Initial 	Level 1 Initial 	Level 1 Initial 



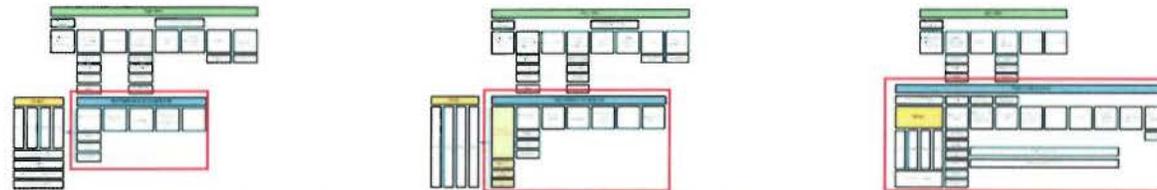
Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

The following chart shows the potential impact on the capability of the Manitoba healthcare system by aligning it to one of the leading practice models.

This analysis demonstrates that there could be significant performance gains associated with higher levels of integration. This has been the basis of decisions made by other jurisdictions like Saskatchewan or Alberta to pursue the integration of all healthcare delivery into a single health services organization.

Potential impact on overall health system organizational capacity by lever



Criteria	Health Administrative Shared Services			Integrated Health Shared Services			Provincial Health Services Organization		
People & Organizational Structure	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 4 Strategic
Process & Delivery	Level 1 Initial		Level 2 Managed	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 4 Strategic
Information Technology	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 4 Strategic
Regulation & Policy	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 4 Strategic
Governance	Level 1 Initial		Level 2 Managed	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 5 Optimized
Overall Change In System Capacity	Level 1 Initial		Level 2 Managed	Level 1 Initial		Level 3 Integrated	Level 1 Initial		Level 4 Strategic

Rating Scale:

- Level 5 Optimized**
Adaptive, opportunistic, synthesized, proactive, agile, continuously improving
- Level 4 Strategic**
Aligned, disciplined, predictable, quantitatively managed and controlled
- Level 3 Integrated**
Defined, structured, measured, competent
- Level 2 Managed**
Emerging, managed, standardized, isolated, repeatable
- Level 1 Initial**
Ad hoc, inconsistent, limited, reactive

Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

The following chart identifies the conceptual actions required to realign Manitoba's system to the respective reference models. Sensitive change opportunities are identified for each option in the final section of the table. The specific actions required to activate the recommended system design will be defined in Phase 2 of the HSIR.

Levers Of Change	Health Administrative Shared Services	Integrated Health Shared Services	Provincial Health Services Organization
 <p>People & Organizational Structure</p>	<ul style="list-style-type: none"> • Consolidate all policy, planning, funding and oversight functions at departmental level. • Standardize regional delivery for core services. • Consolidate jurisdiction level services into centers of excellence. • Streamline role of WRHA as a region. 	<ul style="list-style-type: none"> • Consolidate all policy, planning, funding and oversight functions at departmental level. • Standardize regional delivery for core services. • Consolidate jurisdiction wide services into integrated provincial organization. • Realign role of WRHA as a region. 	<ul style="list-style-type: none"> • Streamline all policy, planning, funding and oversight functions at departmental level. • Establish a single provincial integrated health delivery organization.
 <p>Process & Delivery</p>	<p>Replace site based delivery support for:</p> <ul style="list-style-type: none"> • Dietary; • Laundry; • ICT; • Supply Chain; • Transactional Human Resources shared services; • Transactional Financial shared services; • Health contact/call center. <p>Retain site/program delivery accountability:</p> <ul style="list-style-type: none"> • Management and administration; • Health program delivery; • Business transformation and change. 	<p>Replace site based delivery support for:</p> <ul style="list-style-type: none"> • All level one services; • Facilities management and real estate; • Provincial care centres; • Laboratory program; • Integrated diagnostics and laboratory services; • Medical device management. <p>Retain site/program delivery accountability:</p> <ul style="list-style-type: none"> • Management and administration; • Health program delivery; • Business transformation and change. 	<p>Replace site based delivery support for:</p> <ul style="list-style-type: none"> • All level one services; • All level two services; • Business transformation and change; • Management and administration. <p>Retain site/program delivery accountability:</p> <ul style="list-style-type: none"> • Health program delivery.

Area of Opportunity #1: Strategic System Realignment



Analysis & Observations (Cont.)

Levers Of Change	Health Administrative Shared Services	Integrated Health Shared Services	Provincial Health Services Organization
 <p>Information Technology</p>	<ul style="list-style-type: none"> • Consolidate all ICT delivery into single organization for all sites. • Shift to single integrated enterprise management and administration solution. • Eliminate local site ICT delivery role. • Consolidate eHealth and Information System Branch (ISB) functions. 	<ul style="list-style-type: none"> • Consolidate all ICT delivery into single organization for all sites. • Shift to single integrated enterprise management and administration solution. • Eliminate local site ICT delivery role. • Consolidate eHealth and ISB functions. • Opportunities to include advanced ICT functions like clinical engineering. 	<ul style="list-style-type: none"> • Consolidate all ICT delivery into single organization for all sites. • Shift to single integrated enterprise management and administration solution. • Eliminate local site ICT delivery role • Consolidate eHealth and ISB functions. • Opportunities to include advanced ICT functions like clinical engineering. • Establish single clinical/administrative analytics environment.
 <p>Regulation & Policy</p>	<ul style="list-style-type: none"> • Redefine role and focus of WRHA as healthcare delivery organization. • Realignment of region and site operating agreements. • Develop and implement service purchase agreements for shared services. • Restore all agency funding and oversight functions to MHSAL. 	<ul style="list-style-type: none"> • Redefine role and focus of WRHA as healthcare delivery organization. • Realignment of region and site operating agreements. • Develop and implement service purchase agreements for shared services. • Restore all agency funding and oversight functions to MHSAL. • Changes to legislation and acts for provincial care centres and jurisdiction wide services. 	<ul style="list-style-type: none"> • Legislation and regulations to establish provincial health services organization including changes to RHA and Hospitals Acts. • Develop and implement performance based funding framework agreement.



Area of Opportunity #1: Strategic System Realignment

Analysis & Observations (Cont.)

Levers Of Change	Health Administrative Shared Services	Integrated Health Shared Services	Provincial Health Services Organization
 <p>Governance</p>	<ul style="list-style-type: none"> • Consolidate performance optimization and transformation capabilities at the Provincial-level. • Consolidate all shared services management under a single board. • Retain/refocus RHA and provincial care centre boards and management teams. 	<ul style="list-style-type: none"> • Consolidate performance optimization and transformation capabilities at the Provincial-level. • Consolidate all shared services and provincial centre management under a single board. • Retain/refocus RHA boards and management teams. 	<ul style="list-style-type: none"> • Restructure MHSAL as policy, funding and oversight organization. • Consolidate all RHA and site boards into a single organizational structure. • Focus delivery organizations on integrated care program execution. • Redefine role of site governance on patient care, practice standards and delivery execution.
<p>Sensitive/Strategic Change Opportunities</p>	<ul style="list-style-type: none"> • Consolidation of HR and Finance transactional process teams into a single organization. • Extension of health support services to all regions. • Integration of ISB and eHealth into a single delivery organization. • Shift delivery related functions like Cadham Labs and Selkirk Mental Health Centre (SMHC) to appropriate delivery organization. • Repositioning CancerCare and Addictions Foundation of Manitoba. • Opportunities to leverage alternate delivery for: administrative shared services execution, Supply Chain Management (SCM). 	<ul style="list-style-type: none"> • Consolidate all health administrative shared services actions. • Consolidation of HSC, SBGH, CancerCare, AFM and DSM boards into governance under single delivery organization. • Incorporation of additional health support services with high delivery cost including things like medical devices, pharmacy and diagnostic services. • Opportunities to leverage alternate delivery for: diagnostic, lab, pharmacy, real estate. 	<ul style="list-style-type: none"> • Consolidate all health administrative shared services actions and integrate health shared services plus. • Consolidation of all RHA and site boards into a single delivery organization. • Integration of foundations and community outreach into an integrated program. • Opportunities to change configuration of facilities with emphasis on Winnipeg. • Potential rationalization of hospital sites. • Opportunities to leverage alternate delivery for: system transformation, Public Private Partnerships (P3), additional health delivery services.

Area of Opportunity #1: Strategic System Realignment

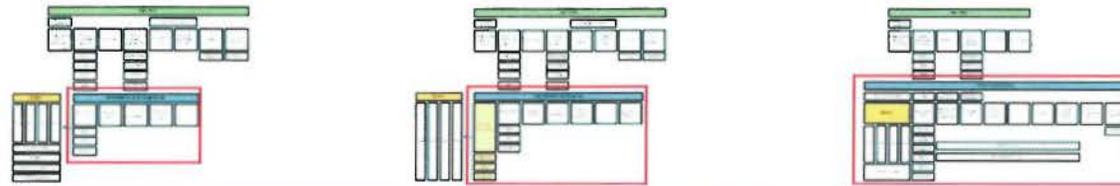
Analysis & Observations (Cont.)

The following chart assesses the impact of strategic system realignment against the HSIR criteria.

This analysis clearly shows that integration at the provincial scale may result in a better strategic result overtime that there are considerable risks associated with initiatives that move to this level of integration in a single step.

A made in Manitoba hybrid model is an option that balances improvement gains against Manitoba's capability and overall system realignment risk.

Potential improvement effect by sustainability review criteria



Criteria	Health Administrative Shared Services	Integrated Health Shared Services	Made in Manitoba Hybrid	Provincial Health Services Organization
Alignment			Made in Manitoba Hybrid to balance improvement gains against capability and implementation risk.	
Economy				
Efficiency				
Effectiveness				
Implementation/Transition on Risk				
Capacity and capability to execute				
Overall Rating				

Rating Scale: Strongly Positive (5) Moderately Positive (4) Neutral / Uncertain (3) Moderately Negative (2) Strongly Negative (1)

Area of Opportunity #1: Strategic System Realignment



Analysis & Observations (Cont.)

Based on this analysis, the following reflections on strategic realignment of Manitoba's health care system have been developed:

- Given the complexity of Manitoba's environment, a significant realignment is required to simplify the system and strengthen accountability for performance. This is a fundamental requirement and it should be considered an enabling action for all other opportunities identified in Phase 1. Not moving forward with system realignment will reduce the ability of the government to achieve gains in many areas and in some cases will reduce identified benefits to negligible levels.
- Efforts by the Department to initiate provincial level councils are a positive step. They have been effective at increasing communication and improving alignment between stakeholders. They have not been effective in achieving standardization or achieving consensus on sustainable resource allocation across the province. High-performing health systems have moved beyond consensus based decision making to professional management structures with clear accountability for system delivery and performance management.
- Realigning and refocusing MHSAL as a department is a fundamental first step. The capability of the department needs to be strengthened to provide effective leadership, direction and oversight to the system. The priority areas for consideration as part of this activity would include:
 - Strategic consolidation and alignment of all policy and planning functions combined with a rationalization of staff and accountabilities.
 - Move all departmental delivery functions into an alternate model or to a healthcare delivery organization.
 - Build capacity of the department to provide system-wide support to planning, commissioning, monitoring and compliance functions.
- The highest level potential for efficiency and economy measures can only be achieved with realignment of core departmental and WRHA functions. Overlap and duplication between the funding and commissioning roles of the WRHA and department contribute to a lack of clarity in the system. There will be a positive impact for all system participants by realignment in this area.
- The highest probability of success would involve refocusing the WRHA as a delivery region with similar accountabilities to other regions in the Province. Strategies to evolve the WRHA into a provincial level organization are possible but will face a significant level of opposition from stakeholders throughout the Province. Consideration needs to be given to the reality that the WRHA has the strongest capacity in many functional and administrative areas. Regardless, it is critical to address the inherent conflicts of the WRHA as both a service provider and health care delivery organization.
- There is strong system-wide understanding of the need for strategic change. There is recognition that this will mean fundamental realignment of services and may challenge organizational roles or functional responsibilities at the leadership level. Despite this realization, stakeholders universally expressed hope that the government would take the necessary steps to address known delivery issues and introduce a bold new vision for healthcare in Manitoba.

Area of Opportunity #1: Strategic System Realignment



Analysis & Observations (Cont.)

- [REDACTED]
- There is potential to realign the highest value system-wide functions into an integrated service delivery organization with emphasis on:
 - Health support services: Dietary, Laundry, Diagnostic Services, Call Center.
 - Administrative support services: Human Resources, Finance, Supply Chain, Capital Planning, Facilities Management and Real Estate, Communications, Legal.
 - ICT service delivery: Clinical, Administrative, Infrastructure, Medical Device Management, Clinical Engineering.
- Core clinical delivery planning and oversight require careful consideration. The *Provincial Clinical and Preventive Services Planning for Manitoba* report has clearly identified the fundamental requirement for a province wide clinical services plan in order to structure all service delivery. There are different configurations of program oversight and delivery that could be pursued within the Department or an integrated health service over time. Priority should be placed on evaluating opportunities to realign delivery for:
 - Tertiary healthcare facilities – Health Sciences Centre and St. Boniface General Hospital.
 - Programs at a Provincial level including services delivered by CancerCare Manitoba, Addictions Foundation of Manitoba and Diagnostics Services Manitoba.
- A strategically realigned system needs to consider the role of First Nations in the healthcare system. The current environment has not achieved good results for the Indigenous population. Consideration should be given to options that build a true sense of partnership in delivery leadership with Indigenous communities to improve trust and accountability. This would include consideration of opportunities to establish an Indigenous Health Care Authority through collaboration with First Nations communities and the Federal Government. This is an engagement and partnership strategy that is showing positive results around the globe in improving outcomes for First Nations communities and improving sustainability.
- Any successful system realignment program needs to recognize the limited transformational capability in all regions and healthcare delivery organizations in Manitoba. There are a wide range of resources available throughout the system that could be aligned to support this type of initiative, however, there is limited experience in successfully leading large change programs to completion. This perspective has been validated by many stakeholders throughout all parts of the healthcare system.

Area of Opportunity #1: Strategic System Realignment



Actions

- It is critical for the Government to reset expectations and operating parameters for all stakeholders that they operate in an integrated system with limited resources is necessary to achieve any meaningful sustainability and efficiency gains. To effectively action this area, the following areas require considerations:
 - Amend the RHA Act and other legislation together with all operating/service delivery agreements to remove inconsistencies and barriers to integration;
 - Change the Independent and Autonomous status for all Regions and Health Care Delivery Organizations;
 - Address the impacts of collective agreements and structure of healthcare delivery organizations as Employers;
 - Align and clarify the role of University of Manitoba Faculty of Health Sciences in healthcare delivery;
 - Align the role and scope of Community Foundations to support the overall healthcare system as a partner;
 - Alignment of CancerCare Manitoba, Addictions Foundation of Manitoba, Diagnostics Services Manitoba and eHealth Manitoba within the proposed system structure;
 - Clarify the role, function and scope of management for all Health Care Delivery Organizations throughout the system;
 - Reduction in the total number of Health Care Delivery Organizations throughout the system;
 - Simplify the role, function and number of boards required to oversee the system.
- Realigning and refocusing MHSAL as a department to provide effective leadership, direction and oversight to the system with an emphasis on:
 - Span of control to identify potential opportunities for improvement consistent with reviews for other government departments as part of the Fiscal Sustainability Review;
 - Strategic consolidation and alignment of all policy and planning functions combined with a rationalization of staff and accountabilities;
 - Move all departmental delivery functions into an alternate model or to a healthcare delivery organization;
 - Build capacity of the department to provide system-wide support to planning, commissioning, monitoring and compliance functions.

Area of Opportunity #1: Strategic System Realignment



Actions

- There should be clear direction to all stakeholders to shift accountability of all regions towards oversight and execution of healthcare delivery within defined performance based agreements and away from accountability as independent operating organizations.
- There should be consideration of an approach to provide for commissioning and contracting for delivery of provincial level services during the initial stage of system realignment.
- Establish and activate a Transformation Management Office with strong delivery leadership and support from resources with experience in healthcare system realignment and value realization.
- Establish a Strategic System Realignment governance team or leadership council with accountability for supporting the Phase 2 HSIR phase and overseeing the implementation of the strategic transformation program through to completion. The composition of this group should be focused to align the various interests across the system. To ensure effective leadership, this group should be no larger than 10-12 individuals. Recommendations on the focus, structure and alignment of this group will be provided in Phase 2.

Area of Opportunity #1: Strategic System Realignment



Benefits & Potential Financial Impacts

- Reduction and consolidation of RHAs and Health Care Delivery Organizations.
- Reduction and elimination of Boards with overlapping mandates that do not contribute value to healthcare system performance.
- Elimination of redundant leadership and management positions that do not contribute value to healthcare system performance.
- Realignment of MHSAL to provide stronger leadership, focus, direction and control functions across the healthcare system.
- Significant effectiveness and agility benefit across the entire healthcare system.
- Better integration of administrative, clinical and clinical support services for all programs across the system.
- Realignment of focus for Health Care Delivery Organization governance on service delivery, patient care and service standards.
- Rationalization of capabilities between MHSAL and WRHA and associated rationalization of staff and accountabilities.

Timeframe: Short and medium-term

- **2017/18: \$3M+**
- **2018/19 and beyond: \$5M+**
- **Total: \$8M+**

Area of Opportunity #1: Strategic System Realignment



Sub-Area	Potential Technical Efficiency Savings (\$M)		Potential Allocative Efficiency Savings (\$M)	
	2017/2018	2018/2019 and Beyond	2017/2018	2018/2019 and Beyond
Performance Management and Compliance	-	-	\$0.5M	\$0.7
System Policy and Planning	\$2M	-	\$0.7M	\$5M
TOTAL: \$8M+	\$2M	-	\$1M+	\$5M+

Key Evaluation

Potential Cost Saving Criteria (Effectiveness/ Economy/ Efficiency)

M

- Direct cost savings will be based on final system design recommendation and rationalization of staff and associated salaries and benefits.
- Strategic level effectiveness gains.

Effort to Implement Criteria (Alignment/ Risk)

H

- Clear alignment to HSIR review capability.
- Fundamental enabler to realization of all other system improvement opportunities.
- High-level organizational change and transformation management.
- Requires significant Transformation Management Office capability through phased implementation program.



Area of Opportunity #4: Core Clinical & Healthcare Services

Description

Core Clinical and Healthcare Services refers to the reconfiguration of the healthcare delivery model to improve effectiveness of core service delivery and shift the model of care away from acute care centered facilities to community- and population-based care.

- Until now, there is no master plan or provincial clinical services plan that outlines where and how services are delivered to reduce overlap and duplication and improve clinical outcomes (e.g., through the creation of Centres of Excellence), while recognizing the recent completion of *Provincial Clinical and Preventive Services Planning – Doing Things Differently and Better*. This has resulted in:
 - Incremental design and development of the healthcare system and a complex, siloed delivery environment, including:
 - Inconsistent clinical standards, practices and levels of care between regions, sites and programs.
 - Different standards of integration, creating confusion and contributing to higher costs of delivery and administration.
 - Competition between different programs and sites, further complicated by the WRHA matrix model.
 - Specialized programs, such as transplant, renal and cardiac, providing care that is provincial in scope without a formal mandate or resourcing.
 - A lack of provincial repatriation agreements or provincial bed registries.



Area of Opportunity #4: Core Clinical & Healthcare Services

Description (Cont.)

The overall system is structured based on acute care delivery and provider-centered care models.

Globally, there is a significant shift in the delivery of healthcare through hub and spoke models of care. These models typically refer to a structure including primary, secondary and tertiary care settings, in which larger centers like hospitals act as hubs connecting to local care in the community. In this way, patients receive more convenient care in a local setting instead of within a hospital. Hub and spoke models have become a very effective method of organizing primary, secondary and tertiary care to generate benefits both for the patient and healthcare system. In addition to reducing costs, increasing access and improving quality, the hub and spoke model is an important and necessary consideration in creating a fully-integrated and patient-centered healthcare system.

Manitoba's health system is based on an acute care model, which is costly and does not meet the needs of its diverse, geographically disparate population:

- Acute, community, and human services are not well-integrated. There are not sufficient programs or processes in place, such as coordinated discharge planning, to prevent acute care re-admissions.
- There are no alternate delivery models that emphasize community or preventative care or strategies to pursue integrated delivery with alternate cost structures. There are limited promising practices in place, such as community paramedic programs, that have not been expanded beyond their current scope.
- There is no integrated primary care strategy aligned with population needs (e.g., chronic disease management, Indigenous health). While there are several primary care programs and models (e.g., QuickCare Clinics, ACCESS Centres), the specific mandate and expected outcomes are not well-defined. The impacts of these programs have not been measured sufficiently to understand their impacts on population health indicators. The numerous types of primary care clinics in close proximity is confusing to patients and causes inconsistency in the continuum of care.
- Technology has not been leveraged to provide community-based care, such as remote home monitoring.
- There is the potential to expand transitional care and supportive living options in Manitoba, which would reduce Alternate Level of Care beds and provide sustainable alternatives to Personal Care Homes (PCHs).



Area of Opportunity #4: Core Clinical & Healthcare Services

Description (Cont.)

- Canadian Triage and Acuity Scale (CTAS) is used in all hospitals in Manitoba and across Canada for all incoming patients. The system categorizes patients by both injury and physiological findings, and ranks them by severity from 1–5 (1 being highest). The model is used by both paramedics and ED physicians and nurses, and also for pre-arrival notifications in some cases. The model provides a common frame of reference for physicians, nurses and paramedics. It also provides a method for benchmarking given its application across all provinces in Canada. CTAS Levels:
 - Level 1: Resuscitation;
 - Level 2: Emergent;
 - Level 3: Urgent;
 - Level 4: Less Urgent;
 - Level 5: Non Urgent.
- Clinical staff are not working to full scope of practice, and clinical teams are not optimized to support patient- and population needs in an efficient and effective way.
 - There are no staffing guidelines to outline optimal skill mix (e.g. RN/LPN/allied health provider), staff rotations, or nurse/patient ratios.
 - In general, the composition of care teams do not leverage each discipline in the most effective way. Although there are pockets of interdisciplinary collaboration, clinical teams are typically physician-centric.
 - Primary care models do not provide incentives or resources for providers to deliver after-hours care, which could be used divert CTAS 4/5s from ER or improve access to primary care.
 - Collective agreements impact how staff are utilized most effectively across the system.
- The WRHA Matrix has not been resolved to provide a model for clear delivery or healthcare, including:
 - Role of sites;
 - Role of programs;
 - Role of administrative support services and corporate functions;
 - Matrix and clinical program integration create/result in patient flow issues and missed service delivery targets/increase wait times.



Area of Opportunity #4: Core Clinical & Healthcare Services

Methodology

We compared health service use and cost in Manitoba and Ontario as agreed by the Advisory Committee. Our approach included selecting appropriate peer regions and hospitals. We also matched Manitoba regions and providers to similar ones in Ontario on the basis of the factors shown below:

Population Adjustments

Region Type:

- Urban, Rural, Remoteness and Population Density;
- Proportion Aboriginal, Immigrants and Employed;
- Income Quintile with Cost of Living Adjustment.

Provider Adjustments

- Teaching, Large Community, and Medium/Small Community Facilities;
- Tertiary;
- Region Type;
- Case mix.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations

- Staffing calculations (in terms of the numbers per role and grades) do not reflect current models of care. As a result, staff mix (LPNs, RNs, allied health, physicians) may not be optimized to reflect patient need and achieve desired outcomes across the continuum.
- There are no staffing guidelines for all services to support how professionals are allocated to different care settings. There are staffing guidelines in Long Term Care, however, these should be reviewed to ensure clinical staff are enabled to work at full scope of practice.
- Alignment of planning, core service delivery and clinical delivery programs is required to improve effectiveness and resource utilization. However, health leaders expressed concern about further centralization due to a bias to local delivery and/or because of their experience with poor centralized execution.
- WRHA is delivering programs across the province without formal scope, mandate, or funding, such as transplant and cardiac services; this has caused tension in other RHAs. Formalizing provincial services would reduce fragmentation and improve continuity of care across Manitoba.
- WRHA's matrix structure does not provide a clear delivery model for its corporate functions, sites, or programs, which directly impacts site capacity, flow, and service delivery targets (e.g., wait times). For example, WRHA surgical services were noted to have widely varying capacity (35% at one site), indicating opportunity to evaluate the feasibility of consolidation.
- Integration of programs and services was a noted challenge across programs and sites in the WRHA. This lack of integration is a barrier to patient navigation to the appropriate provider and facility, which may place unnecessary burden on other parts of the system (e.g., ambulatory-sensitive conditions in ED).
- Rural and remote providers, patients, families and caregivers identified challenges associated a lack of resources and services, which could be improved through technology (e.g., Telehealth) and flexible resourcing.
- Providers are not incentivized to provide care in the community.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

- System performance gains cannot be achieved without provincial organizational reform to address fragmented capacity.
- There are six EDs in Winnipeg despite feedback that certain centres are operating below capacity.
- Opportunities to integrate health and social care, such as building on successes with Early Intervention, were identified as critical to supporting population health.
- There is no standard approach to quality improvement.
- Efforts to standardize services in the WRHA are impacted by the matrix structure.
- There are policy gaps with respect to the services that First Nations patients are able to access closer to home.
- Technology differs across regions and sites, challenging continuity of care and service integration. Telehealth, for example, has not been uniformly integrated across health regions. Although infrastructure is available in most sites consulted, there is opportunity to increase usage to reduce patient transport costs, provide specialized services (e.g., mental health supports) to remote areas, or to provide continuity of care when patients are transferred from Winnipeg to another region.
- There is a lack of alignment on a coordinated strategy to realize information management solutions between parts of the organization, which has led to fragmentation and a number of ICT solutions across the province.
- There is no provincial Electronic Health Record (EHR) or solution that integrates existing records, although a common EHR would alleviate current challenges with consistent patient information, safety, and flow across the continuum.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

- The roles of RHAs and hospitals are not aligned.
- Compliance requirements associated with PHIA legislation add complexity and cost to all processes that most stakeholders do not believe materially increase information security or privacy.
- The role and mandate of MHSAL is not clearly defined within the overall health system. This has led in the past, based on the stakeholder engagement undertaken, to the involvement of MHSAL and elected officials in decisions related to day-to-day service delivery resulting in management staff being distracted from their operational and strategic roles.
- Community foundations impact scope of service delivery and operate outside of control of the region or health system.
- WRHA is not structured to operate as an integrated region, due to:
 - Autonomous nature of sites and programs;
 - Multiple boards and governance not connected to WRHA Board in an integrated manner;
 - Overlap, redundancy and duplication in executive and management teams;
 - Unclear accountability or responsibility.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

ED Visits:

We examined use of ED care on a standardized per capita basis in each RHA to similar regions in Ontario. Main findings include:

1. [Redacted]
2. [Redacted]
3. WRHA had 14% fewer visits than expected at the peer region age standardized rate and therefore likely has few opportunities to substantially reduce ED use.
4. [Redacted]

RHA	Annual ED Visits	Expected ED Visits	Potentially Avoidable ED Visits	Potential Cost Improvement	QuickCare Visits	Access Centres Visits
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
WRHA	266,640	309,428	0	\$0M	63,265	28,867
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Acute Inpatient Admission Rates:

We examined inpatient admission rates for acute inpatient care by hospital and RHA by making use of the detailed patient demographic, geographic, and clinical data captured in the Discharge Abstract Database. We compared admission rates by RHA to similar regions in Ontario. Main findings from this analysis include:

- 1. WRHA has low acute care admission rates relative to the size and age of its population and therefore does not likely have opportunities to substantially reduce admission rates.
- 2. [Redacted]
- 3. [Redacted]

RHA	Hospital	Annual Admissions	Expected Admissions	Potentially Avoidable Admissions	Potential Cost Improvement
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Acute Inpatient Lengths of Stay:

We benchmarked lengths of stay in Manitoba hospitals to Ontario peer hospitals, adjusting for differences in case mix using the CMG+ system.

Main findings include:

1. Lengths of stay in Manitoba are typically substantially longer than the average of their Ontario peers.
2. [REDACTED]
3. Improving lengths of stay represents a substantial opportunity to make better use of Manitoba's health resources. For example, Manitoba would be able to meet the acute bed needs of roughly 8 years of population growth and aging.

RHA	Hospital	Annual Admissions	Average Length of Stay		[REDACTED]			
			Actual	Expected	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Interlake-Eastern RHA	Selkirk & District General Hospital	1,801	7.4	5.0	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Northern Health Region	Flin Flon General Hospital	909	4.9	4.6	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	The Pas Health Complex	1,505	4.1	4.1	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Thompson General Hospital	3,520	4.3	3.4	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Prairie Mountain Health	Brandon General Hospital	8,187	6.8	4.4	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Dauphin General Hospital	2,250	6.0	5.1	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Southern Health-Santé Sud	Bethesda Regional Health Centre	2,488	5.0	3.5	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Boundary Trails Health Centre	4,317	4.3	3.4	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Portage Hospital	2,180	7.5	4.1	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
WRHA	Concordia Hospital	3,781	9.6	6.8	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Grace Hospital	4,918	9.2	6.2	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Health Sciences Centre	27,202	5.6	4.5	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Seven Oaks General Hospital	3,555	11.4	6.9	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	St. Boniface General Hospital	23,331	4.9	4.6	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Victoria General Hospital	3,972	10.1	6.9	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Total		93,916	6.2	4.8	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Day Surgery Substitution for Inpatient Surgery:

We examined the propensity for Manitoba hospitals to favour day surgery over inpatient surgery by comparing day surgery use at Manitoba hospitals with that at Ontario peer hospitals. Main findings include:

1. Manitoba hospitals typically make good use of day surgery to avoid inpatient admissions.
2. St. Boniface General, Victoria General, [REDACTED] may have material opportunities to make better use of day surgery to avoid inpatient admissions.

Potential Cost Improvement	Hospital	Total IP and DS Surgical Procedures	Day Surgery Procedures	Expected DS Procedures at Peer Average	Potentially Avoidable Surgical Admissions	Potential Cost Saving Improvement
Interlake-Eastern RHA	Selkirk & District General Hospital	1,338	1,284			\$
	Flin Flon General Hospital	382	347			\$
Northern Health Region	Thompson General Hospital	699	625			\$
	The Pas Health Complex	170	130			\$
Prairie Mountain Health	Brandon General Hospital	6,427	5,918			\$
	Dauphin General Hospital	1,165	851			\$
Southern Health-Santé Sud	Bethesda Regional Health Centre	758	613			\$
	Boundary Trails Health Centre	1,788	1,661			\$
	Portage Hospital	1,082	861			\$
WRHA	Concordia Hospital	2,436	2,012	2,147	135	\$ 90K
	Grace Hospital	3,987	3,724	3,622	-102	\$ -
	Health Sciences Centre	13,723	11,758	11,449	-309	\$ -
	Seven Oaks General Hospital	4,752	4,129	4,382	253	\$ 190K
	St. Boniface General Hospital	8,695	6,725	7,240	515	\$ 530K
	Victoria General Hospital	7,350	6,110	6,481	371	\$ 249K
Total		54,752	46,748			\$



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Making better use of Home Care Resources: the Method for Assigning Priority Levels (MAPLe) is assigned to all WRHA and all Ontario home care clients. Each client is assigned a MAPLe level, based on their risk for personal care home admission.

The table below compares the MAPLe distribution in Ontario and WRHA.

MAPLe Level	WRHA	Ontario
1. Low and 2. Mild	34%	12%
3. Moderate	30%	34%
4. High and 5. Very High	37%	54%

1. Almost 90% of Ontario clients are in the Moderate to Very High levels, compared to 70% in WRHA. More importantly, the high risk groups are 54% of Ontario clients, compared to only 37% in Manitoba.
2. These results suggest that, as is now done in Ontario, home care services in Manitoba could focus more on higher risk clients, and diverting lower risk clients to community support services.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Making better use of Home Care Resources: RUG are used in Canada and jurisdictions worldwide to measure the resource needs for home care clients and to fund home care providers. Clients are assigned to one of 24 RUG based on medical, functional and cognitive characteristics. Expected home care costs per client in the highest level RUG is fifteen times that of the lowest level RUG.

We assigned each RUG to one of four levels based on expected cost per client and compared the client distribution between Manitoba and Ontario.

RUG Level	WRHA	Ontario
Low	32%	17%
Medium	37%	32%
High	31%	52%

1. In Ontario, 52% of clients are in high acuity home care levels, compared to only 31% in Manitoba.
2. Ontario focuses its spending on higher need home care clients, which suggests that lower need Manitoba clients could be cared for with relatively more community support and relatively less home care services.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Making better use of Home Care Resources: Ontario Community Care Access Centres have introduced new client care models that focus on clients with substantial limitations in performing activities of daily living. The ADL score is often used in the case management decision. Clients with low ADL scores are diverted to community support services, clients with moderate RAI scores are often waitlisted or diverted to other community services, and those with higher ADL scores are prioritized for home care services.

We assigned each WRHA client an ADL level, and compared the distribution with Ontario.

ADL Level	WRHA	Ontario
1	65%	41%
2	24%	31%
3	9%	19%
4	2%	8%

1. Consistent with the lens provided by the MAPLe and RUG analysis, Manitoba clients are less likely than Ontario clients to be highly dependent on support with activities of daily living; 27% of Ontario clients are highly dependent compared with 11% in Manitoba.

Use of Personal Care Home Beds and potential for substitution with Home Care: Overall, Manitoba provides more home care services per capita than Ontario, and it is likely, based on these analyses, that Manitoba could increase allocative efficiency by using home care services for the highest need, highest institutionalization risk clients, and diverting other clients to community support services.

Over time, this strategy would increase the share of clients in higher MAPLe and RUG levels, reduce the proportion of lower care people in personal care homes, reduce hospital days, and allow Manitoba to reduce pressure on personal care home and hospital beds in the future.

Next, we combine these results with the spending analysis to quantify the allocative efficiency improvements.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Consolidating Proximal Small Rural EDs:

We examined the potential to improve resource use by consolidating proximal small rural EDs. Main findings include:

1. There are two potential sources of savings from consolidating EDs: a) economies of scale in costs per visit; b) reduction in the fixed costs by consolidating departments.
2. Our analysis of unit costs at Manitoba's small rural EDs found no strong evidence for economies of scale in unit costs. Put differently, cost per ED visit did not decrease with ED total visits among small Manitoba EDs.
3. Our analysis found that fixed cost savings from consolidations are likely negligible compared to those associated with the potential to reduce unit costs.

Summary of ED Cost Improvement Opportunities

1. The results of all our ED analysis imply the following prioritization: 1) improve ED unit costs; 2) reduce ED visits in Southern RHA; 3) after the first two priorities have been achieved, consider consolidating proximal small rural EDs.

Cost Improvement Opportunity	Approach	Potential Cost Improvement
Reduce ED visits	Compare standardized ED visit rates across peer regions	\$ 5M
Cost per visit efficiency	Benchmark unit costs	\$ 24M
Merging small proximal EDs	Estimate economies of scale and fixed cost improvements	\$ less than 1M



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Consolidating larger EDs, ORs and Diagnostic Imaging: Current Manitoba experience demonstrates limited evidence for economy of scale in the Emergency Room, Operating Room and Diagnostic imaging unit costs in the short-term.

	Potential Savings From Reducing Volumes	Unit Cost Savings	Savings From Economies Of Scale (Short-term)	Potential Service Disruption (Short-term)
Emergency Room	\$ 5M	\$ 24M	Low	High
Operating Room	\$ -	\$ 27M	Low	High
Diagnostic Imaging	\$ 19M	\$ 17M	Low	High

1. Our benchmarking analysis found substantial cost improvement opportunities from reducing costs of these services as currently organized.
2. We also found the potential for cost improvement by reducing use of Emergency Room and Diagnostic Imaging.
3. Given these findings and the potential for disruptions in the short-term from consolidations without extensive clinical engagement and a required whole system reconfiguration approach, the case to support consolidation is weak from a short-term cost improvement perspective.
4. Consolidation should be considered in the context of medium to longer-term sustainability in the context of a strategic configuration of services underpinned by the provincial clinical services plan as set out in Area of Opportunity #10: Infrastructure Rationalization.



Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

The financial benchmarking method has four steps:

1. For each Manitoba hospital, establish a set of peer hospitals based on similarity in size, teaching mission, tertiary services, and region type.
2. For each peer group, establish a benchmark that is both aspirational and achievable.
3. Measure the difference between each hospital's performance and the benchmark.
4. Estimate cost improvements at 25% to 50% of the difference.

Since 40% of Ontario peer hospitals meet the benchmark and Ontario hospitals typically have lower nurse to patient ratios than Manitoba, we feel that the Ontario 40th percentile is both achievable and aspirational.

Since we recognize that the benchmark may be achievable only in the longer term, we estimated cost improvements between 25% and 50% of the difference between each hospital's performance and the benchmark. Our analysis included accounting for nursing overtime and agency costs.

Nurse Hours per Patient Activity [REDACTED]

We compared the hours per patient day, visit and surgical case in each department, hospital and RHA to the 40th percentile of Ontario peers.

Medical Inpatient, Surgical Inpatient, ICU, Pediatric and Obstetrics departments:

1. Nurse hours per patient day are higher than Ontario peers 40th percentile across all Manitoba hospitals.
2. Teaching hospitals nursing hours per patient day are 42% to 55% higher than to Ontario peers, translating into potential cost improvement opportunity of \$28M.
3. [REDACTED]
4. [REDACTED]
5. Manitoba hospitals have a lower occupancy rate in general compared to Ontario hospitals, particularly hospitals in the Northern Health Region. Lower occupancy rates result in standby capacity and increased labour hours per patient day.
6. [REDACTED]



Area of Opportunity #4: Core Clinical & Healthcare Services

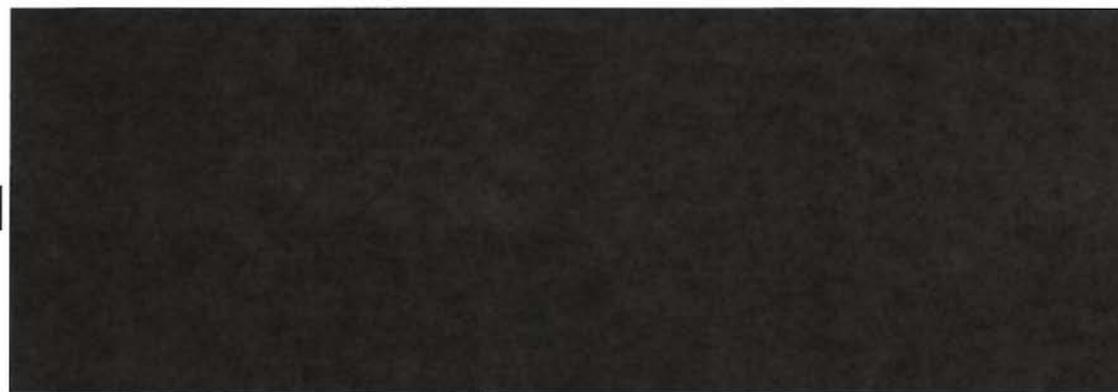
Analysis & Observations (Cont.)

Nursing Hours per ED Visit:

1. Nursing hours per ER visit is more than double that of Ontario peers (3.6 hours per visits compared to 1.5 hours per visit on average) in most hospitals in Manitoba.
2. Reductions in nursing hours per ED visit to Ontario peer 40th percentile could generate up to \$21M in potential cost improvement across the province.

Nursing Hours - Operating Room:

1. Operating room nursing hours per surgical case is on average 30-120% higher than the 40th percentile of Ontario peers for most hospitals.
2. Reductions in nursing hours per surgical case to Ontario peer 40th percentile could generate up to \$12M in cost improvement across the province.





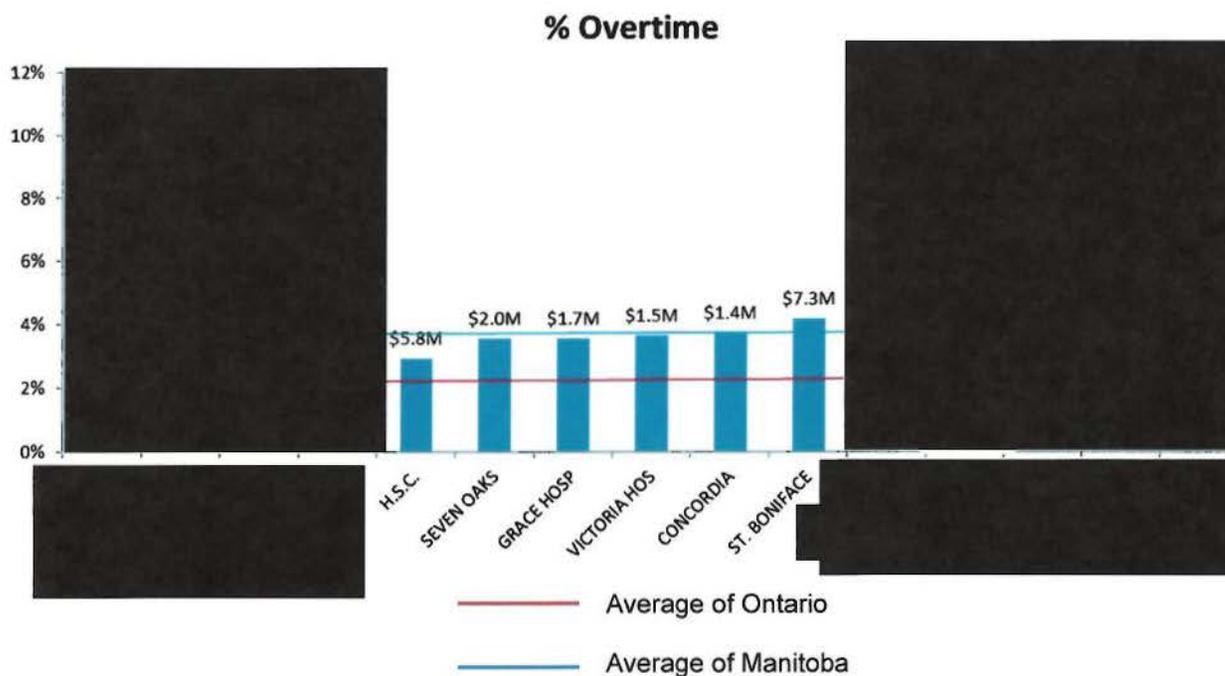
Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Overtime (\$14M cost improvement opportunity)

We compared the percentage overtime in Manitoba relative to Ontario peers and found a significant opportunity.

1. The average percentage overtime in Manitoba hospitals is 3.6% compared to 1.6% in Ontario.
2. Overtime as a percentage of labour expenses are higher than Ontario average in 12 of the 15 hospitals examined.
3. At Ontario average 1.6% overtime, of Manitoba's hospitals could reduce their overtime premium expenses by \$14M.





Area of Opportunity #4: Core Clinical & Healthcare Services

Analysis & Observations (Cont.)

Therapeutic Services (\$4M cost improvement opportunity)

We compared the cost of an therapy attendance day (unit cost) and the number of therapy attendance days per patient day or visit (utilization) for each therapy department across Manitoba hospital and Ontario peer hospitals.

1. Cost improvement opportunities were found in Physiotherapy and Occupational Therapy.
2. High use of physiotherapy in outpatient clinics relative to Ontario peers translates into a \$2M cost improvement opportunity.
3. A higher cost per attendance day in Occupational Therapy relative to Ontario peers translates into a \$1.5M cost improvement opportunity.

Therapeutic Services Cost Improvement Opportunities

RHA	Physiotherapy	Occupational Therapy	Respiratory Therapy
WRHA	\$ 2.0M	\$ 1.4M	\$ 0.5M



Area of Opportunity #4: Core Clinical & Healthcare Services

Actions

The *Provincial Clinical and Preventive Services Planning for Manitoba* report is recognized as a key dependency to transforming core clinical and healthcare services. It is anticipated that a provincial service plan will have a significant impact on drug wastage, capital costs, infrastructure to meet quality and safety standards (e.g., MDRD, systemic chemotherapy) following the recent completion of the report mentioned.

Possible actions to address core clinical and healthcare services were identified by stakeholders and based on leading practice:

- Reduce unit costs/rates, including but not limited to the following services:
 - Nursing services.
- Shift care from acute to community settings, including but not limited to:
 - Reduce acute hospital admissions and lengths of stay;
 - Shift laboratory testing and diagnostics to the community;
 - Adopt remote monitoring;
 - Improve discharge planning and integration with community-based services;
 - Reduce ED visits for CTAS 4/5 patients.



Area of Opportunity #4: Core Clinical & Healthcare Services

Actions

- Rationalize and standardize programs and services, including but not limited to:
 - Realign the WRHA clinical matrix;
 - Revise the WRHA bed map;
 - Standardize medical and surgical supplies.
- Rationalize staffing, scope of practice, and scheduling, including but not limited to:
 - Reduce nurse to patient ratios, where safe/appropriate;
 - Adopt full scope of practice;
 - Increase service expectations for primary care providers;
 - Reduce overtime hours and premiums by reviewing and modifying staff attendance and scheduling, where appropriate;
 - Increase substitution of ambulatory for inpatient surgery;
 - Adjust nursing rotations;
 - Rationalize interdisciplinary teams;
 - Cohort like patients to ensure nurse to patient ratios are matched with patient resource intensity;
 - Close beds and/or change staffing model during holidays and slow times;
 - Implement cross training to enable integrated staffing nursing between obstetrics, nursery and pediatrics;
 - Implement cross training to enable integrated staffing between day surgery and post-surgical recovery.



Area of Opportunity #4: Core Clinical & Healthcare Services

Benefits & Potential Financial Impacts

- The benefits realized from core clinical and healthcare services require medium-term transformation and include:
 - Improved integration of healthcare services across the continuum;
 - Improved patient flow;
 - Improved staff utilization and reduction in overtime costs;
 - Access to primary care services;
 - Redistribution of services to the most appropriate setting, including the provision of care closer to home;
 - Reduction in costs.

Timeframes: medium-term

- **2017/2018: \$7M+**
- **2018/2019 and beyond: \$134M+**
- **Total: \$141M+**



Area of Opportunity #4: Core Clinical & Healthcare Services

Sub-Area	Potential Technical Efficiency Savings (\$M)		Potential Allocative Efficiency Savings (\$M)		Totals
	2017/2018	2018/2019 and Beyond	2017/2018	2018/2019 and Beyond	
Rationalize and Standardize Programs and Services	\$ 6M	\$ 1M	\$ -	\$ 0.7M	\$ 7.7M
Rationalize Staffing, Scope Of Practice, and Scheduling	\$ 0.25M	\$ 53M	\$ -	\$ 10M	\$ 63.25M
Reduce Unit Costs/Rates	\$ -	\$ 3M	\$ 0.7M	\$ -	\$ 3.7M
Shift Care from Acute/Institutional to Community Settings	\$ -	\$ 11M	\$ -	\$ 55M	\$ 66M
Totals	\$ 6.25M+	\$ 68M+	\$ 0.7M+	\$ 66M+	\$ 141M+

Key Evaluation

Potential Cost Saving Criteria

(Effectiveness/ Economy/ Efficiency)



- Core clinical and healthcare services represent the area of opportunity with the highest cost-savings, with significant benefits of efficiency and effectiveness of healthcare services.

Effort to Implement Criteria

(Alignment/ Risk)



- This opportunity represents a fundamental shift in how care is delivered and how providers are utilized across the system.



Area of Opportunity #6: Health Workforce

Analysis and observations

- Manitoba's workforce is managed in one of the most complex environments for a jurisdiction of its size. The environment includes 50 legal entities with formal employer status in addition to employees of the Provincial government and other related health care entities. These employers do not have consistent employment policies and practices. Across these entities there are 169 collective agreements covering nursing, allied health and clinical support staff and separate negotiated agreements with physicians and other professional health care providers. This reality impacts every aspect of service delivery and inconsistencies between the standards in these practices and agreements are one of the largest contributors to cost in the healthcare system.
- The complexity of ~169 collective agreements is a barrier to the effective use and mobility of healthcare workers and restricts the ability to operate as an integrated system. Approximately 113 of these collective agreements in the WRHA.
- The complexity introduced by the administration of these agreements impacts management and supervisory capacity, costs of payroll and benefit administration and service delivery initiatives from clinical programs through to ICT delivery. There were examples of instances where nursing staff could not provide coverage in other parts of the same facility or within programs in Winnipeg due to the nature of collective agreements; impacts to patients included delayed/cancelled procedures (e.g. in cardiac catheterization labs) or longer wait times.
- There does not appear to be a physician engagement strategy which is viewed as an enabler to system-wide change. This is critical to effect changes to system performance indicators or targets.
- In general, there is a perception that regulatory colleges are not engaged by MHSAL in the most optimal manner, with some Colleges providing more advice and insight than others.
- Incentivizing healthcare providers to work in rural or remote settings is an ongoing issue, similar to other remote areas of Canada. Although some flexible healthcare resourcing models have been adopted, professionals may be reluctant to work at rural sites without adequate work experience, access to mentors, and equipment and supports that facilitate safe patient care.
- Any future efforts for provincial clinical planning should include a strategic recruitment and workforce component.
- All health care delivery organizations including long term care facilities and community health agencies universally identified the challenges created by this labour environment with respect to standardizing care and providing better service integration for patients.



Area of Opportunity #6: Health Workforce

Analysis and observations

- All health care delivery organizations including long term care facilities and community health agencies universally identified the challenges created by this labour environment with respect to standardizing care and providing better service integration for patients.
- Other jurisdictions, such of Alberta and Saskatchewan have substantially reduced the number of employers in their system by consolidating regions and health delivery organizations. This has been supported with a strategic rationalization of collective agreements across their healthcare system with the aim of simplifying and integrating the system.
- Manitoba health care organizations have typically not been supported to adjust rotations and positions within the provisions of existing collective agreements to reduce the reliance on part time positions some times with capacity as low as 0.2 or 0.3 FTE levels. Adjusting rotations (in part to create a higher FTE role) under most agreements requires staff to be laid off and rehired into the new rotation. Because of this practice, many organizations have a large number of “unfunded positions” that they would like to introduce while at the same time part time resources are engaged to support work requirements at overtime cost levels. There would be a significant benefit to the system of supporting health care delivery organizations with making necessary adjustments to staff rotations.
- Labour representatives consulted as part of HSIR Phase I indicated that they have consistently advanced this alternative to the previous government but the concept was rejected because it would contribute to growth in the overall FTE count of the public service. They suggested that while this would reduce the overall number of roles under agreements that they traditionally have had mandates to increase full time employment positions. Most management stakeholders agreed that this was a necessary change for the system but noted that employees have taken advantage of the environment for a long time and that there will be some significant resistance to this change in some parts of the system.
- All stakeholders identified potential for a review of scope of practice for all health care system providers in coordination with the clinical services plan. They identified many areas where physician assistants, nurse practitioners or allied health care professionals could provide equivalent services to the system at a reduced cost compared to medical resources. Some stakeholders identified resistance from Nursing and Physician colleges as a barrier to scope of practice changes. Similarly, many stakeholder identified concerns with administrative effort from their early experience with the *Regulated Health Professions Act* for improvement. With refinements, this Act could be used as an enabler to improve interdisciplinary collaboration across the continuum of care by permitting practitioners to work to full scope. The Act is being implemented in a phased approach, with Colleges being transitioned into the Act.
- Formal pension and healthcare benefits in the system are not significantly out of line with other jurisdictions however there are many opportunities to standardize employment related benefits associated with leaves, accumulators and more policy related items like parking allowances. Some of these benefits require collective bargaining changes to implement.
- Many stakeholders suggested that there were opportunities to evaluate the performance of the Health Employees Benefit Plan and Health Employee Pension Plan. A detailed review of the cost performance of these entities was beyond the scope of the Phase I review. Evaluation of HEBP and HEPP operations seem to indicate a relatively effective delivery cost and advantages associated with the trust based risk management structure that underlines the Pension Plan itself. KPMG did identify a number of areas for consideration including:



Area of Opportunity #6: Health Workforce

Analysis and observations

- Process and administrative integration with HEBP and HEPP and the employers resulting in excessive administrative effort. HEBP/HEPP management have implemented a very formal policy of shifting delivery accountability to employers. This contributes to frustration on the part of some stakeholders about their performance. There may be value in evaluating the mandate of HEBP/HEPP to improve their orientation as a service delivery partner in the healthcare system and to break down their independence as an arms length organization.
- Manitoba has a significant unfunded liability across the system for preretirement leave of \$297M. This practice has been identified as a significant issue for all healthcare delivery organizations. It was identified as one area where employees can take advantage of the system to fund early retirement while still working in the system. All management stakeholders suggested the overall level of benefit is not consistent with other health systems and should be scaled back or eliminated altogether. KPMG estimated that 30% of this liability could be eliminated through negotiating changes or cancellation of the benefit with current employees. There will be a requirement for some level of investment to offset this liability as part of any change process.
- The WRHA has achieved a milestone with the implementation of an integrated human resource management shared service supported by the administration of payroll for the regions 26,000 employees on SAP. The shared service rollout has faced a number of challenges associated with the roll out of this type of service. Recent reports and attention that has been given to overpayments (while not to be minimized) do not reflect the fact that the level of overpayments by WRHA sites before consolidation into a shared service was not quantified and that most management stakeholders agree were significantly higher than after the implementation. Still, the service requires a dedicated effort to stabilize and standardize service delivery and this activity is being actioned by WRHA leadership. This shared service and the supporting information system has the technical and business foundation to support the entire healthcare system. There is interest in this from most non-WRHA health care delivery organizations. This potential strategy is described in more detail in the Shared Services Opportunity area.
- All stakeholders identified opportunities to recruit and retain medical and health care delivery providers especially in rural and Northern Manitoba. There is evidence of competition between rural areas for providers and some of this competition results in employment contracts that contribute to system cost and non standardized delivery (e.g. Hiring a surgeon into a rural area requires a facility with an operating room to be available that may not be dictated based on demand or safe clinical practice). Stakeholders identified concerns with the Province's ability to manage and execute on physician recruitment. Some suggested that there may be opportunities to leverage the private sector as part of an integrated recruitment program where the province coordinates demand and service planning and the private sector partners execute the recruitment process.
- Despite these concerns, Manitoba's overall physician workforce grew by 582 physicians since 2005 to a 2016 total of 2768 doctors. The physician workforce still faces significant turnover due in part to high stress work environments with limited clinical service support in rural and northern regions.



Area of Opportunity #6: Health Workforce

Analysis and observations

- There is support from stakeholders to integrate the Province's recruitment and labour management services into an integrated service that could be leveraged by all health care organizations. Labour relations functions are shared between the Province's Manitoba Health Provider Network and health delivery organizations. Health delivery organizations can opt out of advice provided by the Province. Often this practice results in further complexity in the overall system. In many instances it causes grievances that result in large financial settlements. An example of this situation resulted in CancerCareMB having to pay \$400,000 to settle a claim for practices that were not consistent with provincial regulations.
- Stakeholders universally identified issues associated with the alignment of professional compensation with the broader performance objectives of the system as an opportunity area. Provider compensation is a difficult opportunity area because of the competitive nature of the employment market and within Canada because there is a need to maintain alignment with other jurisdictions.
- The majority of the Province's doctors are engaged as Fee for Service providers that operate as private contractors within the system. This arrangement is typical of all Canadian jurisdictions. The model has some advantages because it shifts the responsibility for infrastructure and operations of clinics to provider businesses. It also creates challenges for the system because there is no mechanism to require providers to meet service standards and there is no mechanism for oversight provider practice effectiveness except through administration of provider billing claims.
- Manitoba's efforts to implement a modern claims processing solution has the capability to support alternate compensation models including blended compensation, outcomes based claim payment and introduction of new rules aligned with clinical service based standards instead of individual tariffs. There is evidence in other jurisdictions of significant financial savings and improved health care outcomes from these models and in particular for primary and some areas of specialty care.
- [REDACTED]
- There are a number of areas where the administration of claims under the Manitoba Physician's Manual could be streamlined to reduce administration and eliminate tariffs that do not reflect current clinical practice or compensation strategies in other jurisdictions.
- There are opportunities to evaluate the compensation of all professionals in the health care sector. Specific opportunities identified by stakeholders focused on changes to :
 - Chiropractic services coverage levels or elimination of the coverage completely in order to bring Manitoba in line with other jurisdictions. Some clinical system stakeholders suggested that this type of change is counter to scope of practice changes and that there would be savings associated with increased levels of chiropractic coverage.
 - Pharmacy coverage to standardize services for all pharmacy services and to move away from fees based on a percentage of transaction cost. These practices have been changed in other jurisdictions to a standardized fee schedule for transaction/service type.



Area of Opportunity #6: Health Workforce

Actions

Several possible actions to address the health workforce were identified by stakeholders and based on leading practice:

- Consider opportunities to consolidate the number of employers within the health care system and to align human resources policies and standards across the province;
- Undertake process to rationalize collective agreements to simplify the system, standardize administrative requirements and increase mobility throughout the system;
- Evaluate negotiated and employer funded benefits across all sectors;
- Evaluate the potential to terminate or change the preretirement leave benefit across the system and to eliminate this benefit for all new hires;
- Review role and alignment of HEBP/HEPP as a service provider and evaluate key benefit provisions under these plans for cost effectiveness;
- Review policy of relying on part time resources and support health care delivery organizations to adjust rotations for more effective system management;
- Review scope of practice for all service providers with an emphasis of matching safe service delivery with the lowest cost resource;
- Consider opportunities expedite licensing of internationally trained workers into priority areas of the healthcare system;
- Establish an integrated healthcare recruitment program with an emphasis on balancing service demands and fulfillment across the province;
- Consider opportunities to engage the private sector as part of the fulfillment model for physician recruitment;
- Review the Physician's Manual for opportunities to simplify the administration and adjudication of physician claims with an emphasis on eliminating tariffs that are not consistent with current practices or service standards;
- Implement savings negotiated with DoctorsManitoba as part of the last collective bargaining process;
- Review healthcare provider compensation models with an emphasis on aligning Fee for Service providers and other professionals with the broader performance and delivery objectives of the system;
- Consider opportunities to engage with professional colleges to reset established expectations about their regulatory and service oversight functions as set out in Manitoba legislation; and
- Consider opportunities to implement and integrated health employee shared service with a full scope of practices from labour relations, hiring, development, administration and payroll management services leverage foundation from WRHA.



Area of Opportunity #6: Health Workforce

Benefits & Potential Financial Impacts

Benefits and potential impacts of health workforce initiatives include:

- Rationalized and effective staff composition across all delivery organizations;
- Reduction in overtime and sick leave costs;
- Improved interdisciplinary collaboration;
- Improved provider accountability;
- Greater provider mobility across programs and sites;
- Standardized employee benefits;
- Simplification of overall system; and
- Alignment of professional service practice with system performance and delivery expectations.

Timeframes: Short- and medium-term

- **2017/2018:** \$26M+
- **2018/2019 and beyond:** \$42M+
- **Total:** \$68M+



Area of Opportunity #6: Health Workforce

Sub-Area	Potential Technical Efficiency Savings (\$M)		Potential Allocative Efficiency Savings (\$M)		Totals
	2017/2018	2018/2019 and Beyond	2017/2018	2018/2019 and Beyond	
Rationalize Healthcare Employee Benefits	\$ 4M	\$ 0.6M	\$ 1M	\$ 28M	\$ 34M
Review Healthcare Provider Compensation	\$ 14M	\$ -	\$ 6M	\$ 3M	\$ 23M
Rationalize Collective Agreements	\$ -	\$ 3M	\$ -	\$ 4M	\$ 7M
Rationalize Workforce Composition	\$ -	\$ 3M	\$ 1M	\$ -	\$ 4M
Totals	\$ 18M+	\$ 7M+	\$ 8M+	\$ 35M+	\$ 68M+

Key Evaluation

Potential Cost Saving Criteria
(Effectiveness/ Economy/ Efficiency)



- 2017/18 cost savings opportunities reflect opportunities to implement initiatives that have had initial work completed or require only administrative policy changes with no negotiation.
- Longer term opportunities have a high savings potential but require collective bargaining or negotiations.

Effort to Implement Criteria
(Alignment/ Risk)



- All employment related changes require a high level of change management
- Negotiation processes are protracted and have a high level of complexity
- Some employment related benefits will require payouts or settlements as part of any process change
- Higher potential cost savings are associated with scenarios that have the highest degree of consolidation. These are complex initiatives that require dedicated effort and commitment. These initiatives are critical to long term system sustainability.



Area of Opportunity #8: Integrated Shared Services

Description (Cont.)

WRHA has delivered dietary and food services through its Regional Distribution Facility to 8 sites Winnipeg sites since its inception in 1998. It also manages the food services operation on site at the HSC campus. [REDACTED]

A shared laundry service has been implemented in the WRHA since 2005. [REDACTED]

PMRHA provides an integrated laundry service from a facility located at the Brandon Regional Health Centre, [REDACTED]

- **Implementing an integrated provincial healthcare Supply Chain Management (SCM) function.** A SCM function includes contract management, procurement, vendor management, inventory management, warehousing/distribution and expenditure analytics.

WRHA has implemented an integrated Supply Chain and contract management shared service. This includes a centralized distribution facility/warehouse on Emily Street in Winnipeg. WRHA has taken steps to begin consolidating delivery services but accountability for SCM execution is shared between the Logistics Program and individual sites. Final stage implementation of common Supply Chain Management system was completed in 2016 with deployment of the BPSP solution to HSC.

Capabilities to delivery effective Supply Chain execution are not consistent across other healthcare delivery organizations. CancerCareMB and DSM maintain an independent procurement capability for specialized cancer drugs and diagnostic equipment but there are efforts to leverage some of the WRHA expertise in many situations. MHSAL provides support to all medical equipment procurement through the Regional Policy and Programs branch.

All stakeholders identified an opportunity to consolidate the purchasing of all healthcare delivery procurement in order to achieve better price and volume discounts. One mechanism for this would be to maximize expenditure and compliance with the Province's HealthPro contract or equivalent buying group contracts overtime. WRHA logistics estimates this type of consolidation could result in a 2-4% savings on items procured through a centralized model based on its experience to date.



Area of Opportunity #8: Integrated Shared Services

Description (Cont.)

Some stakeholders identified the potential for consolidating Manitoba's demand with other provinces to maximize volume purchasing scale. Key in this regard is pharmaceutical procurement. One vehicle might be the Western Province Economic Cooperation Agreement or the New West Partnership Trade Agreement which Manitoba official joined on January 1, 2017.

- **Establishing a common program and transformation management capability.** This includes project management, organizational change management, quality and lean management, process engineering and analytical skills.
 - These capabilities vary widely between organizations across the province. In aggregate, there are significant resources that could be aligned into an integrated program.
 - The WRHA has the largest capacity through the BPSP Program and initiatives like the Centre for Health Innovation.
 - MHSAL has a strong capability and investment in data resources through its relationship with the Manitoba's Centre for Health Policy Research.
 - There are many opportunities to align and integrate these resources into a single program and to standardize on methodologies to improve overall consistency and integration.
- KPMG has made the following observations about the shared services capability of the Province:
 - Efforts to consolidate some core services in the past especially during regionalization have had some positive impacts. Unfortunately though, the steps necessary to effectively consolidate and rationalize service delivery structures were not well executed or remain unfinished. This has led to pockets of provincially-run services not fully achieving or realizing the full benefits or intended outcomes.
 - There is a high cost delivery structure in particular for administrative shared services and clinical support functions as each organization also supports investments in information technology and services to implement individualized delivery models.
 - WRHA shared services capability is still a low level of maturity. Effort will be required to stabilize that capability as a Provincial-level service. This type of service would be best delivered at a Provincial-level outside of an individual region. Initial emphasis should be placed on transactional services (e.g. payroll, accounts payable processing) that can be executed as a support to delivery organizations. Consideration of a provincial level service would only be undertaken in the context of reducing the overall number of healthcare organizations and agencies, as made clear in Area #1 – Strategic System Realignment.
 - Leading practices support opportunities for a relatively significant benefit from shared services implementation. The level of benefit can be up to 10-20% of standalone costs over time. Shared services implementation is complex and requires dedication and progressive management over time. KPMG financial benchmarking processes validated savings for administrative services consolidation. This potential savings is identified as an opportunity in the tracker.

Area of Opportunity #8: Integrated Shared Services



Analysis & Observations

- Strong willingness in individuals to consolidate and leverage province-wide processes where possible, yet there is a lack of ability to effectively resource and manage the transition to a shared service arrangement.
- Focus on the above back office and clinical services is taking away time, effort and focus of RHAs' core function - provision of healthcare in their region.
- Current collective agreements are seen as barriers to the implementation of shared services.
- Significant variance in ICT capability across the regions is contributing to inefficiency in process and inconsistent adoption of back office and clinical functions.
- Shared services implementation is enabled through standardization of information systems and technology platforms. Currently, all non-WRHA healthcare delivery organizations maintain their own finance and administrative management systems. This makes consolidation of information and process execution very difficult.
- Fragmented back office processes and procedures within each RHA fuel inconsistent application and delivery of service.
- Maturity of back office and clinical potential shared service functions is inconsistently managed for each region.
- Duplication of governance / leadership roles carrying out likewise functions for each RHA that could be run in an integrated shared services function.
- Increasingly all organizations are recognizing the need to leverage enhance expertise and capability that could be consolidated as a shared service. KPMG noted increased acknowledgement of stakeholders that there is a need to consider shared services delivery in order to ensure system sustainability over the longer term.
- Efforts and the part of MHSAL to standardize delivery through various administrative councils is positive. These have resulted in increased alignment and sharing of information on leading practices but have not resulted in significant standardization. Other jurisdictions have moved beyond basic alignment and coordination approaches towards integrated delivery in order to produce meaningful sustainability outcomes.



Area of Opportunity #8: Integrated Shared Services

Actions

Several possible actions to address integrated shared services were identified by stakeholders and based on leading practice:

- Consider opportunities to the following administrative support services consolidated into an integrated Province-wide shared services solution:
 - Finance;
 - Human Resources;
 - Supply Chain Management.
- Consider opportunities to consolidate the following healthcare support services into an integrated Province-wide shared services solution:
 - Laundry;
 - Dietary;
 - Real Estate;
 - Legal;
 - Communications;
 - Facilities Management
 - Medical device reprocessing.
- Implement common program and transformation management capability with the province by undertaking the following actions:
 - Establish an integrated healthcare transformation function to look after the end-to-end delivery of programs and projects for the province. A critical success factor for building up this capability will be to ensure that a common set of principles is adopted to prioritize, govern, manage and effectively resource all transformational initiatives that are undertaken. Consideration of a provincial level service would only be undertaken in the context of reducing the overall number of healthcare organizations and agencies, as made clear in Area #1 – Strategic System Realignment.
 - Consolidate current shared services programs, processes and resource into the one provincial function.
- Develop an integrated provincial Supply Chain Management function to manage system-level commercial activity in a consistent and integrated way. Actions to get there include but are not limited to:
 - Implementation of consistent commercial / procurement capability across the province with robust policies, procedures and guidelines. This will help to ensure consistency of procurement approach, selection process, contract management and performance indicators.
 - Standardization of medical supplies and equipment. This helps to leverage the buying power of both province and where possible, federal.

Area of Opportunity #8: Integrated Shared Services



Benefits & Potential Financial Impacts

Effectively implementing an integrated shared services model will help reduce and improve sustainability over time through:

- Reduced organizational complexity by minimizing the functions carried out for each healthcare delivery organization.
- Increased Supply Chain Management efficiencies by maximizing contractual / procurement processes.
- Reduced business risk by having consolidated functions in one location.
- Standardization of processes across the healthcare system / reduction in complexity over time.
- Insight and visibility into all inputs and resources to improve system and analysis over time.

Timeframes:

- **2017/2018:** \$ 3M+
- **2018/2019 and beyond:** \$43M+
- **Total:** \$46M+

Area of Opportunity #9: ICT Integration & Enablement



Description

- A number of core opportunities to make strategic investments in ICT solutions for healthcare include but are not limited to:
 - Implementation of a consumer / Telehealth portal to provide real time access to medical records and offset administrative requirements from the healthcare system for diagnostic results retrieval, or supporting registration processes, etc.
 - Implementation of an integrated data / analytics platform to aggregated clinical and financial information to support system planning and commissioning activities.
 - Expansion of Telehealth and internet based remote medicine solutions to offset the requirements for patient travel and as a support to administrative and clinical services delivery by experts located in other parts of the province.
 - Completion of implementation of eChart and integrated registration systems to manage patient information, diagnostic testing results and administrative processes for patient management across all sites.
- Pursue strategic funding and implementation partnerships to reduce system implementation costs and support strategic initiatives.
 - Stakeholders identified several opportunities for collaboration with Manitoba Finance BTT with an emphasis on leveraging the Province's network and desktop management processes. These are mature services delivered by the Province and there are many possible configurations to leverage this capability from integrated delivery to procurement.
 - Federal Canada Health Infoway funding has been identified as a potential source of funding for many initiatives. This funding is available to jurisdictions that execute projects in their jurisdiction that support the overall Infoway Delivery Plan. Key initiatives that could be funded through this method include iPrescribe/ ePrescribe, STD/HIV tracking, Telehealth Expansion and Consumer Portal Development. This is a leading practice delivery model that has been adopted by several other Canadian jurisdictions.
 - Strategic partnerships with First Nations have been identified for many opportunities. These included but were not limited to investments in northern and rural networking infrastructure and partnerships to implement a shared data center operating systems servicing Indigenous communities.

Summary of Advice for Consideration

Key Communication Points (cont.)

- One of the key findings is that most healthcare programs and services have not been subject to a review focused on cost improvement in a very long time or apparently have never been reviewed.
- There is currently no performance management or accountability framework in place across the provincial health system which codifies the mandates, accountabilities and roles of MHSAL, RHAs or providers, both devolved and non-devolved.
- Funding for healthcare programs and services remains based on historic global budgets and not linked to population need with no incentives to improve quality and efficiency.
- The planning and development of healthcare services, including the development of facilities, has not been based on a provincial clinical services plan and evidence-based care resulting in sub-optimal development and utilization of clinical facilities.
- Additionally, the organizational structures of the healthcare system are complex, leading to misalignment and overlap/ duplication on roles and functions for a provincial population of 1.3 million with eight Health Agencies (including five RHAs), multiple provider boards with a lack of performance management and accountability at all levels. Reforms which have occurred in other provinces across Canada with the objective of achieving sustainability such as consolidation of services at a Provincial-level, a shift to a patient-centered, commissioning-based model and funding reform have not occurred in Manitoba.
- Providers, both devolved and non-devolved, have historically defended their autonomy with the retention of governing boards, while their current agreements with the RHAs do not provide effective performance management or accountability in relation to both improving quality, efficiency and effectiveness.
- Other provinces such as Ontario and B.C. have bent the cost curve. Manitoba needs to start system-wide changes now, with directions and required legislative changes brought underway as soon as possible, along with establishing a Transformation Management Office to drive immediate cost improvement efforts and ensure cost savings are realized in a planned, coordinated and phased-in approach.
- Immediate Government direction is required to strategically re-align, focus and simplify the healthcare system, clarify and codify mandates between the Department, RHAs and facilities, and to strengthen accountability for performance. The key opportunity area, Strategic System Realignment, should commence as soon as possible in 2017/18 and continue over the following fiscal years to enable fiscal sustainability.

Next Steps

Following the completion of Phase 1, for each of the key areas of opportunity, Phase 2 will involve the development of work plans and further analysis for each area to guide implementation planning. Work plans will be developed by KPMG and will involve focused, small teams from KPMG and MHSAL as well as other key healthcare stakeholders where required. As Phase 2 is confirmed, will also need to commence for Phase 3 in relations to implementation. This would involve setting up the supporting infrastructure to support implementation including the establishment of a Transformation Management Office.

