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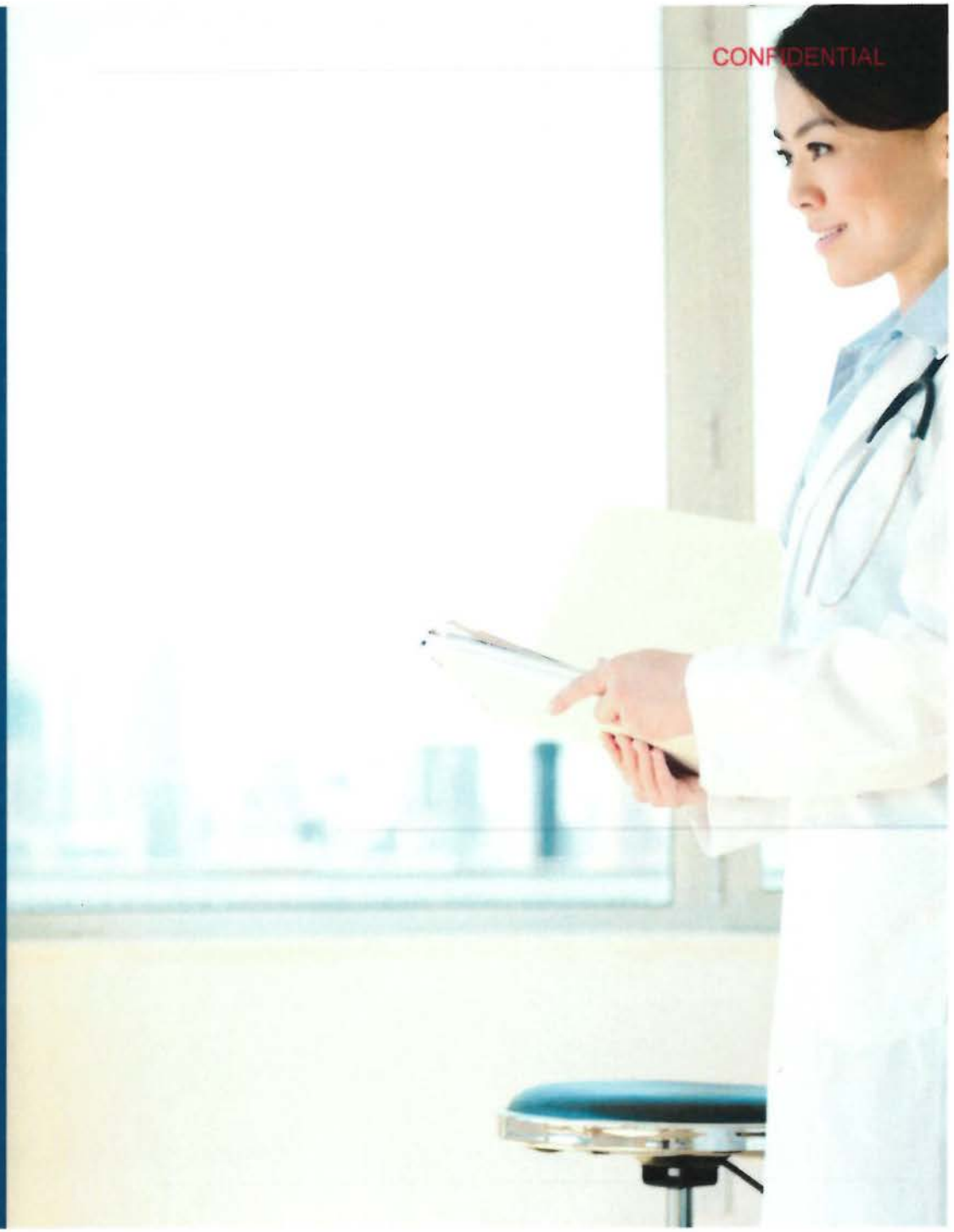
Health System Sustainability & Innovation Review: Phase 2 Report

Manitoba Health, Seniors and Active Living
and Manitoba Finance

March 31, 2017



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 2 Report is to provide work plans and a change management approach and plan in relation to six prioritized areas of significant cost improvement identified in the Phase 1 Scoping Report submitted to MHSAL on January 31, 2017. 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.

Develop Strategic Realignment Work Plan

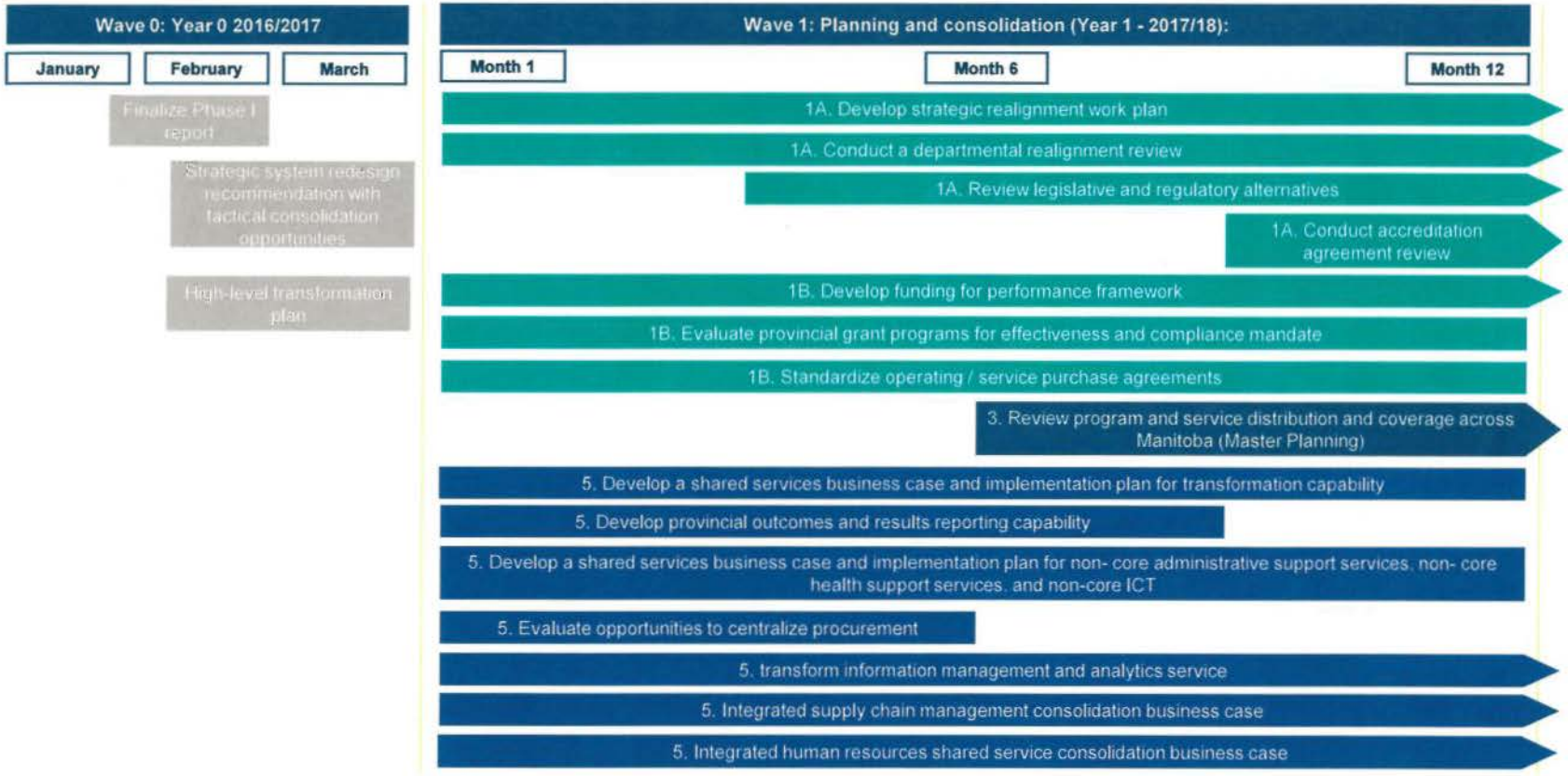
Subtheme: System Policy and Planning	Benefit Year: 2017/18 and beyond	Est. Cost Saving: $3.0M
Implementation Duration: 18 Months	Implementation Effort: High	

Description	Build plan for strategic realignment opportunities based on in-scope items below:
Benefit	• Alignment of health care services with the overall direction of government, financial economy and efficiency gains, overall improvement of organizational / operational effectiveness.
In-scope	• Departmental realignment. • Service purchase/operating agreement optimization. • Outcomes and results dashboard implementation. • Provincial health service integration planning and design. • Shared service feasibility planning. • Supply Chain Management integration planning and design. • Human Resources Shared Services integration planning and design. • Legislative and regulatory alternatives. • Amendments to legislation and regulations. • Funding for performance and commissioning framework. • Single payer optimization/integration.
Key Assumptions	• TBD as part of this project.
Governance	• MHSAL owned with support from other healthcare providers.
Project Management	• MHSAL.
Communication Strategy	• TBD as part of this project.

Risks	Interdependencies
• If a TMO is not established, this opportunity cannot proceed.	• Dependent on Government's decision to proceed on the "Conduct a Departmental Realignment Review" opportunity. • Requires recommended establishment of a TMO.

Strategic Transformation Road Map

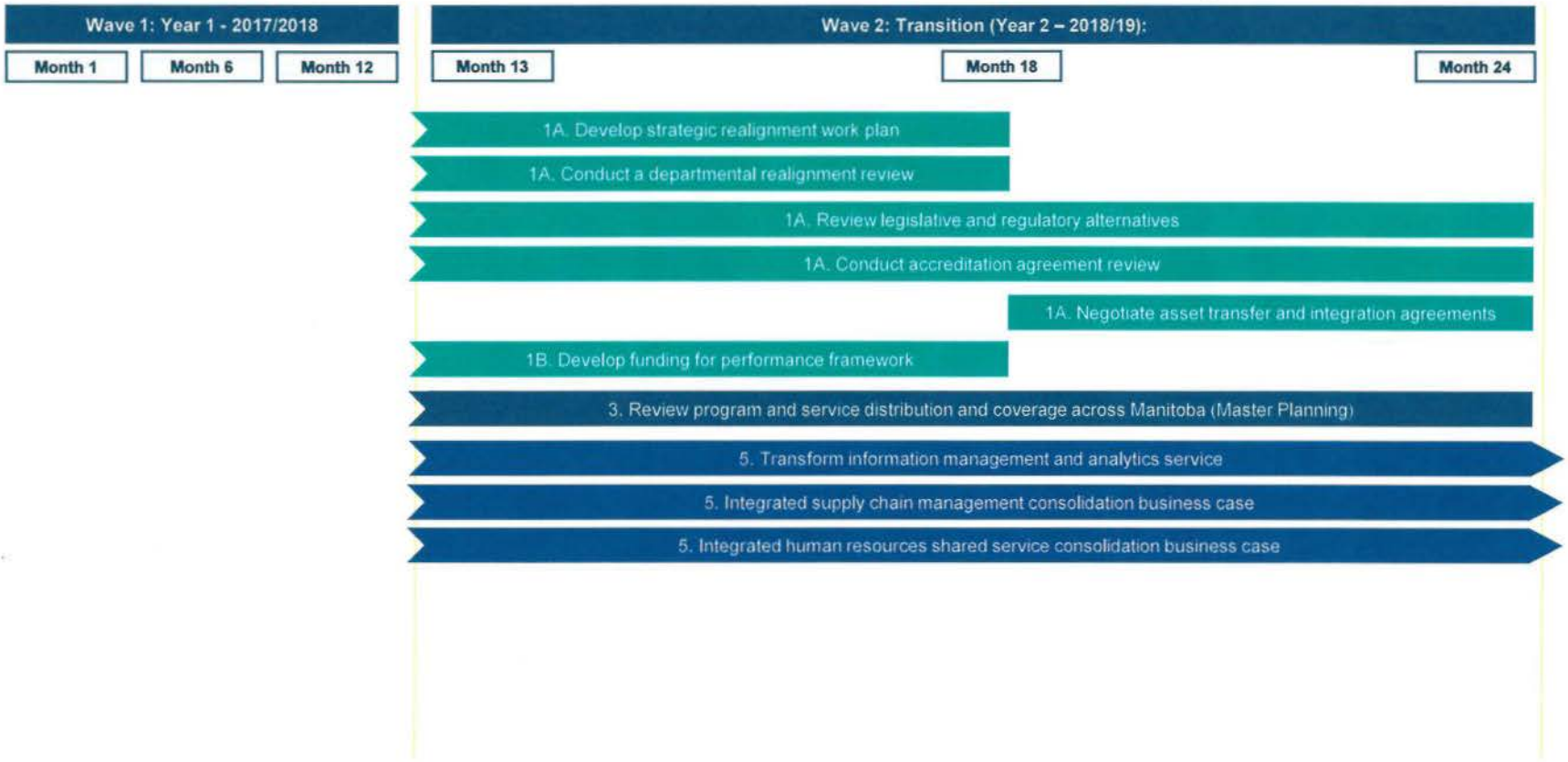
This strategic realignment section also includes projects in other work streams which are identified below. Descriptions of each can be found in their allocated work plans.



Work Plan Key:

1A. Strategic System Realignment	1B. Funding for Performance	2. Insured Benefits	3. Core Clinical & Healthcare Services
4. Healthcare Workforce	5. Integrated Shared Services	6. Infrastructure Rationalization	

Strategic Transformation Road Map



Work Plan Key:

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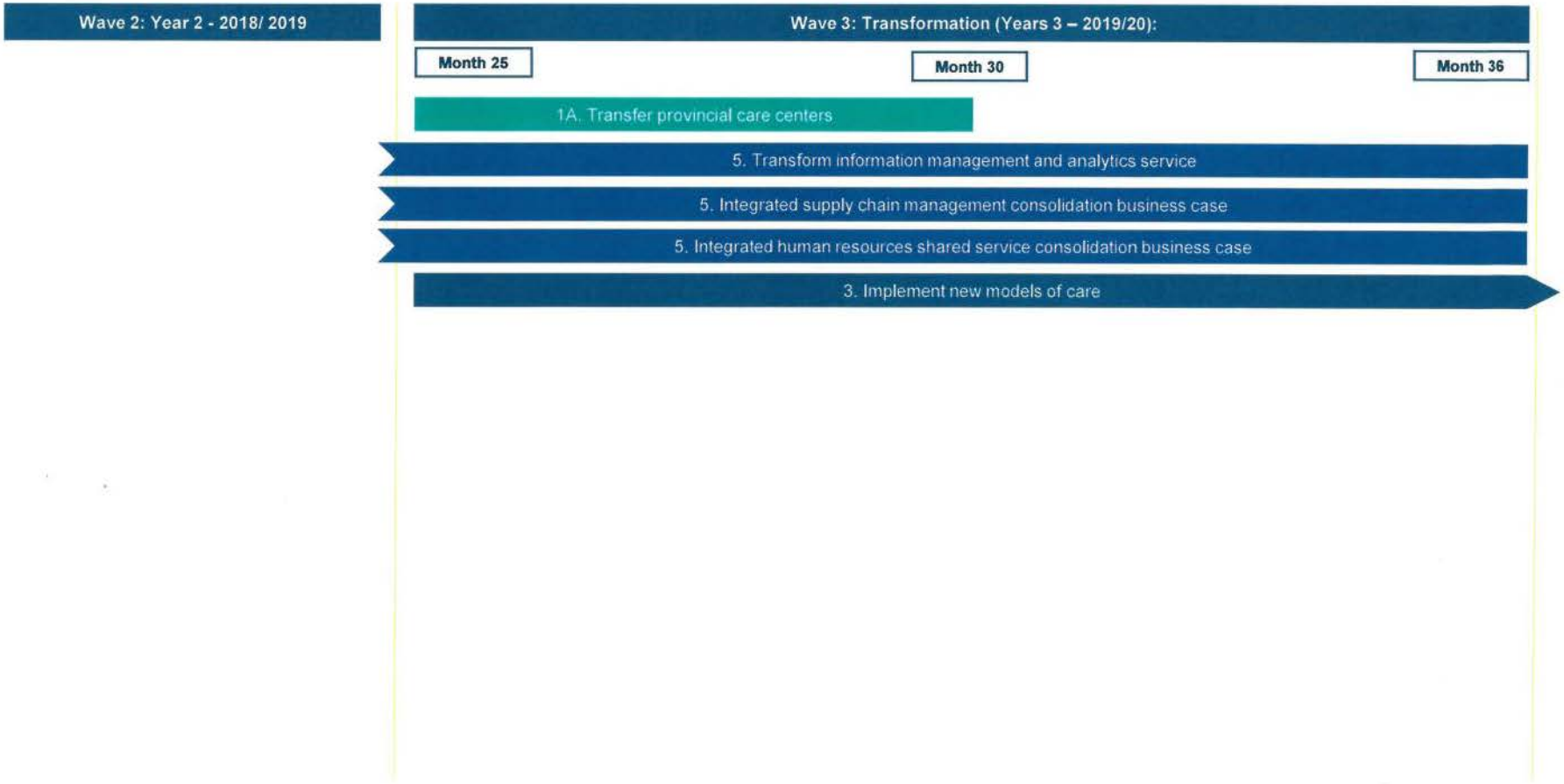
Strategic Transformation Road Map



Work Plan Key:

- 1A. Strategic System Realignment
- 1B. Funding for Performance
- 2. Insured Benefits
- 3. Core Clinical & Healthcare Services
- 4. Healthcare Workforce
- 5. Integrated Shared Services
- 6. Infrastructure Rationalization

Development of a Preferred Option for Consideration

The following pages outline the methodology, approach and process followed for three structured sessions facilitated by KPMG and involving senior officials from MHSAL, Planning and Priorities Secretariat and Treasury Board Secretariat who formed a working group to develop a preferred option for the strategic realignment and transformation of the Manitoba healthcare system. The three sessions were structured as set out below.

- Three working sessions with progressive development and advancement of the content.
- Consensus based evaluation and assessment of options.
- Identification of implementation plan requirements for selected option(s).
- Recommendations for phasing and activation.

Session #1 –

- Overview of work to date from Phase 1 HSIR Report.
- Introduce framework and methodology.
- Confirm evaluation criteria.
- Confirm elements for system configuration development and review.
- Identify/confirm sensitive decisions or option development constraints.
- Confirm number of sessions/next steps.

Session #2 –

- Provide overview of system configuration options.
- Assess and evaluate alternatives.
- Gain consensus on options that should be pursued or recommended to the Provincial Government.
- Eliminate those that are not worth further consideration.
- Get feedback on areas for refinement.

Session #3 –

- Review refined option(s) with supporting recommendations.
- Review conceptual implementation plan and phasing.
- Highlight key requirements for policy/legislative and regulatory change.
- Highlight key requirements for funding and commissioning in interim and longer term.

Summary of Methodology and Approach

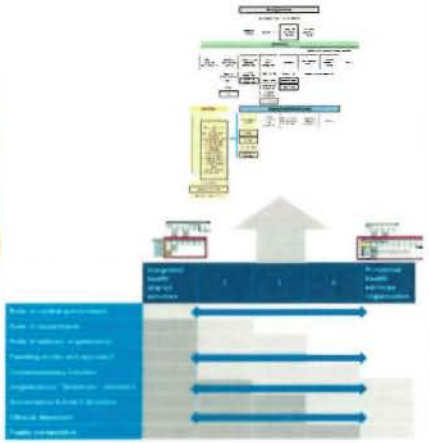
A structured approach was followed over the three working group sessions to identify, assess and evaluate system configuration scenarios to develop a preferred option for the Manitoba healthcare system.

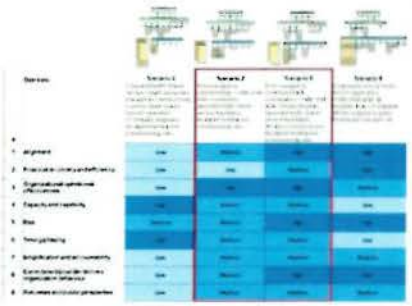
System design principles

Simplify system
Strengthen accountability
Clarify roles
Improve effectiveness
Streamline governance
Reduce unnecessary cost

Elements by function and organization

Evaluation criteria





Confirm design principles, system elements and evaluation criteria

Identify/confirm sensitive decisions or option development constraints

Develop and provide overview of system configuration options

Continuum reflects actionable alternatives informed by leading practice and Manitoba requirements

Assess and evaluate alternatives

Gain consensus on options that should be pursued or recommended to the Provincial Government

Eliminate those that are not worth further consideration

Preferred option with:

- **Conceptual commissioning framework**
- **Implementation roadmap**
- **Key requirements for policy/legislative and regulatory change**

Overview of System Configuration Options: Process and Methodology

Scenarios for system configuration were developed based on increasing levels of provincial integration and the requirements for an enabling funding and commissioning model to achieve sustainability.

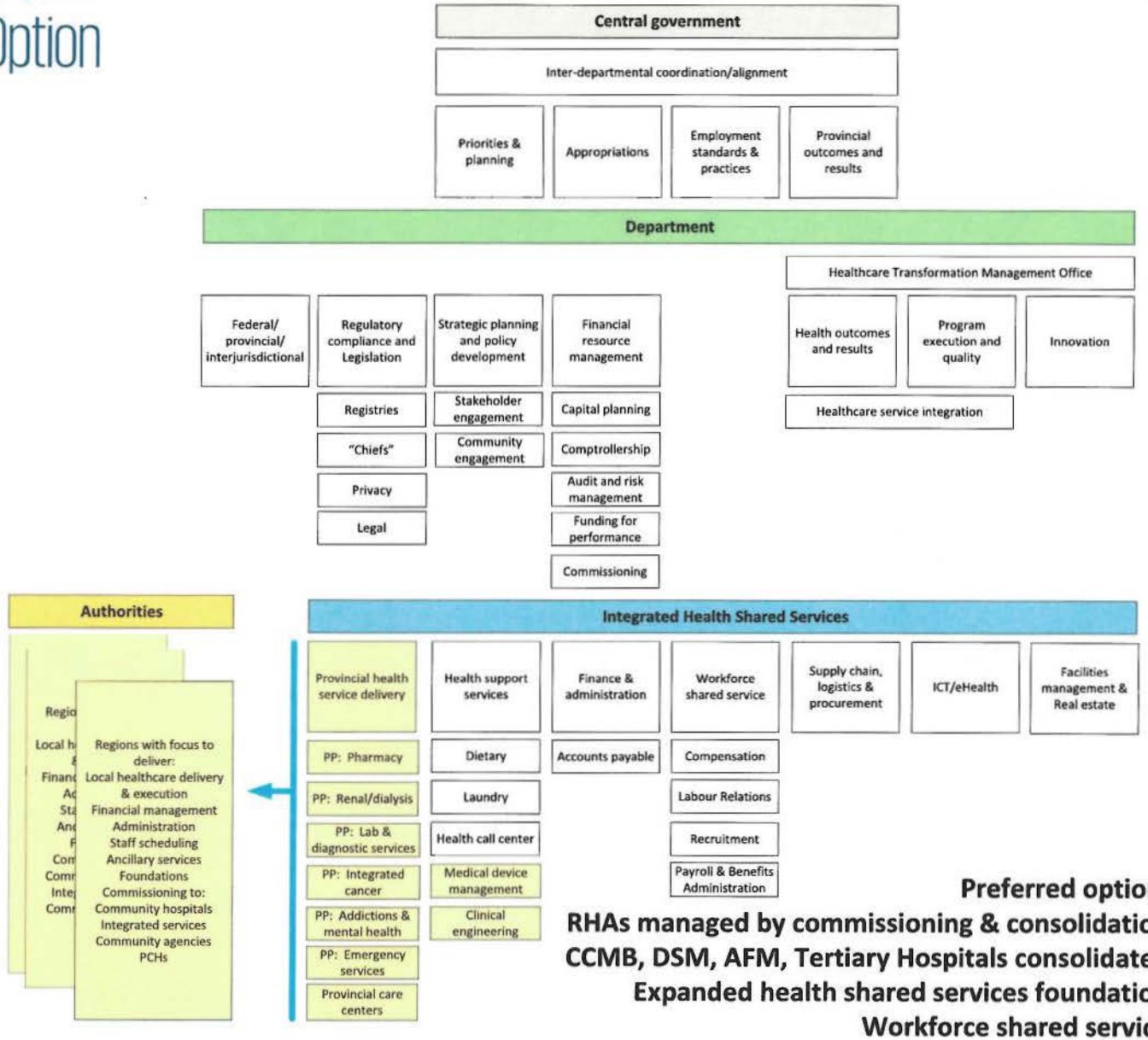
- Focus on alternatives from integrated health shared services to a provincial health services organization
- Structured process to review alternatives constructed to demonstrate the impacts of different factors on a continuum
- Relationship between system design alternatives and the requirements of the funding and commissioning model required to achieve an integrated system outcome will be evaluated throughout the process
- Identify a limited number of options (ideally 1 but likely 2) with a recommendation by the strategic system realignment working group and the Advisory Committee

Assessment and Evaluation of Alternatives

Four scenarios for system configuration were assessed and evaluated in Session #2 by the working group with Scenario 3 agreed as the preferred option which was further refined in Session #3.

#	Overview	Scenario 1 Integrated Health Shared Services; Health Authorities managed by commissioning; Common health shared services foundation; ICT/eHealth integration; Re-aligned funding and commissioning roles	Scenario 2 RHAs managed by commissioning; CCMB, DSM, AFM consolidated; Expanded health shared services foundation; Re-aligned funding and commissioning roles	Scenario 3 RHAs managed by commissioning & consolidation; CCMB, DSM, AFM, Tertiary Hospitals; Expanded health shared services foundation; Workforce shared service; Re-aligned funding and commissioning roles	Scenario 4 Integrated provincial health service organization; CCMB, DSM, AFM, All hospitals, RHAs consolidated; MHSAL realigned to policy, funding and oversight role
1	Alignment	Low	Medium	High	High
2	Financial (economy and efficiency)	Low	Low	Medium	High
3	Organizational/operational effectiveness	Low	High	High	Medium
4	Capacity and capability	High	Medium	Medium	Low
5	Risk	Medium	Medium	High	High
6	Timing/phasing	High	Medium	Medium	Low
7	Simplification and accountability	Low	Medium	Medium	Medium
8	Commitment/provider/delivery organization behaviour	Low	Medium	High	High
9	Outcomes and public perspective	Low	Medium	Medium	Medium

Preferred Option



Preferred option:

RHAs managed by commissioning & consolidation

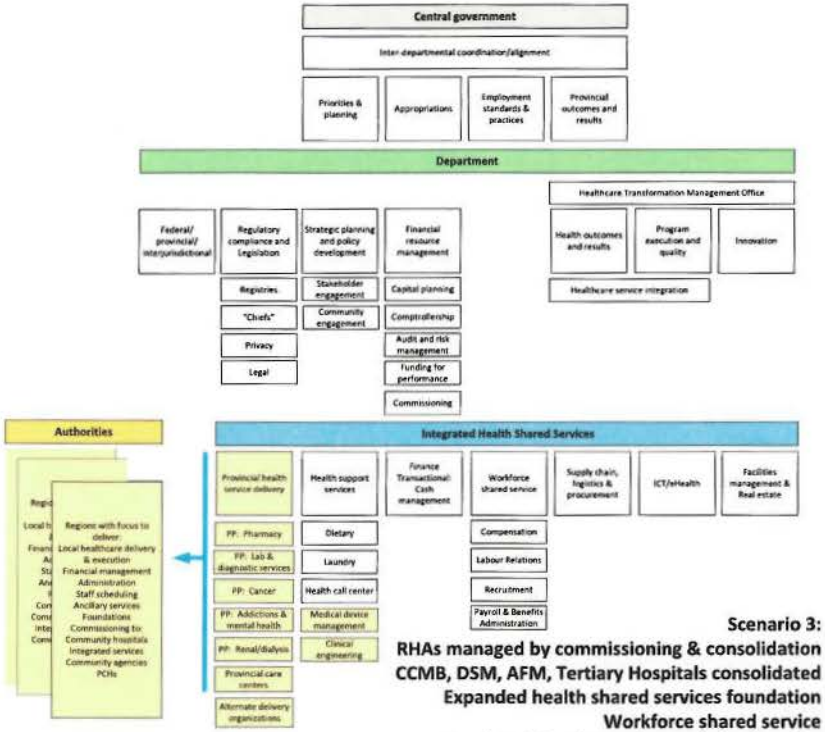
CCMB, DSM, AFM, Tertiary Hospitals consolidated

Expanded health shared services foundation

Workforce shared service

Re-aligned funding and commissioning roles

Preferred Option - Key Features



Scenario 3:
RHAs managed by commissioning & consolidation
CCMB, DSM, AFM, Tertiary Hospitals consolidated
Expanded health shared services foundation
Workforce shared service
Re-aligned funding and commissioning roles

Reference jurisdictions:
BC PHSA, NHS England

Functional realignment

— Consolidation and integration of departmental functions: Regulatory, Policy, Workforce, Financial Resource Management.
— Creation of Transformation Management Office (TMO) with integrated outcomes and execution capability.
— Establish clinical integration function within the TMO.
— Move to shared services delivery for Health Support Services, Payroll & Benefits Administration, Recruiting, Cash Management (potential), Supply Chain, ICT/eHealth, Facilities management & real estate, MDR/Clinical Engineering, Provincial level delivery programs.

Organization/ "Employer" structure

— Consolidation of CCMB, DSM, AFM.

Funding model and approach

— This scenario depends, as critical enablers, on realignment of funding model, operating agreements and service purchase agreements across the system.
— Incorporate concepts of alignment and integration of service delivery as part of an integrated system.

Commissioning function

— Establish and strengthen departmental commissioning capability to all Healthcare Authorities and the Health Shared Service.

Governance & board structure

— Opportunities to streamline or align for shared services, CCMB, DSM, AFM.
— RHA Board integration achieved through funding and commissioning model.

Clinical alignment

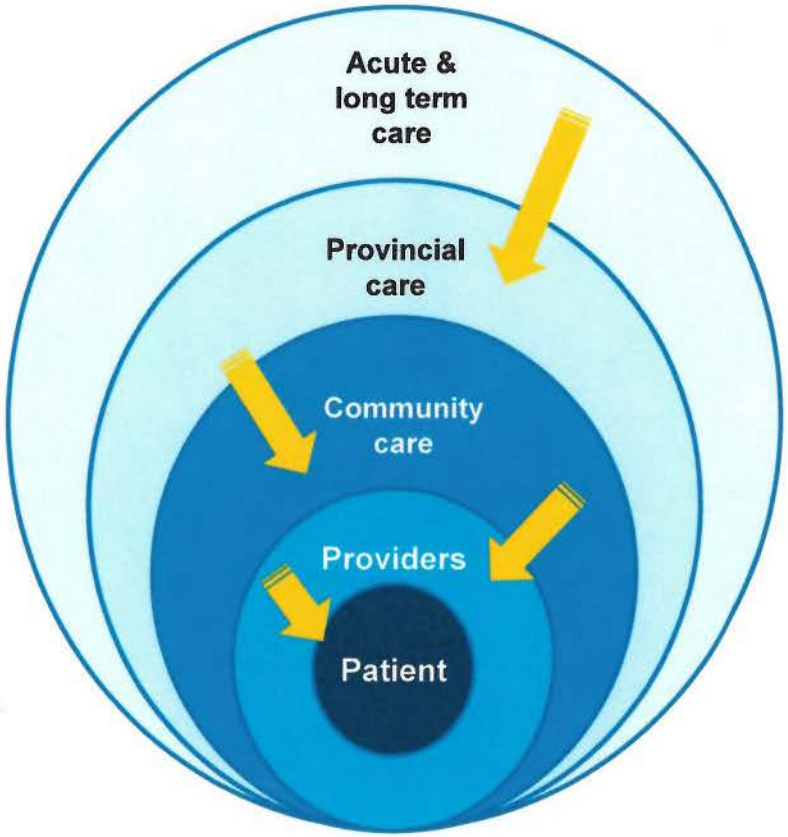
— Achieved through funding/commissioning and agreement through working groups with provincial coordination.
— Core jurisdiction-wide programs consolidated for integrated delivery across province.

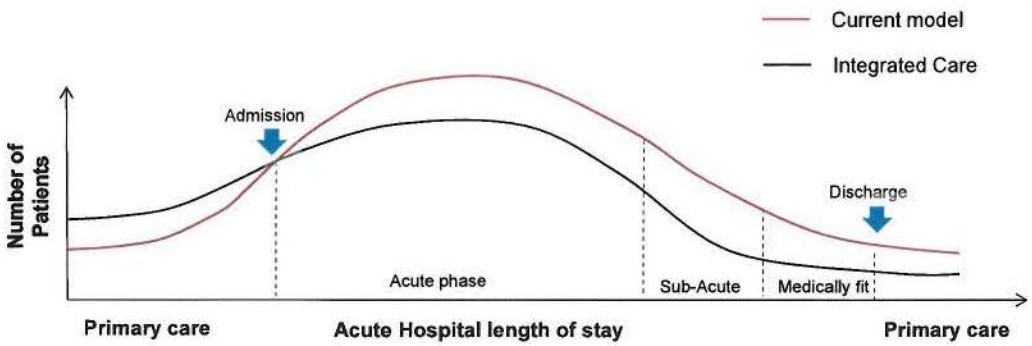
Outcomes

— Cost improvements and efficiencies in implemented shared services.
— Clarification of roles and accountabilities.
— Improved service management capability for provincial-wide programs.
— Operating cost reductions from consolidation of management and administration functions.

Shifting the Model - "The What"

- Structured around a population or pathway centred model of care.
- Streamlines complexity, integrates care and reduces hand-offs between acute provision and community delivered services.
- Rationalizes teams to improve service users ability to navigate services.
- Promotes and supports self-management.
- Emphasizes care delivered closer to home.
- Integrates primary care as a foundational element over time.
- Driving cost efficiencies in parallel with improving patient outcomes.

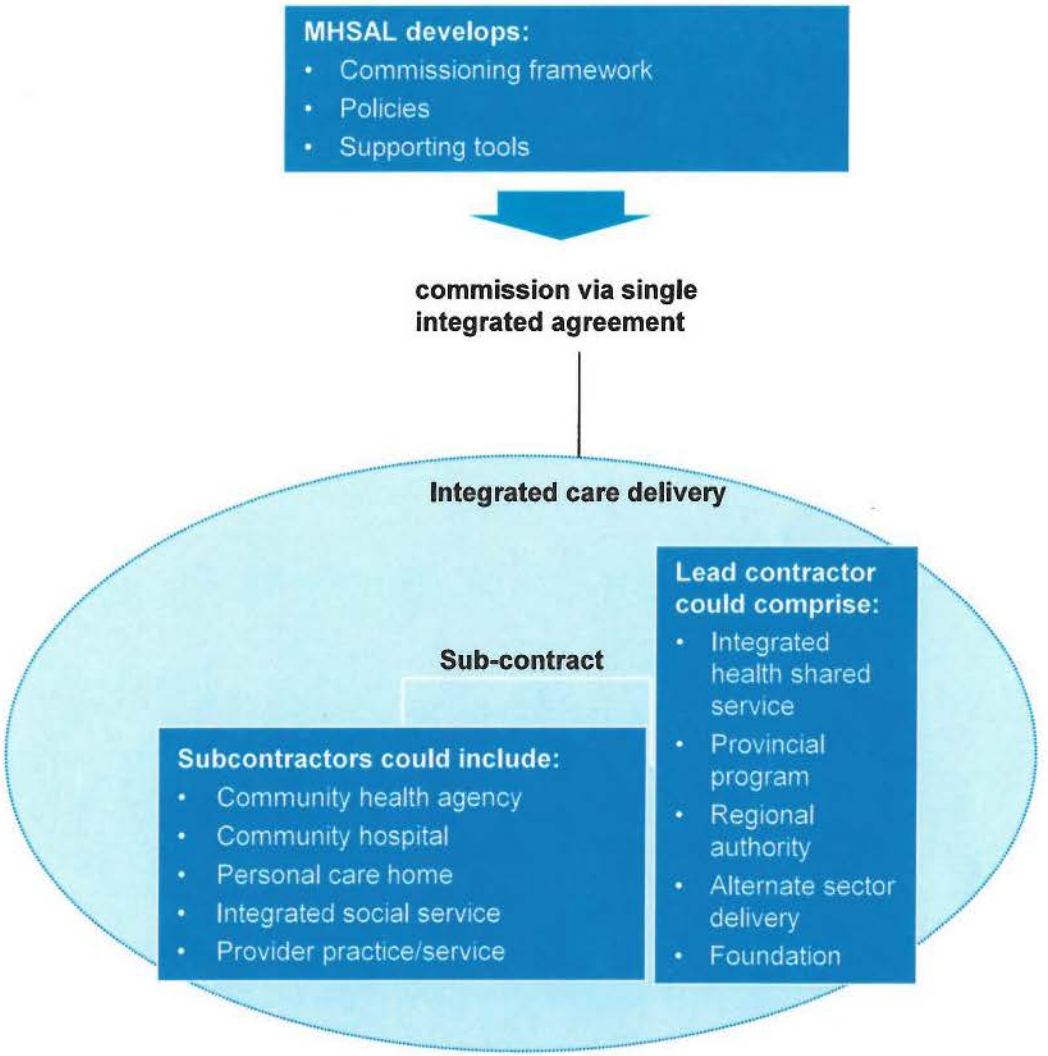




Commissioning Function - "The How"

- Funding and commissioning framework, including policies and supporting tools developed at the provincial level led by MHSAL which will apply to Health Authorities and the Health Shared Service.
- Service planning is required to determine "preferred model".
- Delivery organizations will be incentivized to use services or funded at base cost.
- This requires realignment of existing operating and service purchase agreements to be implemented.

- An entity takes responsibility for the care of a population or pathway (or service).
- Clinically led with multi-specialty involvement where appropriate.
- Involves a transfer of financial risk for the delivery of agreed scope and quality of service as well as health outcomes to strengthen accountability for performance.
- Contractor responsible for appropriate 'make or buy' decisions.
- Extends to provider practice/services over time.



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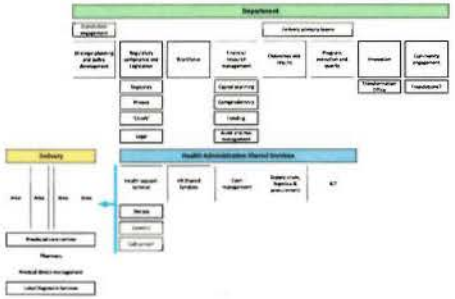
Appendix 1: Background from HSIR Phase 1 Report

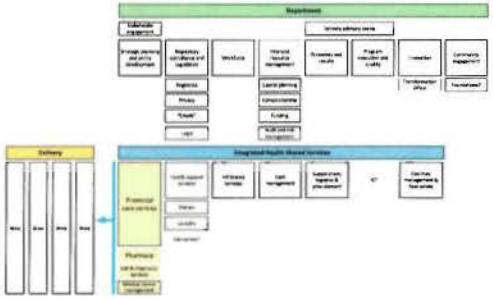
Background: Reference Models

Three reference models were developed in Phase 1 to structure the analysis of reference jurisdictions and to assess the impact of potential changes to Manitoba's health system.

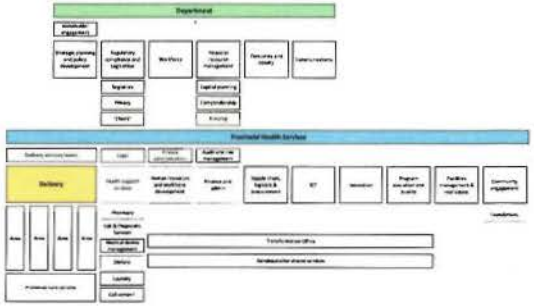
These models are based on the principles of high-performing health systems. Each model separates the role of the Department, Healthcare Delivery Organizations, and Shared Services Organizations. A representative organizational structure has been developed for each model. Each model reflects different levels of governance and delivery integration.



Health shared services organization



Integrated health services organization

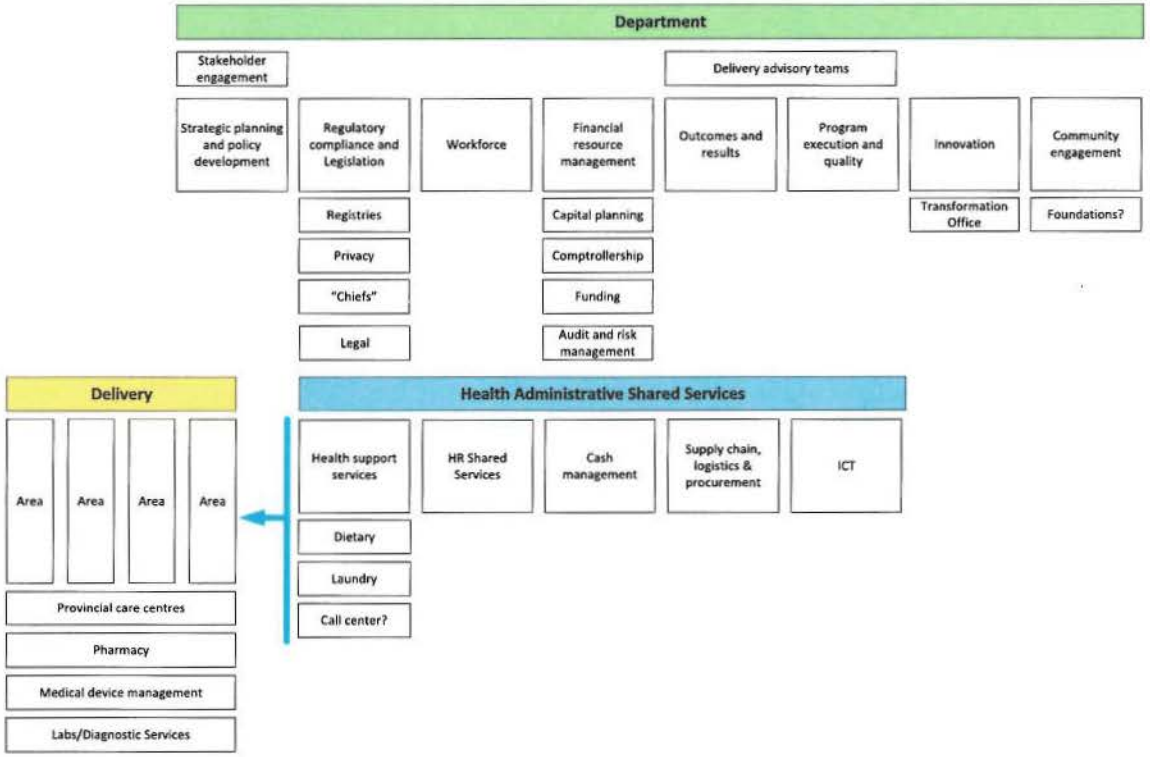


Provincial health services organization

Increasing integration of healthcare delivery and alignment of governance

Background: Reference Models

Reference Model: Health Administrative Shared Services



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

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.

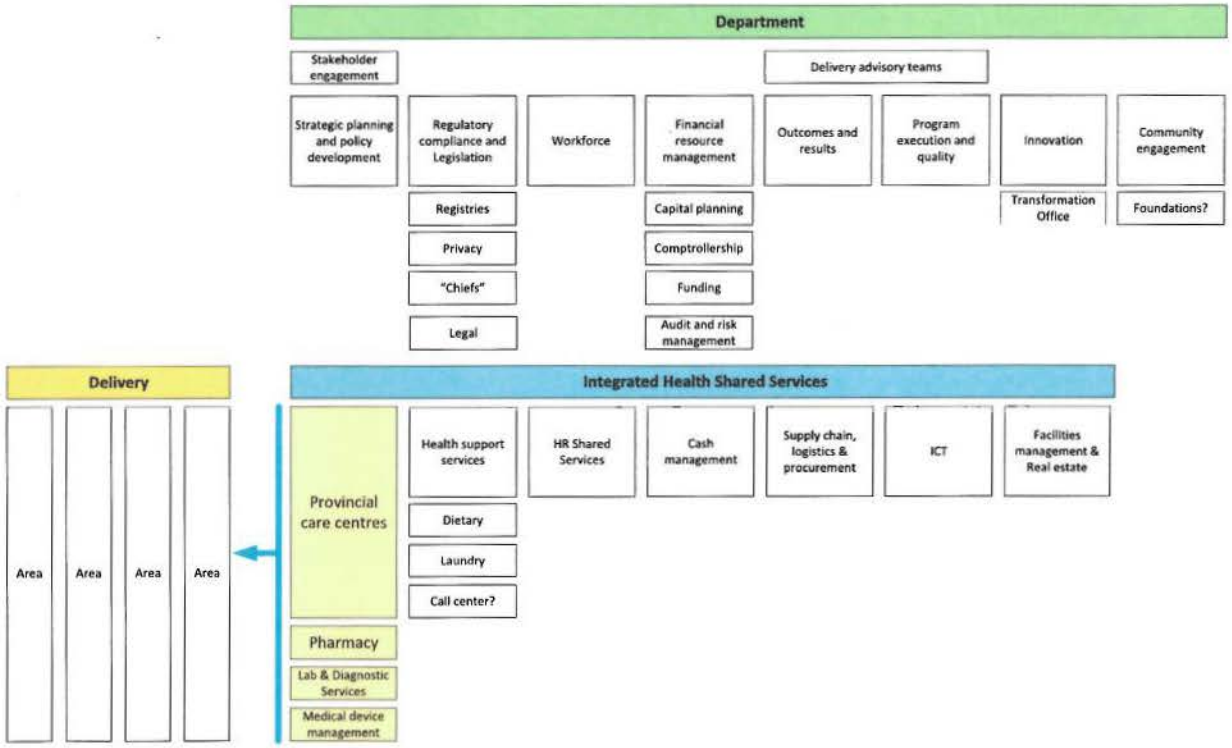
Role of Shared Services Organization

— Integrate and support delivery organizations as service provider.

— Managed with shared governance and SLA/KPIs.

Background: Reference Models

Reference Model: Integrated Health Shared Services



Reference Jurisdictions:
Thedacare

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

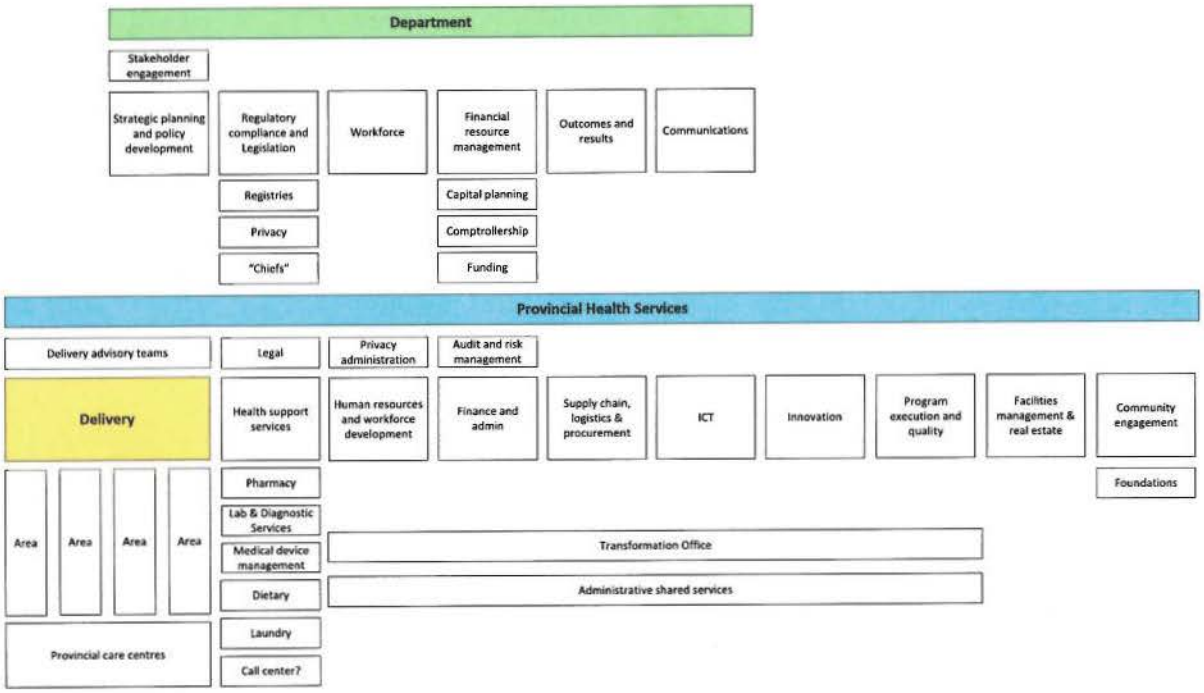
— Integrate and support delivery organizations as service provider.

— Consolidate and integrate whole jurisdiction services and provincial care programs/sites.

— Managed with shared governance and SLA/KPIs.

Background: Reference Models

Reference Model: Provincial Health Services Organization



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

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.

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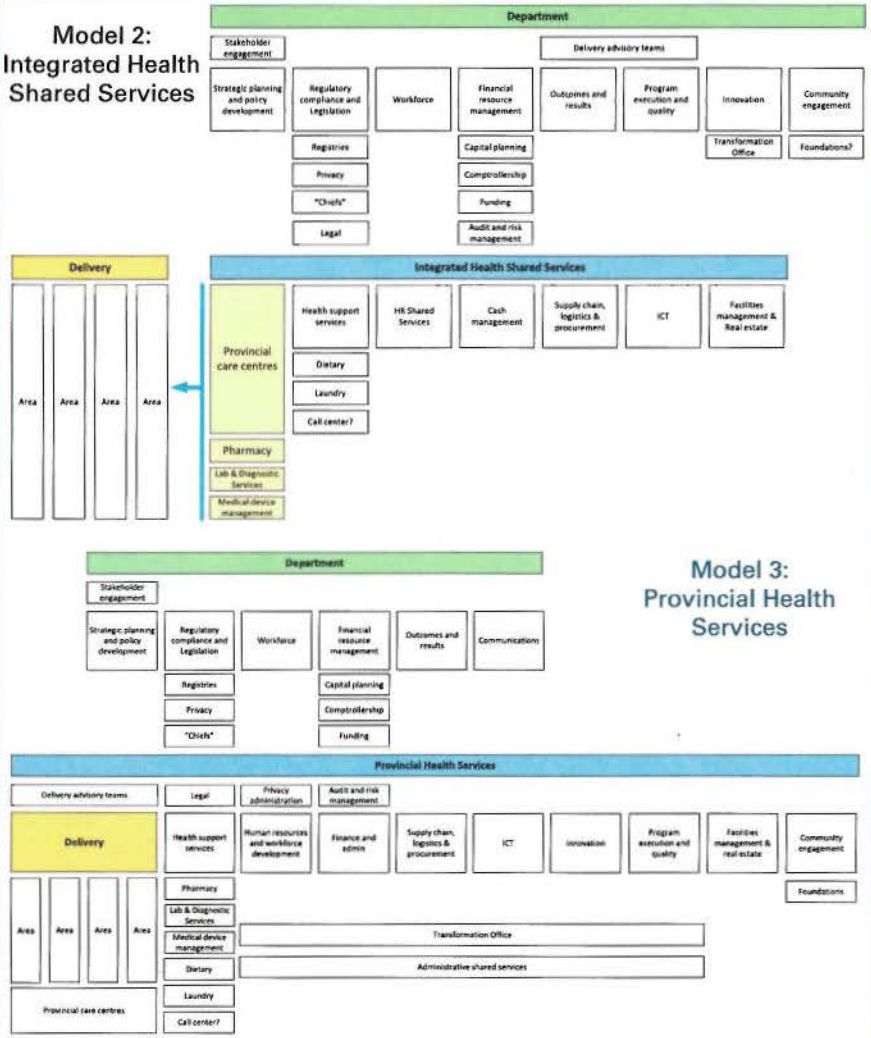
Appendix 2: Session #1: Confirmed elements, design principles and evaluation criteria

This section includes the outputs from working group session #1 as follows:

- Confirmed structural elements to be included in the development of realignment options
- Confirmed design principles to guide development of options
- Confirmed evaluation criteria for subsequent decision-making

Overview of System Configuration Options: Confirmed System Elements from Session #1

Model 2: Integrated Health Shared Services



Model 3: Provincial Health Services

- Strategic planning and policy development
- Federal/provincial/inter-jurisdictional
- Regulatory compliance and legislation
- Legal
- Privacy
- Health workforce
- Financial resource management
  - Capital planning
  - Comptrollership
  - Audit and risk management
- Funding for performance
- Commissioning
- Performance management
  - Outcomes and results
  - Innovation
  - Program execution and quality
- Community and stakeholder engagement
- Shared services
  - Administrative support
    - Human Resources
    - Finance
    - Supply Chain Management
    - Real estate and facilities management
  - Health support services
  - ICT
  - Transformation
- Healthcare service integration
  - Leadership
  - Programs
- Community and stakeholder engagement
- Organizations: Central Government, Department, Regions, Shared services, Hospitals, PCHs, Alternate Deliver Orgs, eHealth, Cancer Care, AFM, DSM, Foundations

Overview of System Configuration Options: Confirmed Evaluation Criteria from Session #1

	Potential criteria	Definition
1	Alignment	Alternative aligns with the overall direction and priorities of government.
2	Financial (economy and efficiency)	Alternative has potential to realize short and long term sustainability, economy and efficiency benefits.
3	Organizational/operational effectiveness	Alternative will improve the organizational and operational effectiveness of health delivery organizations.
4	Capacity and capability	Health sector has the strategic, operational and resource capacity and capability to execute the transition and operate the future state model.
5	Risk	Alternative mitigates system delivery risk.
6	Timing/phasing	Alternative implementation can be implemented to enable other health system initiatives.
7	Simplification and accountability	Alternative reduces complexity and improves accountabilities across the system, reduces overlapping functions.
8	Commitment/provider/delivery organization behaviour	Alternative will have the support and commitment of health sector leadership and encourage/facilitate appropriate provider/delivery organization behaviour.
9	Outcomes and public perspective	Alternative will improve outcomes for patients and be perceived positively by the citizens of Manitoba.

Overview of System Configuration Options: Confirmed Design Principles from Session #1

— Simplification of the overall system.
— Elimination of overlapping and redundant processes.
— Integration of functions and capabilities to achieve a level of expertise and scale to execute.
— Improving accountability and responsibility throughout the system.
— Separating commissioning and delivery functions wherever practical.
— Clarifying the role of central government, the department, regions and healthcare delivery organization.
— Improving the effectiveness of the Department and all Health Care Delivery Organizations as part of an integrated system.
— Achieving cost savings as a result of system realignment.
— Simplify the role, function and number of boards required to oversee the system.

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Appendix 3: Session #2: Strategic system realignment scenarios and evaluation

This section includes the strategic realignment scenarios developed for evaluation by the working group based on decisions in Session #1.

It includes an assessment of each option based on the established evaluation criteria.

Contemplated MHSAL Service Delivery Realignment Opportunities

From Session 1, in addition to confirming evaluation criteria, the following design principles were agreed:

- All scenarios contemplate realignment of health care delivery functions contained in the department.
- Decisions on the final configuration of these services and timelines for implementation will be required as part of the strategic realignment implementation program.
- These include but are not limited to:
  - Insured service claims administration to shared service or alternate service delivery.
    - Fee-for-service.
    - Other insured benefits.
    - Pharmacy.
  - Emergency management functions to shared service.
    - Ambulance fleet management.
    - Medical Transportation Coordination Centre (PMRHA).
    - Emergency Incident Command (potential).
  - CADHAM Provincial Laboratory to authority or integrated diagnostics shared service.
  - Selkirk Mental Health Center to integrated health service as provincial care center.
  - [redacted].
  - Provincial Quick Care Clinics to regional authority or integrated health service.
  - Transportation management functions to shared service.
    - Northern Patient Transportation Program.
    - Lifeflight Service/Air Ambulance.
    - STARS Air Ambulance.
  - Public health inspections to integrated inspections team with MB Agriculture or regional authority
  - Communication functions to shared service.
    - Out of Province Referrals.
    - Seniors Information Line.
    - Provincial Health Contact Centre (Misericordia).
  - Consolidation and alignment of the Medical Officers of Health between MHSAL and all authorities.

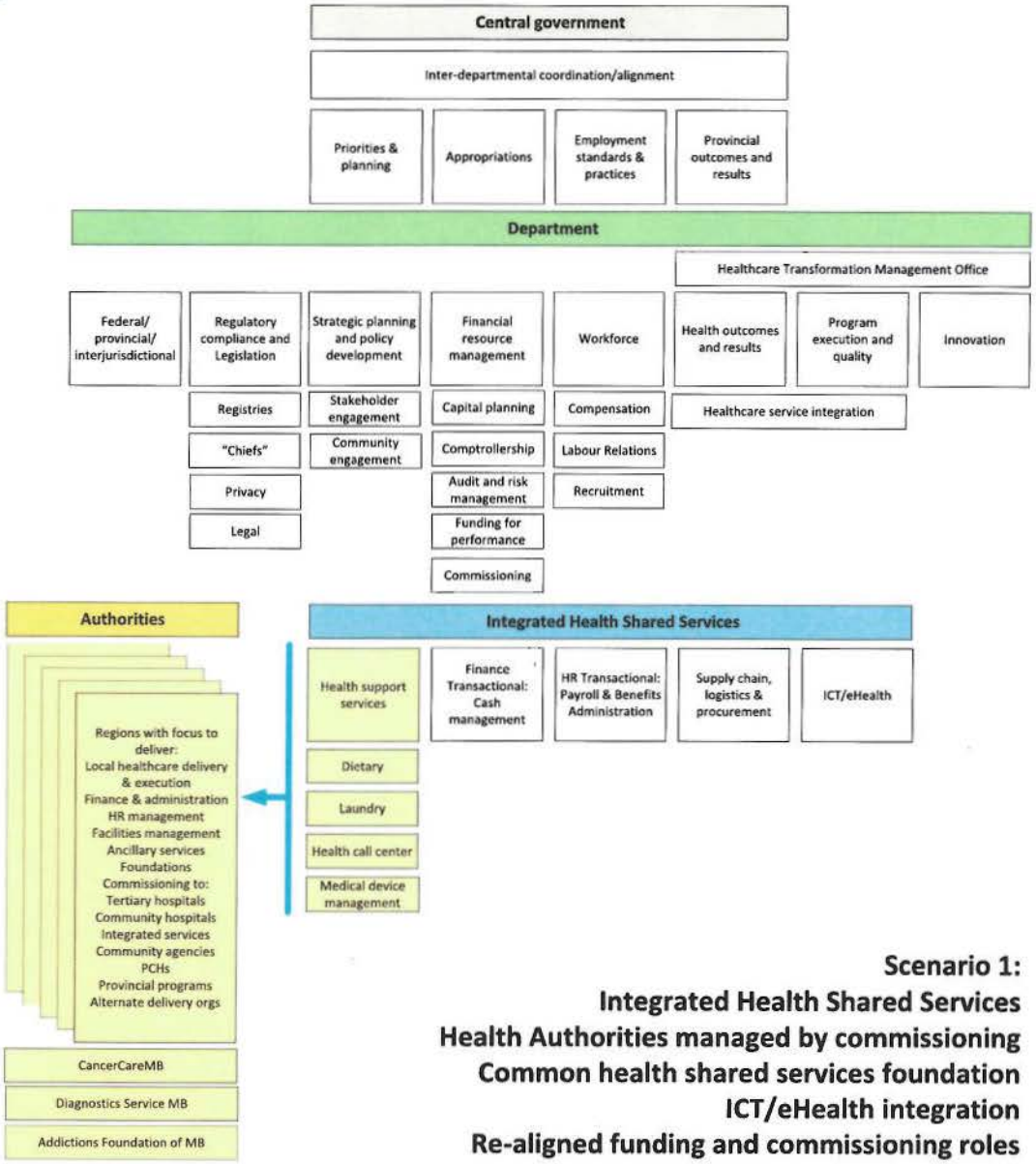
Overview of System Configuration Options: What Functions Make Up a "Health Authority"?

Regions with focus to deliver:
- Local healthcare delivery & execution
- Finance & Administration
- Human Resources
- Supply Chain
- Facilities Management
- Local ICT Support
- Ancillary Services Foundations

Commissioning to:
- Tertiary hospitals
- Community hospitals
- Integrated Services
- Community Agencies
- Personal Care Homes
- Provincial Programs
- Alternate delivery organizations

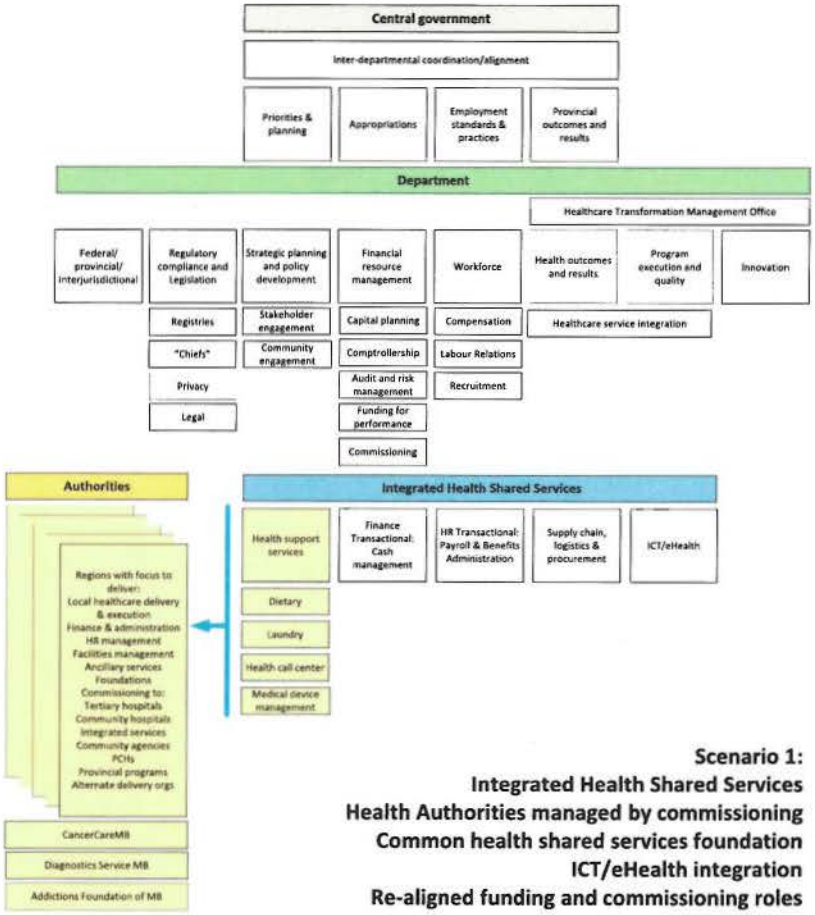
- A health authority incorporates a complete set of organizational functions with independent governance.
- Commissioning roles vary between the organizations with WRHA having the most extensive functional accountability.
- No concept of a "Provincial" region exists in the current legislation so it is not straightforward to structure a jurisdiction-wide service.
- Integration within the system is achieved through funding agreements.
- A key feature of this system is that many entities are engaged through operating and service purchase agreements with regions.
- Current legislation does not permit the realignment of these agreements unilaterally.
- Each of the following scenarios reconfigures the role of health authorities together with different parts of the system.
- There will be different implementation requirements based on the preferred scenario/approach.
- All scenarios would require changes to RHA Act as well as other acts and regulations as part of implementation plan.

Scenario 1



Scenario 1:
Integrated Health Shared Services
Health Authorities managed by commissioning
Common health shared services foundation
ICT/eHealth integration
Re-aligned funding and commissioning roles

Scenario 1



Scenario 1:
Integrated Health Shared Services
Health Authorities managed by commissioning
Common health shared services foundation
ICT/eHealth integration
Re-aligned funding and commissioning roles

Reference jurisdictions:
Saskatchewan 3S, BC PHSA

Functional realignment

— Consolidation and integration of departmental functions: Regulatory, Policy, Workforce, Financial Resource Management.
— Creation of Transformation Management Office (TMO) with integrated outcomes and execution capability.
— Establish clinical integration function within the TMO.
— Move to shared services delivery for Health Support Services, Payroll & Benefits Administration, Cash Management (potential), Supply Chain and ICT/eHealth.

Organization/ "Employer" structure

— Limited change to existing structures.

Funding model and approach

— This scenario depends on realignment of funding model, operating agreements and service purchase agreements across the system.
— Incorporate concepts of alignment and integration of service delivery as part of an integrated system.

Commissioning function

— Establish and strengthen departmental commissioning capability to all authorities and the Health Shared Service.

Governance & board structure

— Opportunities to streamline or align for shared services.
— Board integration achieved through funding and commissioning model.

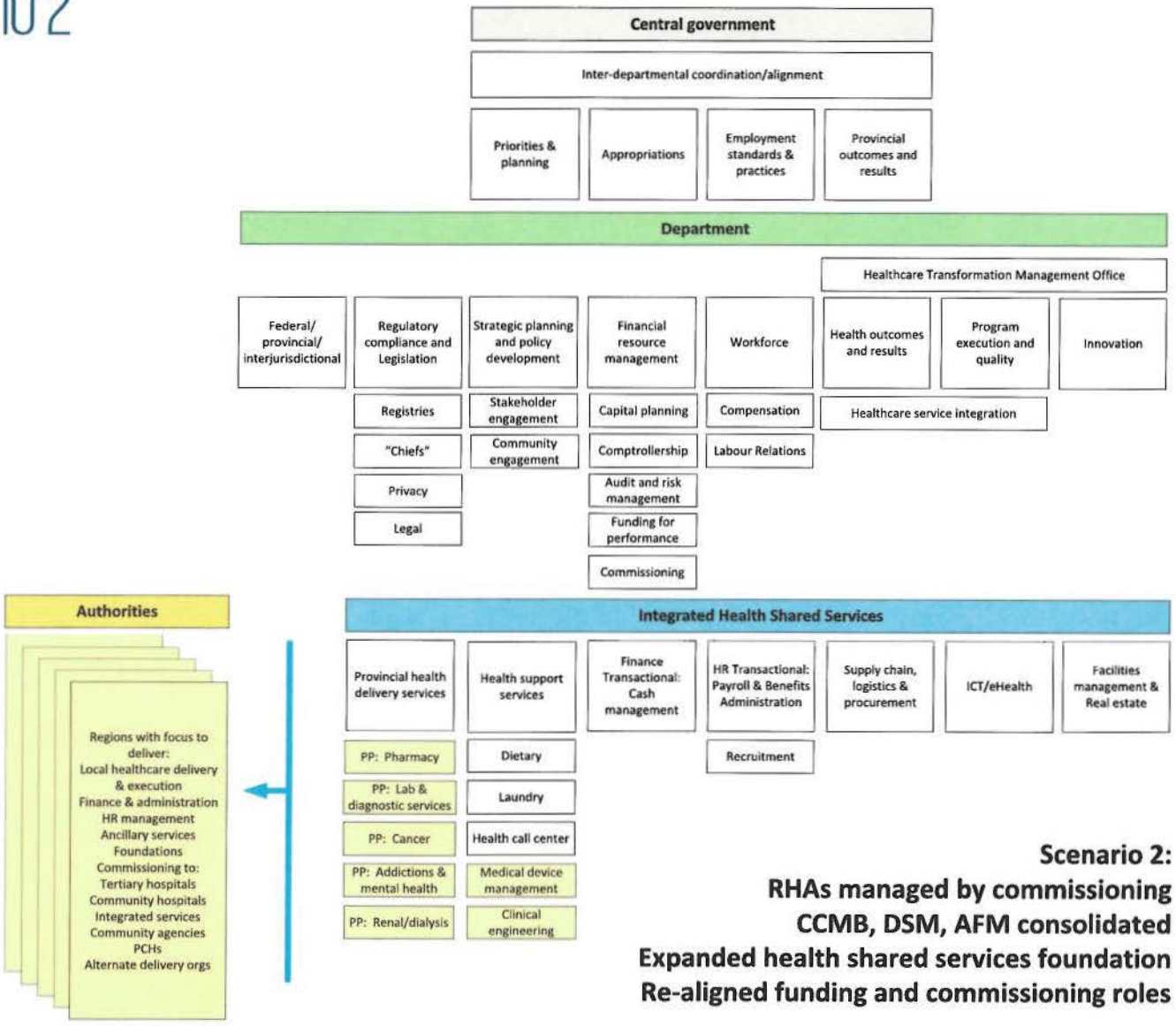
Clinical alignment

— Achieved through funding/commissioning and agreement through working groups with provincial coordination.

Outcomes

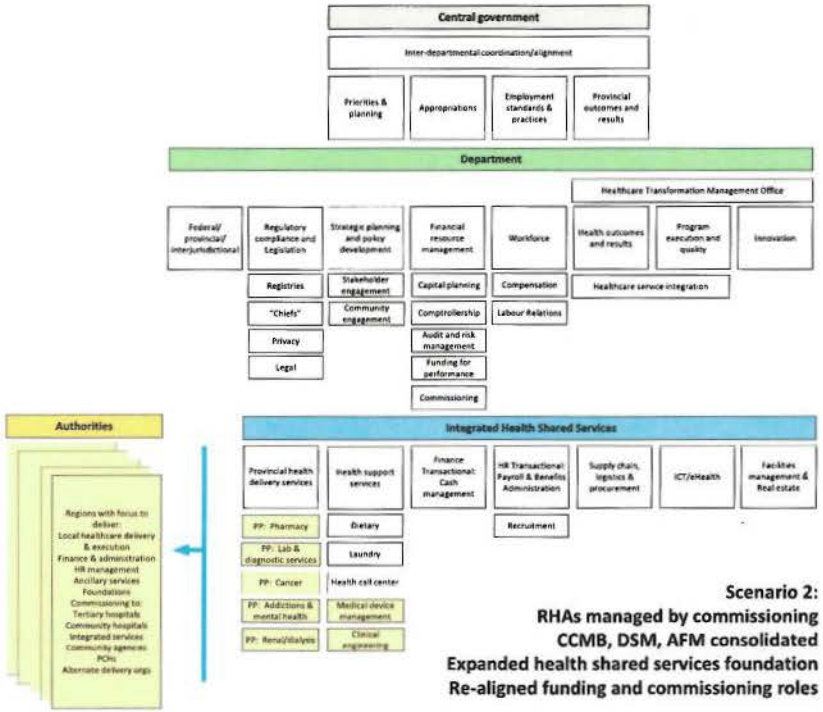
— Cost improvements and efficiencies in implemented shared services.
— Clarification of roles and accountabilities.
— Limited clinical service delivery impacts positive or negative.

Scenario 2



Scenario 2:
RHAs managed by commissioning
CCMB, DSM, AFM consolidated
Expanded health shared services foundation
Re-aligned funding and commissioning roles

Scenario 2



Scenario 2:
RHAs managed by commissioning
CCMB, DSM, AFM consolidated
Expanded health shared services foundation
Re-aligned funding and commissioning roles

Reference jurisdictions:
BC PHSA, NHS England

Functional realignment

— Consolidation and integration of departmental functions: Regulatory, Policy, Workforce, Financial Resource Management.
— Creation of Transformation Management Office (TMO) with integrated outcomes and execution capability.
— Establish clinical integration function within the TMO
— Move to shared services delivery for Health Support Services, Payroll & Benefits Administration, Recruiting, Cash Management (potential), Supply Chain, ICT/eHealth, Facilities management & real estate, MDR/Clinical Engineering, Provincial level delivery programs.

Organization/ "Employer" structure

— Consolidation of CCMB, DSM, AFM.

Funding model and approach

— This scenario depends on realignment of funding model, operating agreements and service purchase agreements across the system.
— Incorporate concepts of alignment and integration of service delivery as part of an integrated system.

Commissioning function

— Establish and strengthen departmental commissioning capability to all authorities and the Health Shared Service.

Governance & board structure

— Opportunities to streamline or align for shared services, CCMB, DSM, AFM.
— RHA Board integration achieved through funding and commissioning model.

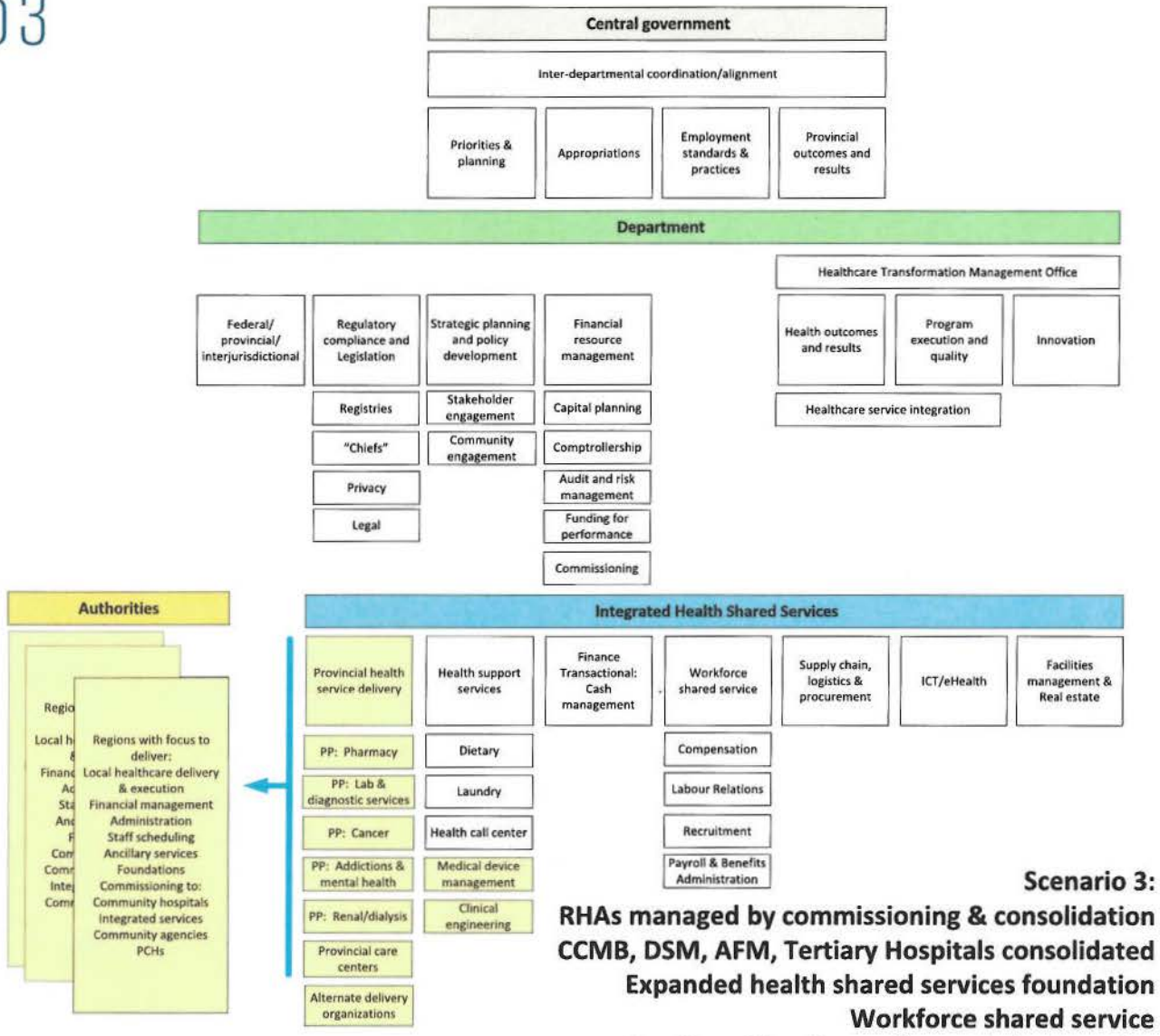
Clinical alignment

— Achieved through funding/commissioning and agreement through working groups with provincial coordination.
— Core jurisdiction-wide programs consolidated for integrated delivery across province.

Outcomes

— Cost improvements and efficiencies in implemented shared services.
— Clarification of roles and accountabilities.
— Improved service management capability for province-wide programs.
— Operating cost improvements from consolidation of management and administration functions.

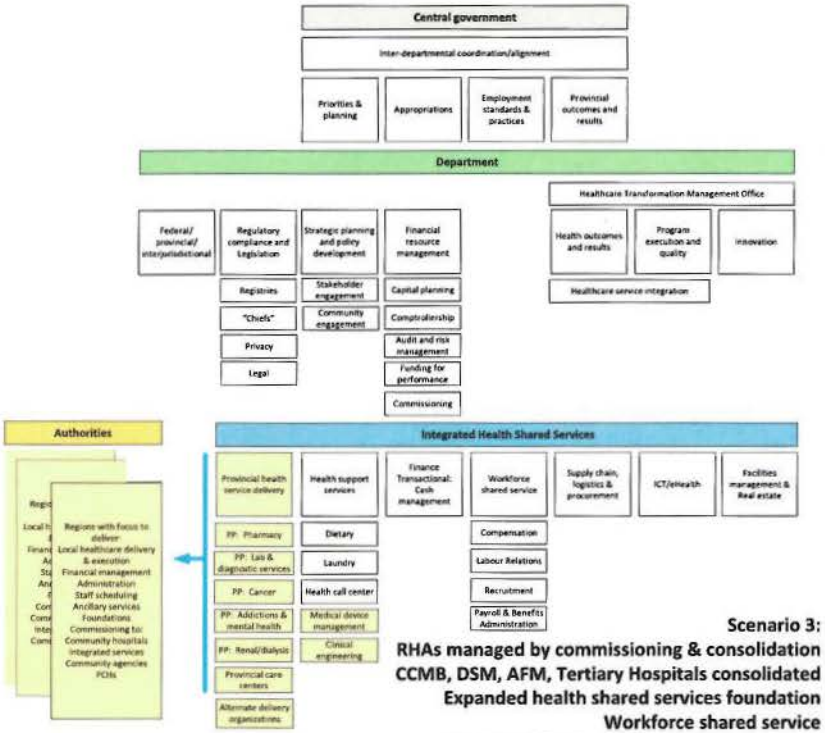
Scenario 3



Scenario 3:

RHAs managed by commissioning & consolidation
CCMB, DSM, AFM, Tertiary Hospitals consolidated
Expanded health shared services foundation
Workforce shared service
Re-aligned funding and commissioning roles

Scenario 3



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Reference jurisdictions:
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Organization/ "Employer" structure

— Consolidation of CCMB, DSM, AFM.

Funding model and approach

— This scenario depends on realignment of funding model, operating agreements and service purchase agreements across the system.
— Incorporate concepts of alignment and integration of service delivery as part of an integrated system.

Commissioning function

— Establish and strengthen departmental commissioning capability to all Health Authorities and the Health Shared Service.

Governance & board structure

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— RHA Board integration achieved through funding and commissioning model.

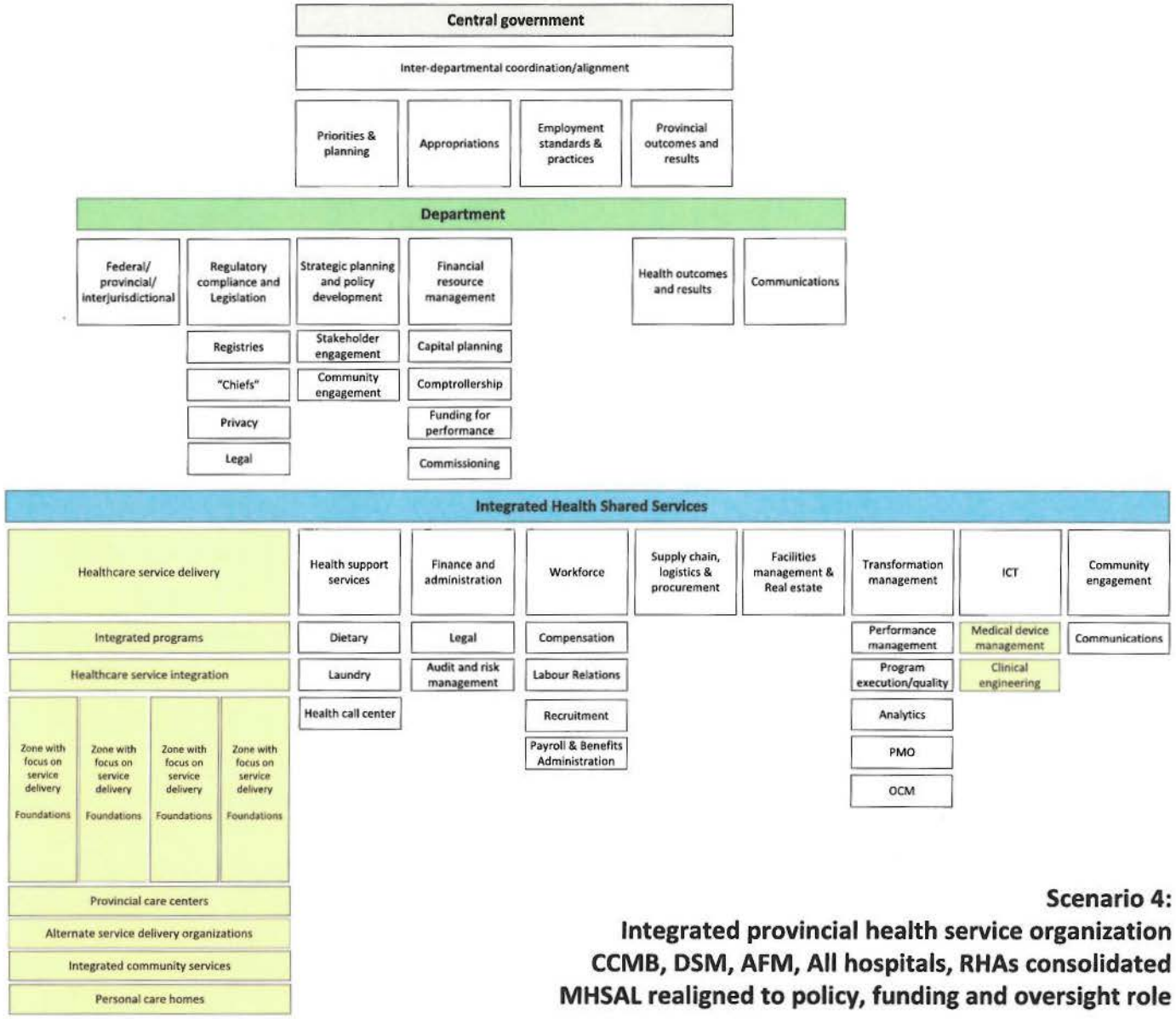
Clinical alignment

— Achieved through funding/commissioning and agreement through working groups with provincial coordination.
— Core jurisdiction-wide programs consolidated for integrated delivery across province.

Outcomes

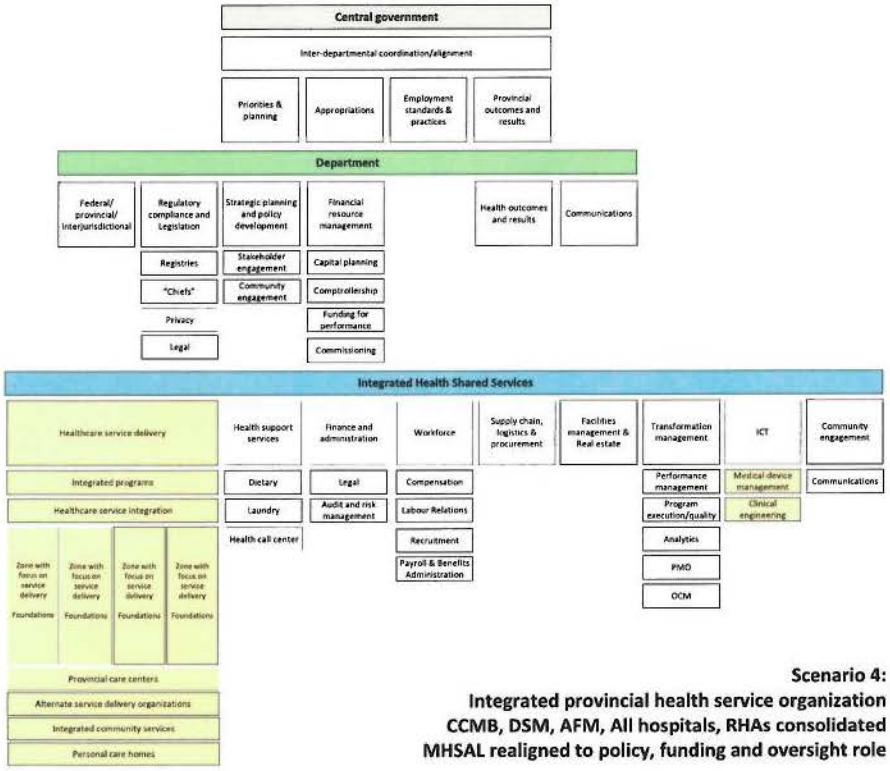
— Cost improvements and efficiencies in implemented shared services
— Clarification of roles and accountabilities.
— Improved service management capability for province-wide programs
— Operating cost improvements from consolidation of management and administration functions.

Scenario 4



Scenario 4:
Integrated provincial health service organization
CCMB, DSM, AFM, All hospitals, RHAs consolidated
MHSAL realigned to policy, funding and oversight role

Scenario 4



Scenario 4:
Integrated provincial health service organization
CCMB, DSM, AFM, All hospitals, RHAs consolidated
MHSAL realigned to policy, funding and oversight role

Reference jurisdictions:
BC PHSA, NHS England, ON LHINs, AB Health Services, SK TBD

Functional realignment

— Consolidation and integration of departmental functions: Regulatory, policy, financial resource management, outcomes and results.
— Move to integrated health shared services delivery for Health Support Services, Payroll & Benefits Administration, Recruiting, Cash Management (potential), Supply Chain, ICT/eHealth, Facilities management & real estate, MDR/Clinical Engineering, Workforce, Provincial level delivery programs.

Organization/ "Employer" structure

— Consolidation of all organizations and regions into a single entity.

Funding model and approach

— Re-aligned funding system with integrate heath shares services entity.

Commissioning function

— Establish and strengthen departmental commissioning capability to the integrated Health Shared Service.
— Alternate service delivery commissioning aligned with provincial programs/sites.

Governance & board structure

— Opportunities to streamline for all entities in the system
— Realign boards to local delivery advisory councils.

Clinical alignment

— Achieved through functional and delivery alignment.

Outcomes Integration

— Clarification of roles and accountabilities.
— Cost improvements and efficiencies in realignment of all finance, workforce, supply chain, real estate/facilities management and ICT services.
— Standardized transformation and performance management capability implemented across entire system.
— Strengthened service management capability for all programs in all areas of the province.
— Operating cost improvements from consolidation of management and administration functions.

Assess and Evaluate Alternatives

#	Overview	Scenario 1 Integrated Health Shared Services; Health Authorities managed by commissioning; Common health shared services foundation; ICT/eHealth integration; Re-aligned funding and commissioning roles	Scenario 2 RHAs managed by commissioning; CCMB, DSM, AFM consolidated; Expanded health shared services foundation; Re-aligned funding and commissioning roles	Scenario 3 RHAs managed by commissioning & consolidation; CCMB, DSM, AFM, Tertiary Hospitals; Expanded health shared services foundation; Workforce shared service; Re-aligned funding and commissioning roles	Scenario 4 Integrated provincial health service organization; CCMB, DSM, AFM, All hospitals, RHAs consolidated; MHSAL re-aligned to policy, funding and oversight role
1	Alignment	Low	Medium	High	High
2	Financial (economy and efficiency)	Low	Low	Medium	High
3	Organizational/operational effectiveness	Low	High	High	Medium
4	Capacity and capability	High	Medium	Medium	Low
5	Risk	Medium	Medium	High	High
6	Timing/phasing	High	Medium	Medium	Low
7	Simplification and accountability	Low	Medium	Medium	Medium
8	Commitment/provider/delivery organization behaviour	Low	Medium	High	High
9	Outcomes and public perspective	Low	Medium	Medium	Medium

Assess and Evaluate Alternatives

#	Overview	Scenario 1 Integrated Health Shared Services; Health Authorities managed by commissioning; Common health shared services foundation; ICT/eHealth integration; Re-aligned funding and commissioning roles	Scenario 2 RHAs managed by commissioning; CCMB, DSM, AFM consolidated; Expanded health shared services foundation; Re-aligned funding and commissioning roles	Scenario 3 RHAs managed by commissioning & consolidation; CCMB, DSM, AFM, Tertiary Hospitals; Expanded health shared services foundation; Workforce shared service; Re-aligned funding and commissioning roles	Scenario 4 Integrated provincial health service organization; CCMB, DSM, AFM, All hospitals, RHAs consolidated; MHSAL re-aligned to policy, funding and oversight role
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6	Timing/phasing	High	Medium	Medium	Low
7	Simplification and accountability	Low	Medium	Medium	Medium
8	Commitment/provider/delivery organization behaviour	Low	Medium	High	High
9	Outcomes and public perspective	Low	Medium	Medium	Medium

Preferred direction

Assess and Evaluate Alternatives

#	Overview	Scenario 1 Integrated Health Shared Services; Health Authorities managed by commissioning; Common health shared services foundation; ICT/eHealth integration; Re-aligned funding and commissioning roles	Scenario 2 RHAs managed by commissioning; CCMB, DSM, AFM consolidated; Expanded health shared services foundation; Re-aligned funding and commissioning roles	Scenario 3 RHAs managed by commissioning & consolidation; CCMB, DSM, AFM, Tertiary Hospitals; Expanded health shared services foundation; Workforce shared service; Re-aligned funding and commissioning roles	Scenario 4 Integrated provincial health service organization; CCMB, DSM, AFM, All hospitals, RHAs consolidated; MHSAL re-aligned to policy, funding and oversight role
1	Alignment	Low	Medium	Working group identified this scenario as the basis for refinement with direction to incorporate elements of other options where most appropriate	High
2	Financial (economy and efficiency)	Low	Low		High
3	Organizational/operational effectiveness	Low	High		Medium
4	Capacity and capability	High	Medium		Low
5	Risk	Medium	Medium		High
6	Timing/phasing	High	Medium		Low
7	Simplification and accountability	Low	Medium		Medium
8	Commitment/provider/delivery organization behaviour	Low	Medium		High
9	Outcomes and public perspective	Low	Medium		Medium

KPMG

Appendix 4: Session #3: Preferred Option and implementation considerations

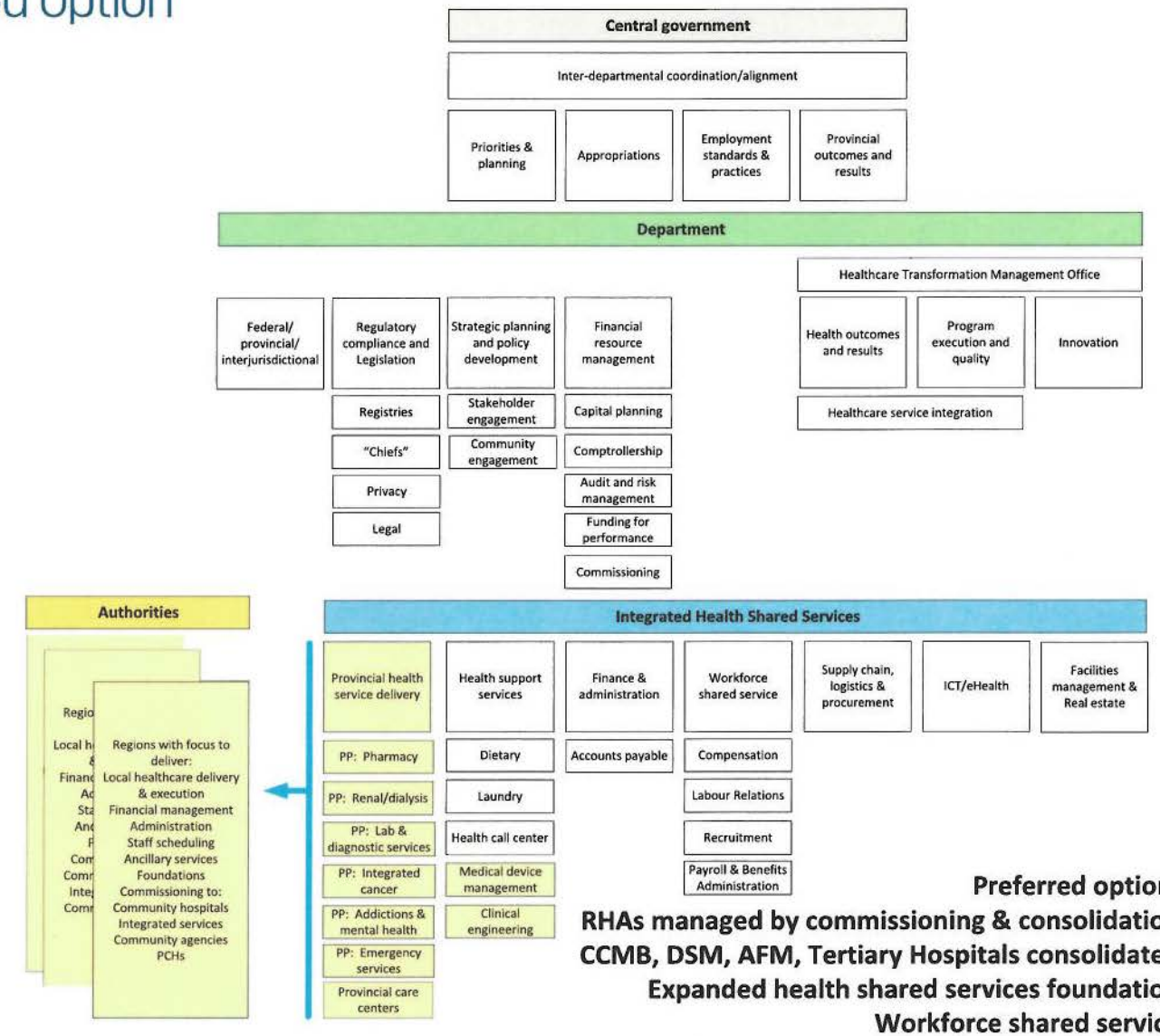
This section documents the preferred option developed by the KPMG team based on the evaluation process conducted with the working group. The information in this section is structured in the following sections:

- Preferred option overview
- Functional accountabilities
- Alternate service delivery options
- Organizational integration decision points
- Implications for commissioning framework including interim actions
- Key requirements for policy/legislative and regulatory change

Preferred Option: MHSAL Service Delivery Realignment Opportunities

- All scenarios contemplate realignment of healthcare delivery functions contained in the department.
- Decisions on the final configuration of these services will be required as part of the strategic realignment implementation program.
- These include but are not limited to:
  - Insured service claims administration to shared service or alternate service delivery.
    - Fee-for-service.
    - Other insured benefits.
    - Pharmacy.
  - Emergency management functions to shared service.
    - Ambulance fleet management.
    - Medical Transportation Coordination Centre (PMRHA).
    - Emergency Incident Command (potential).
  - CADHAM Provincial Laboratory to health authority or integrated diagnostics shared service.
  - Selkirk Mental Health Centre to integrated health service as provincial care center.
  - [redacted].
  - Provincial Quick Care Clinics to regional authority or integrated health service.
  - Transportation management functions to shared service.
    - Northern Patient Transportation Program.
    - Lifeflight Service/Air Ambulance.
    - STARS Air Ambulance.
  - Public health inspections to integrated inspections team with Manitoba Agriculture or regional authority.
  - Communication functions to shared service.
    - Out of Province Referrals.
    - Seniors Information Line.
    - Provincial Health Contact Centre (Misericordia).
  - Consolidation and alignment of the Medical Officers of Health between MHSAL and all authorities.

Preferred Option



Preferred option:

RHAs managed by commissioning & consolidation

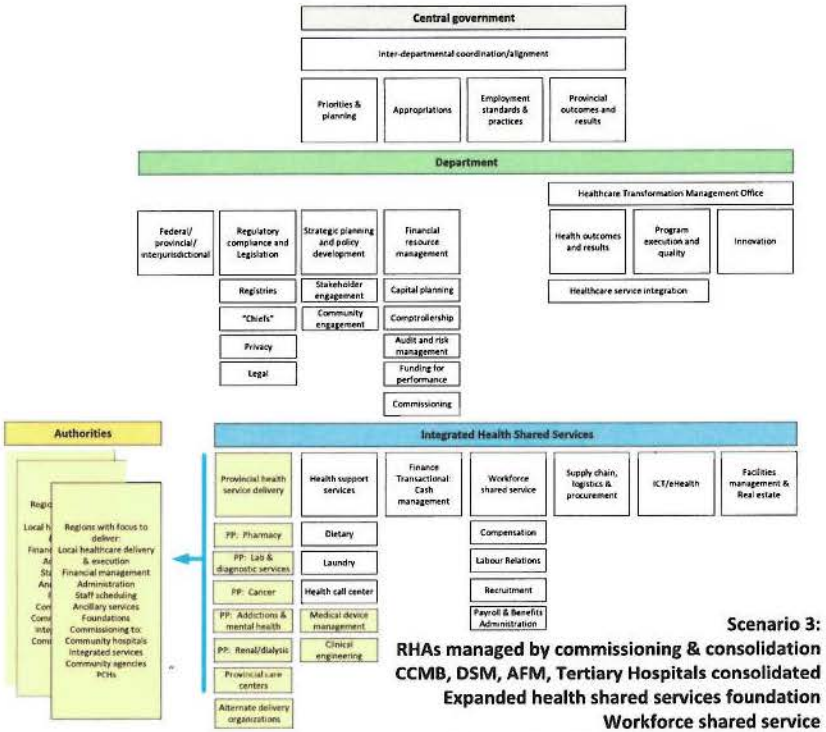
CCMB, DSM, AFM, Tertiary Hospitals consolidated

Expanded health shared services foundation

Workforce shared service

Re-aligned funding and commissioning roles

Preferred Option



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Organization/ "Employer" structure

— Consolidation of CCMB, DSM, AFM.

Funding model and approach

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Commissioning function

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Clinical alignment

— Achieved through funding/commissioning and agreement through working groups with provincial coordination.
— Core jurisdiction-wide programs consolidated for integrated delivery across province.

Outcomes

— Cost improvements and efficiencies in implemented shared services
— Clarification of roles and accountabilities.
— Improved service management capability for province-wide programs.
— Operating cost improvements from consolidation of management and administration functions.

Areas Identified for Clarification within the Preferred Option

— What are the core and optional services in the integrated shared service? Are there elements of the other models that could/should be incorporated?

— Are there opportunities for alternate service delivery or are these all "staff" functions?

— What is the structure of the shared service?

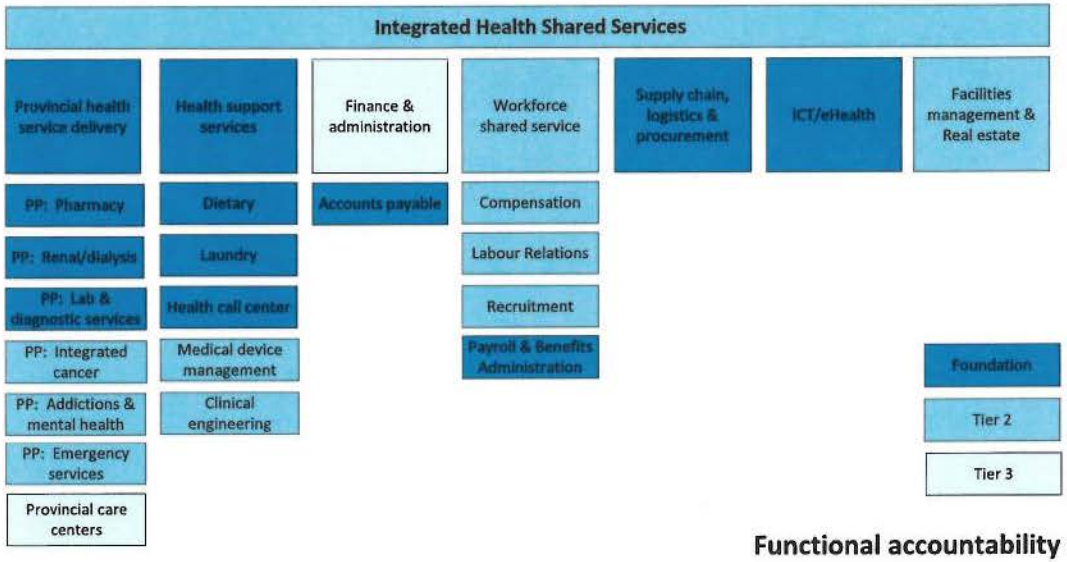
— How will this model improve/reinforce appropriate behaviours? How does it offset bureaucracy with creative tension/competition/innovation?

— What is the patient experience? How will this impact service delivery for them?

— What is the alignment between the Department, Integrated Health Shared Service and Service Delivery Organizations?

— How can an effective commissioning framework be developed and what are the key enabling tools?

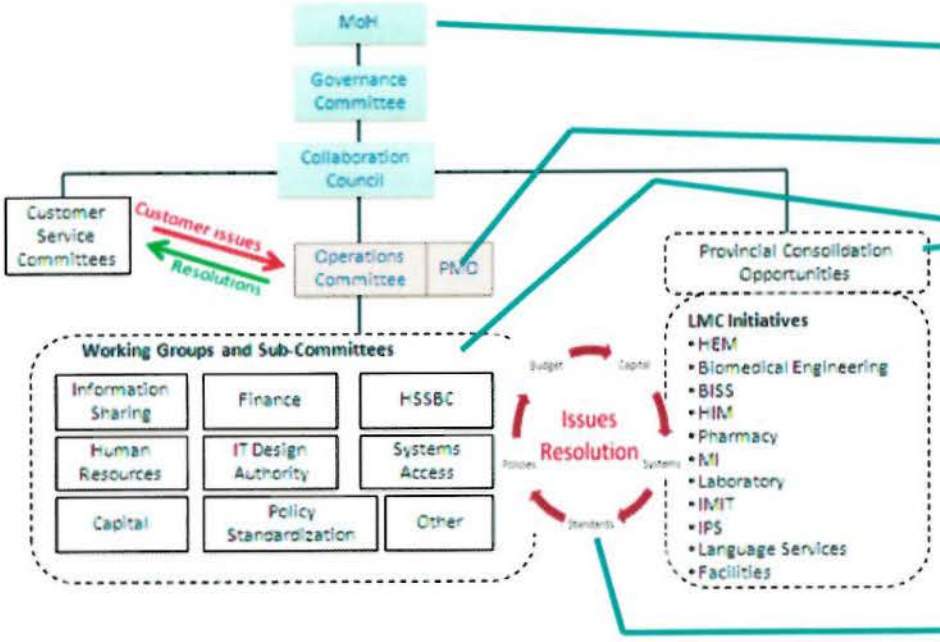
Core Functional Accountability



Functional accountability

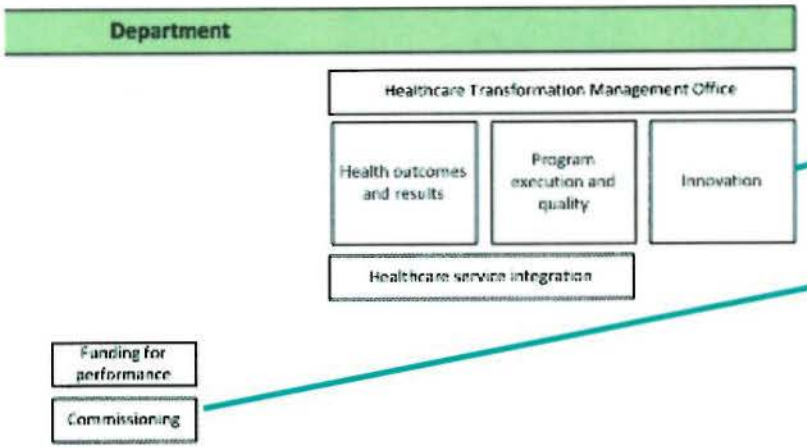
- There are three levels of functional accountability that could be considered for the health shared services organization.
- Foundational accountabilities have been proven as shared services in leading jurisdictions.
- Tier 2 accountabilities are recommended based on HSIR Phase I Report findings.
- Tier 3 health service delivery functions may be achieved through a combination of commissioning and structural realignment.
- Tier 3 finance & administration service can be enabled by leveraging WRHA BPSP implementation at a Provincial scale.

How Have other Jurisdictions Activated Service Planning and Definition?



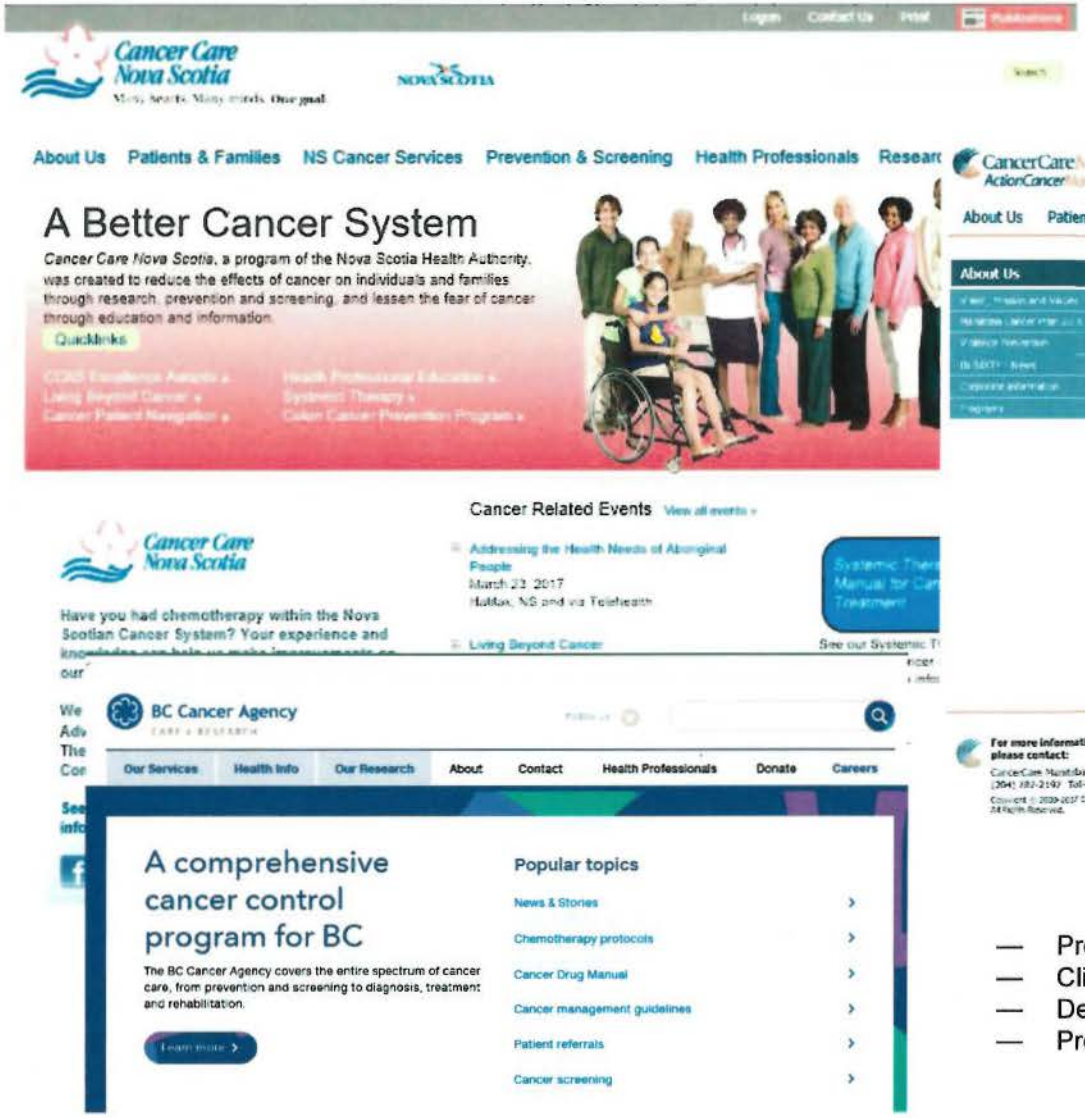
Lower Mainland Integration Planning Program, BC PHSA, 2012

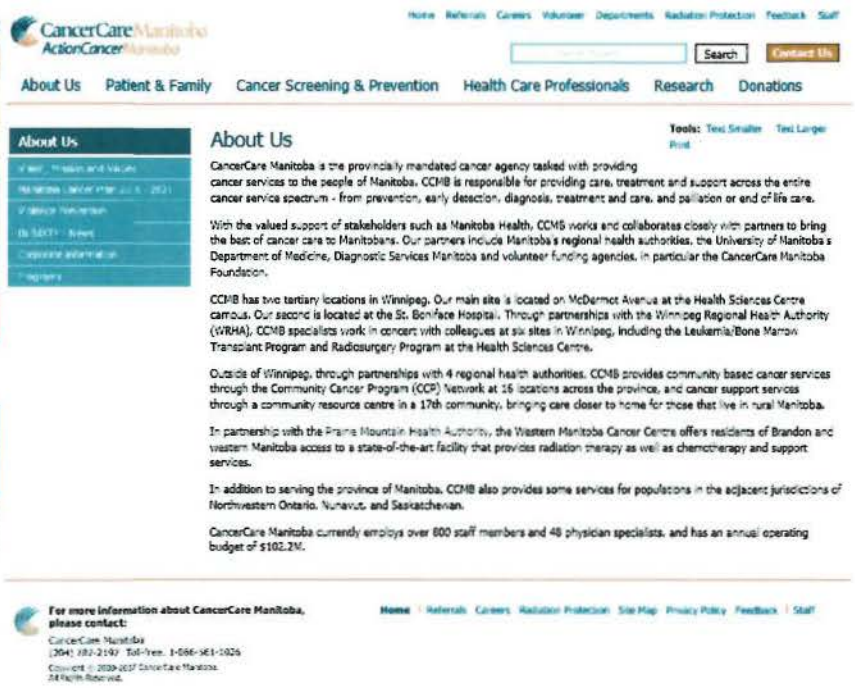
- Clear provincial initiative with system integration governance.
- Integrated transformation program that aligns initiatives and projects.
- Clear vision for integrated health shared services delivery combined with policy, finance, ICT, capital and administrative services planning.
- Active program with integrated issue management:
  - Budget
  - Capital
  - Policy
  - Systems and processes
  - Standards
  - Capacity and infrastructure



- These are the same concepts identified for the healthcare transformation management office.
- These service plans will be activated through system funding reform and changes to the provincial commissioning framework.

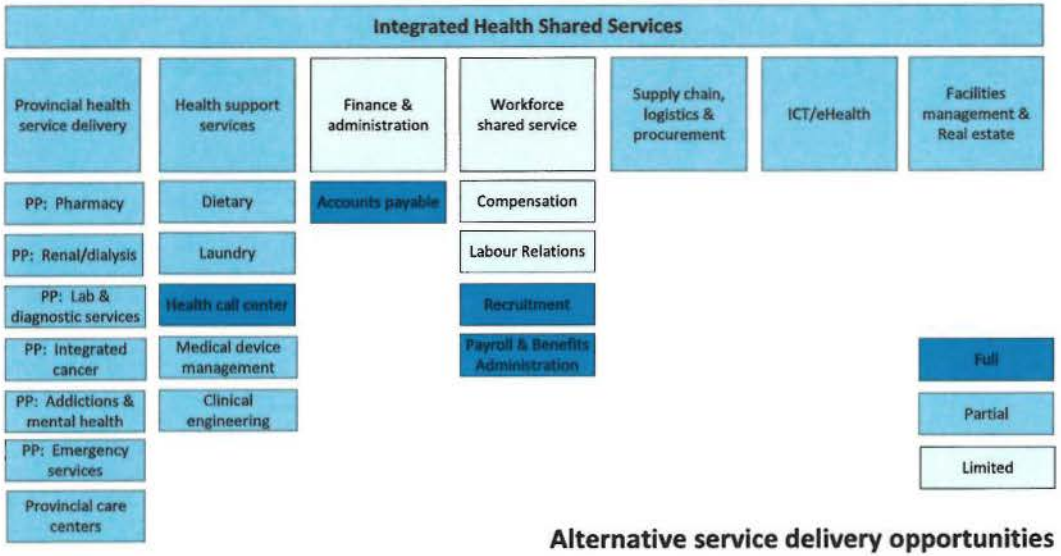
How Have other Jurisdictions Activated Service Planning and Definition?





- Province-wide service planning and execution
- Clinical standards
- Delivery outcomes
- Provider network supports and community

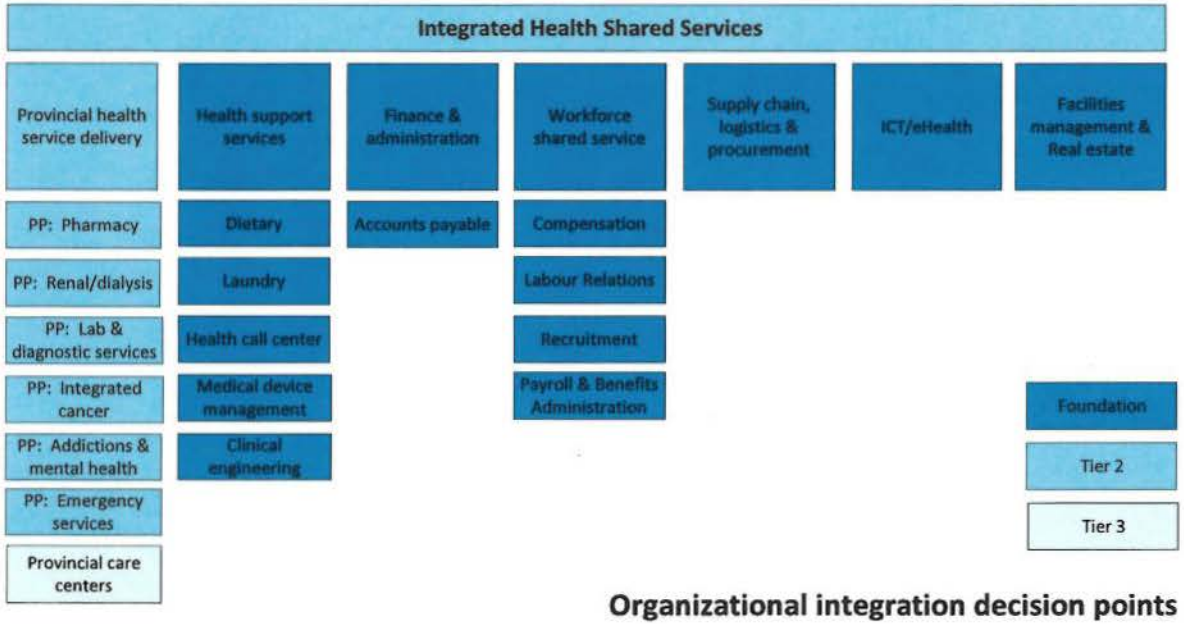
Alternate Service Delivery Opportunities



Alternative service delivery opportunities

- Most services could be delivered through a combination of alternative service delivery and internal functions.
- All work streams include feasibility or planning projects to define the appropriate approach in the first year.
- Key finance and workforce management functions should be retained as staff functions.
- For all partial ASD functions, the health shared service would remain responsible for:
  - Delivery policy and procedure
  - Service planning
  - Service level definition
  - Service and delivery standards
  - Commissioning to authorities and service providers
  - Contract management
  - Delivery oversight and coordination
  - Outcomes and results
  - Service performance/wait lists
- Most system services do not have the maturity to be considered immediate candidates for alternate delivery and stabilization/consolidation initiatives are identified in the work plans for these services.

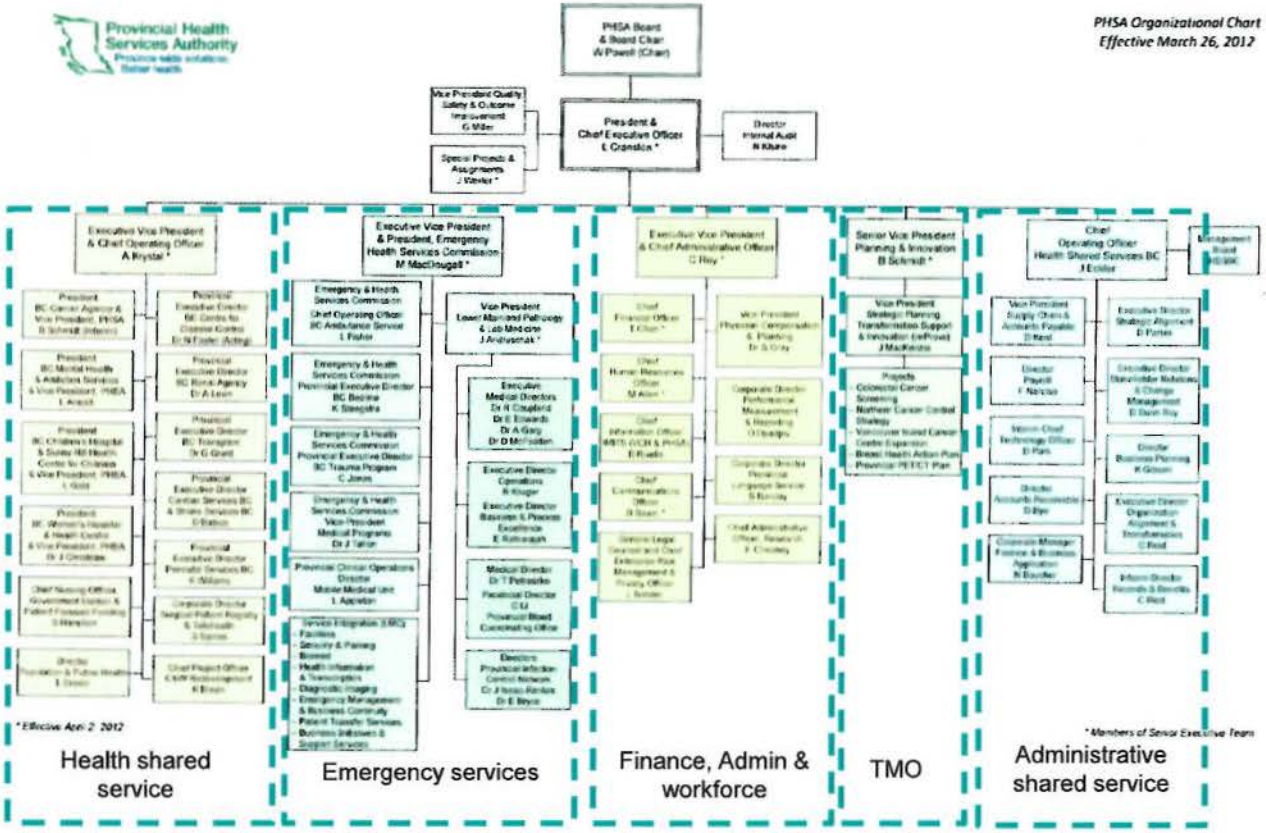
Organizational Integration Decision Points



Organizational integration decision points

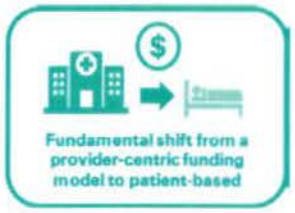
- There are three levels of organizational integration that could be considered for the shared services organization.
- Foundational integration have been proven for shared services organizations in leading jurisdictions.
- Tier 2 integration can be accomplished within the health shared service or in a separate entity with responsibility for provincial health service delivery.
- Tier 3 integration requires devolution of key sites (e.g.. HSC, SBGH, SMHC) within health delivery shared service:
  - This may be achieved through a combination of commissioning and structural realignment.
  - Structural realignment will provide best foundation for clinical integration.
  - It also addresses desire to see WRHA role refined from the perspective of most system stakeholders.

What is the Structure of the Shared Service?



- Other jurisdictions have not done this well and there are many examples of bringing entities together without undertaking service planning or addressing organizational integration where it is necessary.
- This can result in a large organization without anticipated benefit.
- KPMG considerations emphasize:
  - Delivery in local areas managed by pathway or population or network commissioning.
  - Service planning, coordination and oversight at provincial level.
  - Business case based decision making for alternative service delivery of provincial services.
  - Management of retained service delivery through program reviews and cost of service evaluation.
- Learning from the mistakes that other jurisdictions have made by omitting an important step to rationalize existing organizations and to implement changes based on the principles for high-performing health systems.

Definition of Commissioning in Healthcare?



In healthcare, commissioning is:

— Deciding what services or products are needed, acquiring them and ensuring that they meet requirements.

— Determining the most appropriate services for patients at the right time to achieve the best outcomes.

— Securing the best value for citizens and taxpayers.

— Investing in the health of the population.

It is a service planning, resource allocation, decision-making, and delivery management process.

It is not:

— Purchasing.

— Procurement.

— Buying.

— Contracting.

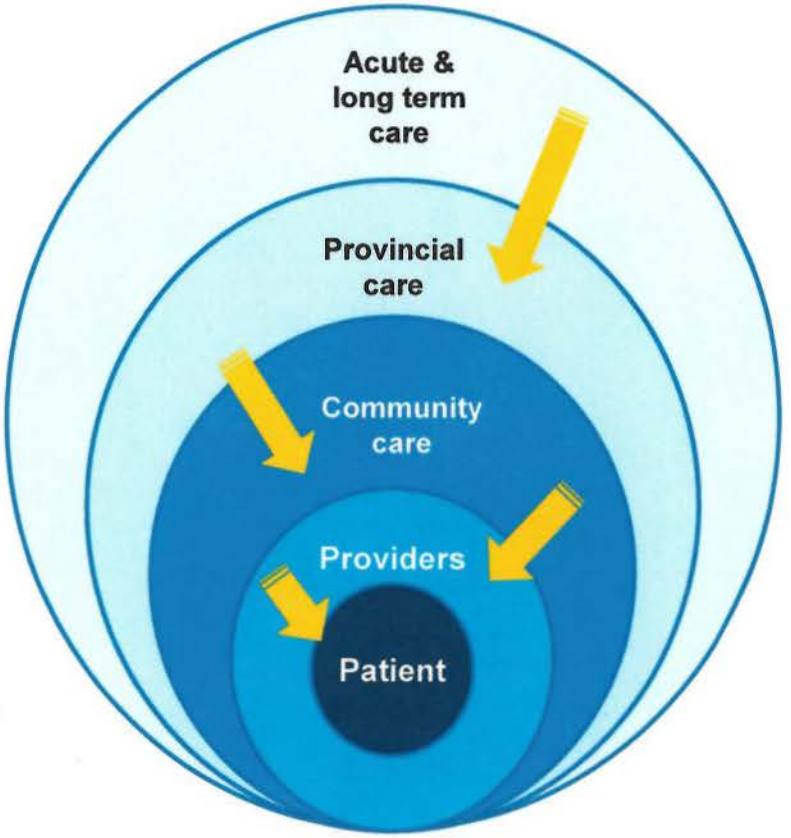
— Supply chain management.

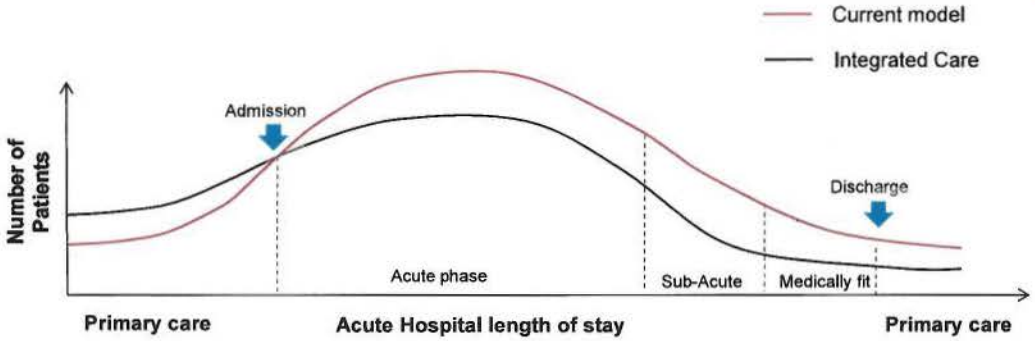
— Strategic sourcing.

— Category management.

Commissioning with an Integrated Care/Integrated Service Delivery Framework

- Structured around a population or pathway centred model of care.
- Streamlines complexity and reduces hand-offs between acute provision and community delivered services.
- Rationalizes teams to improve service users ability to navigate services.
- Promotes and supports self-management.
- Emphasizes care delivered closer to home.
- Integrates primary care as a foundational element over time.

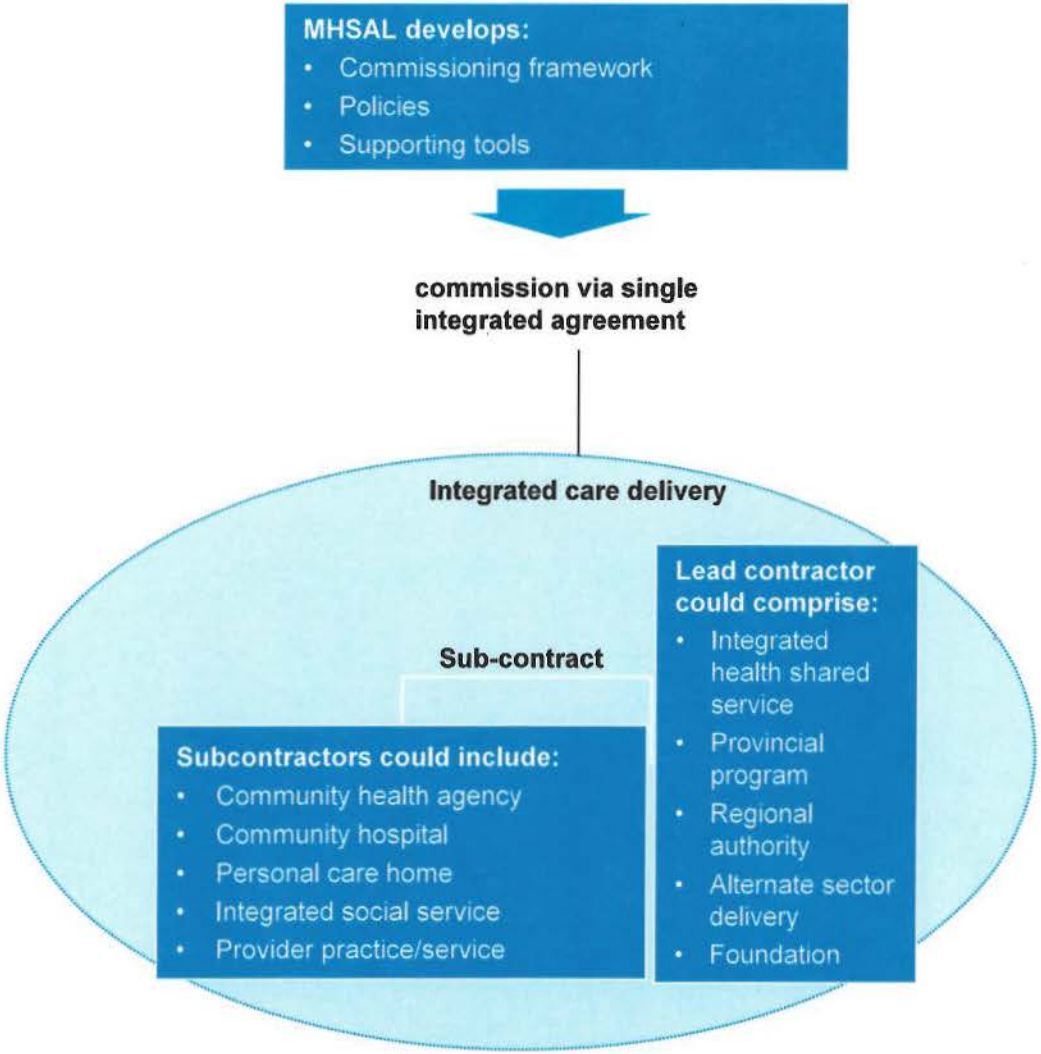




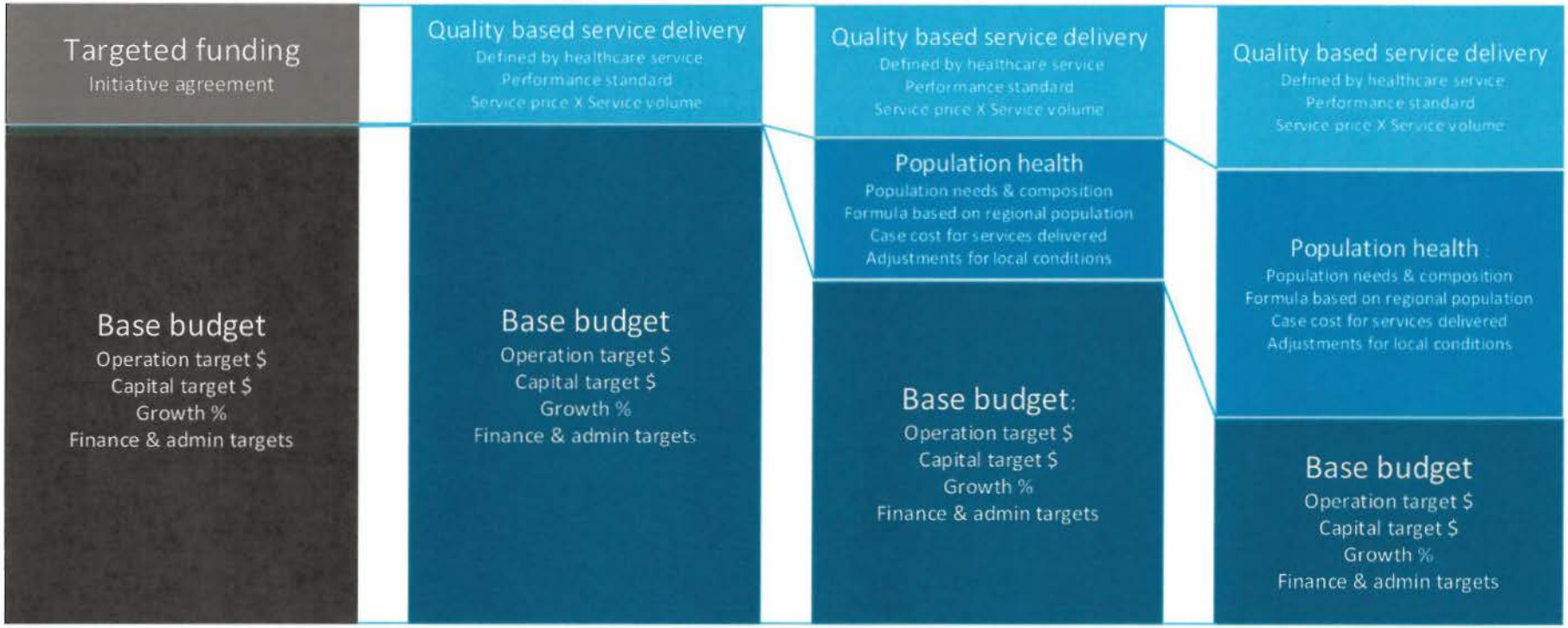
Commissioning with an Integrated Care/Integrated Service Delivery Framework

- Funding and commissioning framework, including policies and supporting tools developed at the provincial level led by MHSAL which will apply to Health Authorities and the Health Shared Service.
- The Health Shared Service and Health Authorities deliver on outcomes within a funding and commissioning framework developed at the provincial level led by MHSAL.
- Service planning is required to determine "preferred model".
- Delivery organizations will be incentivized to use services or funded at base cost.
- This requires realignment of existing operating and service purchase agreements to be implemented.

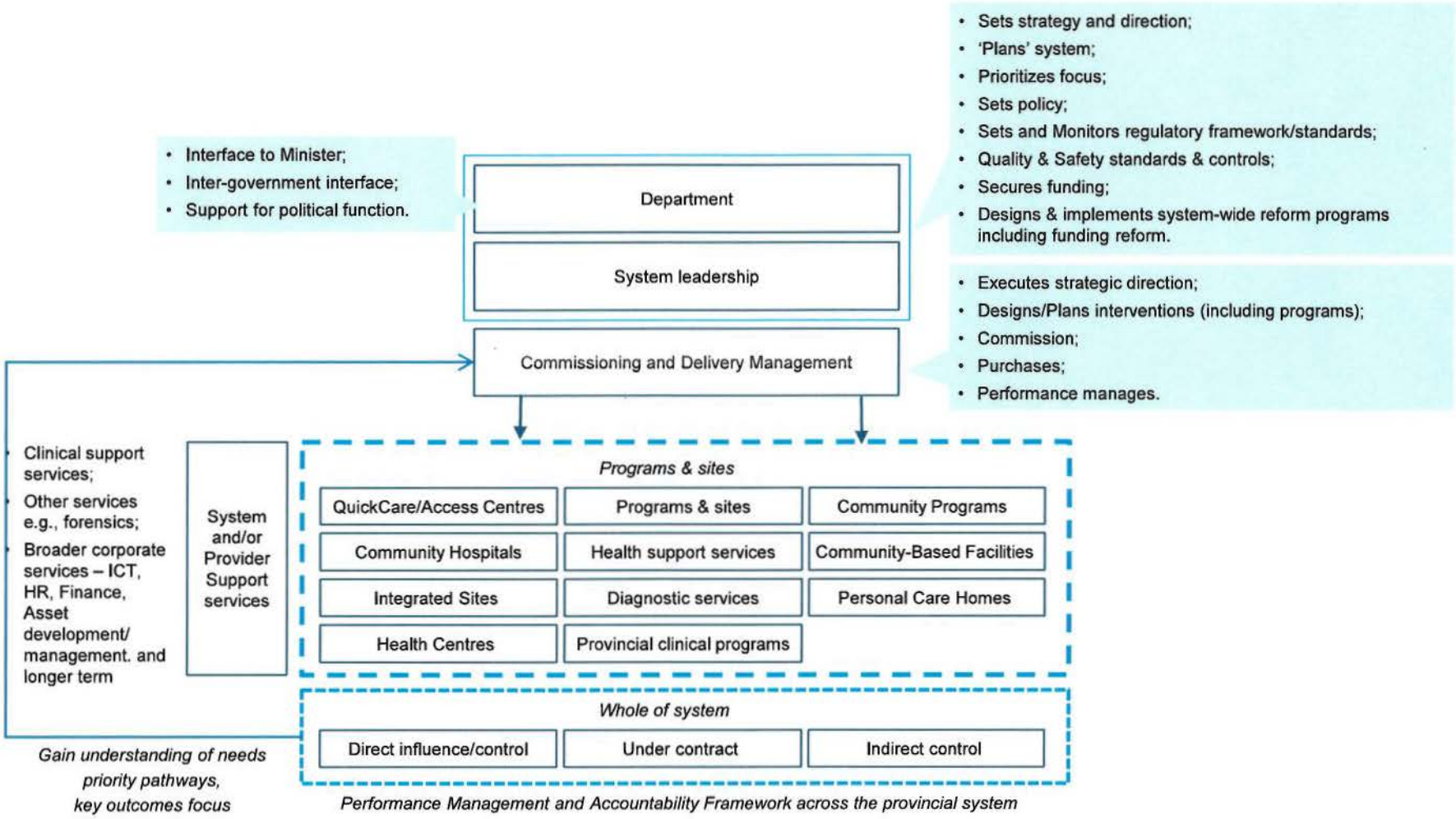
- An entity takes responsibility for the care of a population or pathway (or service).
- Clinically led with multi-specialty involvement where appropriate.
- Involves a transfer of financial risk for the delivery of agreed scope and quality of service as well as health outcomes.
- Contractor responsible for appropriate 'make or buy' decisions.
- Extends to provider practice/services overtime.



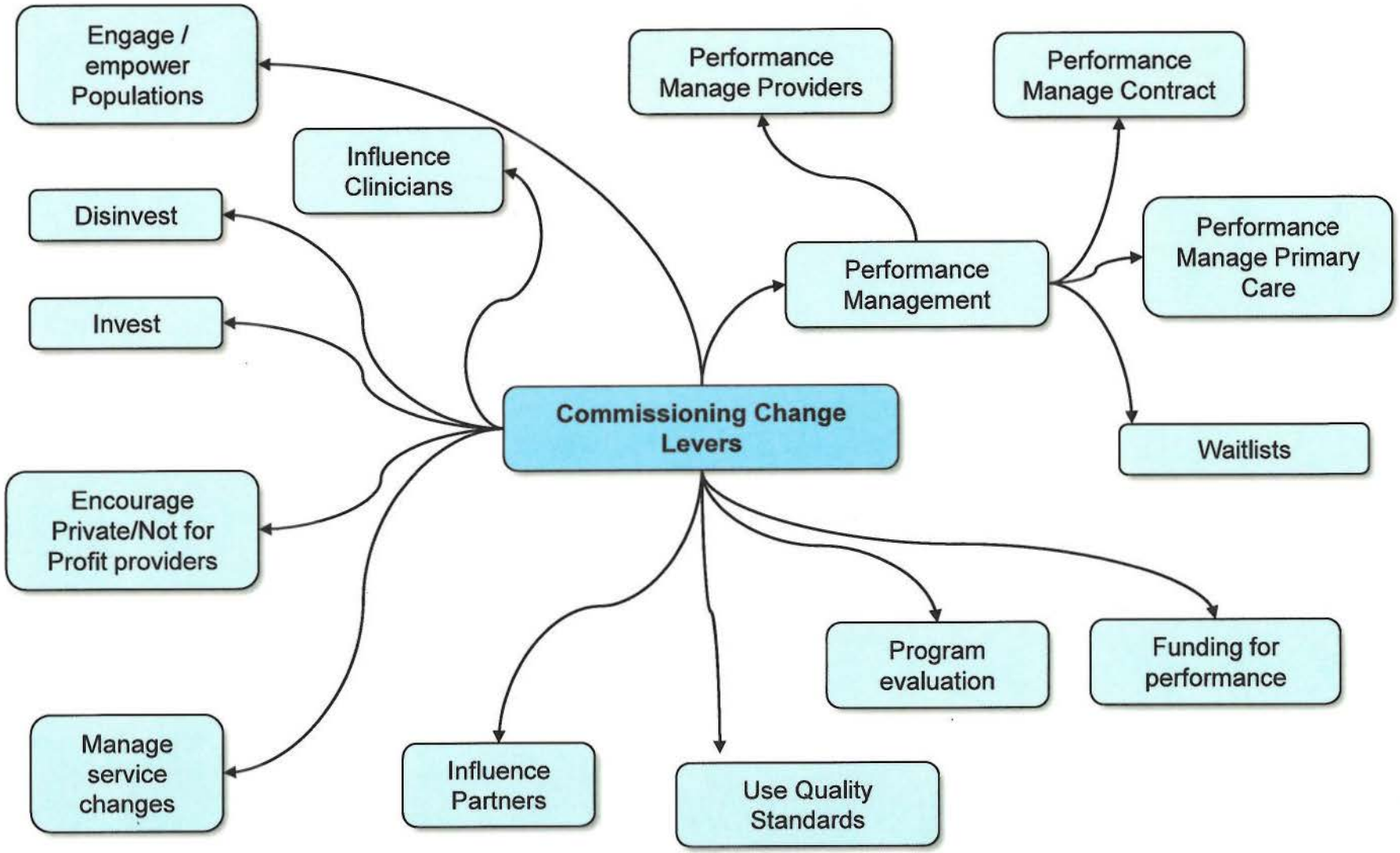
What Does a Commissioned Budget Look Like?



Commissioning with an Integrated Care/Integrated Service Delivery Framework



Commissioning with an Integrated Care/Integrated Service Delivery Framework: Commissioning Levers



Commissioning with an Integrated Care/Integrated Service Delivery Framework: Commissioning Levers

Interim considerations

- Consider effectiveness of regulations that have not been proclaimed to increase authority in next budget year.
- Develop/strengthen budgeting and fiscal planning process with leading practice measures.
- Optimization/standardization of service purchase and operating agreements.
- Develop and establish measures and outcomes reporting capability.

Key Requirements for Policy/Legislative and Regulatory Change

- The information in this section is representative. It is informed by a high-level conceptual impact analysis from MHSAL Legislative Unit. It does not constitute legal advice. Actual requirements may change based on system planning activities.
- The critical legislative and regulatory change requirements to implement the preferred option include but are not limited to:
  - Re-draft/amend and/or realign *RHA Act*, regulations, and authority by-laws.
    - Provincial entity.
    - Responsibilities.
    - Health services.
    - Commissioning.
    - Role and purpose of foundations.
    - Credentialing of providers in authorities.
    - Designated facilities.
    - Transfer of facilities.
  - Repurposing/realignment of DSM under *The Corporations Act*.
    - Regulations that reference DSM, CancerCare, AFM.
  - *The Civil Service Superannuation Act* in relation to employees in existing entities.
  - Repeal of *The CancerCare Manitoba Act*.
  - Repeal of *The Addictions Foundation of Manitoba Act*.
  - Amendments to *The Essential Services Act (Health Care)* to cover new entity.
  - Regulations under *The Mental Health Act* related to designated facilities.
  - Provisions under *The Health Services Insurance Act* that relate to hospital, personal care homes and surgical facilities.

Key Requirements for Policy/Legislative and Regulatory Change (Continued)

- Asset transfer agreements for administrative functions CancerCare, DSM, AFM, Provincial Care Centers if in-scope.
  - Physical assets.
  - Information assets.
  - Registries.
- Redefine/negotiate new operating and service purchase agreements.
  - Commissioning framework.
  - Service levels and outcomes.
  - Participation funding and incentives for shared services.
- Redefine/negotiate new operating and service purchase agreements for private lab/diagnostic and pharmacy services to facilities.
- Integration of breast orthotics program into provincial health service.
- Integration of Renal/Dialysis program into provincial health service.
- Integration of eHealth into provincial health service.
- Integration of pharmacy program into provincial health service.
- Policies and procedures for defining local Allied Health professional deployment.
- Review/update accreditation for reconfigured delivery organizations and services.
- Review legislation/regulations for performance improvements such as streamlining administrative processes – Personal Health Information, Protection for Persons in Care, Infection Control.
- Consideration of devolution in RHAs and in particular for mental health facilities.
- Full pathway or population requires alignment of Fee-For-Service Provider Agreements overtime.

Implement Evidence-Based Protocol for Diabetic Test Strips

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $1.5M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	Conduct a change in benefit reimbursement volumes for Self-Monitored Blood Glucose (SMBG) test strips.
Benefit	The proposed cost savings are obtained through revised reimbursement levels for SMBG test strips from a global cap of four thousand (4000) test strips per benefit year to: • A cap of three thousand six hundred fifty (3650) test strips per year for individuals using insulin; • A cap of four hundred (400) test strips per year for individuals using oral diabetic agents with high risk of hypoglycemia; • A cap of two hundred (200) test strips per year for individuals using oral diabetic agents with low risk of hypoglycemia or managing their diabetes with diet and exercise alone; and • An Exception Drug Status (EDS) policy for individuals in any of the above categories who medically require more.
In-scope/Out of Scope	**Out of Scope**: Insulin, oral diabetes medication.
Key Assumptions	Manitoba currently allows the highest SMBG test strip reimbursement volumes in Canada. Alignment with provincial wide SMBG test strip coverage policies in accordance with Canadian Diabetes Association (CDA) Guidelines.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Under Provincial Policy and Programs, assume 0.1 FTE in MHSAL to progress.
Communication Strategy	Key message is that it would align Manitoba with other provincial coverage and recommended guidelines.

Risks	Interdependencies
• Potential public and patient complaints in relation to co-payment. • Patients, particularly low-income patients, those without third party insurance, and those not on EIA, may find co-payments for equipment/devices challenging and go without treatment.	• Co-payment models applying to other benefits. • Provincial Clinical and Preventative Services Plan. • Core Clinical and Healthcare Services Work Plan.

Implement Evidence-Based Protocol for Diabetic Test Strips

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $1.5M
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Receive Government approval to implement.
- Receive approval of amended policy.

Outputs:

- Approval to implement.

Q2

Key activities:

- Disseminate communication memorandums to stakeholders disclosing amended policy and effective implementation date.
- Commence necessary technical and information system changes to implement the policy.

Outputs:

- Issue guidance to RHAs.
- Technical and information system changes made to support implementation.

Q3

Key activities:

- Monitor impact of policy change in terms of income and analysis of patient outcomes in order to monitor no increase in adverse occurrences.

Outputs:

- Develop any required mitigating actions if required.

Q4

Key activities:

- Evaluation of impact of policy change on reimbursement levels and patient outcomes.
- Agree any other policy adjustments or changes required for 2018/19.

Outputs:

- Assessment of impact of policy change.
- Any required revised guidance for RHAs for 2018/19.

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $67M
Implementation Duration: 3 years	Implementation Effort: Medium	

Description	Address reducing length of stay, acute admissions, and ED visits; and increasing access Personal Care Homes and reinvest in primary, community, sub-acute and home based services.
Benefit	• Improved integration of healthcare services across the continuum. • Repurposing homecare and related community services and reinvesting. • Improved patient flow. • Maximize access to primary care services. • Redistribution of services to the most appropriate setting, including the provision of care closer to home. • Reduction in costs.
In-scope/Out of Scope	**In-scope**: Acute care utilization demonstration projects; substitution of ambulatory for inpatient surgery. **Out of scope**: Workforce optimization.
Key Assumptions	• Alignment with RHA plans.
Governance	• RHA-led working group.
Project Management	• RHA-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks	Interdependencies
• System capacity. • Lack of investment in sub-acute care.	• Provincial Clinical and Preventive Services Plan. • RHA 2017/18 Plans to achieve Financial Balance. • Rationalizing Programs and Services workstream. • Home First Strategy. • Dept policy alignment. • Policy – alignment of remuneration with strategic outcomes.

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Improvement: $67M**

Implementation Duration: 3 years | **Implementation Effort: Medium**

The most significant opportunity identified in Phase 1 was in relation to Reducing Acute Inpatient Lengths of Stay.
The analysis undertaken in Phase 1 benchmarked lengths of stay in Manitoba hospitals to Ontario peer hospitals, adjusting for differences in case mix using the CMG+ system. The main findings included:

1. Lengths of stay in Manitoba are typically significantly (i.e. 30%) longer than the average of their Ontario peers.
2. [redacted].
3. Improving lengths of stay represents a significant opportunity to make better use of Manitoba's health resources. For example, Manitoba would be able to meet the acute bed needs [redacted] roughly 8 years of population growth and aging.

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

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $67M
Implementation Duration: 3 years	Implementation Effort: Medium	

ED Visits Opportunity

the benchmarking analysis from Phase1 examined use of ED care on a standardized per capita basis in each RHA to similar regions in Ontario. The main findings included:

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 significantly 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]	
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]

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $67M
Implementation Duration: 3 years	Implementation Effort: Medium	

Acute Inpatient Admission Rates Opportunity

The benchmarking analysis from Phase 1 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. The analysis compared admission rates by RHA to similar regions in Ontario. The main findings from this analysis included:

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 significantly reduce admission rates.
2. [redacted]
3. [redacted]

RHA	Hospital	Annual Admissions	Expected Admissions	Potentially Avoidable Admissions	Potential Cost Improvement
Prairie Mountain Health	Brandon General Hospital	4,610	4,042	[redacted]	[redacted]
	Dauphin General Hospital	1,547	1,229	[redacted]	[redacted]
Southern Health-Santé Sud	Bethesda Regional Health Centre	1,148	1,005	[redacted]	[redacted]
	Boundary Trails Health Centre	1,961	1,719	[redacted]	[redacted]
	Portage Hospital	1,342	1,164	[redacted]	[redacted]

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $67M
Implementation Duration: 3 years	Implementation Effort: Medium	

There is opportunity to increase the use of community care services and reduce spend in both home care and personal care homes.

Home Care
Key findings from home care analysis include:

- **Program Spending:** At the Ontario per capita spending rate, Manitoba would have spent significantly less on Home Care services in 2015/16.
- **Home Care Clients:** Relative to Ontario, Manitoba has a lower proportion higher care need clients. This implies the potential to substitute community support services for home care for the lower care need clients.

Personal Care Homes
Key findings from personal care home analysis include:

- **PCH Bed Supply:** At the benchmark rate from similar Ontario regions, Manitoba would have used roughly 1,600 fewer PCH beds. Beds could be reduced or put to better use over time by increasing clinical admission standards and by increasing the emphasis on long term supports provided in the community.
- **PCH Bed Use:** Manitoba PCH beds are used more often for low and medium care need clients. PCH admissions and lengths of stay for these clients could likely be reduced by increasing the emphasis on long term supports provided in the community.

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Improvement: $67M**

Implementation Duration: 3 years | **Implementation Effort: Medium**

2017/18

Q1

Key activities:

- Analyze data to understand drivers of readmissions, ED utilization, and length of stay.
- Establish benchmarks/targets.
- Identify target populations and geographies.
- Establish working group.
- Develop project charter to guide key activities and outcomes.

Outputs:

- Project Charter.

Q2

Key activities:

- Initiate demonstration/projects for target populations (including patient throughput reviews).
- Identify gaps in primary and community care as input into primary/community care review (ongoing).

Outputs:

- Throughput review studies.
- Quarterly performance reports.
- Report to primary/community care review.

Q3

Key activities:

- Monitor and evaluate demonstration/proof of concept.

Outputs:

- Demonstration project performance review.
- Quarterly performance reports.

Q4

Key activities:

- Review demonstration project findings with master planning workstream for input into models of care.
- Expansion of initiatives to reduce acute care utilization (dependent on system capacity).

Outputs:

- Submission to master planning workstream.
- Implementation plan for reduced acute care utilization.
- Quarterly performance reports.

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $67M
Implementation Duration: 3 years	Implementation Effort: Medium	

2018/2019	2019/2020
Key activities: • Ongoing participation in master planning to further refine models that support reduced acute care utilization. • Monitor and evaluate initiatives.	**Key activities:** • Ongoing monitoring and evaluation. • Alignment with new models of care.
Outputs: • Quarterly performance reports.	**Outputs:** • Quarterly performance reports.

Reinvest in Primary, Community, and Sub-Acute Care to Reduce Acute Care Utilization

Subtheme: Shift Care from Acute to Community | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Improvement: $67M**

Implementation Duration: 3 years | **Implementation Effort: Medium**

2017/2018	2018/2019	2019/2020	2020/2021+
Project planning, analysis, and benchmarking			
Demonstration projects & evaluation			
	Ongoing participation in master planning to incorporate lessons learned from demonstration projects		
		Alignment with new care configurations	

Rationalize and Reduce Variation in Staffing Models

Subtheme: Rationalize Staffing, Scope of Practice, and Scheduling Implementation	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $62M
Implementation Duration: >3 years	Implementation Effort: Medium	

Description	Rationalizing staffing, scope of practice, and scheduling includes adjustment of rotations, reducing nurse to patient ratios to align with leading practice, reducing overtime, and increasing scope of practice. Optimizing staff skill mix; HPPD and staff ratio.
Benefit	• Improved staff utilization and reduction in overtime costs. • Improved patient care – i.e. continuity.
In-scope/Out of Scope	**In-scope**: Nursing rotations, nurse to patient ratios; nursing administration to nurse ratios; capacity planning/staff scheduling; optimized interdisciplinary teams. **Out of scope**: physician compensation; review of part-time resourcing; benefits/pensions.
Key Assumptions	• Alignment with new models of care.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks

[redacted]

Interdependencies

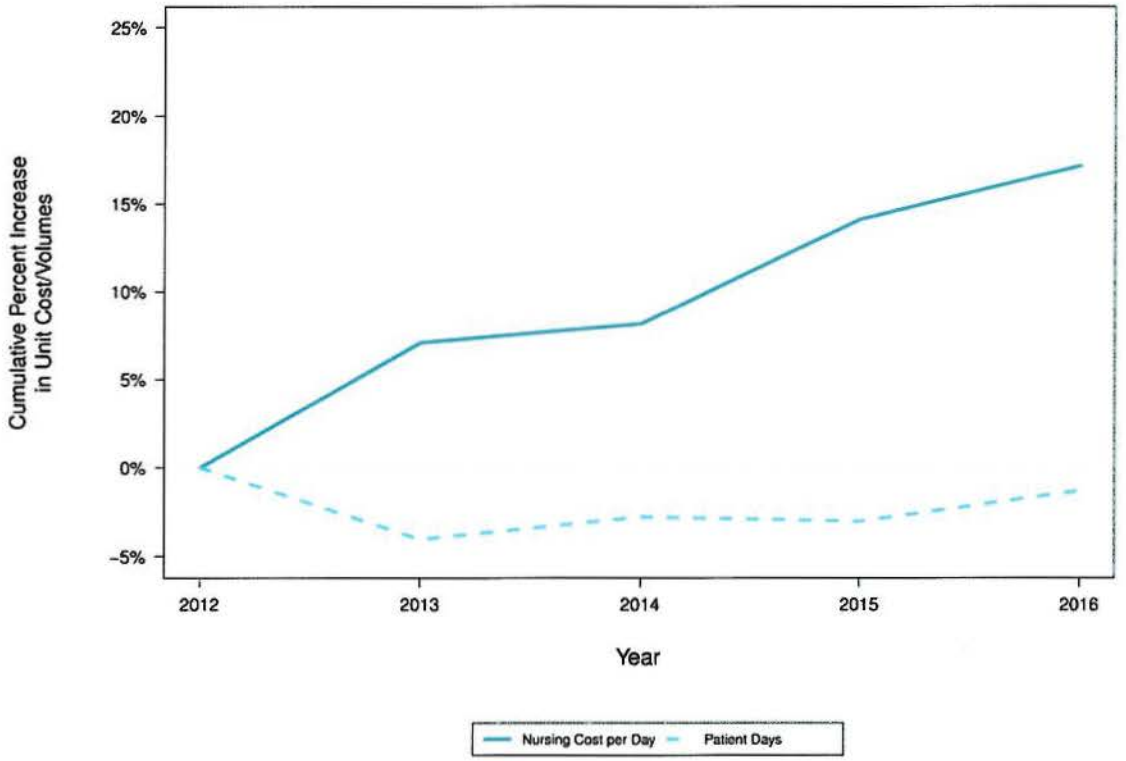
- Health Workforce workstream.
- Bargaining unit restructuring.
- Regulated Health Professions Act implementation.
- Provincial Clinical and Preventive Services Plan.
- WRHA Consolidation.
- Collective agreement rationalization.
- Matrix restructuring.

Rationalize and Reduce Variation in Staffing Models

Subtheme: Rationalize Staffing, Scope of Practice, and Scheduling Implementation	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $62M
Implementation Duration: >3 years	Implementation Effort: Medium	

Nursing Cost Per Day

From the benchmarking analysis undertaken in Phase 1, over the last 4 years, Manitoba's Nursing cost per day has increased by 16%, where as patient days have fallen by 1% ED, Operating Room, and Diagnostic and Therapeutic Services follow the same pattern. Variation in staffing models related to scope of practice, skill mix, scheduling, and number of positions can be addressed by RHAs in the short to medium term. **In particular, there are significant opportunities to reduce nursing hour per day by optimizing nurse to patient ratios and reducing the number of beds in low occupancy units.**



Rationalize and Reduce Variation in Staffing Models

Subtheme: Rationalize Staffing, Scope of Practice, and Scheduling Implementation	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $62M
Implementation Duration: >3 years	Implementation Effort: Medium	

Nurse Hours Per Patient Activity

The benchmarking analysis from Phase 1 identified significant variation in nurse hours per patient activity representing a significant opportunity for improvement. The analysis 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.
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.

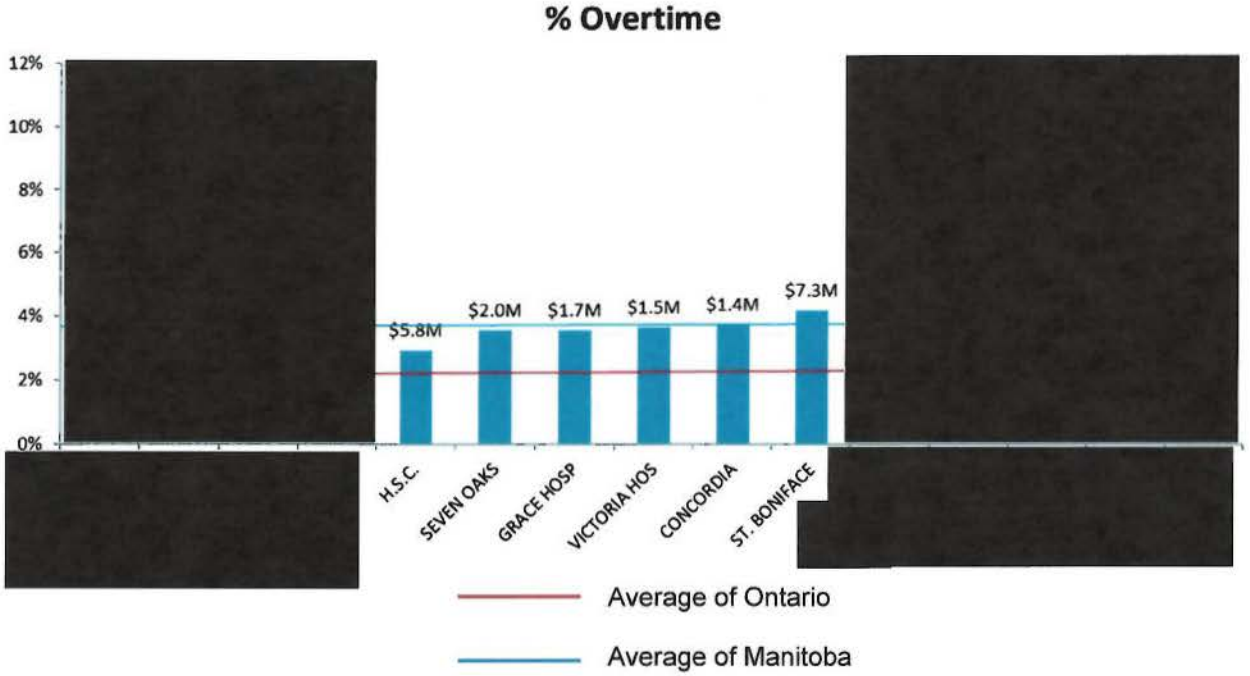
Rationalize and Reduce Variation in Staffing Models

Subtheme: Rationalize Staffing, Scope of Practice, and Scheduling Implementation	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $62M
Implementation Duration: >3 years	Implementation Effort: Medium	

Overtime

The benchmarking analysis undertaken in Phase 1 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.



Rationalize and Reduce Variation in Staffing Models

Subtheme: Rationalize Staffing, Scope of Practice, and Scheduling Implementation

Benefit Year: 2018/19 and Beyond

Est. Cost Improvement: $62M

Implementation Duration: >3 years

Implementation Effort: Medium

2017/2018	2018/2019	2019/2020	2020/2021+
Key activities: • Implement immediate changes not requiring bargaining unit restructuring. • Review vacant positions and staff consolidation opportunities. • Identify opportunities to consolidate. • RHA/Delivery Organization review and approval. • Notice to MHSAL of plan. • Approval of plan by MHSAL. • Union consultations. • Proclamation of Legislation.	**Key activities:** • Determination of composition of bargaining units. • Representation Votes. • Notice to Commence Bargaining. • Identify staffing requirements for new models of care.	**Key activities:** • Initiate bargaining.	**Key activities:** • Monitor for implementation.
Outputs: • Communications plan.	**Outputs:** • Bargaining position.	**Outputs:** • Ongoing communication. • Briefing notes.	**Outputs:** • Realization of benefits.

Implement Changes to Pharmacare Dispensing Fees

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $5.5M
Implementation Duration: 6 Months	Implementation Effort: Medium	

Description	Manitoba is the only province without a dispensing fee cap. Pharmacare average professional fees have risen from $15.28 to $16.80 between 2012/13 and 2015/16. In 2015/16, $51.8 million were paid in professional fees representing a 7.1% year-over-year increase. Implement a dispensing fee cap of $30 per prescription along with policies related to pharmacy service fees (e.g. compounding fees). In Manitoba, there is a maximum of a 100-day supply dispensed in any 90 day period with no restriction on how often dispensing fees can be charged. PDP covers a maximum of 30 days' supply for short-term and for first-time prescriptions of longer term "maintenance" drugs. When a client refills a prescription intended for longer term use, PDP will cover a 100 days' supply. Prescribing and dispensing should reflect higher quantities once the medical therapy of a patient is in the maintenance stage with exceptions only given to unusual circumstances that require quantities to be dispensed in lower days' supply intervals.
Benefit	• Reduce the cost borne by public drug plans; it is estimated that ~$11 million will be saved in the first 1 year. • Consistent with other provincial, territorial or federal policies.
In-scope/ Out of Scope	• **In-scope**: pharmacies include all pharmacies across Manitoba.
Key Assumptions	• No significant time delay reconfiguring information and IT systems to implement the amended dispensing fee policy.
Governance	• MHSAL with oversight/implementation management provided by the central government.
Project Management	• MHSAL.
Communication Strategy	• Disclosure to pharmacy owners within Manitoba, disclosure should include the effective implementation date of the amendment.

Risks	Interdependencies
• Increased pressure to expand the scope of practice services that pharmacists currently offer in Manitoba. • Political risk.	• Introduction of Pharmacare wholesale fee cap.

Implement Changes to Pharmacare Dispensing Fees

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $5.5M
Implementation Duration: 6 Months	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Receive approval from Government to implement. • Draft regulation changes and receive approval of amended policy. • Commence necessary technical and information system changes to implement amended policy. • Disseminate communication memorandums to stakeholders disclosing amended policy and effective implementation date.	**Key activities:** • ISB completes work to make technical changes to DPIN required to operationalize amended policies – IT changes were identified to have short lead times. • Implement amended policy.	**Key activities:** • Monitor for implementation and results of policy change.	**Key activities:** • Monitor for implementation and results of policy change.
Outputs: • Amended policy documents.	**Outputs:** • Update DPIN with technical changes. • Amended policy implemented.	**Outputs:** • Ongoing reporting of the change in policy and the financial impact.	**Outputs:** • Ongoing reporting of the change in policy and the financial impact.

De-Insure Chiropractic Coverage

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $3M
Implementation Duration: 6 Months	Implementation Effort: Low	

Description	Reduction in coverage under the provincial health insurance plan for chiropractic services. A reduction in the amount of the coverage per service from $12.30 to $7.30 (a decrease of 40%) is being proposed. De-insuring coverage would result in even greater savings. An alternative option to a reduction in the amount covered per visit is a reduction in the number of visits per annum that are eligible for coverage. This alternative may result in reduced vulnerability with respect to contractual obligations, as the price (12.30 for 2017/18) was negotiated with the MCA, while the entitlement of Manitoba residents to partial coverage of 12 visits per year is established in Manitoba regulation. A reduction to 5 covered visits per annum could yield projected cost savings of $4.6 million; a reduction to 3 covered visits per annum could yield projected cost savings of $6.7 million.
Benefit	• Proposed reduction from $12.30 to $7.30 would result in a reduction in projected expenditure level from approximately $11.8 million per annum to approximately $7.0 million per annum.
In-scope/ Out of Scope	• **In-scope**: Chiropractic claims submitted for coverage through the provincial health insurance plan.
Key Assumptions	• Cost savings assumes a stagnant number of claims year-over-year at approximately 955,000 claims per year.
Governance	• MHSAL with oversight/implementation management provided by the central government.
Project Management	• MHSAL.
Communication Strategy	• Disclosure of the amended policy should be made to MCA. • Amend MHSAL website to provide updated coverage information to the public.

Risks

[redacted]

Interdependencies

- MPI – may have to take on charges.

De-Insure Chiropractic Coverage

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $3M
Implementation Duration: 6 Months	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Receive approval from government to implement. • Negotiate with MCA. • Draft regulation changes. • Commence necessary technical and information system changes.	**Key activities:** • Implement required changes to MHSAL CPS to reflect claims systems. • Disseminate communication memorandums (e.g. update MSHAL website to provide updated coverage information to the public) to stakeholders disclosing amended policy and effective implementation date.	**Key activities:** • Monitor for implementation and results of policy change.	**Key activities:** • Monitor for implementation and results of policy change. • Audit for rate change implementation – make sure the chiropractor puts in the rate change so the customer receives the discount – this should be policy in order to receive subsidy.
Outputs: • New regulations to implement.	**Outputs:** • Communication memorandum.	**Outputs:** • Ongoing reporting of the change in policy detailing the financial impact.	**Outputs:** • Ongoing reporting of the change in policy detailing the financial impact. • Audit of rate change policy implementation.

Integrated Shared Services - Work Plan Summary

Integrated Shared Services	
Project Summary	• The Integrated Shared Services workstream includes: consolidating health support services; administrative support services; and developing an integrated provincial supply chain.

Objectives & Scope	• To identify functions, both back office and clinical services, that can be leveraged more effectively and efficiently under an integrated provincial shared services model. Integrated shared services refers to the central provisioning of a common service required by all healthcare deliver organizations in the Province.
	  • Some back office functions identified to date for potential integration include the following:
	  • Supply chain management, finance, human resources, real estate, legal, and communications.
	• Some clinical services functions identified to date for potential integration include the following:
	  • Dietary and food services, and laundry.
	  • Consider integration of IMA (Data Analytics) regionally/provincially.

Interdependencies	• Recommendations in the *Provincial Clinical and Preventive Services Planning for Manitoba* report may impact the pharmaceutical supply chain. • Collective agreement rationalization.

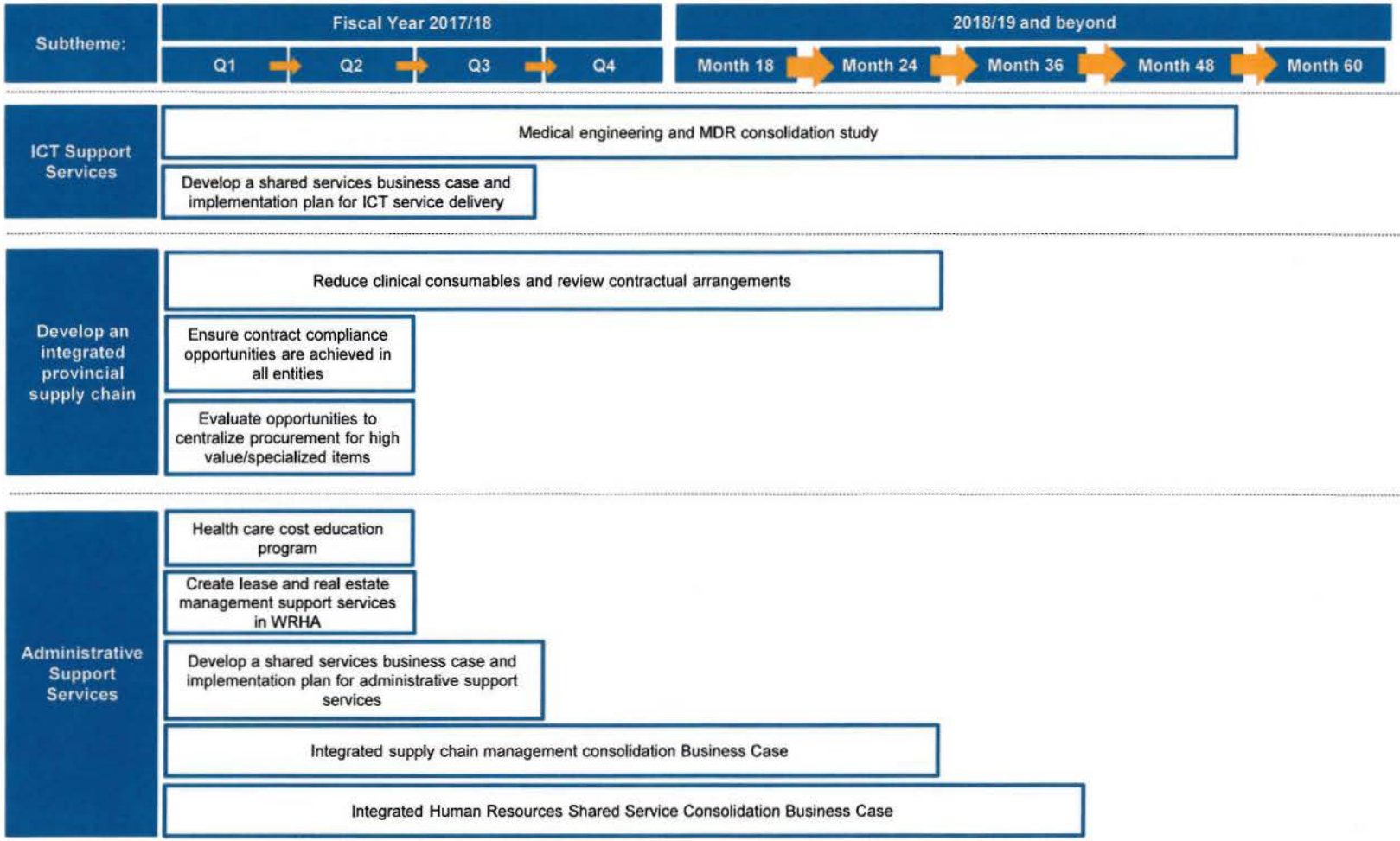
Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Develop an integrated provincial supply chain	Evaluate opportunities to centralize procurement in health authorities for high value/specialized items.	$0.2M	2017/18	RHA specific initiative	• ICT Services Plan. • Clinical Engineering. • Contract Management.	• Dependency of legal and regulatory compliance. • Provider preferences exist which need to be validated.
Administrative Support Services	Create lease and real estate management support services in WRHA.	$5.7M	2017/18	PPP, with RHA Support	• Interdependency on the continued provision of homecare services. • Infrastructure rationalization strategy. • Relationships with ASD.	• No major risks identified.
	Health care cost education program.	Enabler	2017/18	PPP, with RHA Support	• No interdependencies with any other work stream. This is short term tactical opportunity.	• Need to get clinical decision making or support for the progression of this opportunity.
	Develop a shared services business case and implementation plan for administrative support services.	Enabler	2017/18	PPP, with RHA Support	• No core dependencies identified.	• Barriers to implementation need to be understood and considered carefully in this phase.
	Integrated supply chain management consolidation Business Case.	Enabler	2018/19 and Beyond	PPP, with supply chain managemen t group support	• This is not dependent on the delivery of the clinical services plan but there are some linkages. • Provincial Clinical and Preventative Services Plan.	• Barriers to implementation need to be understood and considered carefully in this phase.
	Integrated Human Resources Shared Service Consolidation Business Case.	Enabler	2018/19 and Beyond	PPP, with RHA Support	• Core dependency on health workforce stream. • Provincial Clinical and Preventative Services Plan.	• Barriers to implementation need to be understood and considered carefully in this phase.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

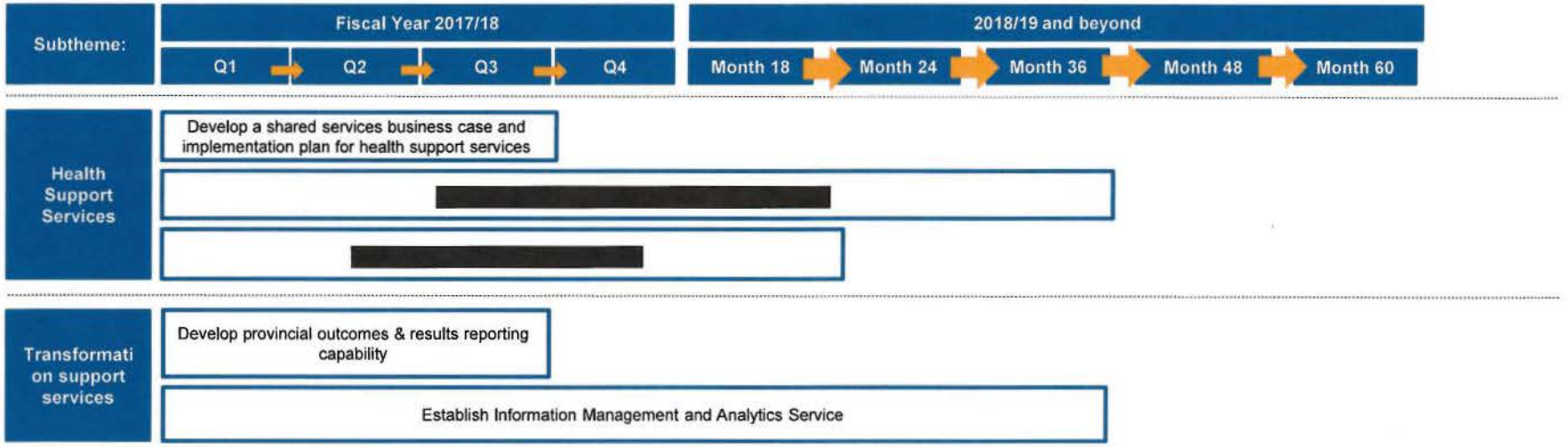
Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Health Support Services	Develop a shared services business case and implementation plan for health support services.	$0.5M / Enabler	2017/18	PPP, with RHA Support	• Provincial Clinical and Preventative Services Plan • Provincial transportation opportunity	• Barriers to implementation need to be understood and considered carefully in this phase.
Transformation support services	Develop provincial outcomes & results reporting capability.	Enabler	2017/18	Integrated team consisting of MHSAL / eHealth	• IM&A priorities need to be developed at a provincial level before this initiative can commence. • Solution needs to be in alignment with the provincial performance management framework.	• Lack of input from each region to support the development of a provincial wide reporting dashboard. • Discrepancies in data due to the current information system environment across the regions.
	Establish Information Management and Analytics Service.	Enabler	2018/19 and beyond	Integrated team consisting of MHSAL / eHealth with support from others	• Consideration around future personalized data and genomics. • All of government province of Manitoba big data and analytics initiative.	• Lack of buy-in from each region to support the development of a provincial wide IM&A. • Lack of clear leadership. • Lack of IM resources across the region to support.

Work Plan - High-Level Roadmap



Work Plan - High-Level Roadmap



Reduce Clinical Consumables and Review Contractual Arrangements

Subtheme: Develop an integrated provincial supply chain	Benefit Year: 2018/19	Est. Cost Improvement: $12.5M
Implementation Duration: 2 years	Implementation Effort: Low	

Description	Conduct a review to evaluate the reduction of consumables and opportunities to centralize procurement and contractual arrangements. Where there are discrepancies on standard products and services, a rationalization exercise will be undertaken to ensure province-wide consistency.
Benefit	• Reduction in use of clinical consumables. Standardization of supplies and drugs province-wide.
In-scope/Out of Scope	**In-scope:** • All healthcare providers province-wide. • Develop policies to reduce the use of blankets, pads, diapers, and tissue paper in nursing wards. • Exploring opportunities for switching to more cost effective types of clinical supplies. • Exploring opportunities to standardize types of supplies use in operating room. • Explore opportunities for Implementing drug formularies and switching to generic drugs.
Key Assumptions	• TBD.
Governance	• MHSAL with RHA execution.
Project Management	• RHA specific initiative with clinical support.
Communication Strategy	• TBD would be developed as part of this initiative.

Risks	Interdependencies
• Balancing single source vs scale and control.	• Provincial Clinical and Preventative Services Plan. • Clinical Standards. • Service purchase agreements. • MOU's. • Vendor management.

Contract Compliance Opportunities

Subtheme: Develop an integrated provincial supply chain	Benefit Year: 2017/18	Est. Cost Improvement: $1.2M
Implementation Duration: 6 Months	Implementation Effort: Low	

Description	Conduct a current state review of procurement and commercial services to ensure contractual compliance opportunities are achieved in all entities. Align rural RHAs with a single procurement model/better alignment with HealthPro contract for all entities.
Benefit	• Less duplication of commercial functions between organizations and in the case of many organizations the development of separate organizations with individual policies, procedures and practices that are not consistent from a system perspective.
In-scope/Out of Scope	**In-scope:** • Procurement / commercial arrangements within RHA's, CCMB, DSM, AFM. • Maximizing rebates. • Maximize provincial wide contracting arrangements.
Key Assumptions	• TBD.
Governance	• MHSAL with RHA execution.
Project Management	• RHA specific initiative.
Communication Strategy	• TBD would be developed as part of this initiative.

Risks	Interdependencies
• Dependency of legal and regulatory compliance. • Provider preferences exist which need to be validated.	• Dependent on the business case and implementation plan for administrative support services.

Shared Services Business Case and Implementation Plan for Health Support Services

Subtheme: Health support services | **Benefit Year: 2017/18** | **Est. Cost Improvement: $0.5M / Enabler**

Implementation Duration: 9 Months | **Implementation Effort: Low**

2017/18

Q1

Key activities:

- Assess internal capacity and capability to complete.
- Develop ToR.
- Procurement of services to complete study / Issue RFP, if required.

Outputs:

- ToR
- Carry out procurement of services (if required).

Q2

Key activities:

- Conduct study encompassing:
  - Defining the service delivery method.
  - High-level governance structure.
  - Cost benefit analysis.
  - Assess the to-be situation.
  - Market assessment for alternative service delivery.
  - Review provincial inter government opportunities.
- Develop recommendations.
- 'Go / no-go' decision to proceed.

Outputs:

- Study
- 'Go / No-go' recommendation document

Q3

Key activities:

- Develop a business case including:
  - Clear framework and scope.
  - Project team structure.
  - SLAs
  - Implementation timeframes.
  - Technology enablement.
  - Procurement timeframes and commercial implication planning.
- Government decision to proceed.
- Implementation planning.

Outputs:

- Business case.
- Government decision to proceed.
- Implementation plan.

Q4

Key activities:

- N/A

Outputs:

- N/A

Evaluate Opportunities to Centralize Procurement

Subtheme: Develop an integrated provincial supply chain	Benefit Year: 2017/18	Est. Cost Improvement: $0.2M
Implementation Duration: 6 Months	Implementation Effort: Low	

Description	Conduct a review to evaluate opportunities for health authorities to centralize procurement for high value / specialized items such as prosthetics, wound management, pharmaceuticals, and specialized equipment. Where there is discrepancies on standard products and services, a rationalization exercise will be undertaken to ensure province-wide consistency.
Benefit	• Less duplication of commercial functions between organizations and in the case of many organizations the development of separate organizations with individual policies, procedures and practices that are not consistent from a system perspective.
In-scope/Out of Scope	**In-scope:** • Procurement / commercial arrangements within RHAs, CCMB, DSM, AFM. • Maximizing rebates. • Provincial wide contracting arrangements.
Key Assumptions	• TBD.
Governance	• MHSAL with RHA execution.
Project Management	• RHA specific initiative.
Communication Strategy	• TBD would be developed as part of this initiative.

Risks	Interdependencies
• TBD.	• ICT Services Plan. • Clinical Engineering. • Contract Management.

Evaluate Opportunities to Centralize Procurement

Subtheme: Develop an integrated provincial supply chain | **Benefit Year: 2017/18** | **Est. Cost Improvement: $0.2M**

Implementation Duration: 6 Months | **Implementation Effort: Low**

2017/18

Q1

Key activities:

- Current state review including:
  - SKUs
  - Establish/confirm standards under existing contracts.
  - Are rebates on specialized / high value items being received.
  - Identify opportunities for other items to be included.
- Identify opportunities for change.
- Finalize actions / decision.

Outputs:

- Current state review.
- Opportunity analysis.

Q2

Key activities:

- Communicate changes to providers and sites.
- Develop / update standards and policies.
- Make changes to non conforming products and purchases.

Outputs:

- Communications delivery.
- Make changes to non conforming product purchases.

Q3

Key activities:

- Monitor for implementation.

Outputs:

- Progress report.

Q4

Key activities:

- Monitor for implementation.

Outputs:

- Progress report.

Integrated Supply Chain Management Consolidation Business Case

Subtheme: Administrative support services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: Enabler
Implementation Duration: 36 Months	**Implementation Effort: Medium**	

Description	Conduct a business case to look at the ability to consolidate supply chain management for healthcare across the province and develop a new operating model. This study could focus on contracting / procurement, and should also be expanded to include warehousing / distribution / logistics.
Benefit	• Leveraging province-wide economies of scale, standardization of process and delivery, standard service level agreements, less duplication of effort and cost.
In-scope/Out of Scope	**In-scope**: • All regions and PSOs. • Rationalization of sites ability. • Use and adaptation of integrated information system. • Alignment/coordination with Provincial procurement processes where appropriate. • Alignment with Provincial Clinical and Preventative Services Plan.
Key Assumptions	• Potential for all RHAs and healthcare facilities to improve supply chain management and reduce overall system-wide procurement costs in certain supply categories.
Governance	• MHSAL, Provincial Policy and Programs.
Project Management	• Provincial Policy and Programs with support from supply chain management.
Communication Strategy	• Clear and concise communications to ensure a collaborative approach for the benefit of the whole system.

Risks	Interdependencies
• Barriers to implementation need to be understood and considered carefully in this phase.	• This is not dependent on the delivery of the clinical services plan but there are some linkages. • Provincial Clinical and Preventative Services Plan.

Transform Information Management and Analytics Service

Subtheme: Transformation support services	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: Enabler
Implementation Duration: 36 Months	Implementation Effort: Medium	

Description	Three year transformation of current information management and analytics maturity and capability to better support IM&A capability across the Manitoba healthcare system. Describe the analytics service and IM&A environment (users, policy strategy, performance management indicators).
Benefit	• This opportunity will allow the Manitoba healthcare system to collect, use and share data and information to support quality care, evidence-informed decision-making, research, policy development and planning, and the accomplishment of healthcare system objectives.
In-scope/Out of Scope	**In-scope**: • All RHAs and healthcare providers in the Manitoba healthcare system. • Clarity of data scientist and data architect roles.
Key Assumptions	• Requires buy-in and support from health authorities and healthcare providers.
Governance	• MHSAL-led with support from other health authorities and healthcare providers.
Project Management	• Integrated team consisting of MHSAL / eHealth with support from others.
Communication Strategy	• Communicating the benefits of information management and analytics capability. • Will be developed as part of this initiative to focus on specific audiences.

Risks

- Lack of buy-in from each region to support the development of a provincial wide IM&A.
- Lack of clear leadership.
- Lack of IM resources across the region to support.
- Lack of standardized data.
- Non-integrated IM technology solutions with different capability.
- Lack of clear provincial policy to support healthcare system use of all health information.

Interdependencies

- Consideration around future personalized data and genomics.
- All of government province of Manitoba big data and analytics initiative.

Transform Information Management and Analytics Service

Subtheme: Transformation support services | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: Enabler**

Implementation Duration: 36 Months | **Implementation Effort: Medium**

2017/18

Q1

Key activities:

- Add in preliminary steps (page 38 IM&A study).
- Governance, policy, procedure and standards review.
- Develop organizational alignment and change management plan.

Outputs:

- N/A

Q2

Key activities:

- Continue governance, policy, procedure and standards review.
- Continue development of organizational alignment and change management plan.
- Develop communication plan.

Outputs:

- Governance, policy, procedure and standards review.

Q3

Key activities:

- Establish and operationalize enterprise wide governance model.
- Continue development of organizational alignment and change management plan.
- Continue developing communication plan.

Outputs:

- Organizational alignment and change management plan.

Q4

Key activities:

- Continue developing communication plan.
- Establish data quality standards.
- Define analytics operating model.
- Define enterprise data model and technical architecture.
- Defining early adoption of analytics projects.

Outputs:

- Communication Plan.

Transform Information Management and Analytics Service

Subtheme: Transformation support services | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: Enabler**

Implementation Duration: 36 Months | **Implementation Effort: Medium**