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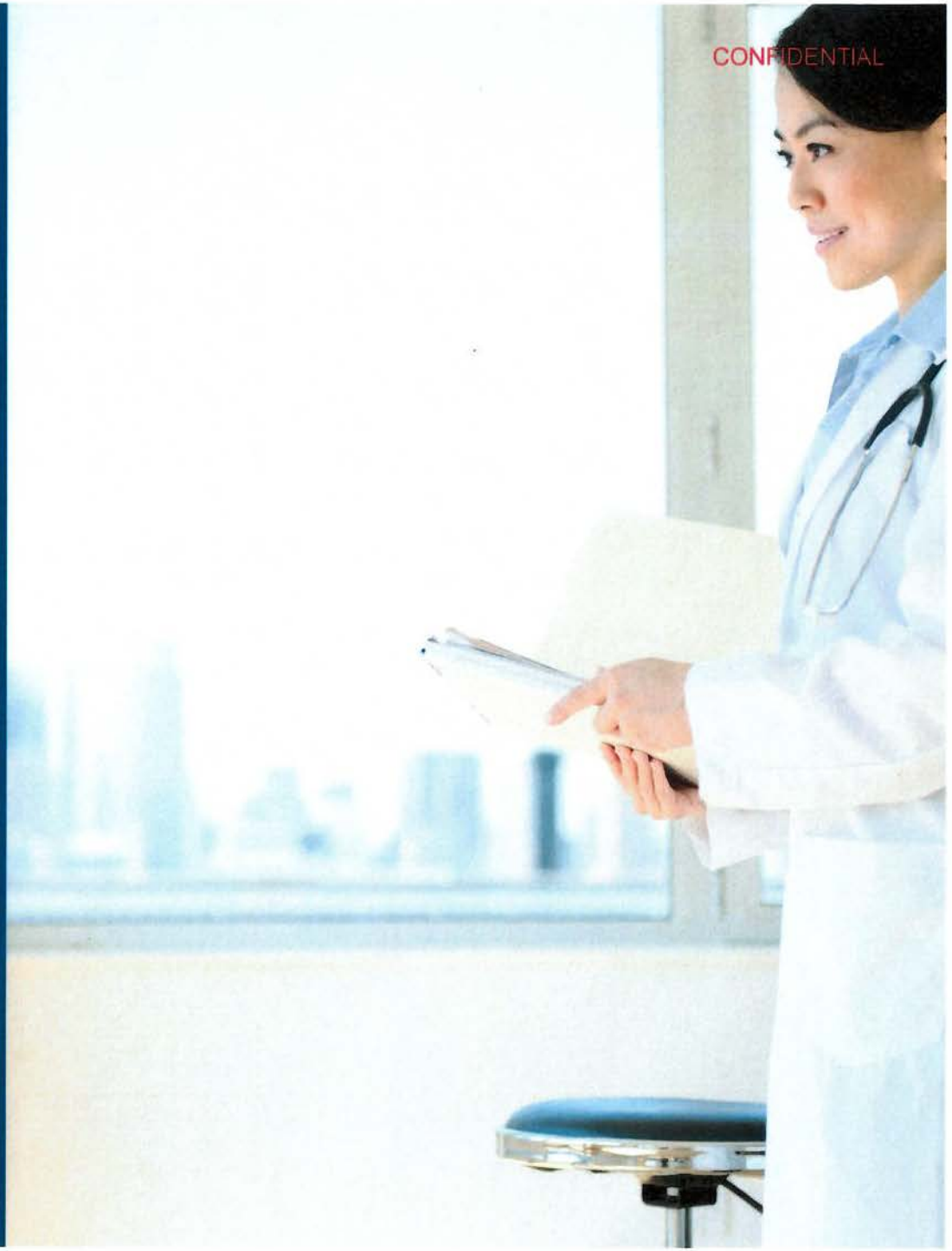
Health System Sustainability & Innovation Review: Phase 2 Report

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.

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1. Executive Summary

Executive Summary

Background

- The new Government of Manitoba committed to undertake an independent Health Sustainability and Innovation Review (HSIR or "the Review"), following on from the Fiscal Performance Review underway across all other core government departments, to understand how the cost curve in relation to the growth in healthcare funding could be bent, to improve the efficiency and effectiveness of healthcare services so the healthcare system is sustainable and supports improved health outcomes for Manitobans.
- The in-scope spending for the Review is approximately $6 billion based on the 2016/17 Budget for the Department of Health, Seniors and Active Living (MHSAL or "the Department") which is approximately 45% of the total government budget for program operating expenditures.
- Additional components of the HSIR includes an assessment of the current organizational structure of Winnipeg Regional Health Authority (WRHA) and reflections on the current structure of the provincial healthcare system including MHSAL.

Approach

- This Review is proceeding in phases.
  - *Phase 1* Scoping Report provided a high-level assessment of the Manitoba healthcare system, defined a Health Fiscal Performance Review Framework, and identified areas of opportunity for cost improvement.
  - *Phase 2* (the focus of this report) involved further investigation and the development of work plans for each of the six prioritized areas of opportunity agreed with the Advisory Committee, to provide guidance for implementation planning.
  - *Phase 3* is focused on implementation and ensuring sustainable benefits are realized, over both the short-term (2017/18 fiscal year) and the medium-term (next 3-4 years), driven by the setup and building of a Transformation Management Office (TMO) in MHSAL.

Executive Summary

Phase 1 Report – Key Findings

— Identified areas of potential cost improvement estimated at $90M+ for 2017/18, with potential cost improvement of $300M+ over 3-4 years.

Area of Opportunity	Recommendations for Key Areas of Opportunities
1. Strategic System Realignment 2. Funding for Performance	• Immediate action to realign and focus the roles, responsibilities and accountabilities between the Department, the RHAs, and facilities. • Explore new models for capital and infrastructure funding. • Establish commissioning and single payer funding model. • Implement performance-based funding program. • Implement expenditure management programs.
3. Insured Benefits & Funded Health Programs	• Bring benefits and funded program in alignment with Canadian standards. • Review inter-jurisdictional coverage agreements. • Changes to provider and professional compensation.
6. Healthcare Workforce	• Rationalize healthcare employee benefits. • Review healthcare provider compensation.
4. Core Clinical & Healthcare Services 7. Healthcare Transportation	• Reduce unit costs/rates. • Reduce variability of care/ reduce length of stay. • Shift care from acute to community settings. • Rationalize and standardize programs and services. • Rationalize staffing, scope of practice, and scheduling. • Review transportation program efficiency, and effectiveness.
10. Infrastructure Rationalization	• Leverage external/alternative funding and service delivery models. • Rationalize facilities with system demand. • Implement new standards for infrastructure delivery.
8. Integrated Shared Services	• Consolidate health support services. • Consolidate administrative support services. • Implement common program and transformation management. • Develop an integrated provincial Supply Chain.

Executive Summary

Phase 2 Report – Key Findings *(continued)*

— In the development of the Phase 2 work plans, specific opportunities were considered in terms of timings, additional data analysis, interdependencies and risks resulting in some adjustments in the estimates for each opportunity as identified in the Phase 1 report. While some cost estimates were adjusted in Phase 2, the overall level of potential cost savings were confirmed.

Area of Opportunity	Phase 1 – 2017/18 Estimated Cost Improvement	Phase 2 – 2017/18 Revised Cost Improvement Estimated	Phase 1 – 2018/19 and Beyond Estimated Cost Improvement	Phase 2 – 2018/19 and Beyond Revised Cost Improvement Estimate
1. Strategic System Realignment	$ 3M+	$ 3M+	$ 5M+	$ 5M+
2. Funding for Performance	$ 24M+	$ 24M+	$ 18M+	$ 14M+
3. Insured Benefits & Funded Health Programs	$ 30M+	$ 19M+	$ 9M+	$ 14M+
6. Healthcare Workforce	$ 26M+	$ 34M+	$ 42M+	$ 38M+
4. Core Clinical & Healthcare Services	$ 7M+	$ 6M+	$ 134M+	$ 134M+
7. Healthcare Transportation	$ 3M+	$ 3M+		
8. Integrated Shared Services	$ 3M+	$ 8M+	$ 43M+	$ 36M+
10. Infrastructure Rationalization	$ 0.3M+	$ 1M+	$ 62M+	$ 62M+
TOTAL ESTIMATE	**$ 90M+**	**$ 90M+**	**$ 300M+**	**$ 300M+**

Executive Summary

Phase 2 Report – Key Findings *(continued)*

- Phase 2 commenced in February 2017 and development of the work plans was taken forward by the establishment of expert working groups consisting of senior officials from MHSAL as well as senior executives from RHAs. KPMG collaborated with the working groups for each work plan to guide the development of opportunities.
- Each of the six work plans have been developed to be standalone documents, however, we have also identified the interdependencies between workstreams including the impact of Strategic System Realignment on other work plans. For example, there are interconnections between the development of Master Services Planning under the Core Clinical and Healthcare Services work plan, and the phasing and development of the work plan for Infrastructure Rationalization.
- **The potential cost improvements and implementation timing identified in Phase 1 have largely been confirmed.**
  - Each of the six work plans identified high-level requirements to support implementation along with key risks.
  - Additional data analysis on cost savings estimates was also undertaken. This includes taking forward the data analysis to RHA and facility level to support the Core Clinical and Healthcare Services work plan.
- **There is a need for structural changes to the Manitoba healthcare system** to clarify roles and functions to address the misalignment issues between MHSAL, Health Authorities and Providers.
  - This also includes the development of a commissioning framework and funding model to drive a consistent focus on cost improvement, accountability, innovation and improved health outcomes for Manitobans.
- **The scale of the transformation over the next 3-4 fiscal years is significant and will create challenges within MHSAL and across the wider healthcare system given gaps in capacity and capability.**
  - The delivery of early benefits and cost opportunities in 2017/18 will be key to build confidence in the ability of MHSAL to be successful with the broader transformation moving forward.

Executive Summary

.Next Steps and Moving Forward to Phase 3

— The immediate critical step for MHSAL is to proceed with establishing a Transformation Management Office (TMO) to support implementation in a planned, phased-in approach.

— An important first step will be defining the TMO scope, structure and definition in relation to both supporting the delivery of cost improvements from 2017/18 and enabling transformational change.

— The key activities and requirements of the TMO are:

  — Build on the momentum created through Phase 1 and Phase 2 and capture short-term cost improvements for 2017/18.

  — Take forward key planning activities in 2017/18 for more medium-term, transformational opportunities.

  — Coordinate improvements and maintain support for change.

  — Harness leadership and improvement resources within MHSAL and across the provincial healthcare system.

  — Create a foundation for sustainable change through supporting strategic realignment of the provincial system and its aligned transformation to a commissioning-based framework and approach.

Further information on operationalizing the TMO is provided in Section 3 "Guidance on Implementation and Achieving Cost Improvement".

Critical Outcomes for MHSAL to achieve in 2017/18

— We have identified four key outcomes for MHSAL to achieve success in 2017/18 and set the path for sustainability:

1. Establishing the TMO in April 2017 to support driving forward implementation in a planned, phased-in approach and to continue momentum.
2. Capturing 2017/18 Budget cost savings which will build confidence in MHSAL's ability to lead medium-term transformational change.
3. Achieving substantive progress on the simplification and realignment of the Manitoba healthcare system, consolidation of services provincially in alignment with leading practice, and a fundamental shift to a commissioning-based approach to strengthen accountability for performance, which are critical enablers to the other cost improvement initiatives.
4. Understanding that the majority of the medium-term, transformational cost savings identified relate to changes in clinical services and rationalizing infrastructure with the necessity for planning work to be undertaken in 2017/18 to realize benefits from 2018/19 and beyond. These cost savings can also only be realized through a rigorous focus on both shifting care from acute to more community settings and consolidation of acute care programs and facilities though a provincial master services planning process.

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2. Approach and Introduction to Work Plans

Phase 2: Objectives & Introduction

Objective of the HSIR:

To identify opportunities to eliminate waste and inefficiency, and improve the effectiveness and responsiveness within the healthcare sector within the next 3-4 years.

The objective of Phase 2 of the HSIR, which commenced in February 2017, was the development of Work Plans and an aligned change management approach and plan. These documents are intended to provide guidance on taking forward implementation in relation to six prioritized areas of opportunity identified in the Phase 1 Report.

This involved the establishment of working groups to oversee the development of work plans for each of the 6 prioritized areas of opportunity and collaboration between KPMG, MHSAL and Health Authorities which was established in Phase 1. The working groups focused on:

— The development of opportunities related to each work plan including key planning and implementation activities and milestones for each quarter of 2017/18 and where relevant for subsequent years.

— Identification of governance, communications and project delivery support for each opportunity.

— Identification of key risks and interdependencies for each opportunity and both interdependencies between different work plans and between other policy initiatives such the development of a Provincial Clinical and Preventative Services Plan and the Wait Times Taskforce.

— Agreement on the timing and phasing of opportunities.

— Identification of benefits linked to key performance objectives.

— Additional data analysis on cost savings estimates, where feasible given the short time period, including taking forward the data analysis undertaken in Phase 1 to RHA and facility level to support the Core Clinical and Healthcare Services work plan.

— Ensuring alignment of the work plans to leading practice both in Canada and globally.

Project Work Plan Overview

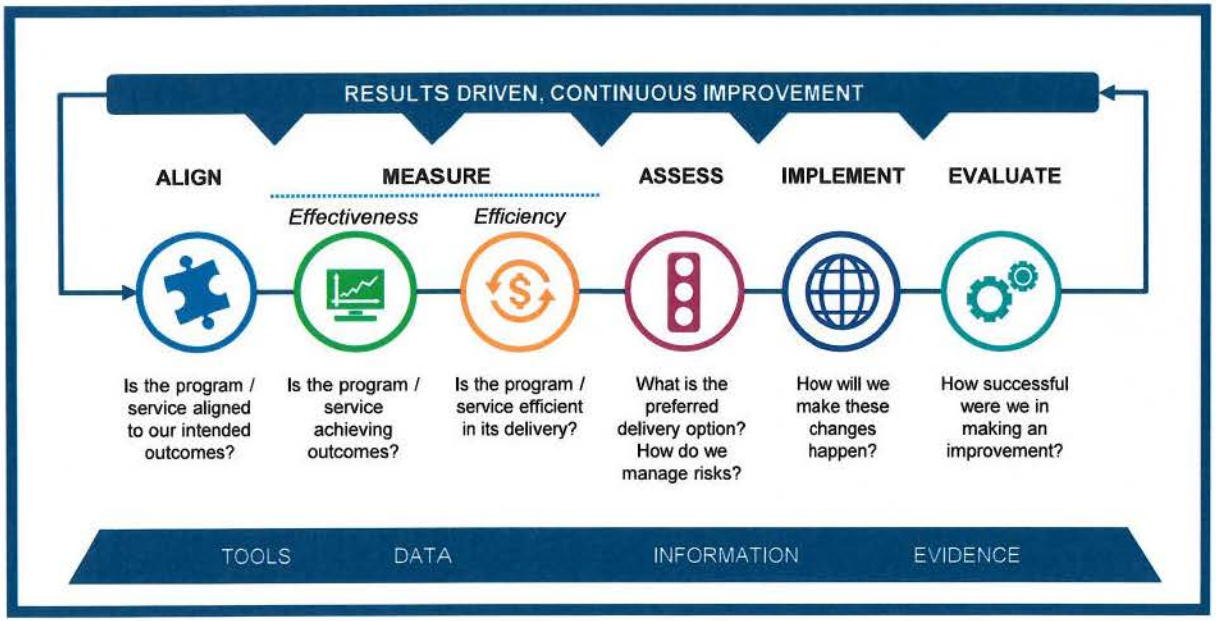
As Phase 2 is completed, the Government will need to commence preparing for Phase 3 in relation to implementation. This would involve setting up the Transformation Management Office and related infrastructure to support implementation.

Phase	Phase 1: Current State and Improvement Opportunities	Phase 2: Implementation Planning	Phase 3: Implementation
Timeline	Nov 2016 – Jan 2017	Feb 2017 – Mar 2017	Apr 2017 – Oct 2017+
Key Deliverables	1. Fiscal Performance Review Framework and Evaluation Criteria. 2. Current state assessment of Manitoba healthcare spend. 3. At least six high-priority potential cost savings improvement opportunities for further investigation 4. Reflections on Manitoba's healthcare system	1. Develop work plans for each of the six areas of opportunities to support Manitoba's implementation of each area of opportunity. 2. Further analysis in each area of opportunity and guide implementation and transformation planning. Each work plan would include: project summary; objectives and scope; governance and team roles and responsibilities; costing and delivery assumptions; further analysis from Phase 1; breakdown and validation of cost improvement estimates; benefits and costs; key risks; implementation plan; milestones; performance measures and tracking; and communications. 3. Develop a Change Management Approach and Plan to provide guidance and tools for change management across all healthcare system cost improvement initiatives.	1. Implementation Delivery: • Commencement of delivery of immediate and tactical/operational cost improvement opportunities. • Development of benefits tracking tools and processes. • Planning of allocative efficiency/strategic opportunities. • Implementation of Change Management Plan. 2. Structural and System Transformation: • Development of in-depth Transformation Roadmap. • Establishment of central Transformation Management Office.

Health Fiscal Performance Review Framework

The Manitoba healthcare operating budget for 2016/17 is approximately $6 billion, with an average annual increase of $223 million over the last decade. The rate of actual spending growth is not sustainable. Manitoba faces specific challenges with the necessity to bend the cost curve and ensure that its healthcare system is fiscally sustainable while improving the quality of care and achieving better health outcomes. The Health Fiscal Performance Review Framework is complementary to the Fiscal Performance Review Framework developed for core government, and provides principles and guidelines to place attention and fiscal discipline on all spending, and on the provision of efficient and effective MHSAL programs and services to improve health outcomes for Manitobans and ensuring a sustainable healthcare system.

The Health Fiscal Performance Review Framework is applied across a series of steps that consist of a set of questions that decision-makers are expected to ask, and provides a guide for how analysis should be approached and evidence-built. The use of reliable evidence, supported by standards and tools, will determine the successful application of this Framework. The Framework is contained in **Appendix 5 of the Phase 1 Report**.



To measure financial performance by effectiveness and efficiency, the following two lenses are applied for healthcare spending:

1. **Allocative Efficiency**: The extent to which limited funds are directed towards commissioning the right mix of health services in line with the preferences of those commissioning the services (e.g., doing the right things). This includes assessment of those services not only invested in but services disinvested from. It ensures the healthcare system can effectively evaluate healthcare programs and services and institute the optimal investment/disinvestment.

2. **Technical Efficiency:** The extent to which a healthcare provider is securing the minimum cost for the maximum quality in delivering its agreed healthcare outputs. This includes operational performance assessment and the extent to which resources are being wasted (e.g., doing things the right way). This includes assessment of the healthcare system's capability to optimize those healthcare services already provided through various means of quality improvement.

Technical & Allocative Efficiencies

We followed a comprehensive approach based on the measurement criteria set out in the Health Fiscal Performance Review Framework to identify immediate (2017/18), tactical / operational opportunities and medium-term transformation opportunities (2018/2019 and beyond) required to ensure sustainability. We also considered technical or allocative efficiency for each area of opportunity.

Lens	Examples	Criteria	Improvement Category	Timelines
Technical Efficiency *'doing things the right way'*	**Potential areas of opportunity for 2017/18** • Tactical cost reduction programs in larger hospitals via opportunities identified through benchmarking. • Consolidation of procurement functions and transformation of supply chain. • Improved drugs procurement.	Economy & Efficiency	**Immediately Implementable** *High impact cost management opportunities realized in-year.*	2017/18
			Analysis: *Tactical cross-cutting programs across healthcare system.*	2018/19+
Allocative Efficiency *'doing the right things'*	**Areas of potential opportunities in 2017/18 to realize significant savings in a 3-4 year fiscal year timeframe** • Reallocation of funding. • Clinical support services in relation to consolidation/ outsourcing.	Effectiveness	**Analysis: Strategic Redesign** *Redesign models of care/service reconfiguration.*	1+ Years
			Analysis: Strategic Partnerships *Working with others to deliver existing and new services differently.*	1+ Years

Introduction to Work Plans

In agreement with the Advisory Committee, the following six areas of opportunity were prioritized in Phase 1 to be taken forward in Phase 2 for the development of Work Plans:

1. Strategic Realignment and Funding for Performance.
2. Insured Benefits & Funded Health Programs.
3. Core Clinical and Healthcare Services.
4. Healthcare Workforce.
5. Integrated Shared Services.
6. Infrastructure Rationalization.

Phase 2 involved the development of concise work plans over 6 weeks, for each of the six areas of opportunity, to guide implementation planning and the path forward for transformation. Each work plan involved small, focused teams from KPMG, MHSAL and other key stakeholders.

Each Work Plan includes:

— Project summary, objectives and key interdependencies.

— Identified subthemes and listing of opportunities under each subtheme by estimated value of potential cost improvement.

— Identified benefits linked to key performance objectives.

— The development of key opportunities under each subtheme including key planning and guidance on implementation activities and milestones for each quarter of 2017/18 and where relevant for subsequent years.

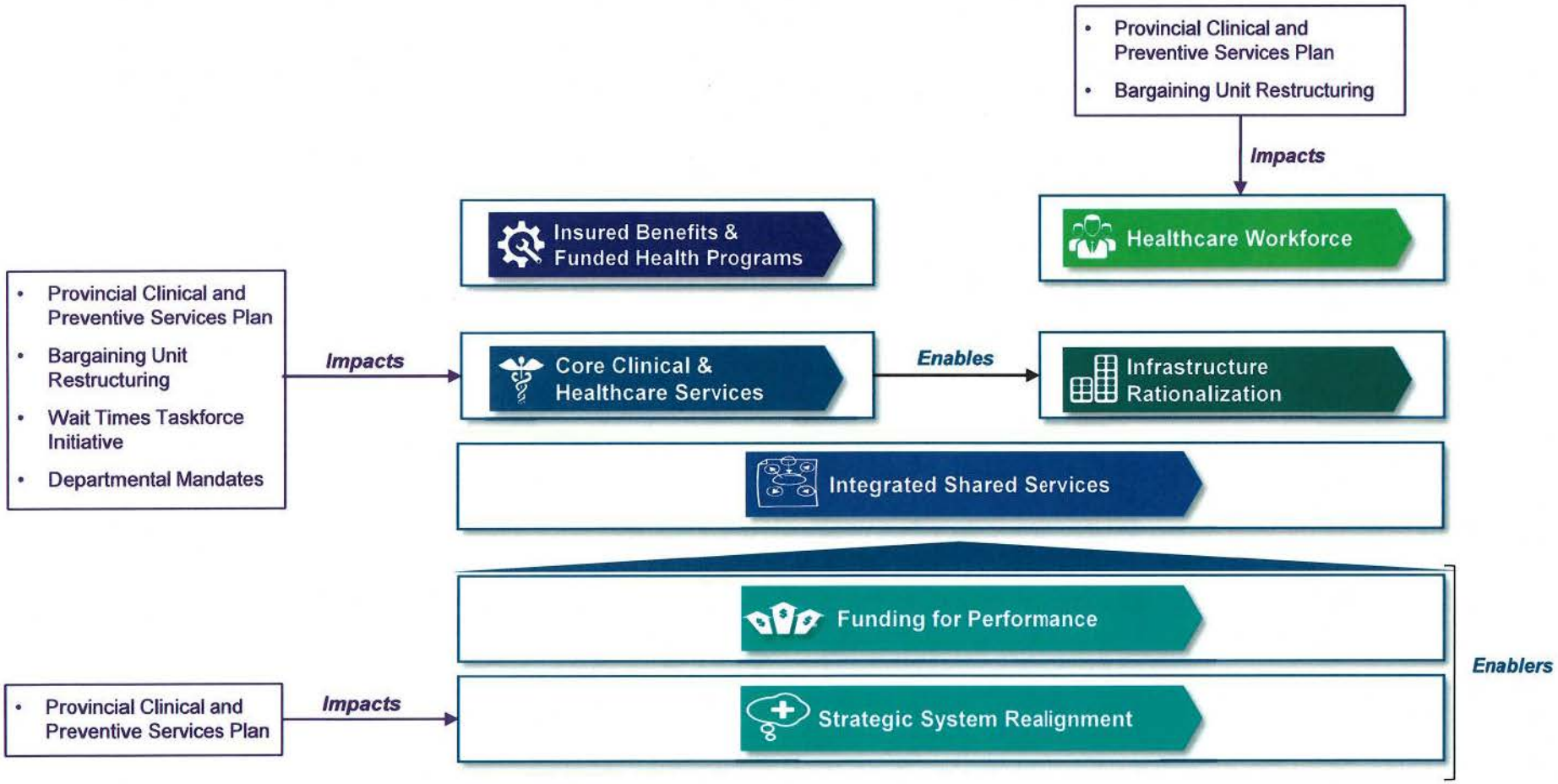
— Identification of governance, communications and project delivery support for each opportunity.

— Identification of key risks and interdependencies for each opportunity.

While the Work Plans have been developed as standalone documents to guide implementation planning, there are key interdependencies between the Work Plans, a summary of which is shown on the following page.

Enabling Workstreams & Related Interdependencies

We have identified the key interdependencies and enablers between workstreams and other key policy impacts.



High-Level Phasing and Benefits Realization

Work on development of the Work Plans has made explicit the challenge of the necessity to deliver short-term cost savings in 2017/18 while in parallel, planning for delivering medium-term transformational opportunities for 2018/19 and beyond.

	Fiscal Year 2017/18	Fiscal Year 2018/19 and Beyond
Strategic System Realignment *Key Enabler*		
Funding for Performance *Key Enabler*		
Core Clinical & Healthcare Services		
Insured Benefits & Funded Health Programs		
Healthcare Workforce		
Integrated Shared Services *Key Enabler*		
Infrastructure Rationalization		

Potential Cost Savings

 **<$5M**

 **$5-20M**

 **$20-40M**

 **>$40M**

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3. Guidance on Implementation and Achieving Cost Improvement

Background

During both Phase 1 and Phase 2, momentum has been built in the Province around the need for change in the short term to drive tactical cost improvement and in the medium term through transformation to achieve fiscal sustainability.

The scale and interdependent nature of improvement initiatives are driving the need for a strong, centrally managed TMO that will oversee the broader transformation and establish the tools and capabilities required to ensure successful, on-time and on-budget delivery for each of the Work Plans.

An effective TMO will fulfill the following objectives:

- Build on the momentum from Phase 1 and Phase 2 to support the realization of 2017/18 cost improvement opportunities.
- Take forward key planning activities in 2017/18 to start to operationalize medium-term, transformational opportunities.
- Harness leadership and cost improvement resources in the Province to coordinate improvements and maintain support for change.
- Help create a foundation for sustainable change in supporting the strategic realignment, and broader transformation of the provincial healthcare system.

Transitioning from Phase 2 to Phase 3

Moving from implementation planning to implementation delivery is a critical next step for MHSAL and the provincial healthcare system. The diagram below illustrates the key challenges in executing healthcare transformation based on KPMG's deep experience in other jurisdictions in Canada and globally.

Phase	Phase 1: Current State and Improvement Opportunities	Phase 2: Implementation Planning	Phase 3: Implementation
Objective	***Understanding of current state and identification of key opportunities***	***Development of roadmap and implementation approach & plan***	***Implementation delivery and realization of savings***

Key challenges from global healthcare transformation:

1. Sequencing and coordination of initiatives aligned with capacity for change.
2. Robust benefits realization and tracking.
3. Leverage existing change resources – but with infrastructure to focus and align efforts.
4. Effective change management, sustainability and capability building embedded in all initiatives.
5. Leveraging global insights and ongoing sharing of learnings across the network.

Building and Operationalizing the TMO

The approach to ensuring a fully embedded TMO should be undertaken in two distinct stages.

— **Stage 1,** which should be undertaken from April 2017 to the end of May 2017, is for MHSAL to build and establish a TMO. This will require the scoping and definition of TMO roles, TMO resourcing and capability building, creating TMO infrastructure that includes enabling tools and templates, and onboarding of the initiative leads and key resources.

— **Stage 2,** which should be undertaken from June 2017 to the end of September 2017, is fully operationalizing the TMO in relation to support effective execution of the opportunities in each Work Plan, benefits realization tracking, progress monitoring and reporting, and change management.

The next page illustrates the potential key next steps commencing in April 2017 to build and mobilize the TMO.

Stage 1: Potential Next Steps to Build the TMO

- Confirm TMO build schedule and key working sessions
- Confirm TMO Lead (internal) and sponsor

- Define scope of TMO mandate
- Define structure and roles of TMO:
  - Steering Committee
  - Transformation Lead
  - Sponsors
  - Initiative heads
  - Initiative team
  - Support resources (change management, data/analytics, process specialist)
- Define timing and sequence for review
- Define reporting relationships

- Build internal team to support TMO
- Skills review and capability building plan:
  - Change management
  - Project Management
  - Analytics
- Identify change leaders
- Orientation of Change leaders

- Develop TMO toolkit
  - Work Plan
  - Milestone tracker
  - Issue log
  - Risk register
  - Interdependencies tracker
- Create benefits realization model and dashboard
- Communication and stakeholders management plan
- Knowledge management and sharing approach
- Establish metrics and reporting

- Launch meeting with initiative leads
  - Role of TMO
  - Resourcing
  - Objectives / charter
  - Work Plan reviews
- Stakeholder review and communication
- Incorporate feedback into structure and approach of TMO

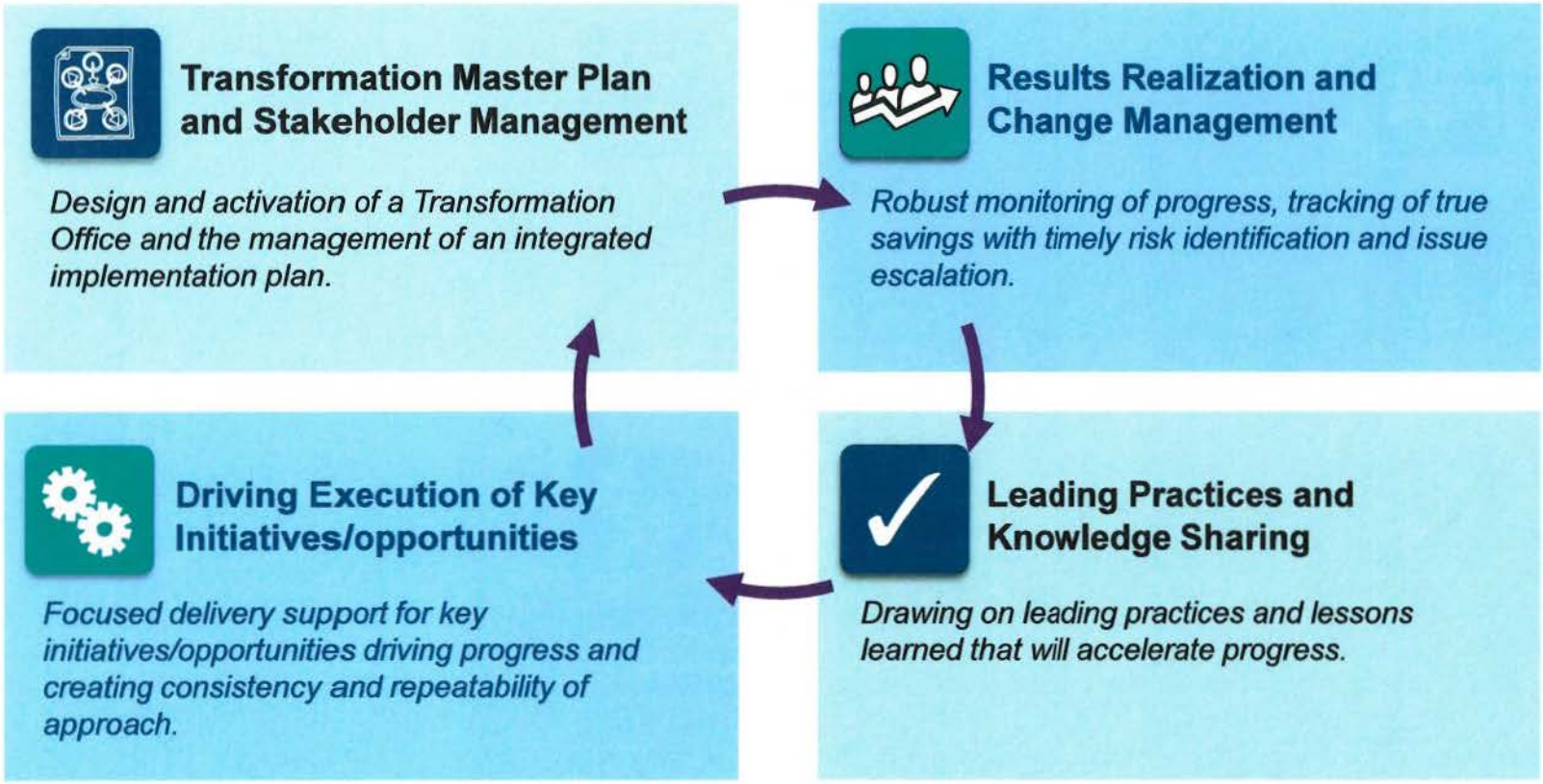
Stage 2: Operationalizing the TMO

Once the TMO is fully embedded in MHSAL, the key functions that will need to be executed week-in, week-out by the TMO are:

- Developing and updating Work Plans, standard meeting templates and reporting templates;
- Supporting and facilitating regular cadence meetings and reporting;
- Ongoing management of Risks, Issues and Interdependency Logs;
- Tracking/monitoring of Work Plans by opportunity milestones;
- Tracking and monitoring benefits realization including escalation and mitigation processes if delivery is off track;
- Supporting ongoing communications and change management including ongoing alignment of key stakeholders on the transformation vision;
- Providing ongoing updates to MHSAL Minister and Leadership, Treasury Board, Planning & Priorities, and an Advisory Committee as required;
- Access to expert advice and guidance in relation to implementation of the Work Plans including access to leading practice; and
- Advice and support in relation to Strategic System Realignment and the broader transformation of the Provincial healthcare system including access to a Global Advisory Panel of seasoned healthcare leaders.

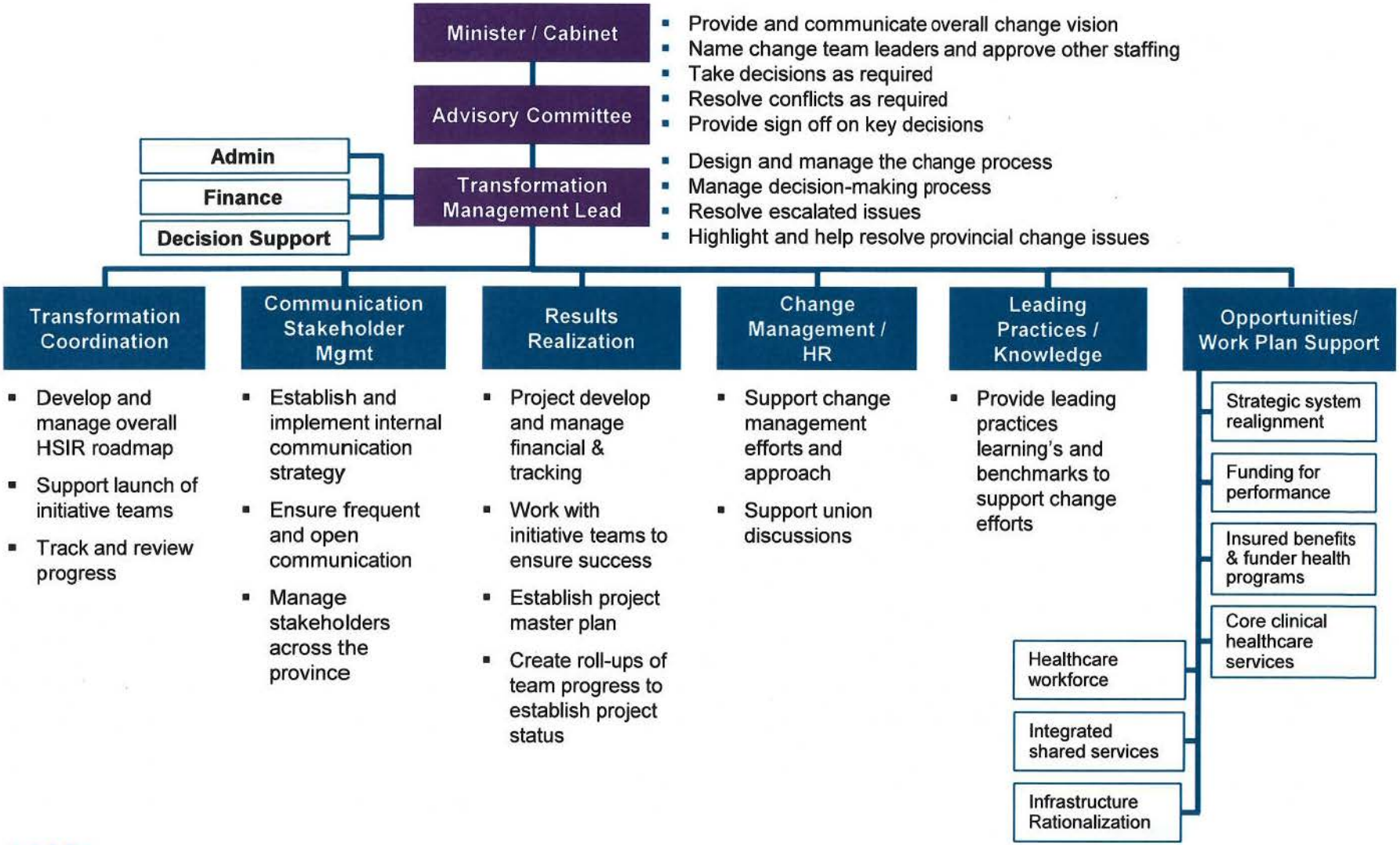
The next page illustrates the key role and functions of a fully operationalized TMO.

Role and Functions of the TMO



Governance and Structure of the TMO

It will be critical that the governance and structure aligns to key accountabilities of the TMO. A potential model is shown below.



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Work Plans

1a. Strategic System Realignment

1b. Funding for Performance

2. Insured Benefits and Funded Health Programs

3. Core Clinical and Healthcare Services

4. Healthcare Workforce

5. Integrated Shared Services

6. Infrastructure Rationalization

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Work Plan 1A: Strategic System Realignment

Notice

This Strategic System Realignment Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

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Strategic System Realignment - Work Plan Summary

Strategic System Realignment

Project Summary

- This workstream includes "Strategic System Realignment" identified within the MHSAL HSIR Phase 1 Report.
- **Strategic System Realignment** includes realigning and focusing the roles, responsibilities and accountabilities between the Department, the RHAs, and other healthcare entities in relation to policy, planning, oversight, commissioning and delivery.

Background

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

Strategic System Realignment - Work Plan Summary

Strategic System Realignment	
Objective & Scope	• **Strategic System Realignment** will aim to improve governance, management and service delivery structures by providing structural and policy considerations to Manitoba in the development of a rationalized province-wide healthcare system structure. This "new target state" structure will supersede the existing current state which is considered fragmented and/or regionalized. The new structure will underpin performance management and compliance by shifting focus to key performance indicators/metrics and system policy, planning, oversight, controls, commissioning, and delivery roles. In other words, the realignment will seek to align the roles of MHSAL, the RHAs, and other healthcare delivery organizations with that of a high-performing healthcare system. • This work plan includes the results of a structured process to guide the development of a preferred option for system realignment to address these issues. This includes reflections on the requirements for a refined funding for performance and commissioning framework to reinforce strategic system changes and ensure that improvement benefits from realignment are achieved in health care delivery.
Interdependencies	• 2017/18 MSHAL Treasury Board Submission. • Provincial Clinical and Preventive Services Plan: • Recommendation to transfer Selkirk Mental Health Centre administration to provincial entity.

Summary of Opportunities

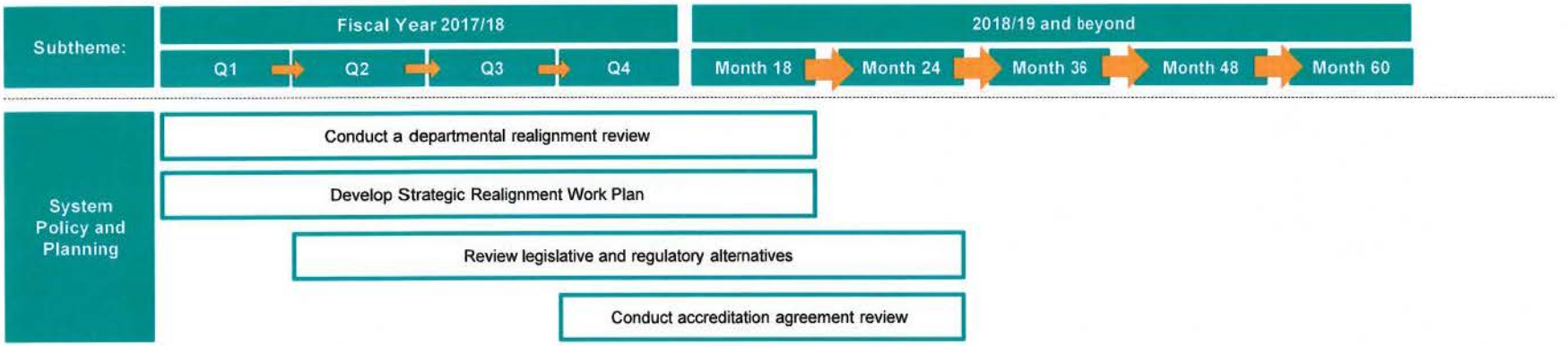
This table provides a summary of the total cost savings for the Strategic System Realignment Work Plan broken down by benefit year and sub category.

Sub Category	2017/18 Potential Cost Savings	2018/19 and Beyond Potential Cost Savings	Total
System Policy and Planning	$ 2.9M	$ 5.3M	$ 8.2M

The following table provides an overview of each opportunity included in the Strategic System Realignment Work Plan.

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
System Policy and Planning	Conduct a departmental realignment review.	$1.7M	2017/18	MHSAL	• MHSAL to manage to budget for 2017/18.	• If this opportunity does not meet timeframes, this will have downstream affects on other opportunities. • Requirement for supporting system and changes associated with this opportunity are not assessed.
		$3.5M	2018/19 and beyond			
	Develop Strategic Realignment Work Plan.	$1.2M	2017/18	MHSAL	• Partially dependent on the Departmental Realignment opportunity and governments decision to proceed. • Requires recommended establishment of a TMO.	• If a TMO is not established, this opportunity cannot proceed.
		$1.8M	2018/19 and beyond			
	Review legislative and regulatory alternatives.	-	2018/19 and beyond	MHSAL owned with potential support from external legal services	• Government decision and approval of strategic realignment option. • Legislative or regulatory changes are in process. • Operating agreements and Service Level Agreements are negotiated agreements between Health Authorities and delivery organizations. Timeframes for implementation need to be approved and further planned.	• All legislative and regulatory requirements have not been identified.
	Conduct Accreditation Agreement Review.	-	2018/19 and beyond	Impacted Health Authorities reporting directly to MHSAL	• Interdependencies with "Conduct a Departmental Realignment Review" and "Review Legislative and Regulatory Alternatives".	• Accreditation needs to be addressed before changes are fully implemented. • Substantial effort required.

Work Plan - High-Level Roadmap



This section also includes projects in other work streams and these are identified where shown but described in the other work plan areas.

Conduct a Departmental Realignment Review

Subtheme: System Policy and Planning	Benefit Year: 2017/18 and beyond	Est. Cost Saving: $5.2M / enabler
Implementation Duration: 18 Months	Implementation Effort: Medium / High	

Description	Review and reorganize all departmental functions within MHSAL as set out in Phase I HSIR report.
Benefit	• Alignment of healthcare services with the overall direction of government, financial economy and efficiency gains, overall improvement of organizational / operational effectiveness.
In-scope/Out of Scope	**In Scope:** • CMOs/Officers of health. • Insured service claims administration to shared service or alternate service delivery. • Emergency management functions to shared service. • CADHAM Provincial Laboratory to authority or integrated diagnostics shared service. • Selkirk Mental Health Centre to integrated health service as provincial care center. • Provincial Nursing Stations to regional authority or First Nations Entity. • Provincial Quick Care Clinics to regional authority or integrated health service. • Transportation management functions to shared service. • Public health inspections to integrated inspections team with Manitoba Agriculture or regional authority. • Communication functions to shared service. • Consolidation and alignment of the Medical Officers of Health between MHSAL and all Healthcare Authorities.
Key Assumptions	• Scope of the realignment is dependent on Government decisions as to what services will stay.
Governance	• MHSAL owned with support from other healthcare providers for devolved services.
Project Management	• MHSAL.
Communication Strategy	• TBD as part of this project.

Risks	Interdependencies
• If this opportunity does not meet timeframes, this will have downstream impacts on other opportunities.	• MHSAL to manage to budget for 2017/18.

Conduct a Departmental Realignment Review

Subtheme: System Policy and Planning	Benefit Year: 2017/18 and beyond	Est. Cost Saving: $5.2M / enabler
Implementation Duration: 18 Months	Implementation Effort: Medium / High	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Conduct options analysis and business case. • Develop recommendation document.	**Key activities:** • Decision made by Minister. • Initiate change projects. • Develop communication plan.	**Key activities:** • Announce and implement changes over 6-12 months.	**Key activities:** • Continue to implement changes.
Outputs: • Options analysis and business case. • Recommendations document.	**Outputs:** • Ministerial recommendation. • Initiate change projects. • Communications plan.	**Outputs:** • Announcement of changes.	**Outputs:** • N/A.

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.

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**

2017/18

Q1

Key activities:

- Decision by Government to proceed.

Outputs:

- Decision to proceed.

Q2

Key activities:

For each opportunity conduct the following steps:

- Initiate.
- Consolidate planning steps from other work streams looking specifically at the following:
  - Process.
  - System.
  - People/change.
  - Policy.
  - Communications to public.
  - Legislation.
  - Patient communications and engagement.

Outputs:

- Initiate.
- Plan.

Q3

Key activities:

- Continue planning.

Outputs:

- Plan.

Q4

Key activities:

- Prepare Treasury Board submission.
- Approval to proceed with opportunity.
- Implement.
- Repeat process for each opportunity included in the strategic realignment work plan.

Outputs:

- Recommendation document.
- Approval to proceed.
- Begin implementation of opportunity.

Review Legislative and Regulatory Alternatives

Subtheme: System Policy and Planning	Benefit Year: 2018/19 and Beyond	Est. Cost Saving: Enabler
Implementation Duration: 21 Months	Implementation Effort: High	

Description	Review and update current legislative and regulatory change requirements to support and enable system-wide transformation based on a Government decision to proceed with an option for implementation.
Benefit	• Enables alignment of health care services with the overall direction of government, financial economy and efficiency gains, overall improvement of organizational / operational effectiveness.
In-Scope	• Re-draft/amend and/or realign *RHA Act*, regulations, and authority by-laws. • Repurposing/realignment of DSM under *The Corporations Act.* • *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. • Asset transfer agreements for administrative functions within CancerCare, DSM, AFM, Provincial Care Centers (if in-scope). • Redefine/negotiate new operating and service purchase agreements. • 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. • 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.
Key Assumptions	• Depending on the scope of the project, it may be necessary to implement legislative and regulatory changes outside of the normal legislative review process.
Governance	• MHSAL owned with support from Legal Services Branch and Legislative Counsel.
Project Management	• MHSAL owned with potential support from external legal services.
Communication Strategy	• TBD as part of this project.

Review Legislative and Regulatory Alternatives

Subtheme: System Policy and Planning	Benefit Year: 2018/19 and Beyond	Est. Cost Saving: Enabler
Implementation Duration: 21 Months	Implementation Effort: High	

Risks	Interdependencies
• All legislative and regulatory requirements have not been identified.	• Government decision and approval of strategic realignment option. • Legislative or regulatory changes are in process. • Operating agreements and SLA's are negotiated agreements between Health Authorities and delivery organizations. Timeframes for implementation would require approval and further planning.

Review Legislative and Regulatory Alternatives

Subtheme: System Policy and Planning | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Saving: Enabler**

Implementation Duration: 21 Months | **Implementation Effort: High**

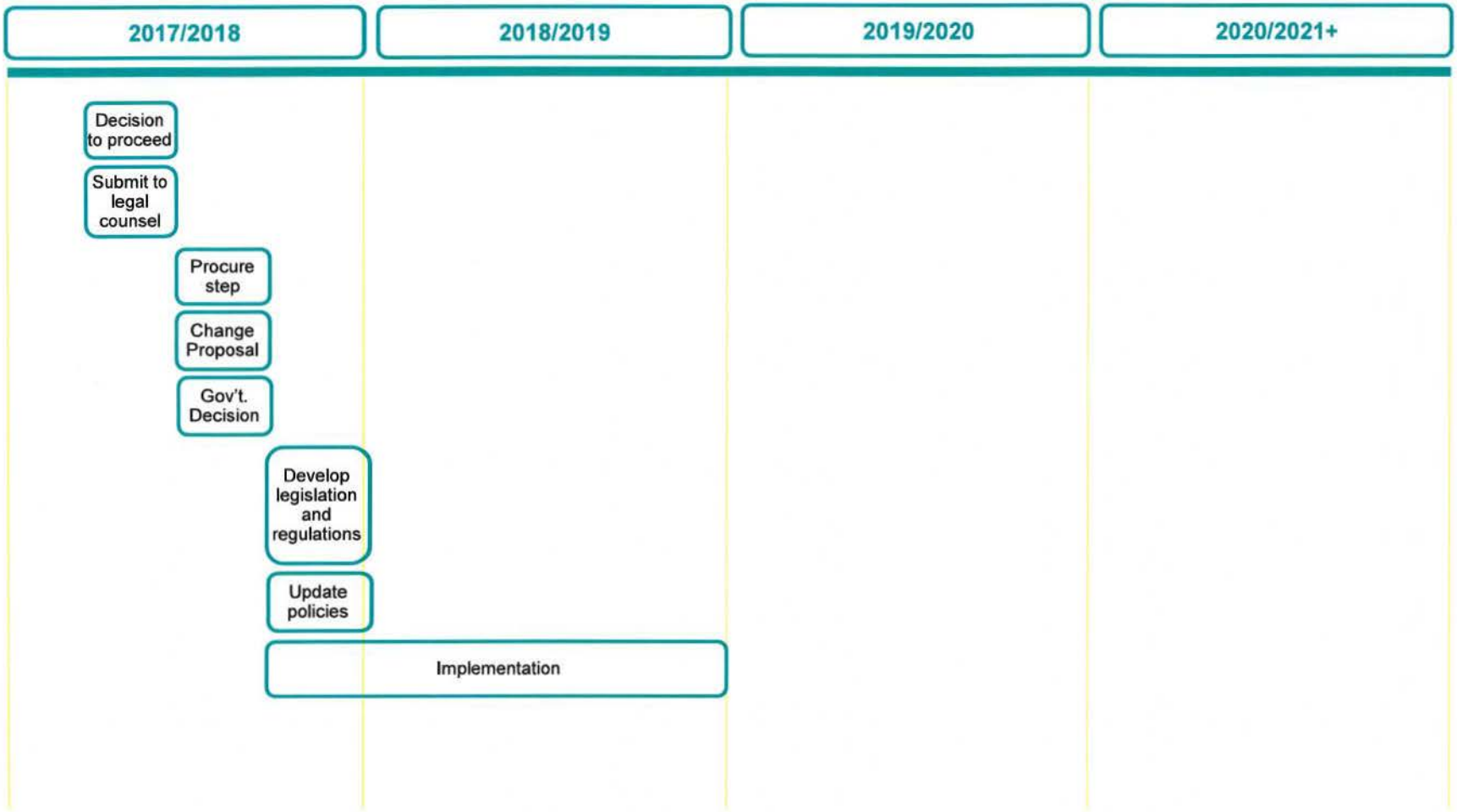
2017/18

Q1	Q2	Q3	Q4
Key activities: • N/A.	**Key activities:** • Government decision to proceed. • MHSAL Legislative services branch review. • Submission to Civil Legal and legal counsel.	**Key activities:** • Procurement of external counsel services. • Develop change proposal for Government. • Government decision to proceed.	**Key activities:** • Develop enabling legislation and regulations. • Develop / update policies. • Implement.
Outputs: • N/A.	**Outputs:** • Government decision. • Submission to legal counsel.	**Outputs:** • Procurement documents. • Change proposal. • Government decision.	**Outputs:** • Legislation and regulations. • Updated policies. • Begin implementation.

Review Legislative and Regulatory Alternatives

Subtheme: System Policy and Planning | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Saving: Enabler**

Implementation Duration: 21 Months | **Implementation Effort: High**



Conduct Accreditation Agreement Review

Subtheme: System Policy and Planning	Benefit Year: 2018/19 and Beyond	Est. Cost Saving: Enabler
Implementation Duration: 15 Months	Implementation Effort: High	

Description	Conduct a review of the current accreditation agreement to address gaps for health service organizations that have been changed.
Benefit	• Enables alignment of health care services with the overall direction of government, financial economy and efficiency gains, overall improvement of organizational / operational effectiveness.
In-scope	Each step in the four year accreditation agreement cycle: • Complete self assessment. • Complete instruments. • Submit accreditation information. • Plan on-site survey activities and logistics. • On-site survey. • Receive accreditations and report decision. • Submit evidence for progress review. • Mid-cycle consultation.
Key Assumptions	• TBD as a part of this project.
Governance	• MHSAL initiative with delivery by impacted Health Authorities.
Project Management	• Impacted Health Authorities reporting directly to MHSAL.
Communication Strategy	• TBD as part of this project.

Risks	Interdependencies
• Accreditation needs to be addressed before changes are fully implemented. • Substantial effort required.	• Interdependencies with "Conduct a Departmental Realignment Review" and "Review Legislative and Regulatory Alternatives".

Conduct Accreditation Agreement Review

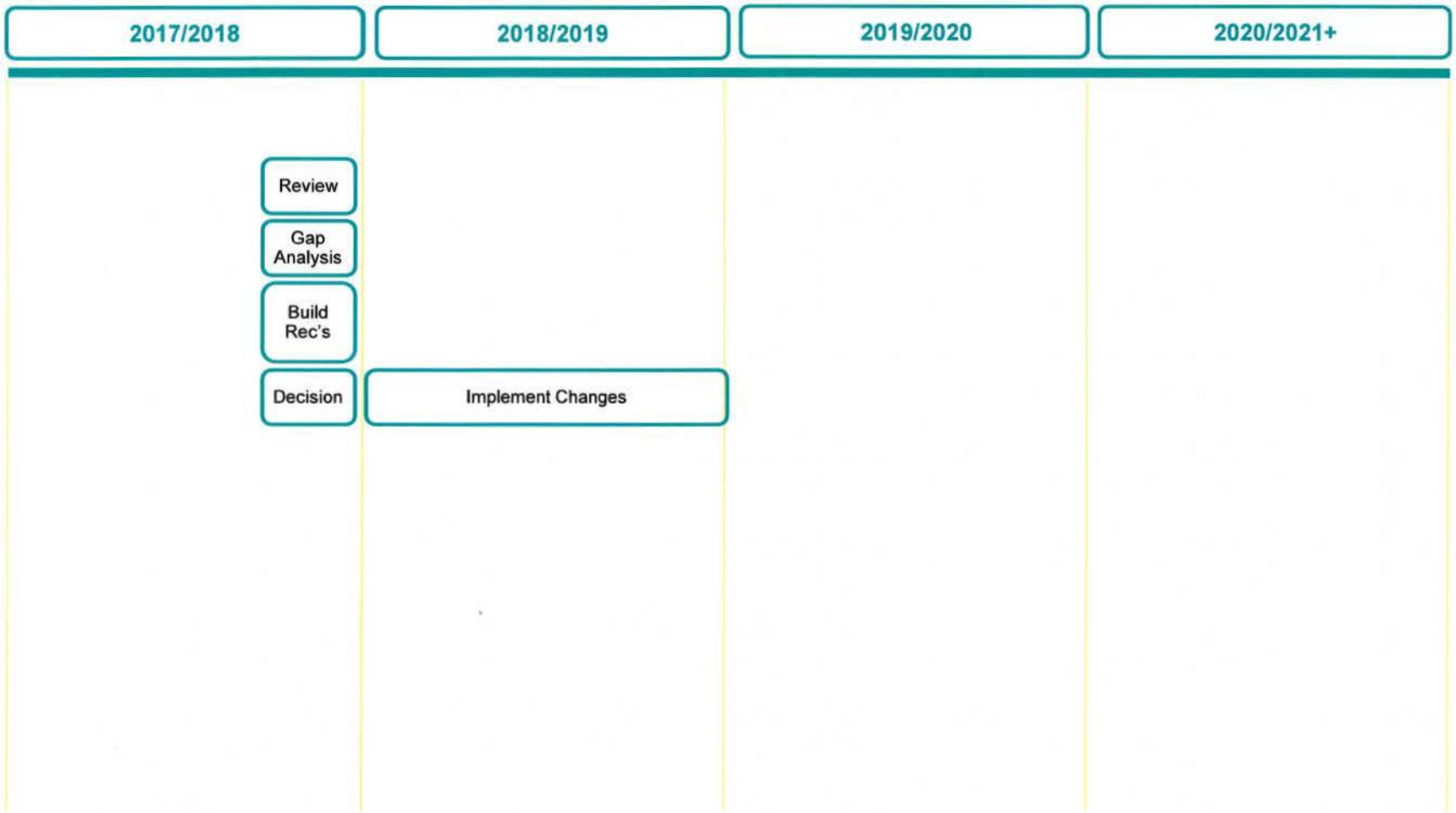
Subtheme: System Policy and Planning	Benefit Year: 2018/19 and Beyond	Est. Cost Saving: Enabler
Implementation Duration: 15 Months	Implementation Effort: High	

2017/18

Q1	Q2	Q3	Q4
Key activities: • N/A.	**Key activities:** • N/A.	**Key activities:** • N/A.	**Key activities:** • Conduct review of accreditation agreement activities and associated timeframes. • Conduct gap analysis. • Develop recommendations document. • Decision to proceed with accreditation updates. • Implement changes.
Outputs: • N/A.	**Outputs:** • N/A.	**Outputs:** • N/A.	**Outputs:** • Review. • Gap analysis. • Recommendations document. • Decision to proceed. • Implement changes.

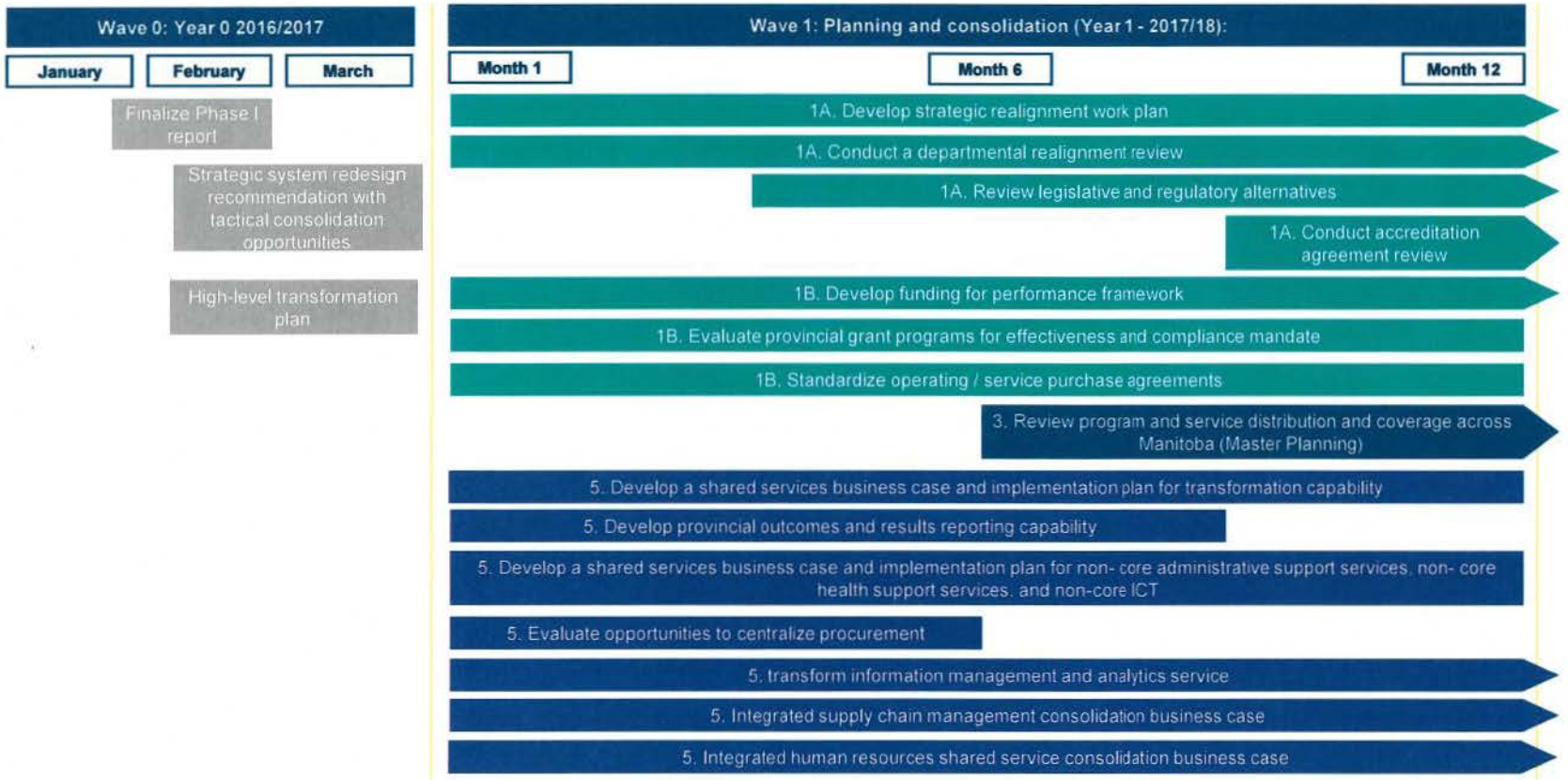
Conduct Accreditation Agreement Review

Subtheme: System Policy and Planning	Benefit Year: 2018/19 and Beyond	Est. Cost Saving: Enabler
Implementation Duration: 15 Months	Implementation Effort: High	



Strategic Transformation Road Map

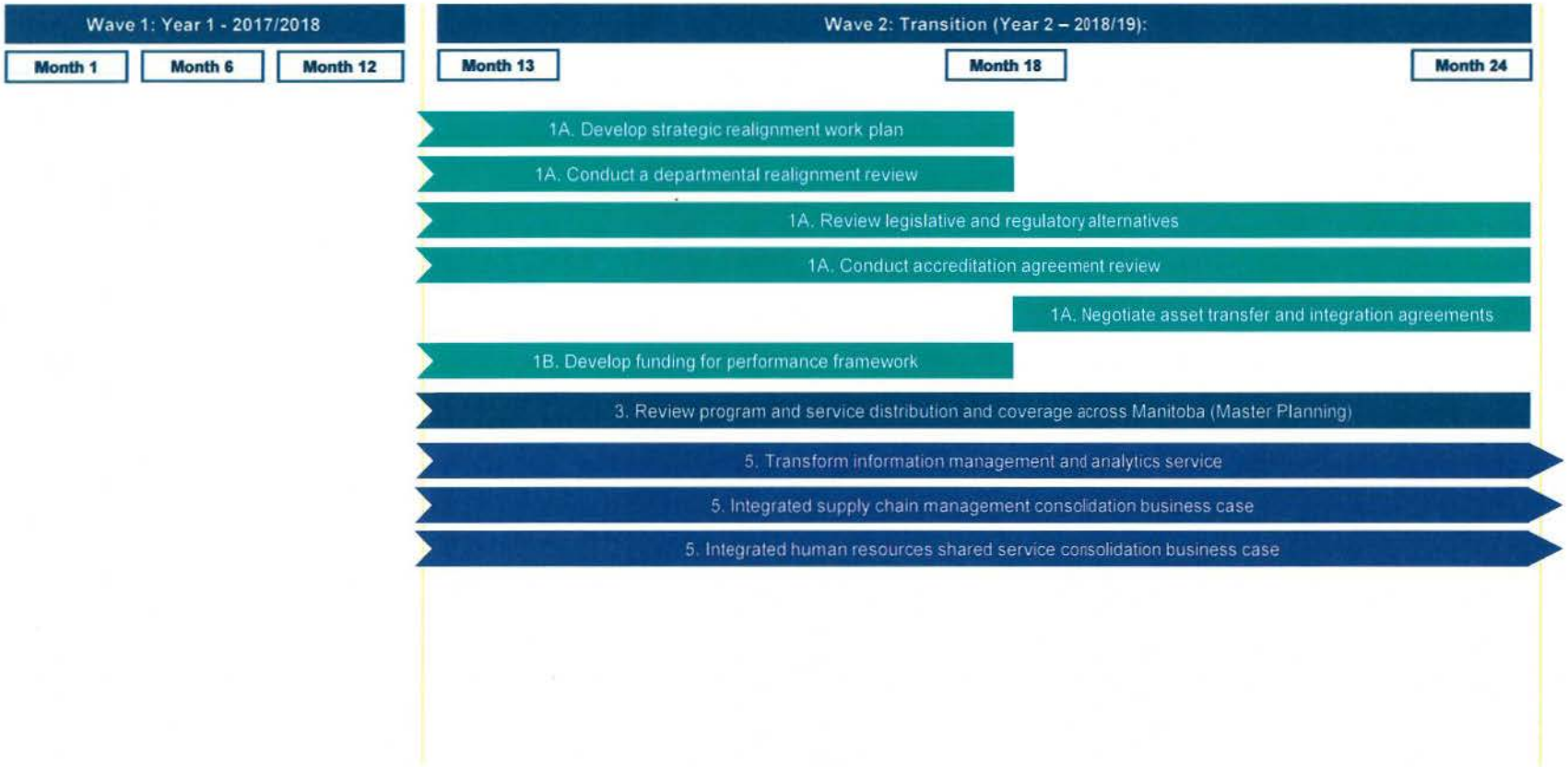
This strategic realignment section also includes projects in other work streams which are identified below. Descriptions of each can be found in their allocated work plans.



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

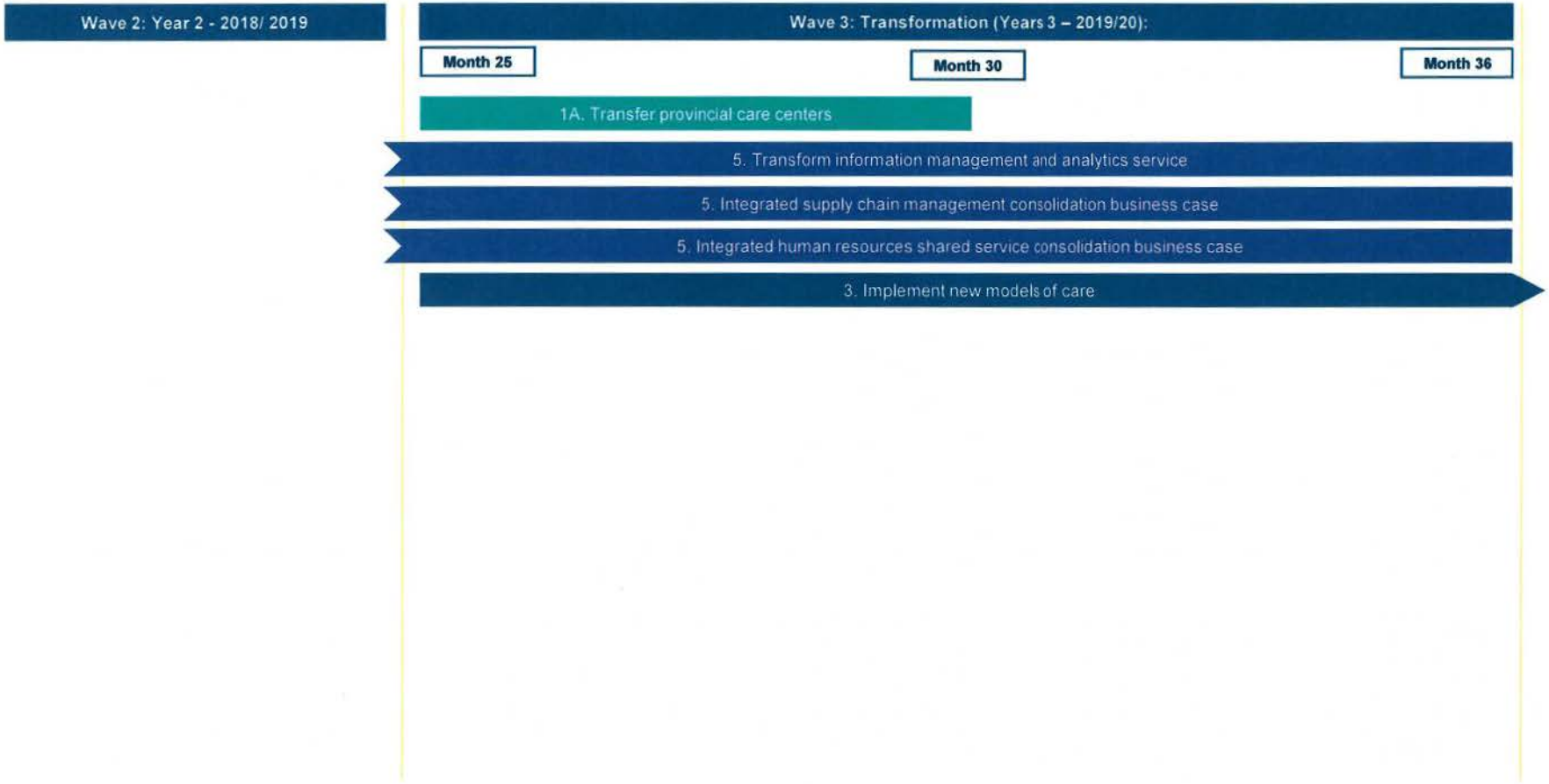


Work Plan Key:

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:

- 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

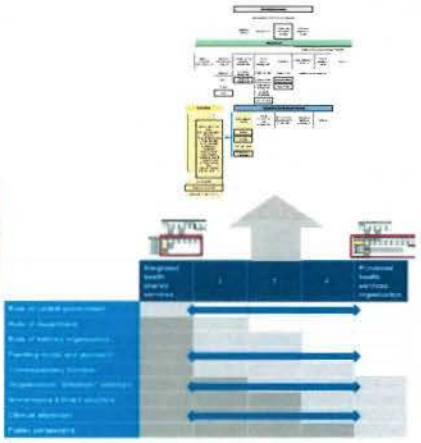
A structured approach was followed over the three working group sessions to identify, assess and evaluate system configuration scenarios to develop a preferred option for the Manitoba healthcare system.

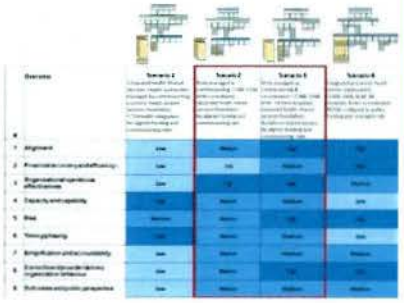
System design principles

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

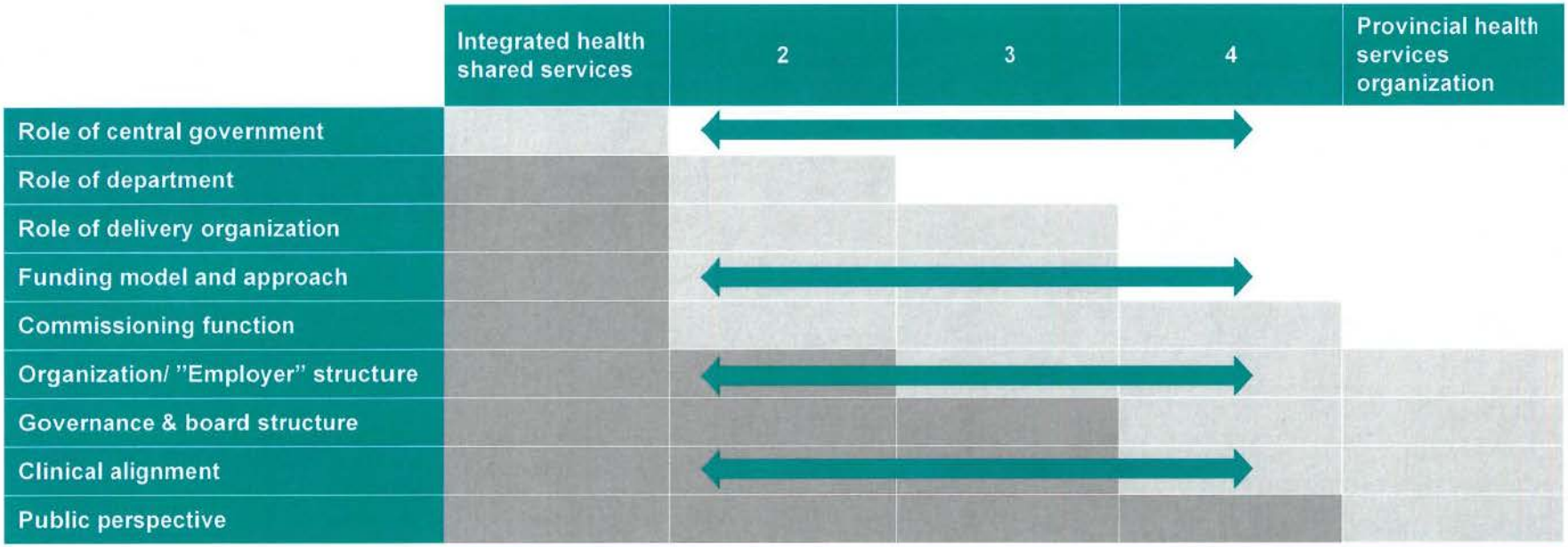
Eliminate those that are not worth further consideration

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.



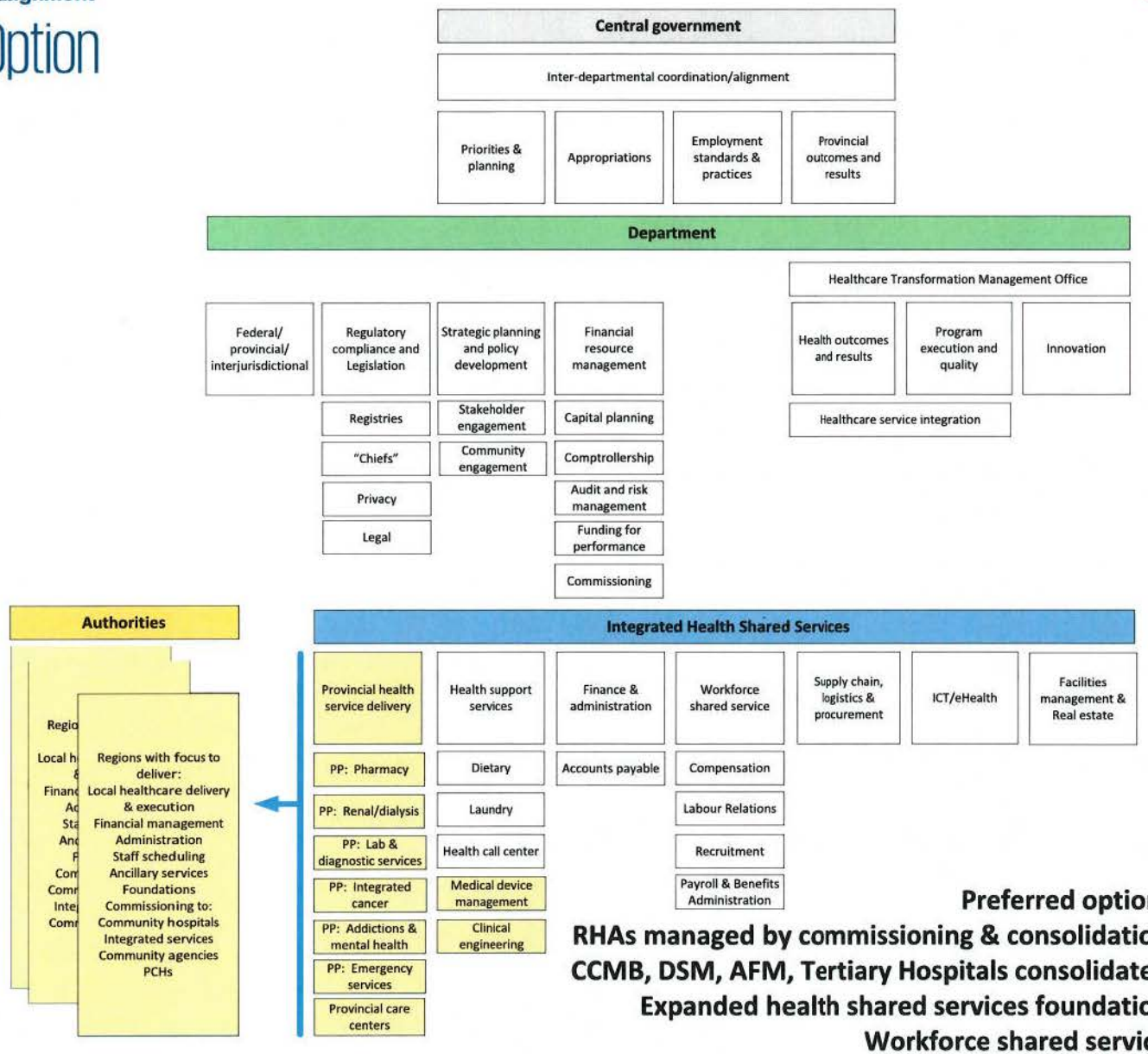
- Focus on alternatives from integrated health shared services to a provincial health services organization
- Structured process to review alternatives constructed to demonstrate the impacts of different factors on a continuum
- Relationship between system design alternatives and the requirements of 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

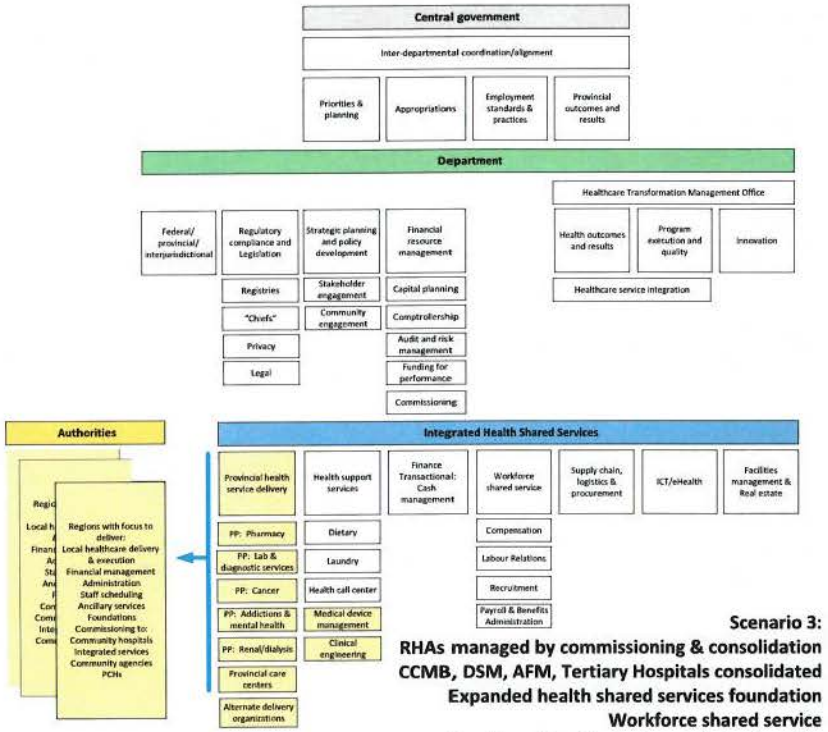
CCMB, DSM, AFM, Tertiary Hospitals consolidated

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

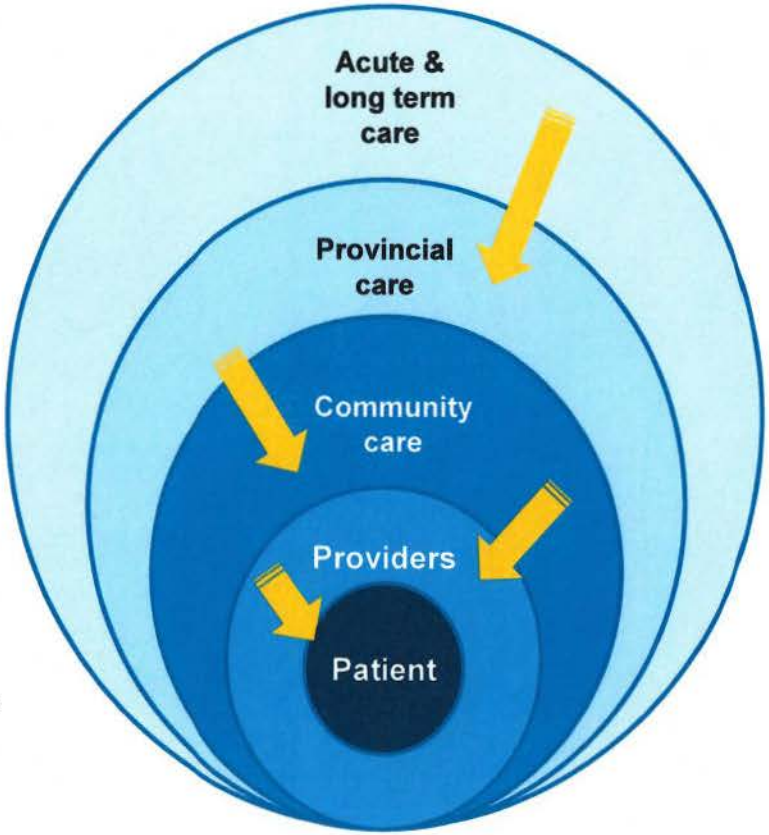
— Achieved through funding/commissioning and agreement through working groups with provincial coordination.
— Core jurisdiction-wide programs consolidated for integrated delivery across province.

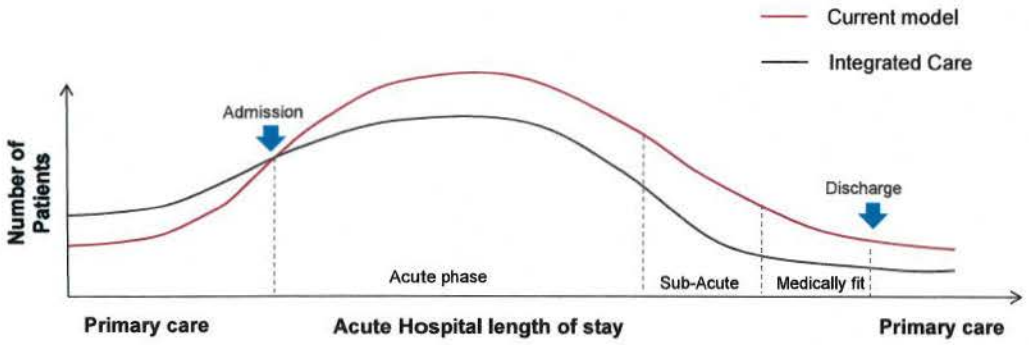
Outcomes

— 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.

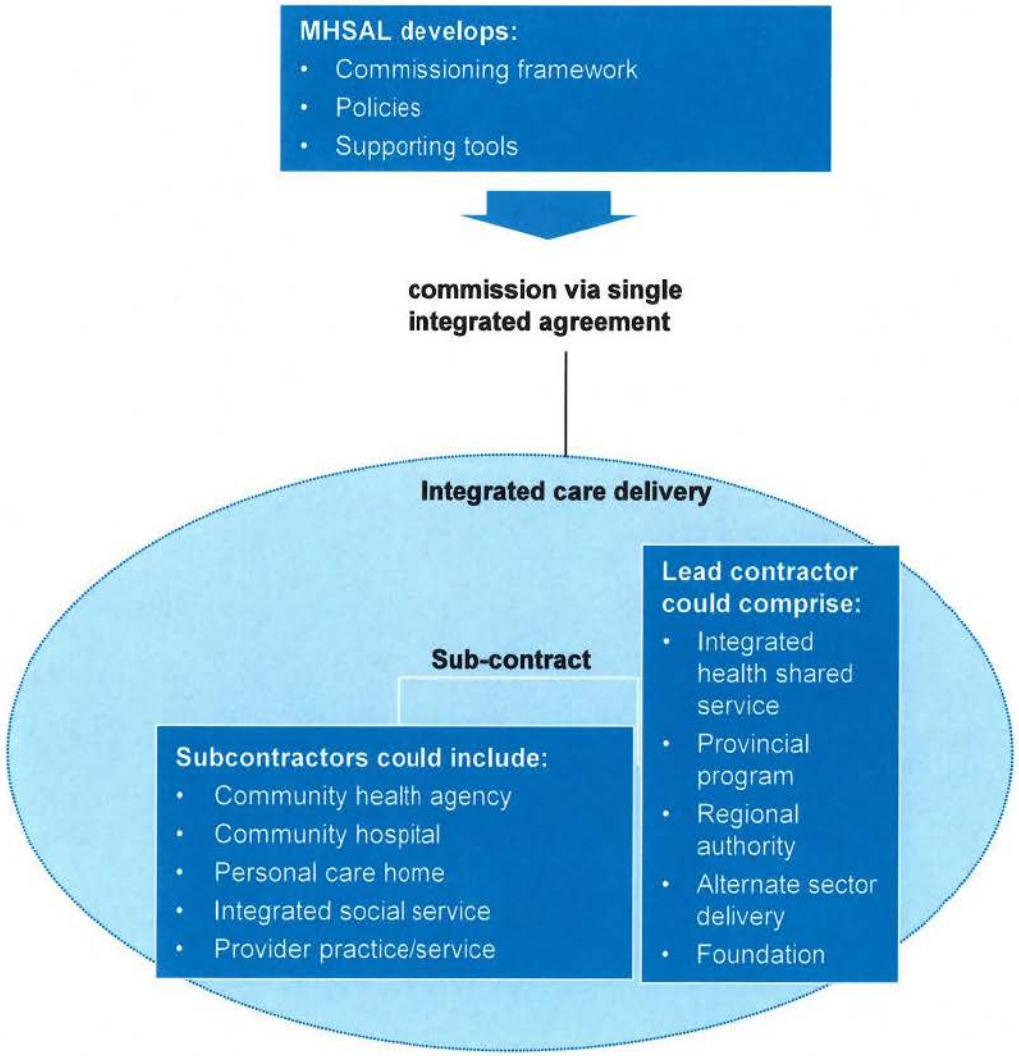




Commissioning Function - "The How"

- 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.



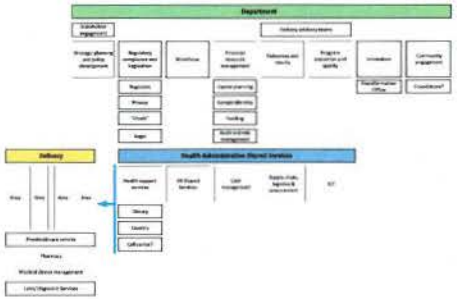
KPMG

Appendix 1: Background from HSIR Phase 1 Report

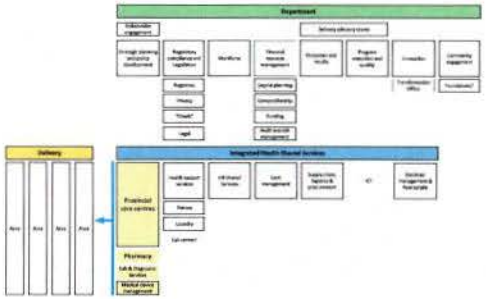
Background: Reference Models

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.

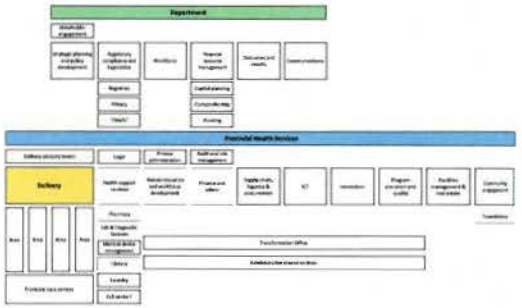
These models are based on the principles of high-performing health systems. Each model separates the role of the Department, Healthcare Delivery Organizations, and Shared Services Organizations. A representative organizational structure has been developed for each model. Each model reflects different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



Health shared services organization



Integrated health services organization

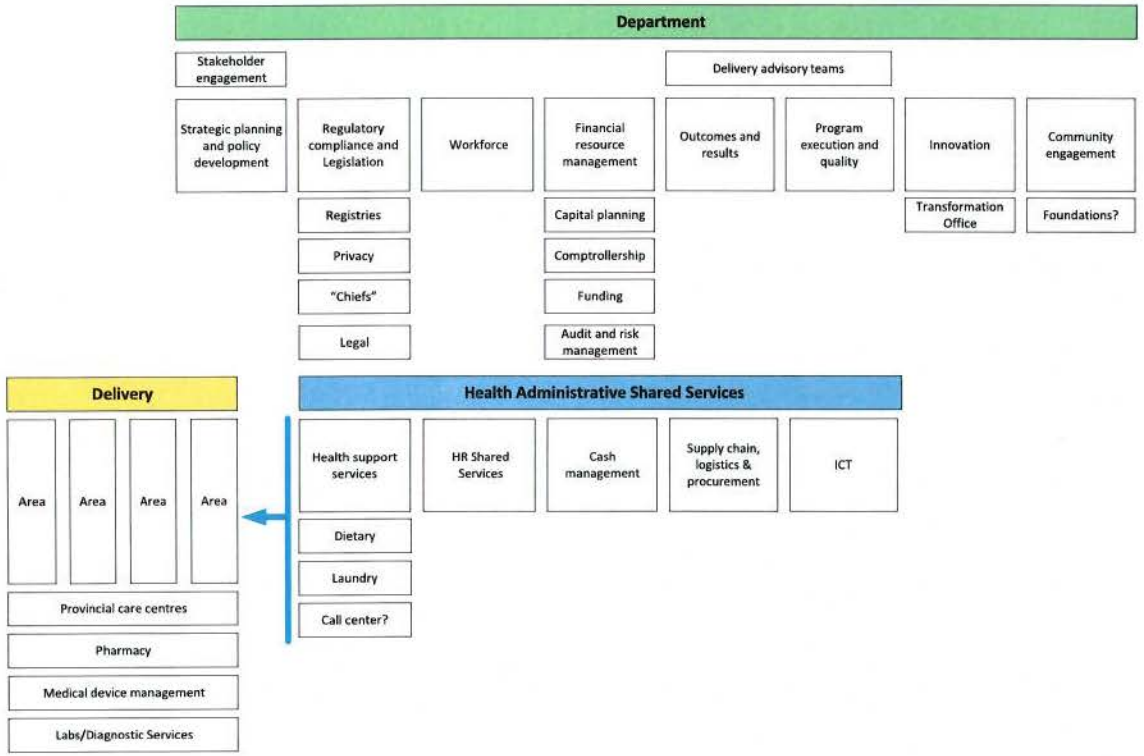


Provincial health services organization

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.

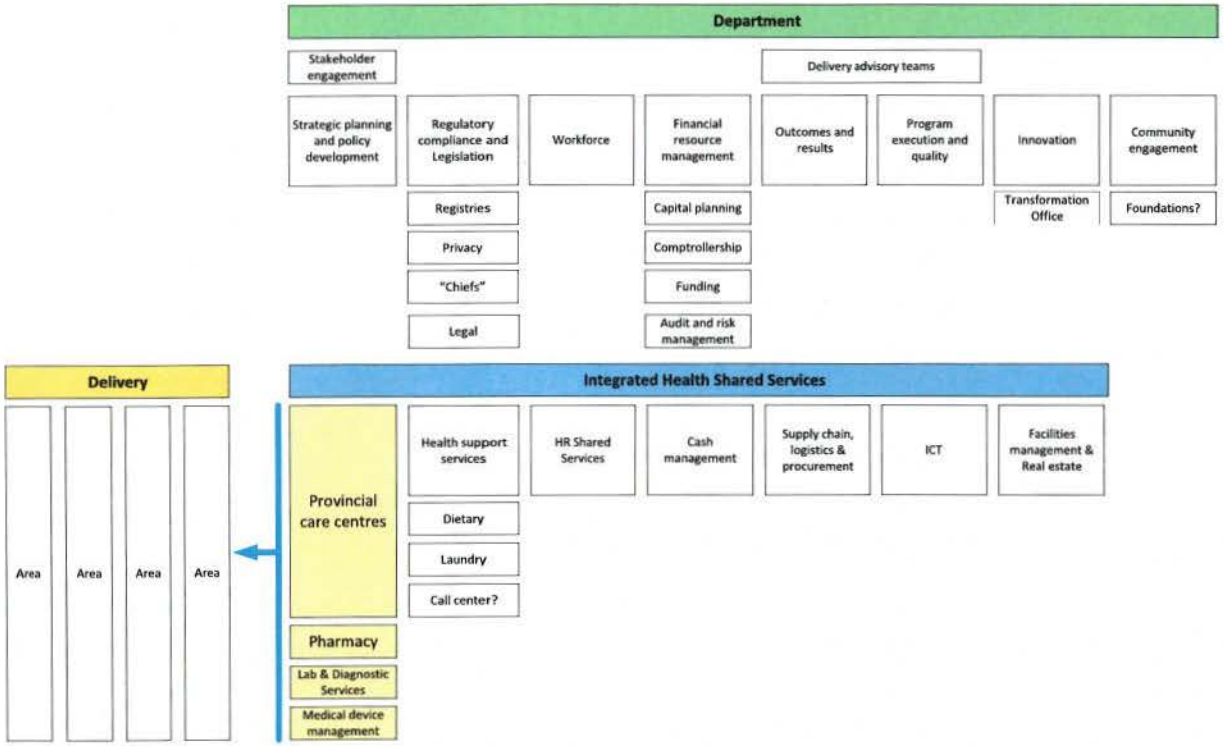
Role of Shared Services Organization

— 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

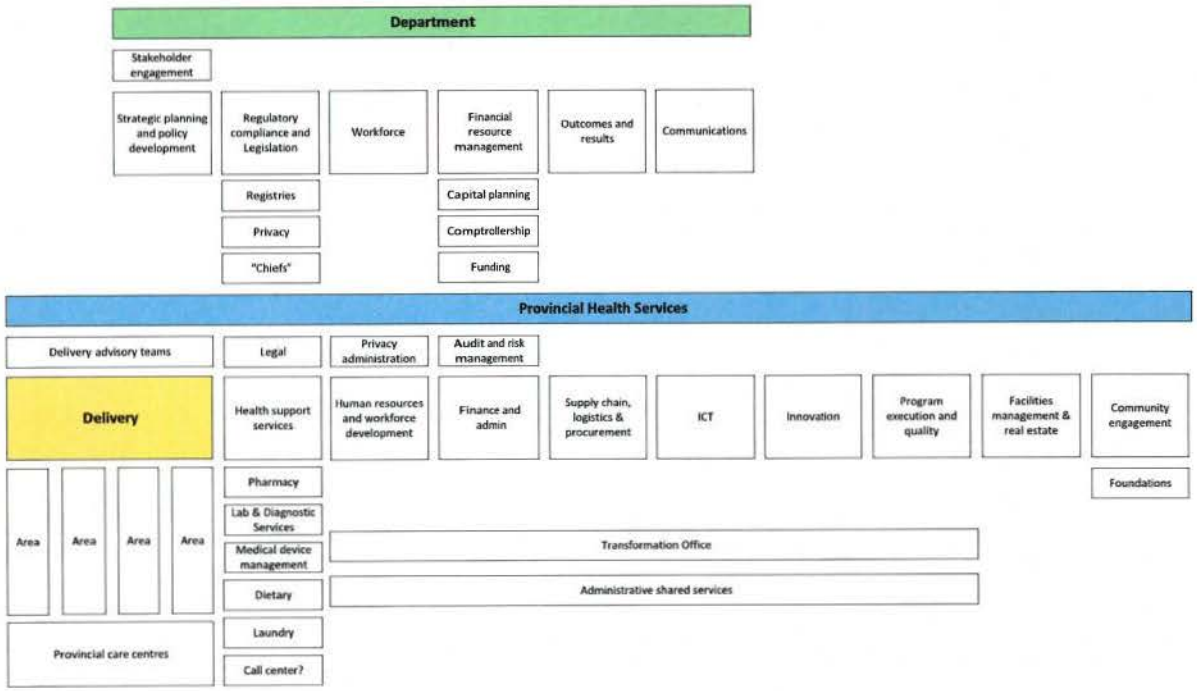
— Integrate and support delivery organizations as service provider.

— 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.

Background: Conceptual Impact of Realignment Using Sustainability Review Criteria

Potential improvement effect by sustainability review criteria:

Criteria	Health administrative shared services	Integrated health shared services	Made in Manitoba Hybrid to balance improvement gains against capability and implementation risk	Provincial health services organization
Alignment	Neutral / Uncertain (3)	Moderately Positive (4)		Moderately Positive (4)
Economy	Neutral / Uncertain (3)	Moderately Positive (4)		Moderately Positive (4)
Efficiency	Neutral / Uncertain (3)	Moderately Positive (4)		Strongly Positive (5)
Effectiveness	Moderately Positive (4)	Moderately Positive (4)		Strongly Positive (5)
Implementation/Transition Risk	Moderately Positive (4)	Moderately Negative (2)		Strongly Negative (1)
Capacity and capability to execute	Neutral / Uncertain (3)	Neutral / Uncertain (3)		Moderately Negative (2)
Overall Rating	Neutral / Uncertain (3)	Neutral / Uncertain (3)		Moderately Positive (4)

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

The working group agreed that the evaluation of strategic realignment alternatives be focused on the Made in Manitoba Hybrid.

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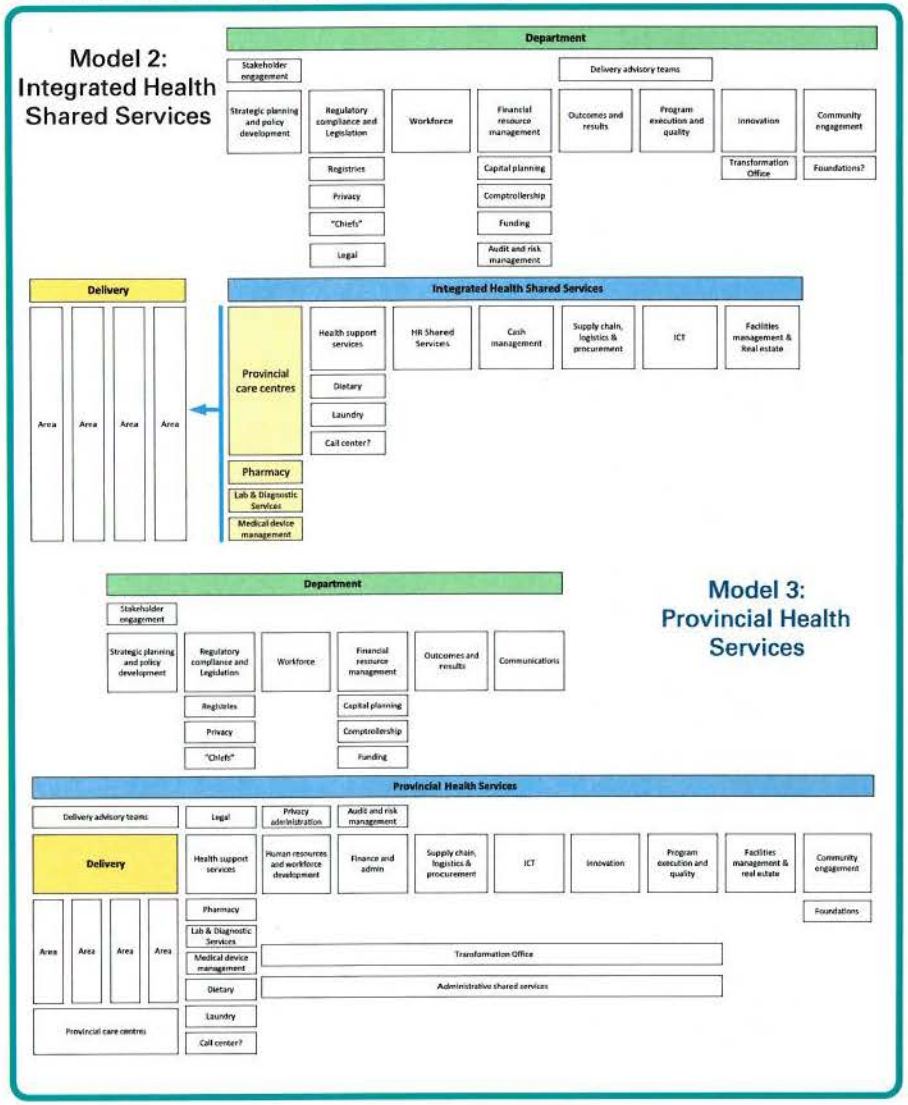
Appendix 2: Session #1: Confirmed elements, design principles and evaluation criteria

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



- 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:

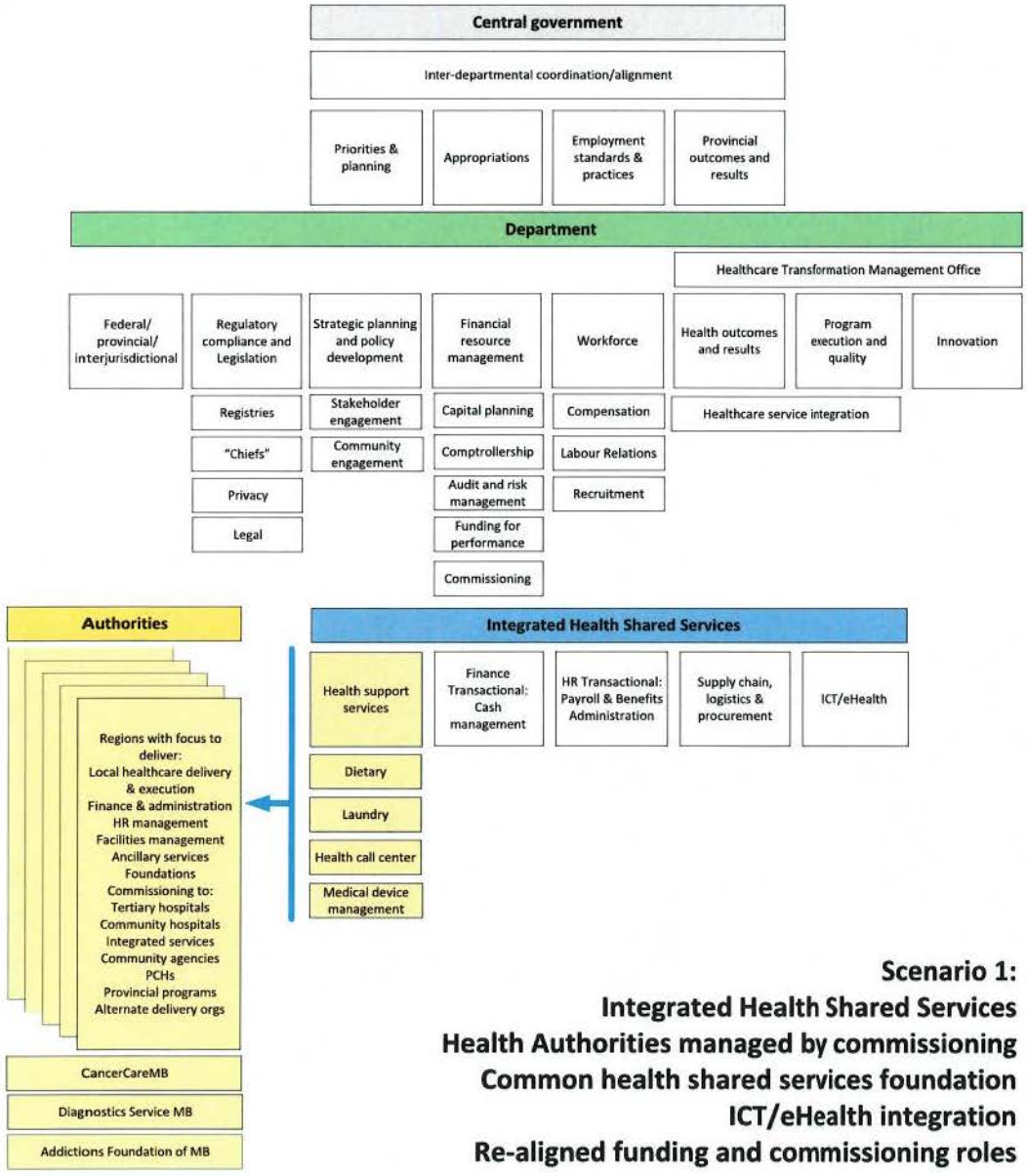
- Local healthcare delivery & execution
- Finance & Administration
- Human Resources
- Supply Chain
- Facilities Management
- Local ICT Support
- Ancillary Services Foundations

Commissioning to:

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

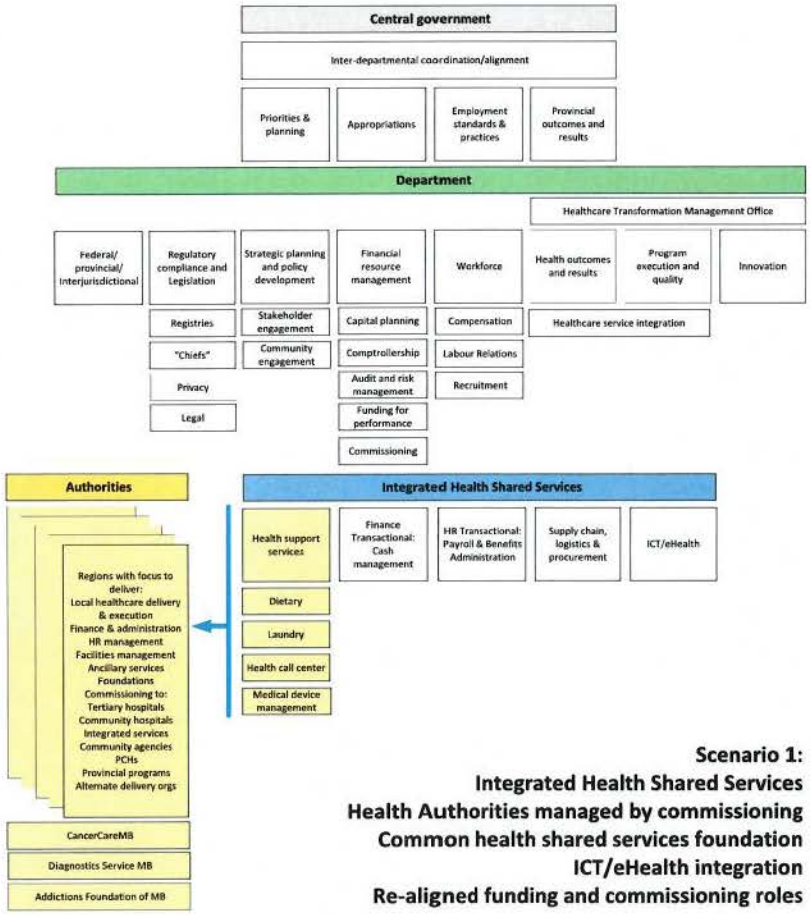
- A health authority incorporates a complete set of organizational functions with independent governance.
- Commissioning roles vary between the organizations with WRHA having the most extensive functional accountability.
- No concept of a "Provincial" region exists in the current legislation so it is 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.

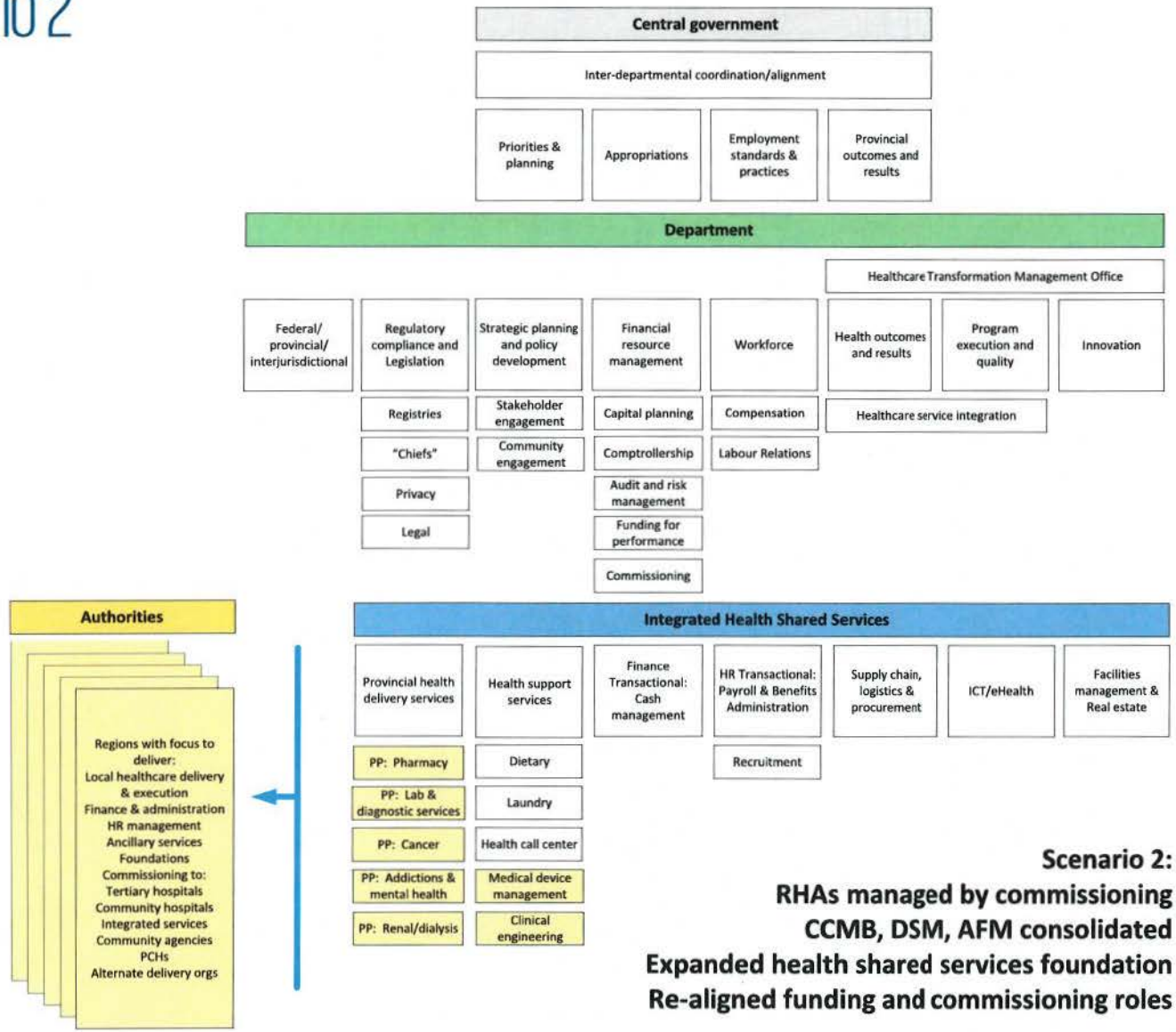
Clinical alignment

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

Outcomes

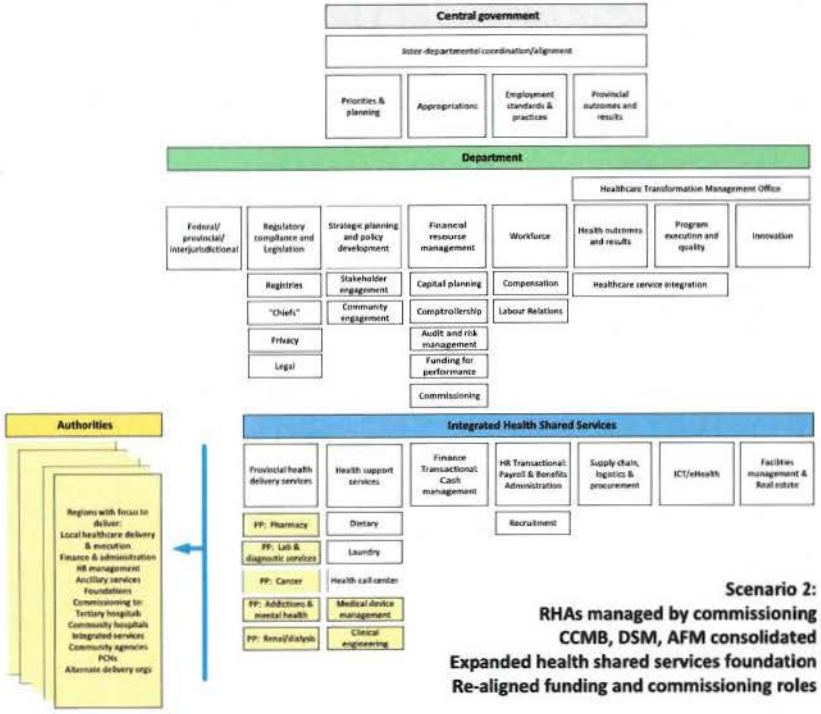
— Cost improvements and efficiencies in implemented shared services.
— Clarification of roles and accountabilities.
— Limited clinical service delivery impacts positive or negative.

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.

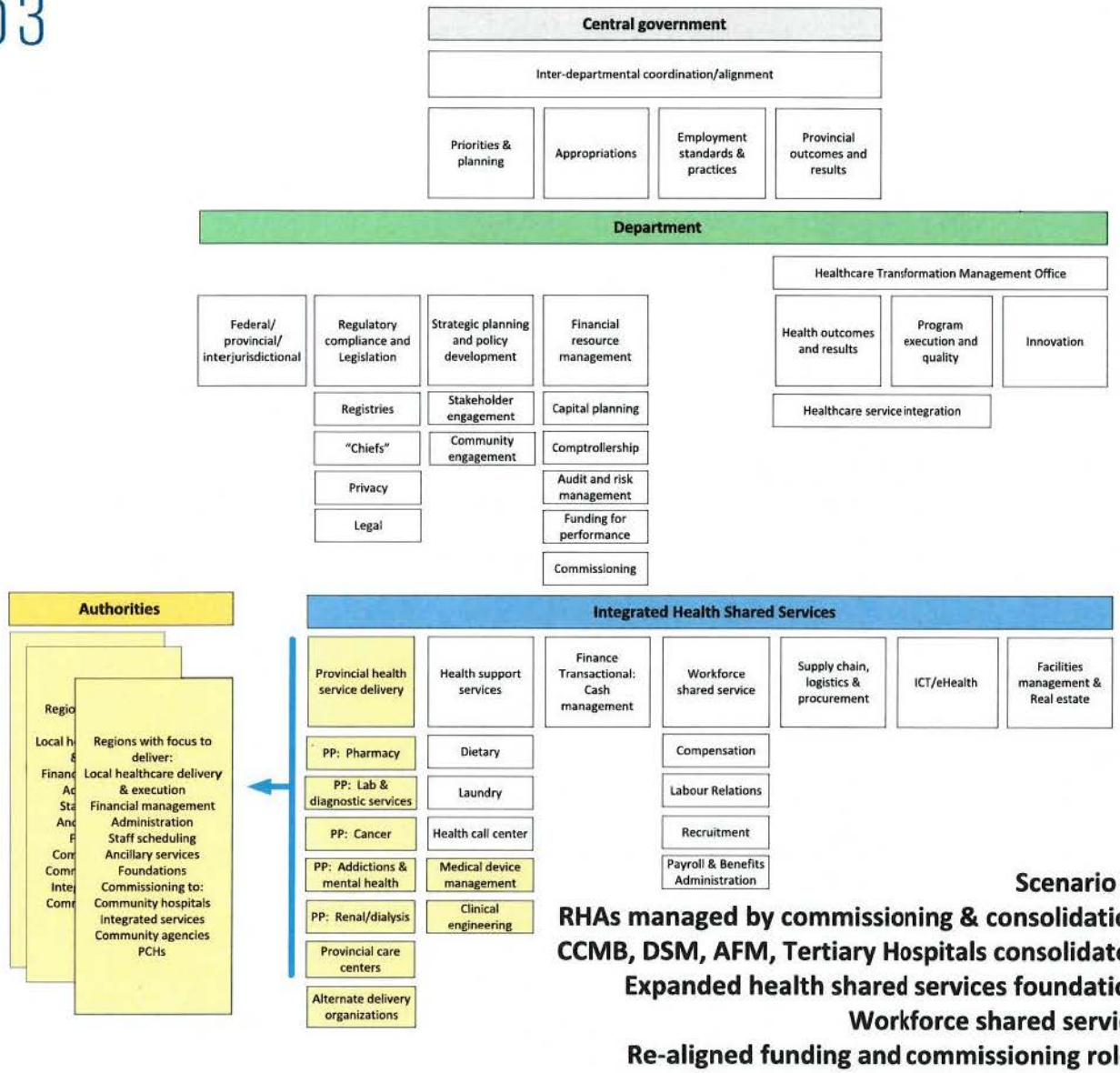
Clinical alignment

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

Outcomes

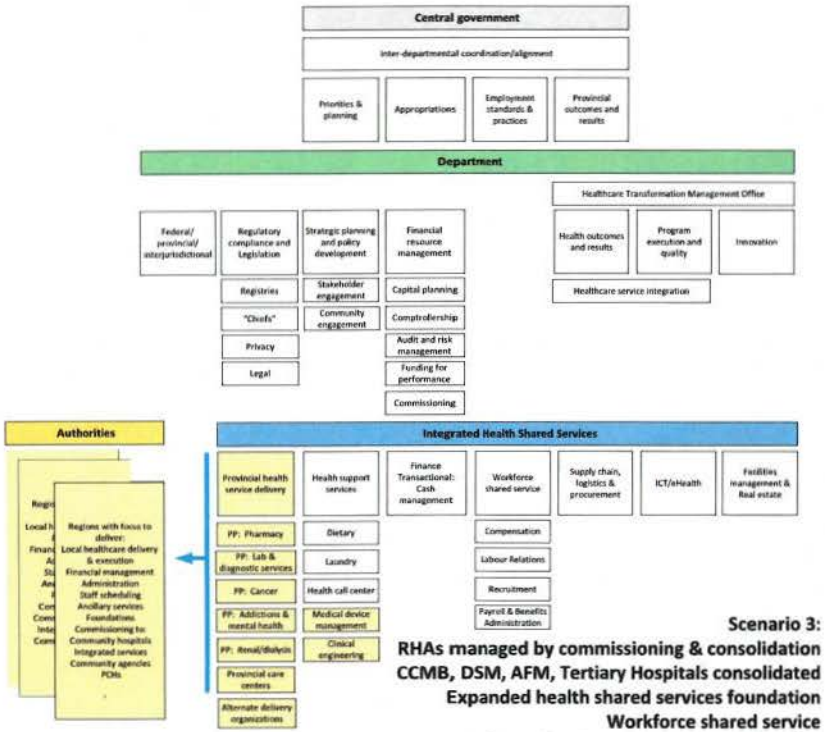
— Cost improvements and efficiencies in implemented shared services.
— Clarification of roles and accountabilities.
— Improved service management capability for province-wide programs.
— Operating cost improvements from consolidation of management and administration functions.

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



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 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

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

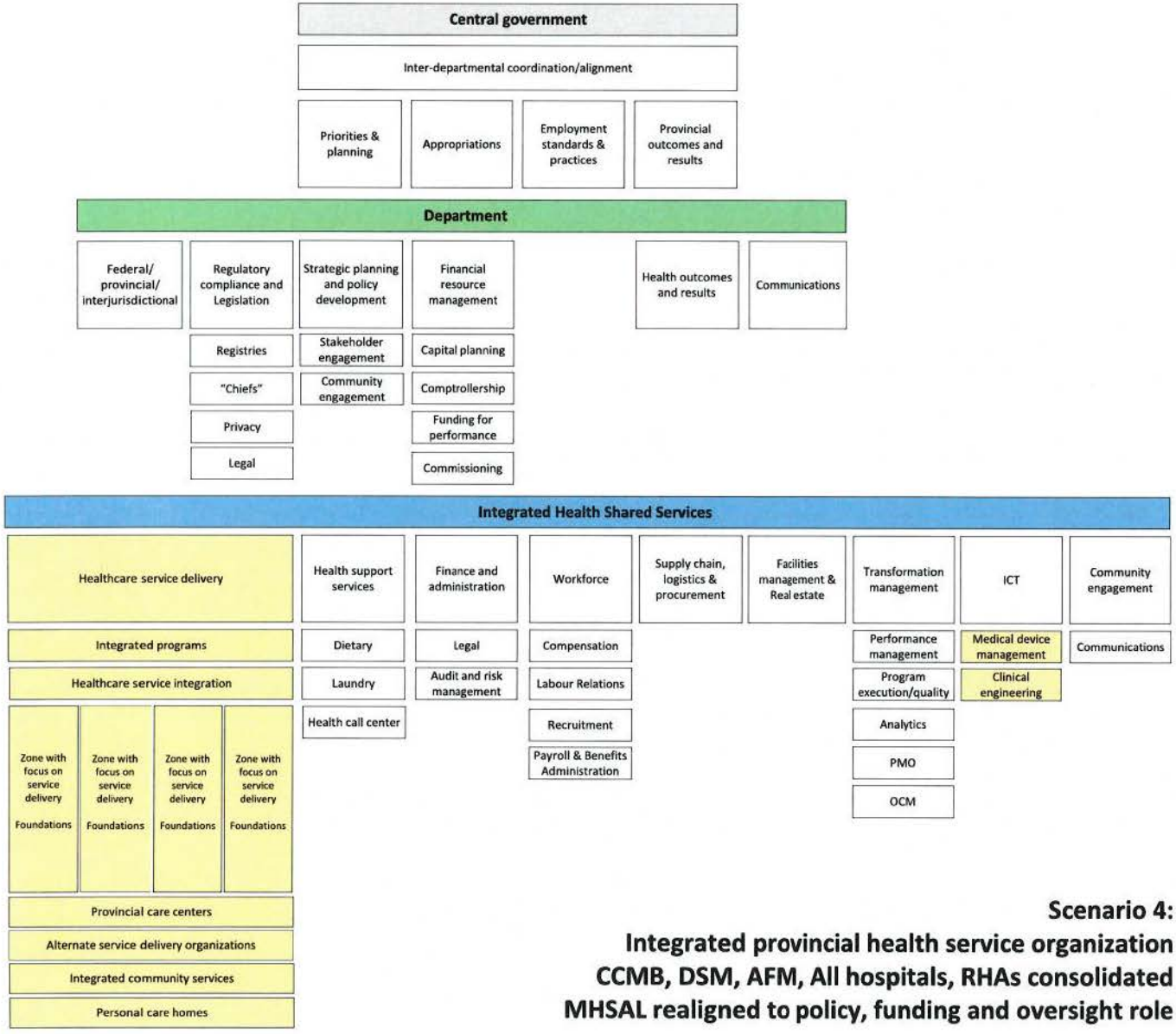
Clinical alignment

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

Outcomes

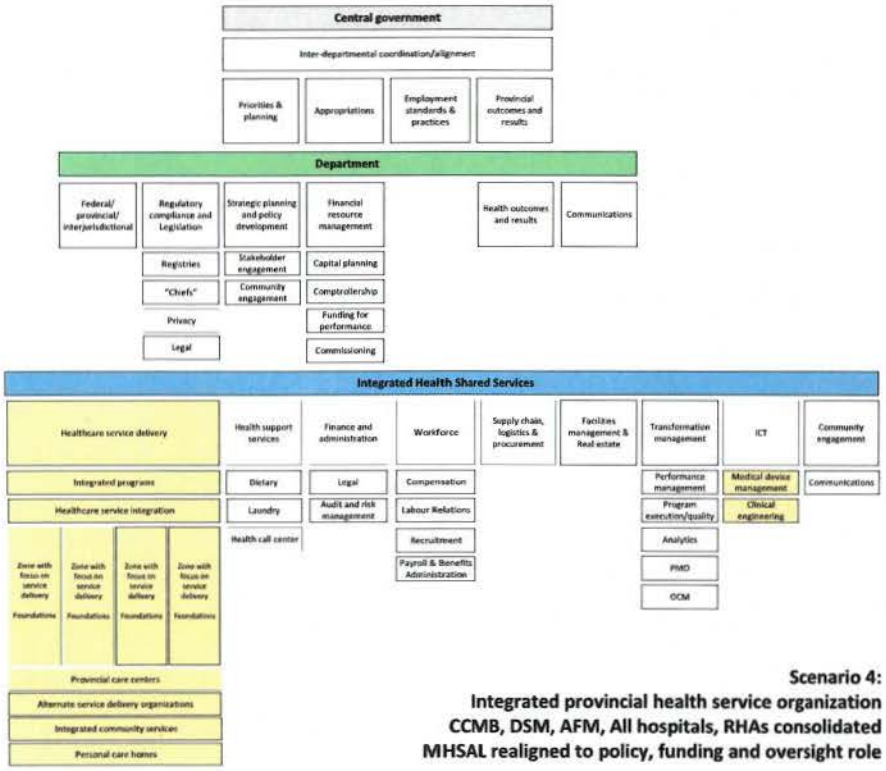
— Cost improvements and efficiencies in implemented shared services
— Clarification of roles and accountabilities.
— Improved service management capability for province-wide programs
— Operating cost improvements from consolidation of management and administration functions.

Scenario 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	Scenario 2	Scenario 3	Scenario 4
		Integrated Health Shared Services; Health Authorities managed by commissioning; Common health shared services foundation; ICT/eHealth integration; Re-aligned funding and commissioning roles	RHAs managed by commissioning; CCMB, DSM, AFM consolidated; Expanded health shared services foundation; Re-aligned funding and commissioning roles	RHAs managed by commissioning & consolidation; CCMB, DSM, AFM, Tertiary Hospitals; Expanded health shared services foundation; Workforce shared service; Re-aligned funding and commissioning roles	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
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 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

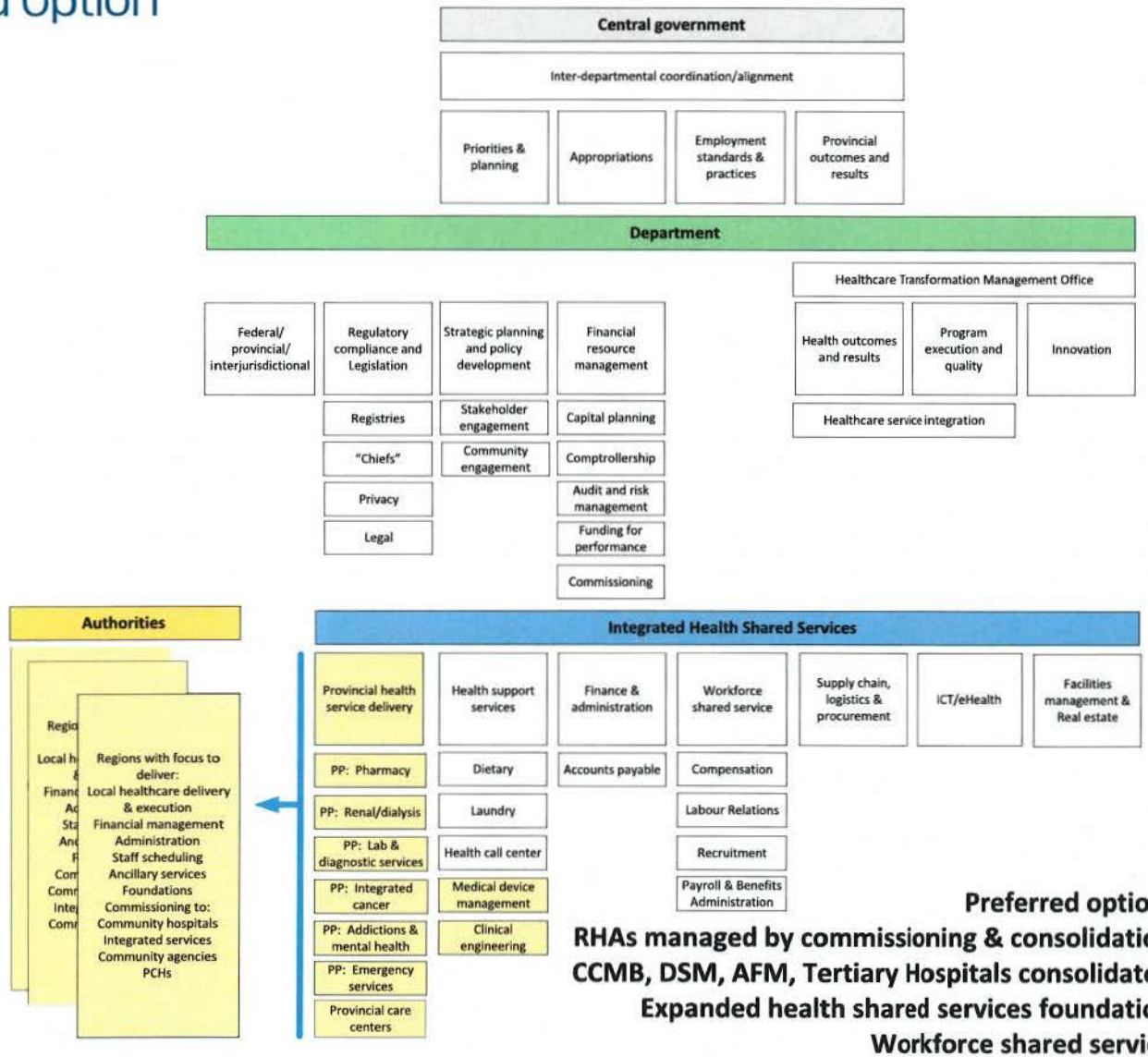
This section documents the preferred option developed by the KPMG team based on the evaluation process conducted with the working group. The information in this section is structured in the following sections:

- 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

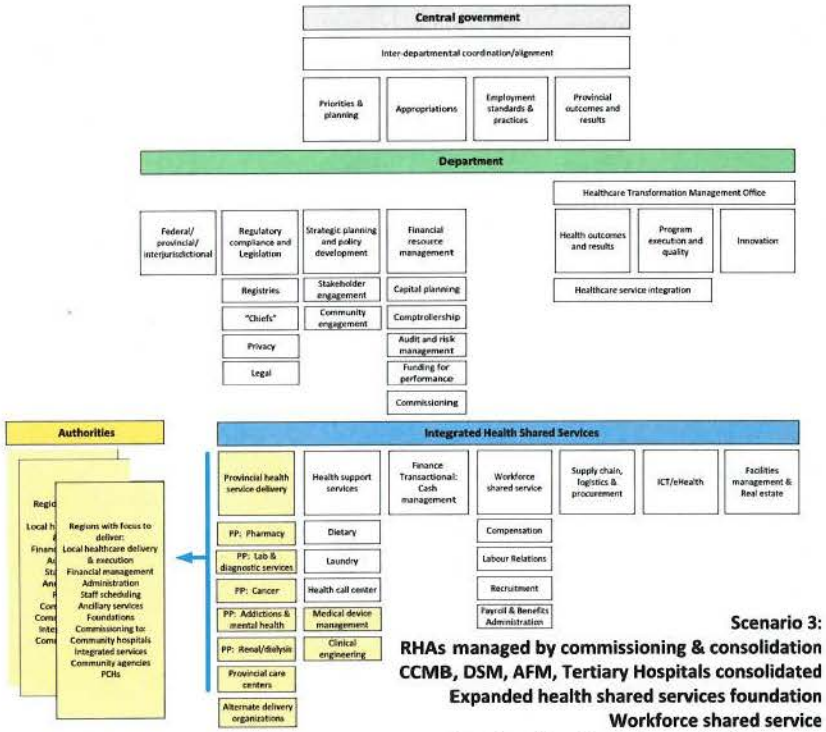
CCMB, DSM, AFM, Tertiary Hospitals consolidated

Expanded health shared services foundation

Workforce shared service

Re-aligned funding and commissioning roles

Preferred Option



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 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

— 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.

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?

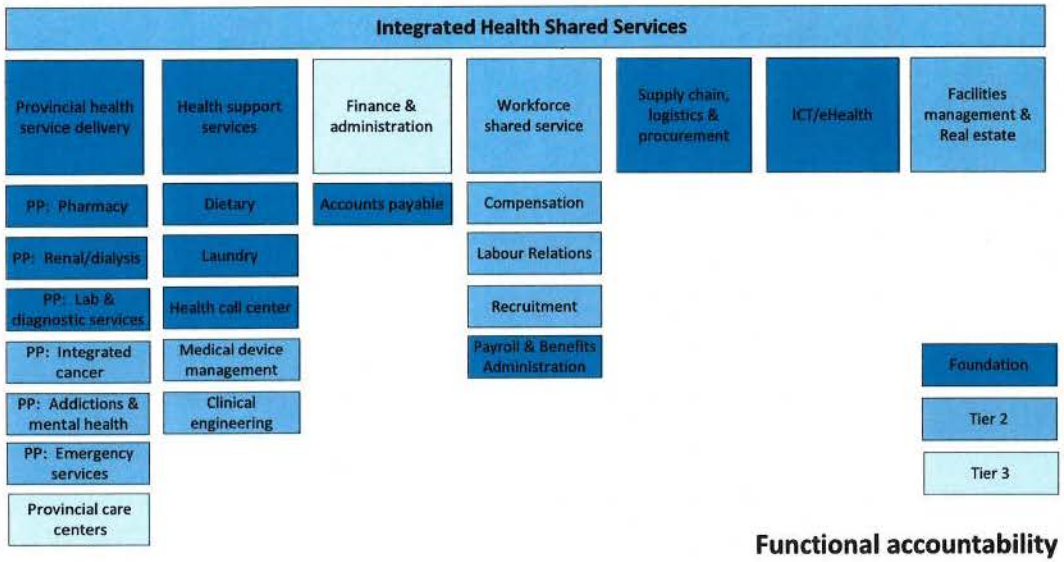
— How will this model improve/reinforce appropriate behaviours? How does it offset bureaucracy with creative tension/competition/innovation?

— 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?

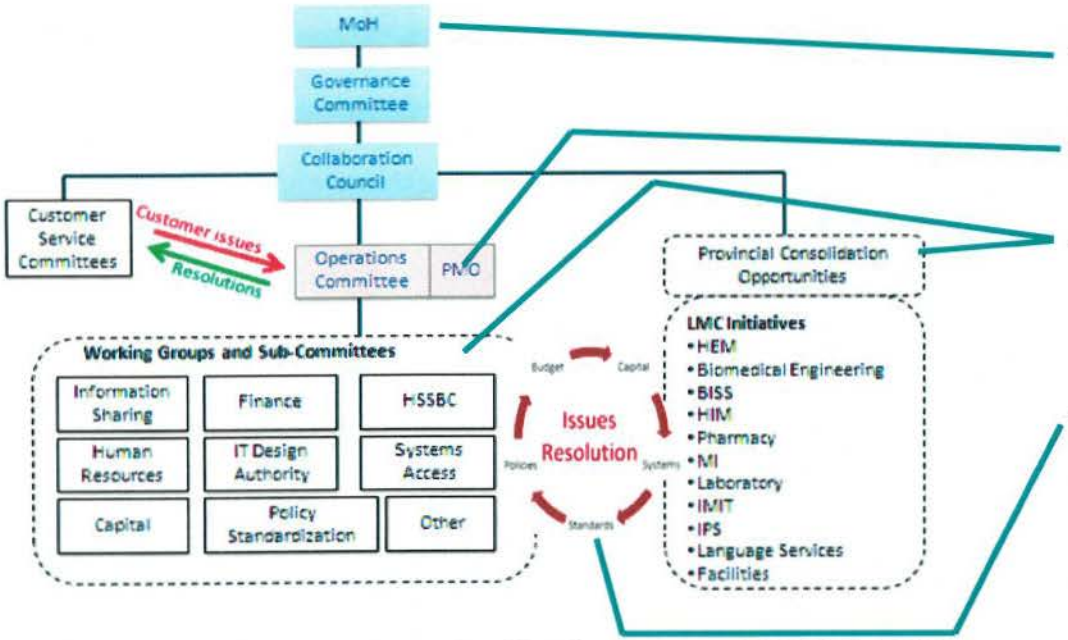
— How can an effective commissioning framework be developed and what are the key enabling tools?

Core Functional Accountability



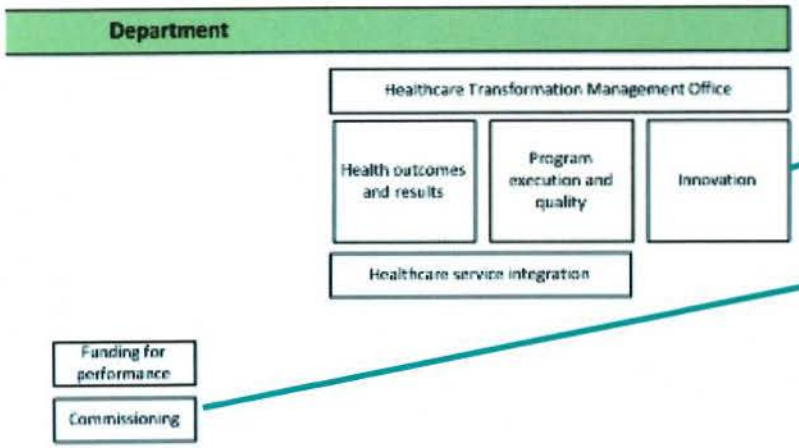
- There are three levels of functional accountability that could be considered for the health shared services organization.
- Foundational accountabilities have been proven as shared services in leading jurisdictions.
- Tier 2 accountabilities are recommended based on HSIR Phase I Report findings.
- 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?



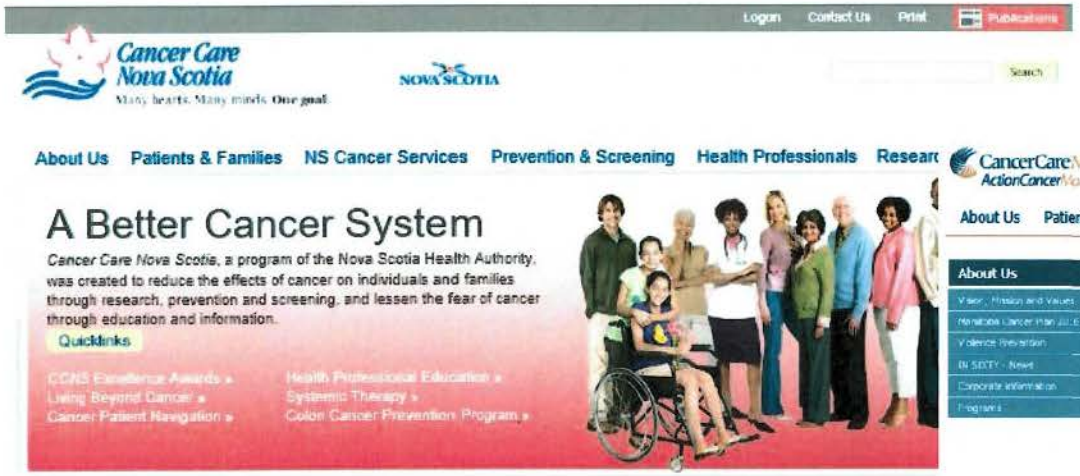
Lower Mainland Integration Planning Program, BC PHSA, 2012

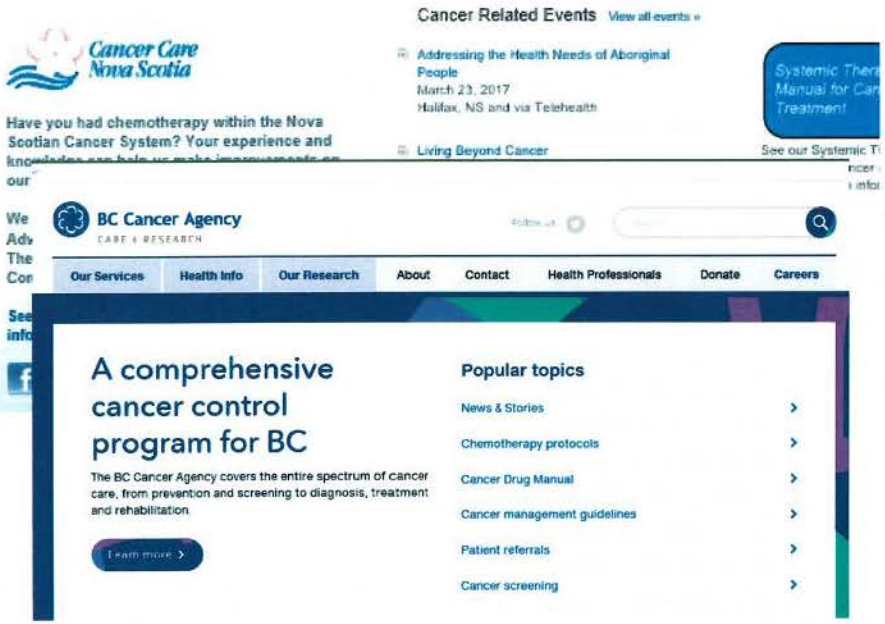
- Clear provincial initiative with system integration governance.
- Integrated transformation program that aligns initiatives and projects.
- Clear vision for integrated health shared services delivery combined with policy, finance, ICT, capital and administrative services planning.
- Active program 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.

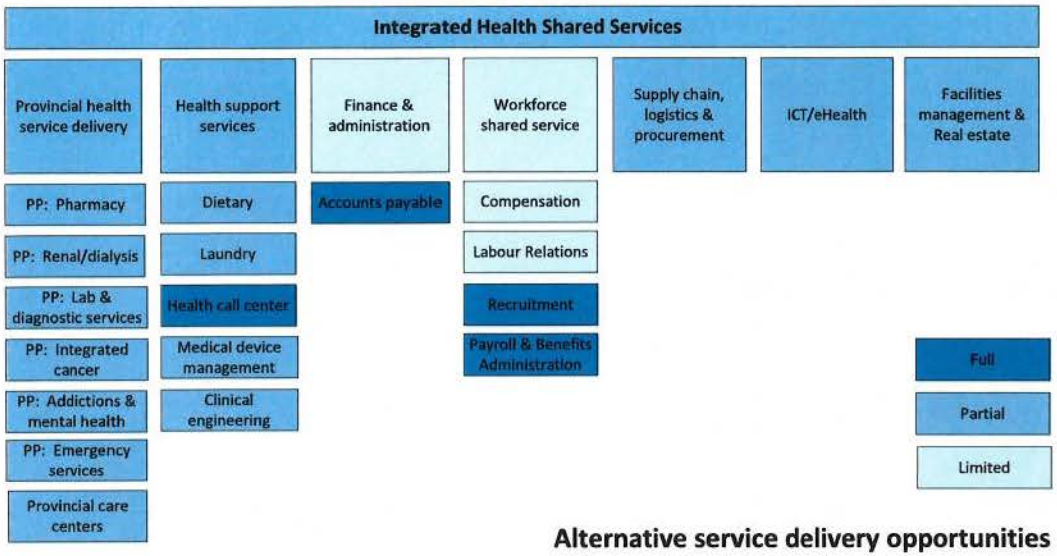
How Have other Jurisdictions Activated Service Planning and Definition?





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

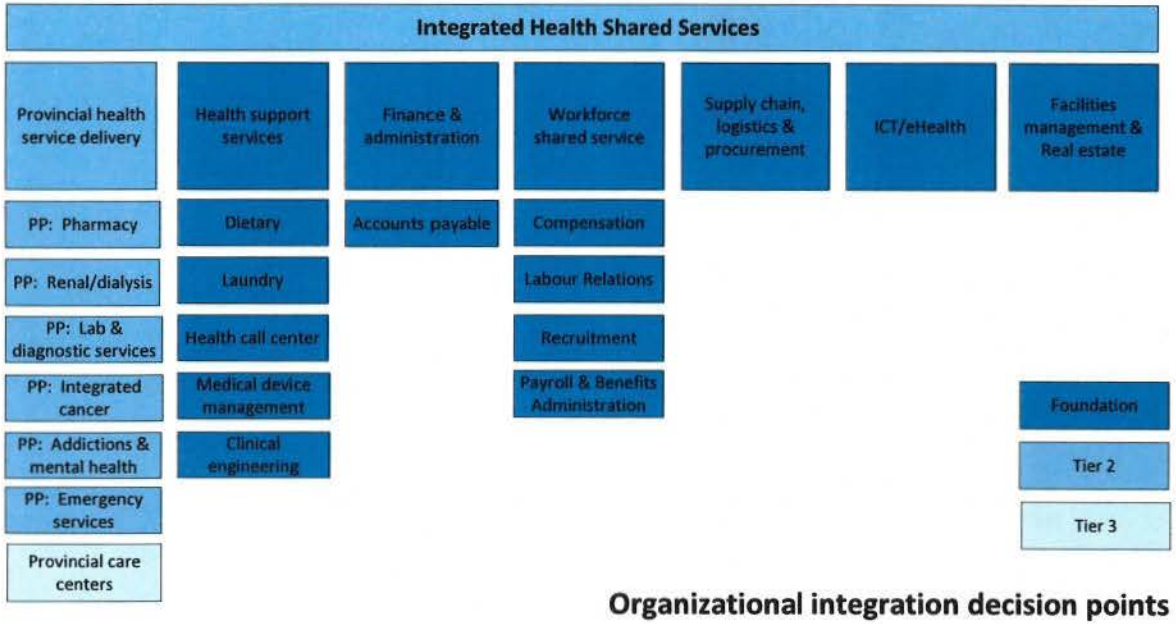
Alternate Service Delivery Opportunities



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.

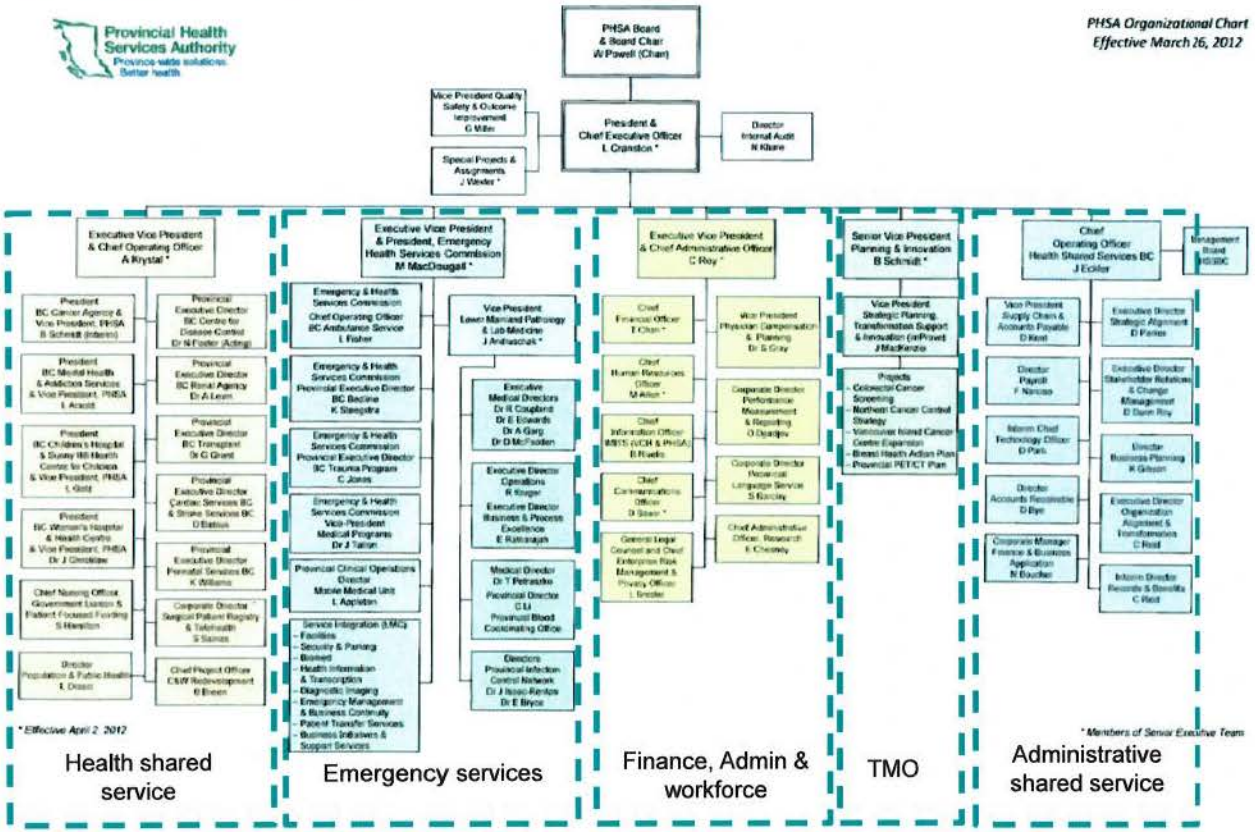
Organizational Integration Decision Points



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.

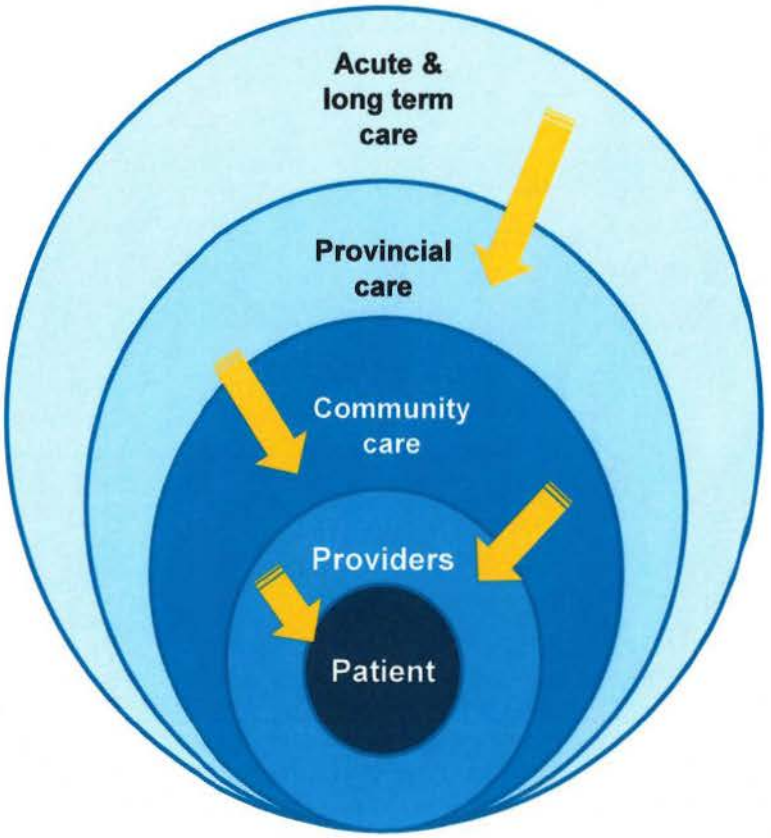
— Supply chain management.

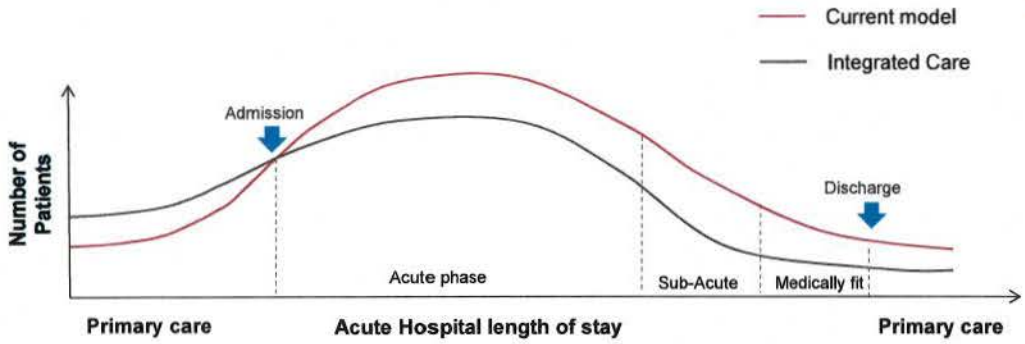
— Strategic sourcing.

— 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.

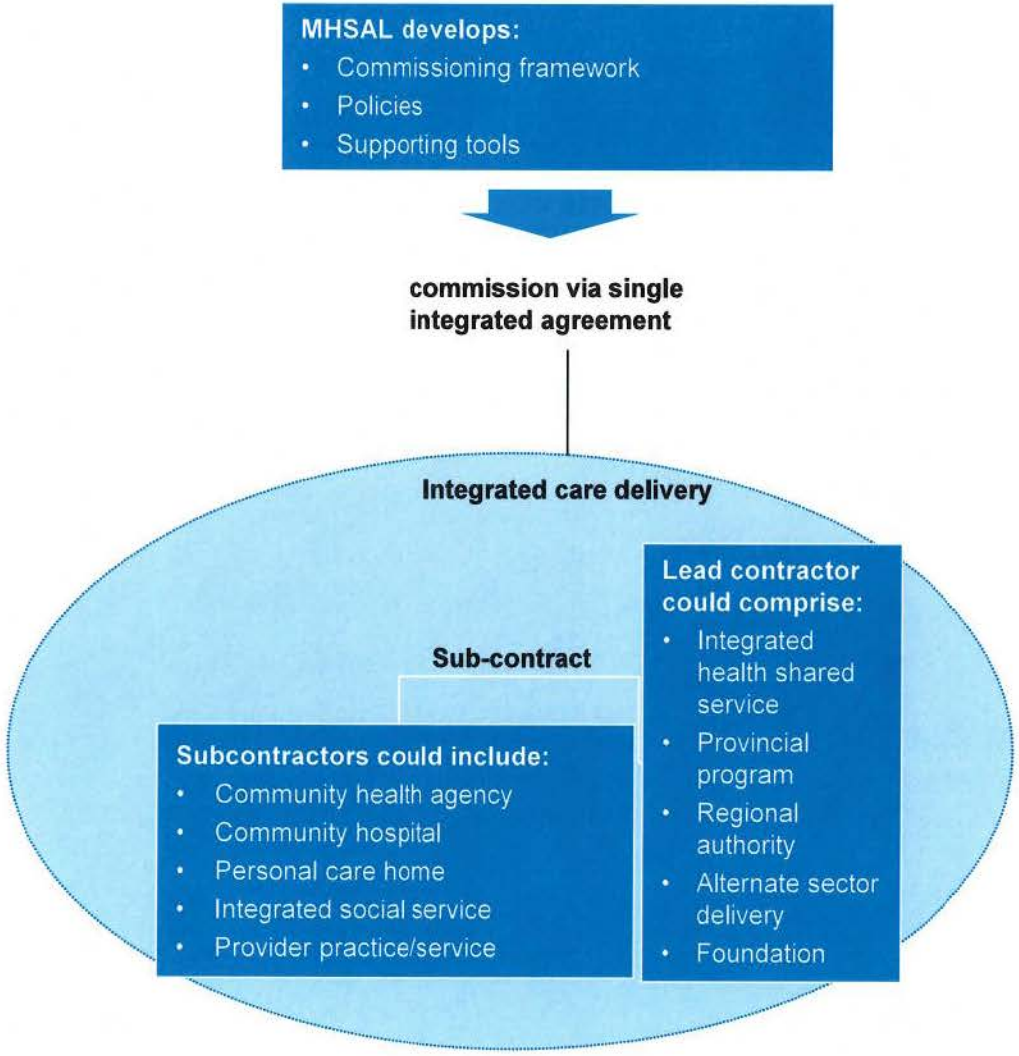




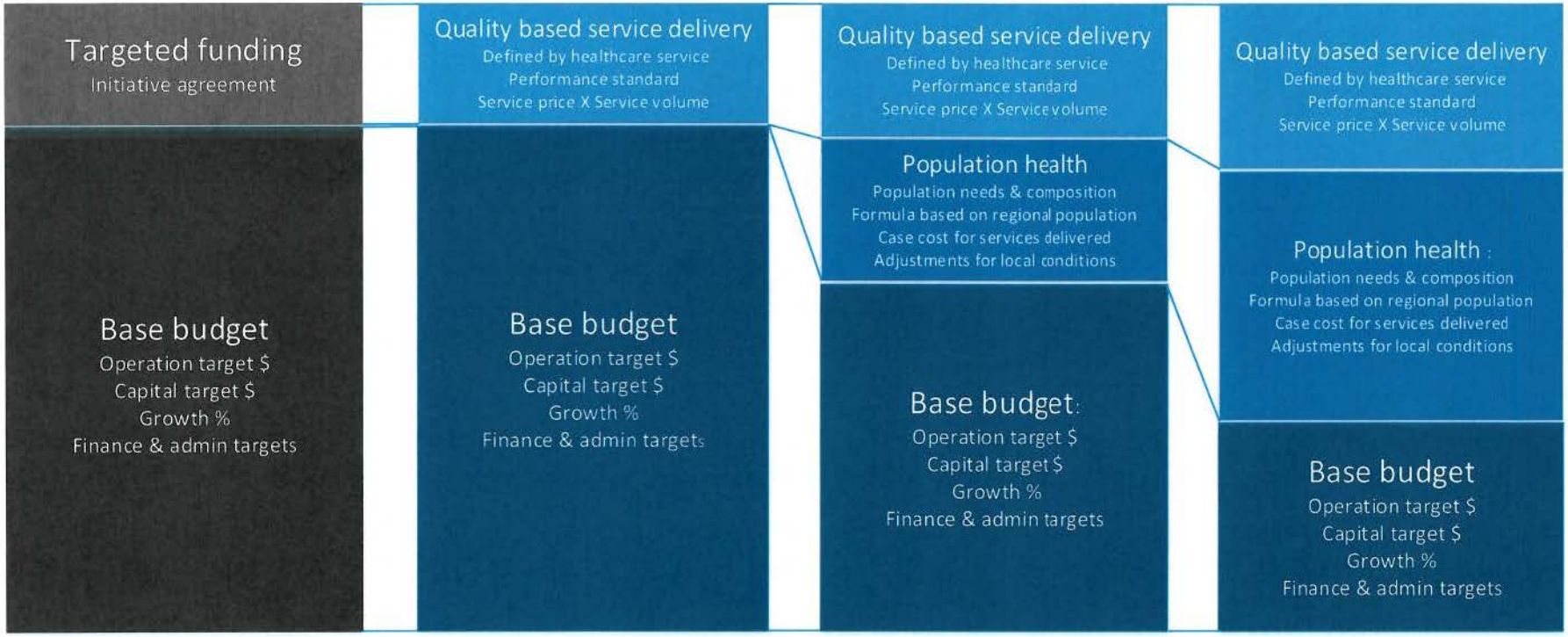
Commissioning with an Integrated Care/Integrated Service Delivery Framework

- 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.

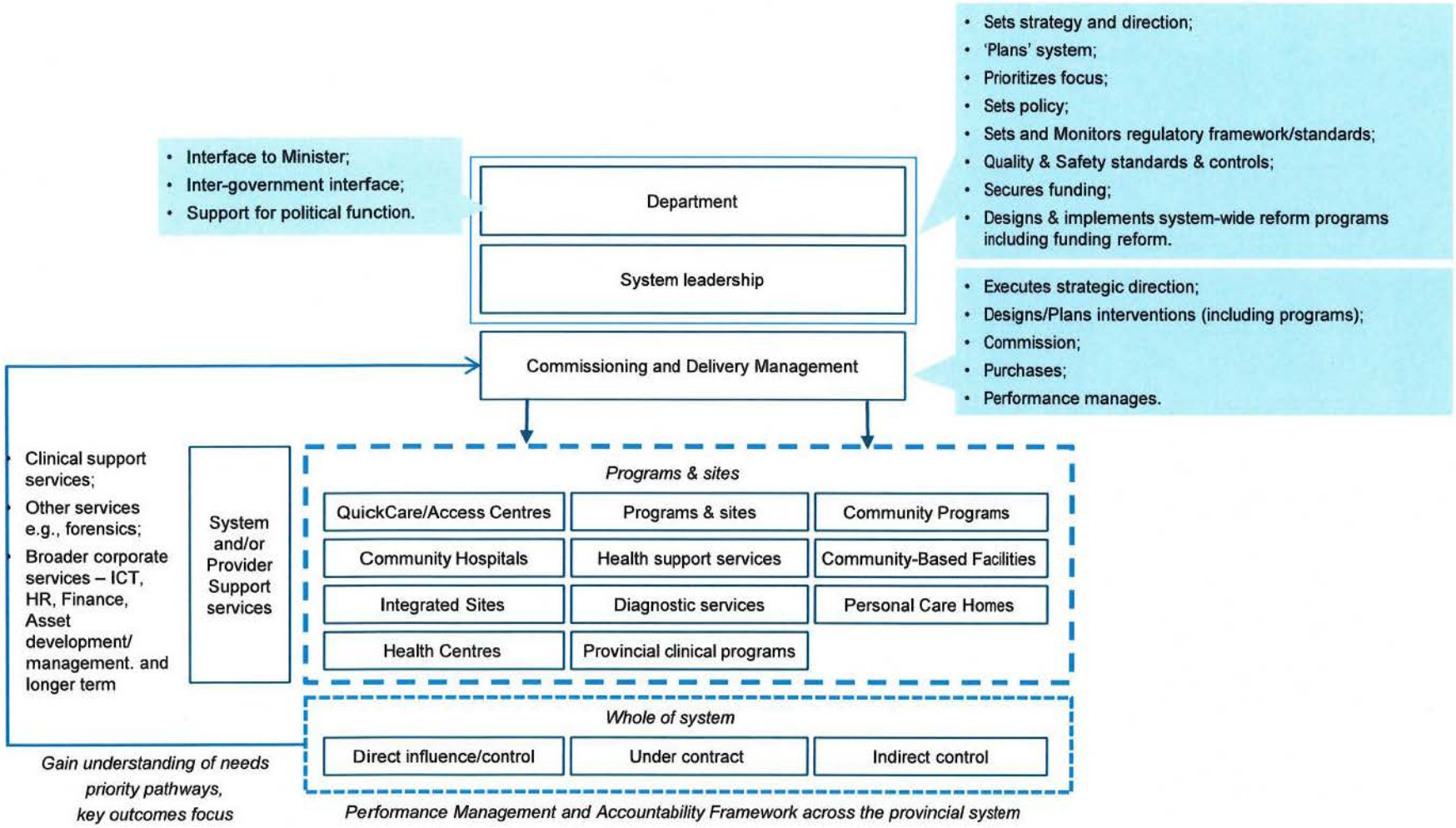
- An entity takes responsibility for the care of a population or pathway (or service).
- Clinically led with multi-specialty involvement where appropriate.
- Involves a transfer of financial risk for the delivery of agreed scope and quality of service as well as health outcomes.
- Contractor responsible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



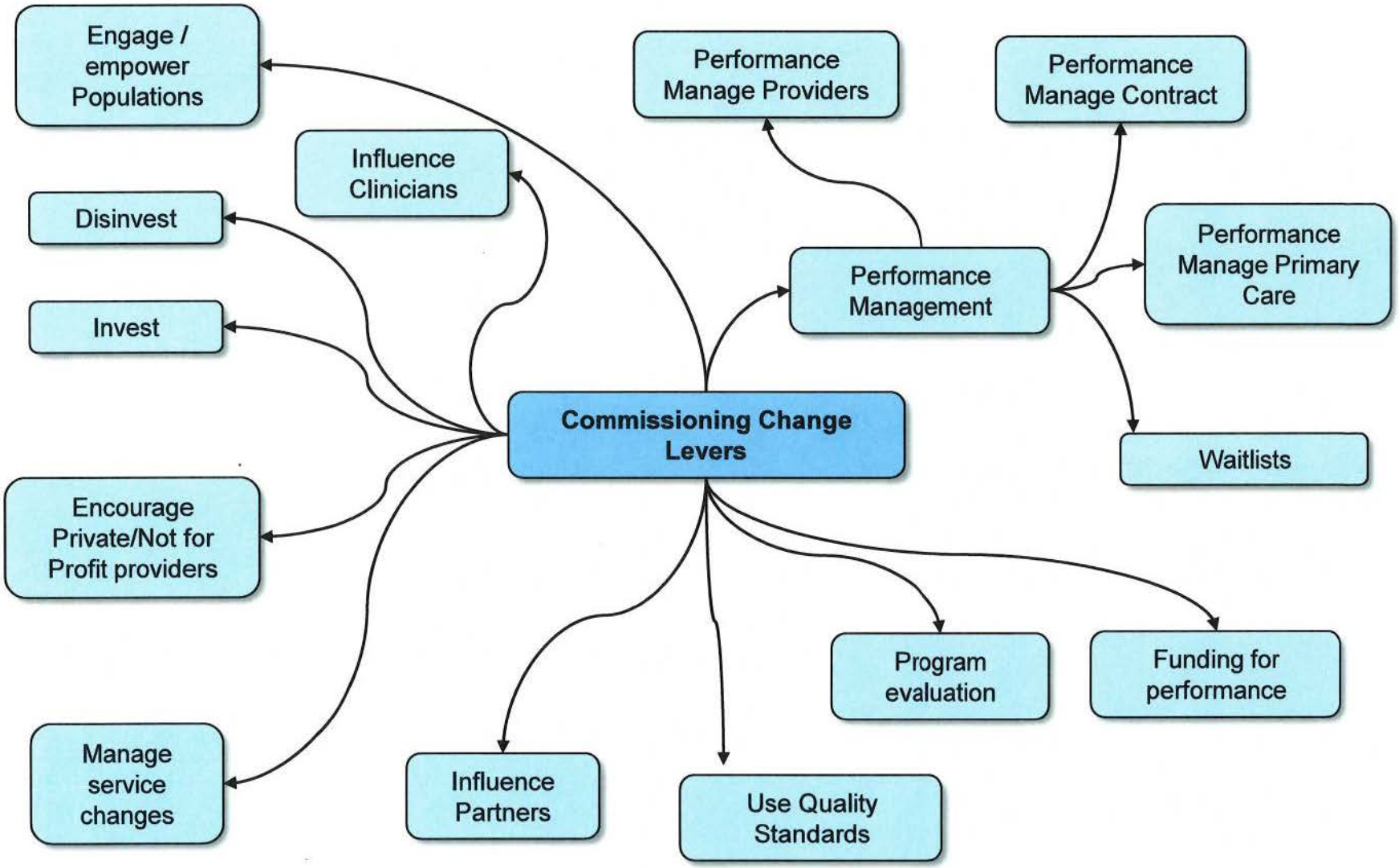
What Does a Commissioned Budget Look Like?



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.

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Work Plan 1B: Funding for Performance

Notice

This Funding for Performance Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

Funding for Performance - Work Plan Summary

Funding for Performance	
Project Summary	• This workstream includes "Funding for Performance", identified within the MHSAL HSIR Phase 1 Report. • **Funding for Performance** includes exploring new models for capital and infrastructure funding; establishing commissioning and a single payer funding model; coordinating service delivery and funding with other jurisdictions; implementing a performance-based funding program; and implementing expenditure management programs.
Objective & Scope	• **Funding for Performance** is aimed to realign Manitoba's approach to funding with an aim on improving system effectiveness and strengthening funding to improve system performance. It will include exploring new models for capital and infrastructure funding, exploring the potential for funding reform of healthcare services including population and activity-based models, and implementing expenditure management programs to contain delivery costs on a short timeframe.
Interdependencies	• 2017/18 MSHAL Treasury Board Submission. • Provincial Clinical and Preventive Services Plan: • Recommendation to transfer Selkirk Mental Health Centre administration to a provincial entity.

Summary of Opportunities

This table provides a summary of the total approximated cost savings for the Funding for Performance Work Plan broken down by benefit year and sub-category.

Sub Category	2017/18 Potential Cost Savings	2018/19 and Beyond Potential Cost Savings	Total
Expenditure management	$22M	TBD	$22M
Implement performance-based funding framework	-	$12M	$12M
Coordinate service delivery and funding with other jurisdictions	-	$1.5M	$1.5M
Single payer funding model	$2M	TBD	$2M
TOTAL	**$24M**	**$13.5M**	**$37.5M**

The following table provides an overview of each opportunity included in the Funding for Performance Work Plan.

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Expenditure management	Initiate annual RHA/PHO expenditure management initiatives.	$ 17M	2017/18	TBD	• Manage to Budget process.	• This initiative could have an impact on service and delivery outcomes over the short-term if not appropriately focused and targeted.
	Address vacant positions and consolidate staff.	$ 0.2M	2017/18	TBD	• RHA Manage to Budget process. • Link to deletions process.	• Public/union perception of reduction to front-line services • Potential for negative press coverage.
		$ 4.7M	2018/19 and beyond			

Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Implement performance based funding framework	Standardize operating/service purchase agreements.	*Enabler*	2017/18	TBD	• Potential legislative analysis and review. • May be opportunity to leverage Department of Families process.	• TBD.
	Develop funding for performance framework.	$ 12M	2018/19 and beyond	TBD	• Potential legislative/regulatory changes. • Contracting reviews. • Complete planning at least 6 months prior to the beginning of next fiscal year.	• Capacity and capability (multiple competing priorities).
	Initiate alternate service delivery demonstration project.	TBD	2018/19 and beyond	TBD	• TBD.	• Perception of two-tiered system by the public/unions.
Coordinate service delivery with other jurisdictions	Develop position paper and initiate discussions with FNHIB, First Nations, FNHSSM.	$ 1.5M	2018/19 and beyond	TBD	• There will be an expectation that MHSAL participates in the initiative with investment similar to other parties.	• [redacted]
Single payer funding model	Evaluate provincial grant programs for effectiveness and compliance mandate.	$ 1.2M	2017/18	TBD	• MHSAL 2017/18 Treasury Board Submission. • Process could be leveraged by other departments.	• Public perception/negative press of disinvestment in grant-funded organizations.
	Simplify tax management between entities.	$ 0.8M	2017/18	TBD	• Stakeholder engagement processes. • Strategic System Realignment.	• Ability to effectively coordinate across levels of government within prescribed timelines.
	Evaluate funding model for all health supported organizations.	TBD	2017/18	TBD	• Justice/Healthy Child/Families contracting processes. • Evaluation of provincial grant funded programs for efficiency and effectiveness opportunity. • Tools/processes to leverage from 2011 NPO Strategy. • SAP review of funding arrangements (ID all vendors).	• Capacity to implement amidst other priorities. • Capacity of civil legal service to support contract development process.

Work Plan - High-Level Roadmap

Subtheme:	Fiscal Year 2017/18				2018/19 and beyond				
	Q1	Q2	Q3	Q4	Month 18	Month 24	Month 36	Month 48	Month 60
Single Payer Funding Model	Simplify tax management between entities								
	Evaluate provincial grant programs for effectiveness and compliance mandate								
	Evaluate funding model for all health supported organizations								
Expenditure Management	Implement annual RHA/Service Provider Organization expenditure management initiatives								
	Address vacant positions and staff consolidation								
Coordinate service delivery and funding with other jurisdictions	Develop position paper and initiate discussions with FNHIB, First Nations, FNHSSM								
Implement performance based funding framework	Standardize operating/service purchase agreements								
	Develop funding for performance framework								
	Initiate Alternate Service Delivery demonstration projects								

Initiate RHA/PHO Expenditure Management Initiatives

Subtheme: Implement expenditure management	Benefit Year: 2017/18	Est. Cost Improvement: $17M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	Expenditure management for all RHAs and PHOs.
Benefit	• Alignment of funding processes. • Delineation of MHSAL, RHAs, and provider responsibility and accountability. • Focus on performance, results and value for money.
In-scope/Out of Scope	• **In-Scope:** WRHA, RHA, CancerCare MB, DSM, AFM, and eHealth expenditure management • **Out of Scope:** WRHA vacant positions and finance/administration staff consolidation
Key Assumptions	• Savings included in this area are based on typical annual expenditure management initiatives that are part of normal annual management processes in all Manitoba health regions. No expenditure management initiative has been evaluated for MHSAL as a department in this analysis. • A $50m expenditure management target was set with RHAs in 16/17 and the department implemented quarterly tracking of status with the last update showing tracking at $33m savings achieved.
Governance	• RHA/PHO responsibility with coordination among funded entities.
Project Management	• TBD.
Communication Strategy	• To be developed.

Risks	Interdependencies
• This initiative could have an impact on service and delivery outcomes over the short-term if not appropriately focused and targeted.	• Manage to Budget process.

Initiate RHA/PHO Expenditure Management Initiatives

Subtheme: Implement expenditure management	Benefit Year: 2017/18	Est. Cost Improvement: $17M
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Develop expenditure management plan in accordance with MHSAL manage to budget call (minor, moderate and major strategies). • Health Financial Planning Task Force meetings. • Institutionalize fiscal planning. • Design tools and templates.	**Key activities:** • Health Financial Planning Task Force meetings. • Implementation of minor strategies. • Review and evaluate opportunities (ongoing; part of "day job" – all levels of the organization). • Institute ongoing process for benefits tracking & accountability.	**Key activities:** • Ongoing monitoring and evaluation. • Review and evaluate opportunities (ongoing; part of "day job"). • Ongoing benefits tracking.	**Key activities:** • Ongoing monitoring and evaluation • Review and evaluate opportunities (ongoing; part of "day job") • Ongoing benefits tracking
Outputs: • 2017/18 Health Plan Impact Assessments.	**Outputs:** • RHA/PHO progress updates.	**Outputs:** • RHA/PHO progress updates	**Outputs:** • RHA/PHO progress updates

Develop Funding for Performance Framework

Subtheme: Implement performance-based funding framework	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $12M
Implementation Duration: >1 year	Implementation Effort: Low	

Description	Assessment and implementation of a funding framework to incentivize standardized quality care, accessible by patients in the right location, at the right time, by the right provider. This may include a phased rollout on certain procedures.
Benefit	• Alignment of funding processes. • Delineation of MHSAL, RHAs, and provider responsibility and accountability. • Focus on performance, results and value for money.
In-scope/Out of Scope	• **In-Scope:** Shift from current block funding model to a performance-based funding framework.
Key Assumptions	• Legislative and regulatory review required.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• TBD.

Risks	Interdependencies
• Capacity and capability (multiple competing priorities).	• Potential legislative/regulatory changes. • Contracting reviews. • Complete planning at least 6 months prior to the beginning of next fiscal year.

Develop Funding for Performance Framework

Subtheme: Implement performance-based funding framework	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $12M
Implementation Duration: >1 year	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Review existing funding framework and supporting legislation/regulation for global funding. • Conduct jurisdictional scan.	**Key activities:** • Develop alternate funding model. • Identify funding criteria and approach. • Identify areas to test budget and project selection criteria. • Budget process alignment. • Assess legislation and regulatory impacts. • Treasury Board approval.	**Key activities:** • Develop implementation plan for demonstration projects. • Develop new policies and procedures. • Communication with regions and entities. • Rollout plan.	**Key activities:** • Demonstration project preparation for Q1 2018/19.
Outputs: • Jurisdictional Review. • Business Case.	**Outputs:** • Options Analysis (including legislative analysis and review). • Financial & Clinical Models.	**Outputs:** • Detailed demonstration project implementation plan. • Communication plan. • Change management plan. • Treasury Board submission.	**Outputs:** • Communication and change management plans. • Evaluation strategy.

Develop Funding for Performance Framework

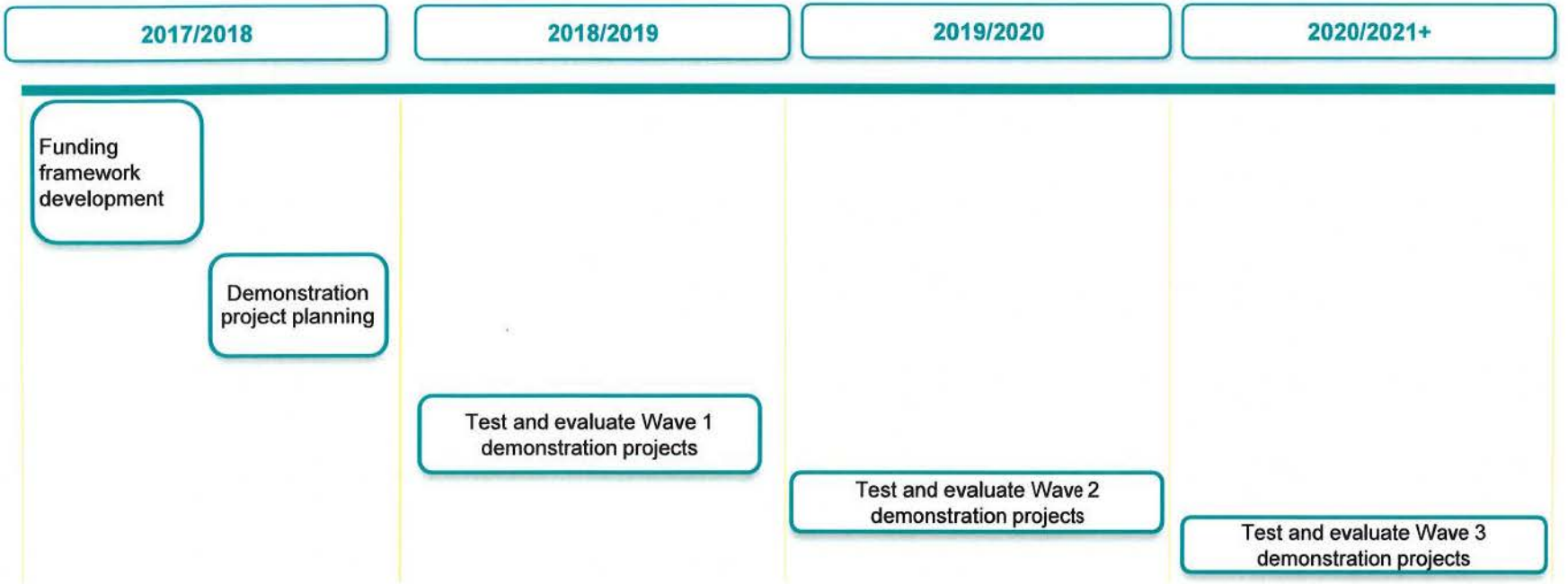
Subtheme: Implement performance-based funding framework	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $12M
Implementation Duration: >1 year	Implementation Effort: Low	

2018/2019	2019/2020	2020/2021+
Key activities: • Test Wave 1.demonstration projects (1 year) and evaluate against specified targets.	**Key activities:** • Test Wave 2 demonstration projects (1 year) and evaluate against specified targets.	**Key activities:** • Test Wave 3 demonstration projects (1 year) and evaluate against specified targets.
Outputs: • Wave 1 evaluation report. • Wave 2 implementation plan.	**Outputs:** • Wave 2 evaluation report. • Wave 3 implementation plan.	**Outputs:** • Wave 3 evaluation report.

Develop Funding for Performance Framework

Subtheme: Implement performance-based funding framework | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Improvement: $12M**

Implementation Duration: >1 year | **Implementation Effort: Low**



Address Vacant Positions and Consolidate Staff

Subtheme: Implement expenditure management	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $5M
Implementation Duration: >3 years	Implementation Effort: Low	

Description	Identification of vacant positions and staff consolidation opportunities in order to reduce the size of the workforce or consolidate unfilled positions.
Benefit	• Focus on performance, results and value for money.
In-scope/Out of Scope	• **In-Scope:** All RHAs and PSOs • **Out of Scope:** Non-workforce expenditure management initiatives; MHSAL expenditure management; reduction in front-line services.
Key Assumptions	• Adherence to collective agreement notice to change.
Governance	• MHSAL-led.
Project Management	• RHAs/delivery organizations with reporting to MHSAL.
Communication Strategy	• To be developed.

Risks	Interdependencies
• Public/union perception of reduction to front-line services. • Potential for negative press coverage.	• RHA Manage to Budget process. • Link to deletions process.

Address Vacant Positions and Consolidate Staff

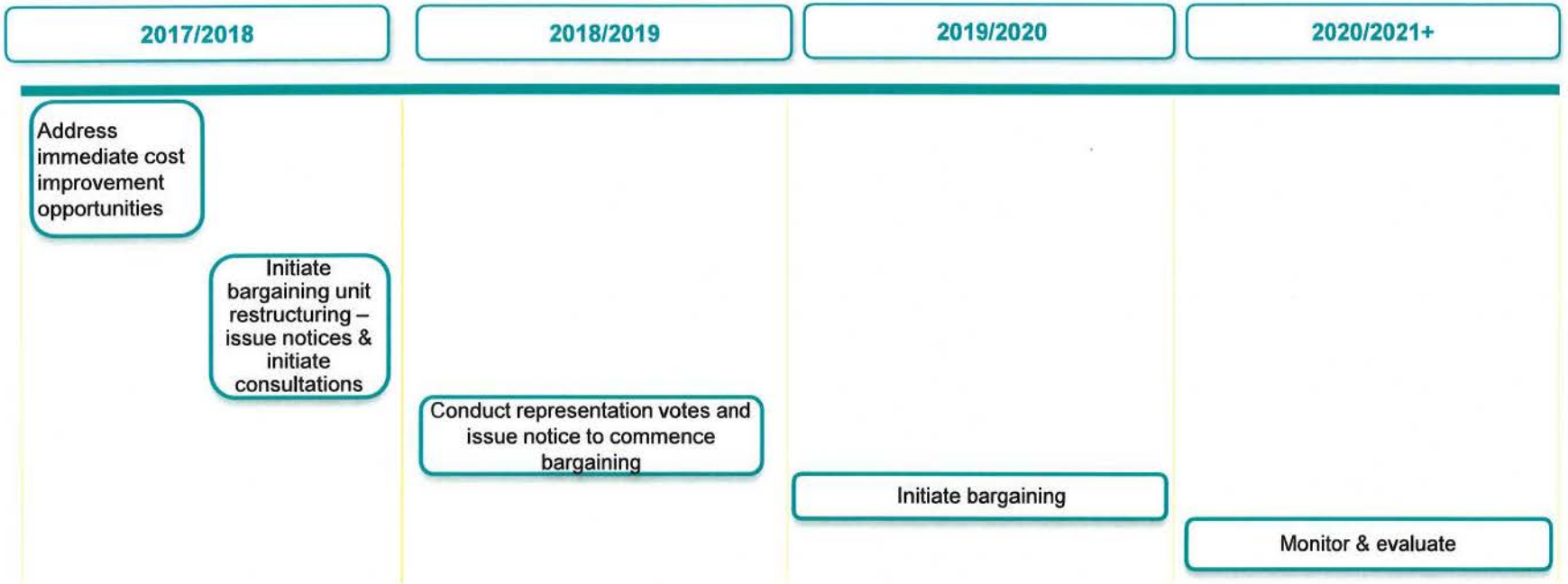
Subtheme: Implement expenditure management	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $5M
Implementation Duration: >3 years	Implementation Effort: Low	

2017/2018	2018/2019	2019/2020	2020/2021+
Key activities: • Address immediate changes not requiring bargaining. • 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.	**Key activities:** • Initiate bargaining.	**Key activities:** • Monitor for implementation.
Outputs: • Communications plan.	**Outputs:** • Bargaining position.	**Outputs:** • Ongoing communications planning; briefing notes.	**Outputs:** • Change management plan.

Address Vacant Positions and Consolidate Staff

Subtheme: Implement expenditure management | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: $5M**

Implementation Duration: >3 years | **Implementation Effort: Low**



Develop Position Paper and Initiate Discussions with First Nations and Health Canada

Subtheme: Coordinate service delivery with other jurisdictions	Benefit Year: Beyond 2018/19 and beyond	Est. Cost Improvement: $1.5M+/ Enabler
Implementation Duration: >3 years	**Implementation Effort: Medium-High**	

Description	Identification of opportunities to remove jurisdictional gaps for First Nations communities, including evaluation of models to increase and autonomy/accountability, and evaluation of joint funding and support models from Federal Government. This initiative would inform the Manitoba Government's position and options on working with First Nation and Health Canada on improvements to the system of healthcare delivery and overall governance models.
Benefit	• Removal of barriers to healthcare access for First Nations communities. • Improved health outcomes for First Nations communities. • Improved accountability and responsibility of all parties.
In-scope/Out of Scope	• **In Scope:** Jurisdictional scan, stakeholder engagement, development of position paper, community engagement and recommendations on next step, plan for further discussions.
Key Assumptions	• The process would leverage FNHSSM relationship as linkage to northern communities.
Governance	• To be jointly determined with First Nations communities, FNHIB, FNHSSM.
Project Management	• To be jointly determined with First Nations communities, FNHIB, FNHSSM.
Communication Strategy	• To be jointly determined with First Nations communities, FNHIB, FNHSSM.

Risks	Interdependencies
• Obtaining commitment from First Nations to participate in process and to identify a clear governance/representation structure.	• There will be an expectation that MHSAL participates in the initiative with investment similar to other parties.

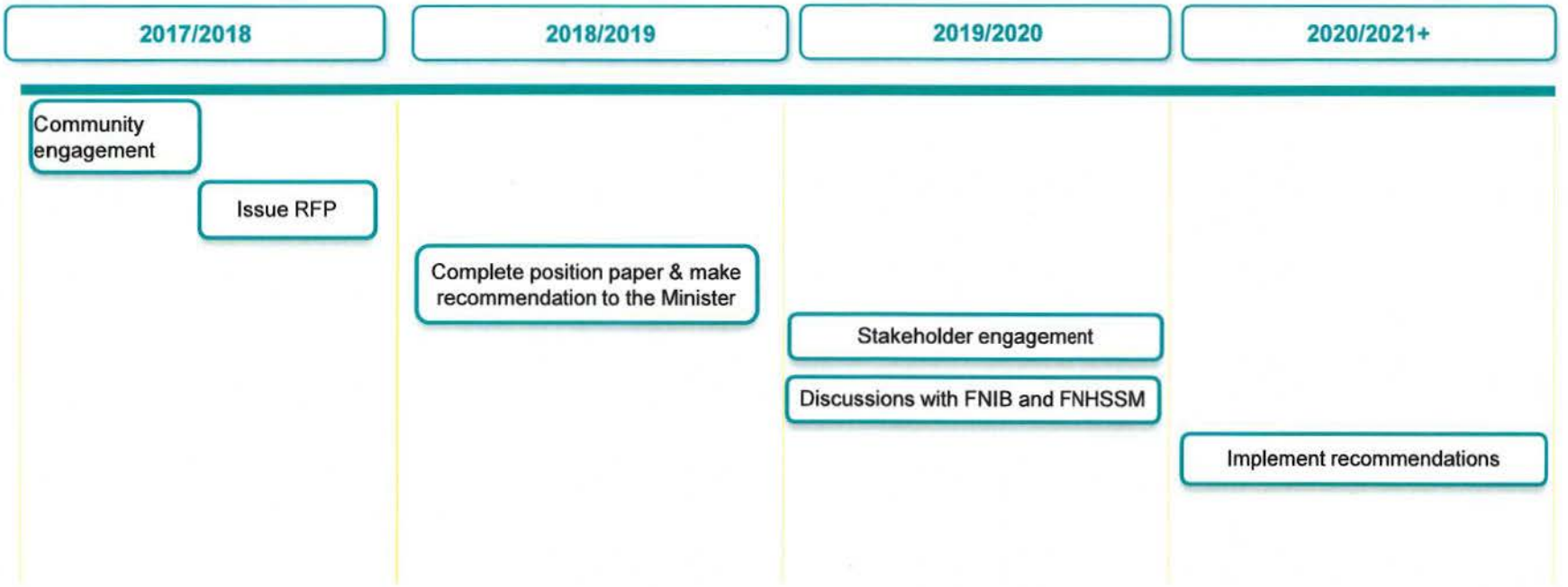
Develop Position Paper and Initiate Discussions with First Nations and Health Canada

Subtheme: Coordinate service delivery with other jurisdictions	Benefit Year: Beyond 2018/19 and beyond	Est. Cost Improvement: $1.5M+/ Enabler
Implementation Duration: >3 years	Implementation Effort: Medium-High	

2017/2018	2018/2019	2019/2020	2020/2021+
Key activities: • Community engagement on process, expectations and deliverables. • Develop agreement on service delivery. • Assess internal capacity and capability to progress opportunity. • If internal capacity / capability does not exist, develop terms of reference. • Develop budget. • Get approval. • Issue RFP.	**Key activities:** • Select vendor. • Complete study. • Review findings and develop position paper. • Options Analysis. • Recommendation to the Minister. • Decision by Government.	**Key activities:** • Stakeholder engagement. • Initiate discussions with FNHIB. • Initiate discussion with FNHSSM.	**Key activities:** • Monitor for implementation.
Outputs: • Study report. • Position Paper.	**Outputs:** • Stakeholder consultation report. • Report on options. • Decision by Government.	**Outputs:** • Options analysis. • Framework for advancing health care for First Nations.	**Outputs:** • TBD.

Develop Position Paper and Initiate Discussions with First Nations and Health Canada

Subtheme: Coordinate service delivery with other jurisdictions	Benefit Year: Beyond 2018/19 and beyond	Est. Cost Improvement: $1.5M+/ Enabler
Implementation Duration: >3 years	Implementation Effort: Medium-High	



Evaluate Provincial Grant Programs

Subtheme: Single payer funding model	Benefit Year: 2017/18	Est. Cost Improvement: $1.2M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	Review of existing operating, service purchase and grant funding processes (MHSAL) to establish an integrated single payer funding model.
Benefit	• Improved coordination among service delivery organizations. • Streamlining of granting and procurement processes. • Improved accountability for delivery and outcomes across existing healthcare delivery organizations.
In-scope/Out of Scope	• **In-scope:** Evaluation of provincial grants and funding support (including grant-funded and continuing service agreement agencies) provided by MHSAL and WRHA. • **Out of scope:** Evaluation of provincial grant-funded programs for efficiency and effectiveness.
Key Assumptions	• Expiration of service purchasing agreements in 2017. • 90 day notice for termination clauses.
Governance	• MHSAL responsibility; each branch responsible for funding to evaluate each agency against criteria and make recommendations for de-investment.
Project Management	• MHSAL responsibility.
Communication Strategy	• To be developed.

Risks	Interdependencies
• Public perception/negative press of disinvestment in grant-funded organizations.	• MHSAL 2017/18 Treasury Board Submission. • Process could be leveraged by other government departments.

Evaluate Provincial Grant Programs

Subtheme: Single payer funding model | **Benefit Year: 2017/18** | **Est. Cost Improvement: $1.2M**

Implementation Duration: 1 year | **Implementation Effort: Low**

2017/18

Q1

Key activities:

- Identify underperforming or ineffective grants.
- Quantify/revise funding support model.
- Communicate notice of review to all recipients and joint funding stakeholders.
- Develop key performance indicators/evaluation criteria.
- Evaluate grants and recipients.
- Obtain Treasury Board approval for changes not already included in submission.
- Obtain Minister/DM approval.
- Provide update to Treasury Board.
- Communicate decision to grant recipients.

Outputs:

- 5-8 performance criteria/evaluation framework.
- Revised Service Purchase Agreements (SPAs).

Q2

Key activities:

- Redefine monitoring requirements.
- Provide notice of termination within 90 days.

Outputs:

- Updated agreements aligned with review criteria.

Q3

Key activities:

- Ongoing monitoring of funded agencies.

Outputs:

- Progress updates from funded agencies.

Q4

Key activities:

- Initiate SPA/CSA review for 2018/19.

Outputs:

- Review process for 2018/19 granting activities.
- Revised granting policies and SPA templates.
- Briefing note.

Improve Tax Management Between Entities

Subtheme: Single payer funding model	Benefit Year: 2017/18	Est. Cost Improvement: $0.8M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	A significant effort is expended by all entities in the system to manage provincial and federal taxes between entities, which contributes to increased finance overhead and administrative costs.
Benefit	• Reduction in unnecessary administrative effort within the healthcare system.
In-scope/Out of Scope	• **In-scope**: Evaluation of processes associated with the administration of provincial and federal taxes. • **Out of scope**: community/private provider tax structures.
Key Assumptions	• Improvements in this area would not impact the Province's overall tax revenues since these taxes are generally funded by the system to the government as a whole with no corresponding net revenue.
Governance	• MHSAL responsibility with coordination among funded entities.
Project Management	• MHSAL responsibility.
Communication Strategy	• To be developed.

Risks	Interdependencies
• Ability to effectively coordinate across levels of government within prescribed timelines.	• Stakeholder engagement processes. • Strategic System Realignment Work Plan.

Improve Tax Management Between Entities

Subtheme: Single payer funding model	Benefit Year: 2017/18	Est. Cost Improvement: $0.8M
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1- Q2

Key activities:

- Issue and opportunity identification.
- Stakeholder engagement: OAG, MB Finance, CRA, entities.
- Policy/legislation review.
- Options analysis; determine level of savings.
- Recommendation to Treasury Board/Cabinet.

Outputs:

- Briefing notes and/or business cases.

Q3

Key activities:

- Develop new policy and approval by Treasury Board and Cabinet.
- Identify system and management changes.
- Implement changes.
- Initiate new procedures.
- Implement budget adjustments.

Outputs:

- Communications plan.
- Updated policy & taxation framework.

Q4

Key activities:

- Sustain, control and evaluate.

Outputs:

- Progress update back to Minister/DM/Department.

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Funding for Performance: Opportunities Not Yet Costed

Standardize Operating/Service Purchase Agreements

Subtheme: Implement performance-based funding framework	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 1 year	Implementation Effort: Low	

Description	Review existing agreements for opportunities to standardize agreements and improve their effectiveness.
Benefit	• Improved efficiency, effectiveness, and standardization of contracting processes.
In-scope/Out of Scope	• **In-Scope**: Existing operating and service purchase agreements.
Key Assumptions	• Regulations are in draft and can be proclaimed.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• To be developed.

Risks	Interdependencies
• TBD.	• Potential legislative analysis and review. • May be opportunity to leverage Department of Families process.

Standardize Operating/Service Purchase Agreements

Subtheme: Implement performance-based funding framework	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Review existing operating agreements. • Review existing service purchase agreements. • Identify opportunities to standardize and align. • Legal review and recommendation on options.	**Key activities:** • Develop new operating agreement. • Develop new service purchase agreement. • Identify regulatory change requirements. • Draft new regulations. • Proclaim new regulations with appropriate notice. • Negotiate/replace agreements over time or at start of new fiscal year.	**Key activities:** • Monitor for implementation.	**Key activities:** • Monitor for implementation.
Outputs: • Options analysis.	**Outputs:** • New operating agreement/Service Purchase Agreement (SPA) templates.	**Outputs:** • TBD (new agreements if implemented over time).	**Outputs:** • TBD (new agreements if implemented over time).

Evaluate Funding Model for MHSAL-supported Organizations

Subtheme: Single payer funding model	Benefit Year: 2017/18	Est. Cost Improvement: TBD
Implementation Duration: 1 year	Implementation Effort: Low	

Description	Realignment of funding for all healthcare entities to reduce duplication and improve accountability, including: • Moving all operating and service purchase agreements for all health funded agencies into an integrated process; and • Evaluation of funding provided by other government departments (i.e. Justice, Healthy Child, Families/Social Services) to health funded organizations to remove overlap and to clarify accountability).
Benefit	• Consistent performance measures for funded organizations. • Improved accountability for delivery and outcomes across existing healthcare delivery organizations.
In-scope/Out of Scope	• **In-scope:** Move to a single payer/funder model for all organizations (i.e. Community Health Agencies, PCHs); evaluation of provincial grants and funding support provided by MHSAL and WRHA; standardization of operating/purchase agreements. • **Out of scope:** Evaluation of provincial grant-funded programs for efficiency and effectiveness.
Key Assumptions	• TBD
Governance	• MHSAL responsibility with coordination among funded entities.
Project Management	• MHSAL responsibility.
Communication Strategy	• To be developed.

Risks	Interdependencies
• Capacity to implement amidst other priorities. • Capacity of civil legal to support contract development process.	• Justice/Healthy Child/Families contracting processes. • *Evaluation of provincial grant-funded programs for efficiency and effectiveness* opportunity. • Tools/processes to leverage from 2011 NPO Strategy. • SAP review of funding arrangements (ID all vendors).

Evaluate Funding Model for MHSAL-supported Organizations

Subtheme: Single payer funding model	Benefit Year: 2017/18	Est. Cost Improvement: TBD
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4

Key activities:
• Communicate notice of review to all funded organizations.
• Evaluate funding from all sources to:
  • Community Health Organizations.
  • Personal Care Homes.
  • Health funded organizations.
• Evaluate funding to organizations from MJUS, Healthy Child, MFAM, WRHA and MHSAL.
• Identify opportunities to consolidate funding into integrated approach.
	Key activities:
	• For identified opportunities, review funding agreements/service purchase/operating agreements.
	• Develop integrated support framework with funding from all sources.
	• Government/Minister/DM approval
	• Develop funding proposal/framework for negotiation with organization.
	• Negotiate changes to existing agreements or implement at next renewal.
		Key activities:
		• Monitor for implementation.
			Key activities:
			• Monitor for implementation.

Outputs: • Funding map. • Options analysis.	**Outputs:** • Funding Framework. • Briefing Note. • Revised contracting templates.	**Outputs:** • Status update.	**Outputs:** • Review process for 2018/19 funding activities. • Revised contracting policies.

Initiate Alternate Service Delivery Demonstration Project

Subtheme: Implement performance-based funding framework	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: >3 years	Implementation Effort: Medium-High	

Description	Determine feasibility of publically funded private contracting for insured services (i.e. cataracts, renal dialysis, plastic surgery) to align with leading practice.
Benefit	• Lower cost delivery of a wide range of publically funded healthcare services. • Access to alternate financing and strategic delivery models.
In-scope/Out of Scope	• **In-Scope:** Insured services.
Key Assumptions	• Feasibility study only.
Governance	• MHSAL responsibility.
Project Management	• MHSAL responsibility.
Communication Strategy	• To be developed.

Risks	Interdependencies
• Perception of two-tiered system by unions/public. • Union objections in relation to perceived 'privatization.	• Provincial Clinical and Preventative Services Plan.

Initiate Alternate Service Delivery Demonstration Project

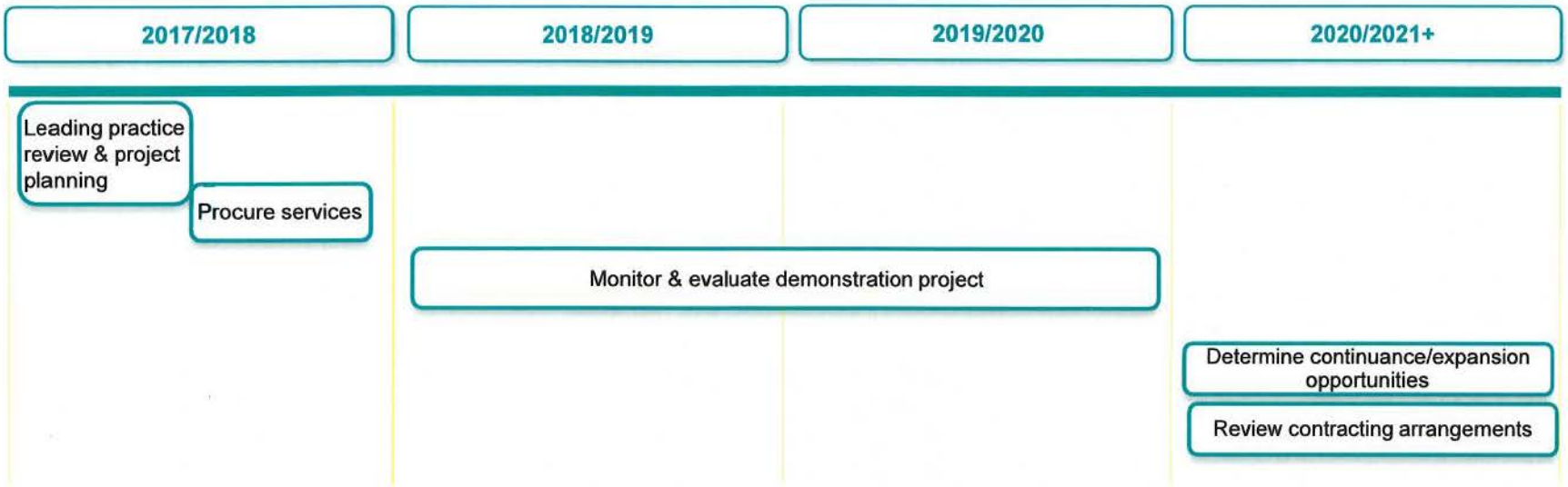
Subtheme: Implement performance-based funding framework	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: >3 years	Implementation Effort: Medium-High	

2017/2018	2018/2019	2019/2020	2020/2021+
Key activities: • Conduct leading practice review to identify options for privately provided services (i.e. wait time linkages). • Test market to assess capacity/willingness. • Prepare RFI. • Identify demonstration project areas (by procedure and geography). • Develop/refine requirements with clinical leadership teams. • Define tariff and volume model. • Develop RFP. • Award contract. • Develop/negotiate agreements. • Develop implementation/cut over plan. • Initiate service delivery.	**Key activities:** • Annual program review.	**Key activities:** • Annual program review.	**Key activities:** • Conduct program evaluation and determine continuance/expansion opportunities. • Review contracting arrangements.
Outputs: • Leading practice review. • RFP. • Provider service delivery agreement (incl. KPIs).	**Outputs:** • Performance report.	**Outputs:** • Performance report.	**Outputs:** • Program review.

Initiate Alternate Service Delivery Demonstration Project

Subtheme: Implement performance-based funding framework | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: TBD**

Implementation Duration: >3 years | **Implementation Effort: Medium-High**



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Work Plan 2: Insured Benefits and Funded Health Programs

Notice

This Insured Benefits and Funded Health Programs Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

Insured Benefits & Funded Health Programs - Work Plan Summary

Insured Benefits & Funded Health Programs	
Project Summary	• The Insured Benefits & Funded Health Programs project includes bringing benefits and funded programs in alignment with Canadian standards, and reviewing inter-jurisdictional coverage agreements.
Objective & Scope	• To align Manitoba's Insured Benefits (regulated under *The Canada Health Act)* and other benefits with current practices and coverage standards in other jurisdictions. • To review the processes to manage coverage and service provision with other jurisdictions. • To identify future areas where Insured Benefits could be targeted to support healthcare system sustainability.
Interdependencies	• [redacted] • [redacted]. • [redacted]. • [redacted].

Summary of Opportunities

This table provides a summary of the total cost savings for the Insured Benefits and Funded Healthcare Programs Work Plan broken down by benefit year and sub category.

Sub Category	2017/18 Potential Cost Savings	2018/19 and Beyond Potential Cost Savings	Total
Alignment with Canadian Standards	$18.3M	$13.1M	**$31.4M**
Reviewing Inter-Jurisdictional Coverage	$0.5M	$1.2M	**$1.7M**
Incentivizing Sustainability	TBD	TBD	**TBD**
TOTAL	**$18.8M**	**$14.3M**	**$33.1M**

The following table provides an overview of each opportunity included in the Insured Benefits and Funded Healthcare Programs Work Plan.

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Alignment with Canadian Standards	Change/introduce deductible for cancer drugs to align with other jurisdictions.	$ 4.5M	2017/18	PPP 0.1 FTE	• Deductible models applying to other drugs. • Provincial Clinical and Preventative Services Plan.	• Potential public and patient complaints with the potential for sustained campaign of opposition.
	Assess cost improvement opportunities for Home Care Housekeeping Services.	$ 4.5M	2018/19 and Beyond	RPP 1 FTE	• Core Clinical and Healthcare Services Work Plan in relation to refocusing home care services on reducing length of acute stays.	• Strong likelihood of a negative public reaction to loss of benefit/access. • Potential loss of jobs / re-scoping of current JDs.
	Consider changes to existing income based Pharmacare deductible program to include options for purchasing additional coverage and increase deductible/co-payment amount.	$ 4M	2018/19 and Beyond	PPP 0.2 FTE	• Overall Pharmacare coverage and benefits.	• Public reaction to a perceived 'cut' in Pharmacare coverage and pushing coverage to private insurance plans. • Ability of private insurance companies to react quickly • May require legislative amendments.
	Implement clinical standards and revise funding structure for Home Oxygen Program.	$ 4M	2017/18	RPP 0.2 FTE	• Current policies, process and clinical protocols/standards in relation to the Home Oxygen Program.	• Public reaction to deductible/funding limit. • Access to accurate data on home oxygen use and ability to assess potential impact on Length of Stay.

Summary of Opportunities

Sub category	Opportunity	Est .Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Alignment with Canadian Standards	Explore options to delist Supplies and Implement a Co-payment model for Sleep Apnea Patients.	$ 2.7M	2017/18	RPP 0.2 FTE	• Co-payment models applying to other benefits.	• Patients, particularly low-income patients, those without third party insurance, and those not on EIA, may find cost of supplies challenging and go without treatment.
	Increase uptake of Direct Funding to Self/Family Managed Care.	$ 2.5M	2017/18	RPP 0.2 FTE	• Current policies in relation to commissioning of homecare services.	• RHAs are challenged to offer Directly Funded Services given potential financial impact of committed homecare hours.
	Increase uptake of Tenant Companionship.	$ 2.5M	2017/18	RPP 0.2 FTE	• Current policies in relation to commissioning of homecare services. • Provincial Clinical and Preventative Services Plan.	• RHA's are challenged to offer Tenant Companionship given potential financial impact of committed homecare hours.
	Modify orthotics program to reduce or align benefits with other Canadian jurisdictions.	$ 2M	2018/19 and Beyond	PPP 0.2 FTE	• Overall Pharmacare coverage and benefits.	• Public reaction to a perceived 'cut' in Pharmacare coverage and pushing coverage to private insurance plans.
	Implement evidence-based protocol for diabetic test strips.	$ 1.5M	2017/18	PPP 0.1 FTE	• Co-payment models applying to other benefits. • Provincial Clinical and Preventative Services Plan.	• Potential public and patient complaints.in relation to co-payment. • Potential complexity in implementing a tracking system.
	Modify ancillary programs to reduce or align benefits with other Canadian jurisdictions.	$ 1.2M	2018/19 and beyond	PPP 0.2 FTE	• Benefits coverage for other programs. • Provincial Clinical and Preventative Services Plan.	• Public opposition/protests to a loss of a benefit (s). • Potential for perverse incentives through increasing demand for acute care.

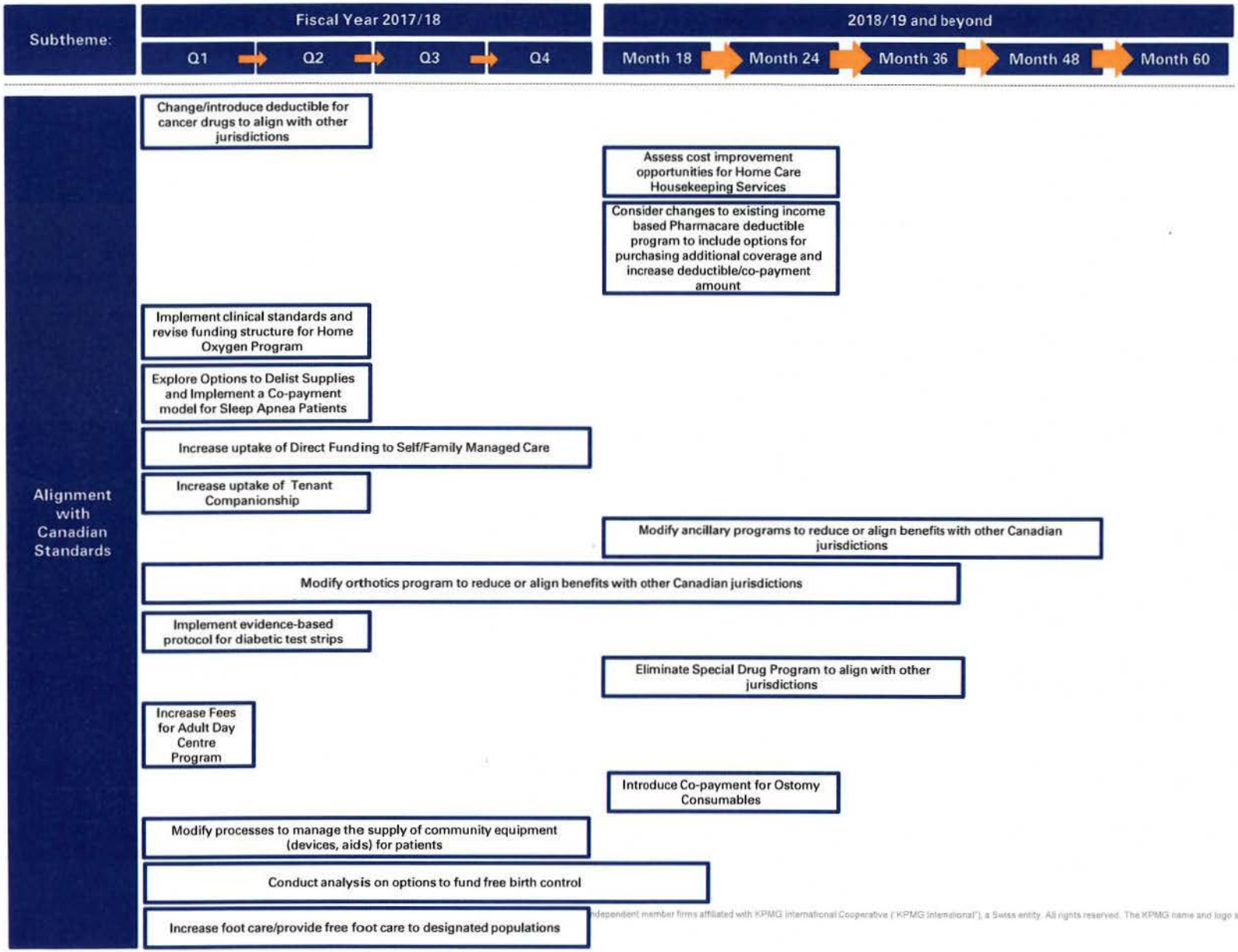
Summary of Opportunities

Sub category	Opportunity	Est .Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Alignment with Canadian Standards	Eliminate Special Drug Program to align with other jurisdictions.	$ 0.9M	2018/19 and beyond	PPP 0.2 FTE	• Pharmacare and overall provincial drug coverage. • Overarching policy in relation to out-of-country care. • Provincial Clinical and Preventative Services Plan.	• Public opposition/protests to a loss of a benefit. • Misalignment with CRA tax assessment timings.
	Increase Fees for Adult Day Centre Program.	$ 0.6M	2017/18	RPP 0.2 FTE	• Other planned fee increases to other programs.	• Potential public and patient complaints in relation to fee increase.
	Introduce Co-payment for Ostomy Consumables.	$ 0.5M	2018/19 and beyond	RPP 0.2 FTE	• Co-payment models applying to other benefits.	• Potential public and patient complaints in relation to co-payment.
	Modify processes to manage the supply of community equipment (devices, aids) for patients.	TBD	2017/18 and beyond	RPP 0.2 FTE	• Co-payment models applying to other benefits.	• Potential complexity in implementing a tracking system. • Potential public and patient complaints in relation to co-payment.
	Increase foot care/provide free foot care to designated populations.	TBD	2018/19 and beyond	Primary Health Care 0.2 FTE	• Benefits coverage for other programs. • Provincial Clinical and Preventative Services Plan.	• Challenges in ability to directly co-relate the implementation of the policy to reductions in acute care and Personal Care Home admissions.
Reviewing Inter Jurisdictional Coverage	Reconfigure funding relationships with adjacent jurisdictions (NW Ontario, Saskatchewan, Nunavut).	$ 1.2M	2018/19 and beyond	RPP 0.2 FTE	• Ongoing funding relationship review with NW Ontario. • Funding for Performance (patient volumes and funding support) opportunity. • Notice from Saskatchewan.	• Loss of services/increased cost to Manitoba.

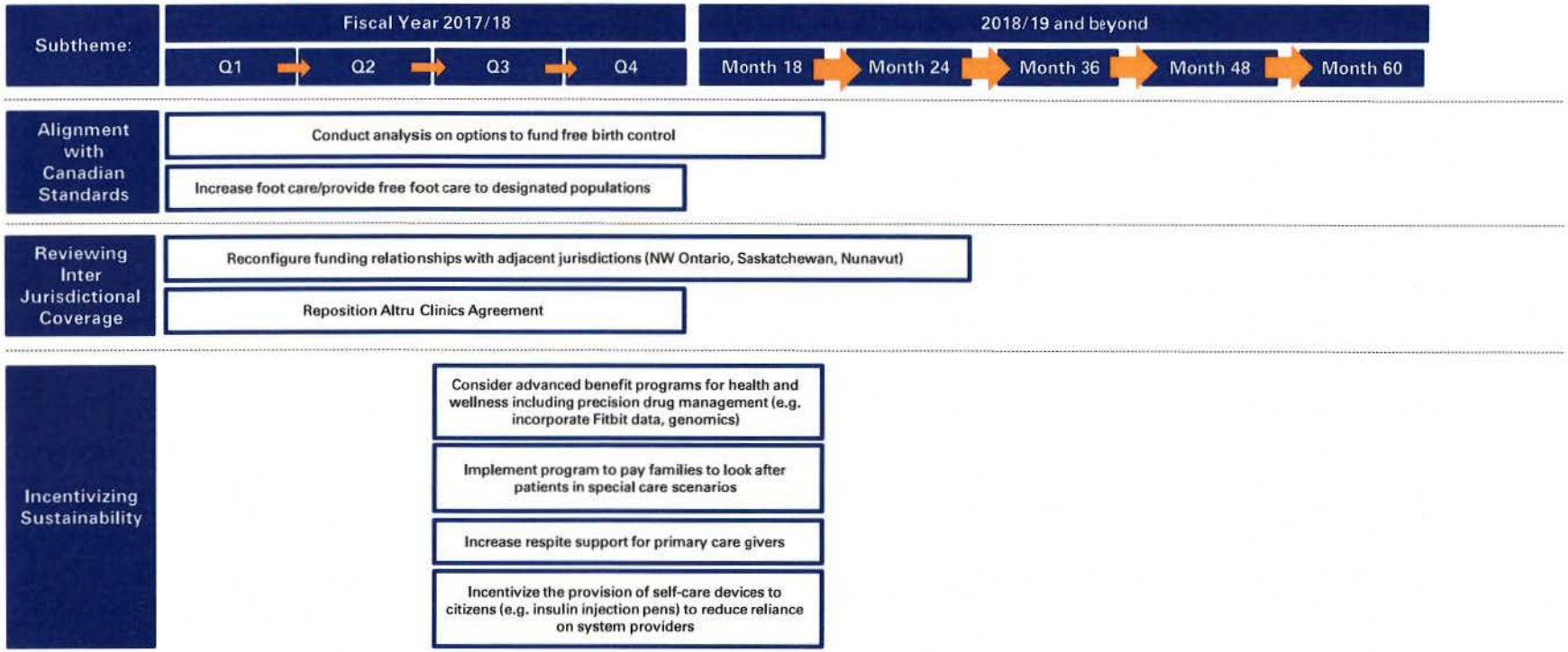
Summary of Opportunities

Sub category	Opportunity	Est .Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Reviewing Inter Jurisdictional Coverage	Reposition Altru Clinics Agreement.	$ 0.5M	2017/18	Health Workforce Secretariat 0.2 FTE	• Overarching policy in relation to out-of-country care. • Provincial Clinical and Preventative Services Plan.	• Lack of effective communications means that this could be perceived as a cut or reduction in access to care.
Incentivizing Sustainability	Consider advanced benefit programs for health and wellness including precision drug management (e.g. incorporate Fitbit data, genomics).	TBD	2018/19	PPP 0.2 FTE	• Provincial Clinical and Preventative Services Planning. • Policies in relation to genomics.	• Difficulties in being to accurately cost the benefit. • Privacy issues in relation to genomic data. • Maturity of precision drug management in Manitoba and ability to provide access at scale.
	Implement program to pay families to look after patients in special care scenarios.	TBD	2018/19	RPP 0.2 FTE	• Provincial Clinical and Preventative Services Planning. • Current policies in relation to commissioning of homecare services.	• Having access to sufficient data to enable sufficient targeting. • Public perception in relation to introducing a new benefit when others are being restricted or eliminated.
	Increase respite support for primary care givers.	TBD	2018/19	RPP 0.2 FTE	• Current policies in relation to commissioning of homecare services and PCHs.	• Agreeing extent of the respite offer and is neither overly generous or insufficient to enable care givers to continue to provide care at home
	Incentivize the provision of self-care devices to citizens (e.g. insulin injection pens) to reduce reliance on system providers.	TBD	2018/19	Public Health 0.2 FTE	• Prescribing policy and rules applying to primary care physicians.	• Sufficient and convincing evidence base to enable the development of a robust business case. • May be viewed by sections of the public as substituting for 'cuts' elsewhere in the healthcare system.

Work Plan - High-Level Roadmap



Work Plan - High-Level Roadmap



Timeframes for the Insured Benefits and Funded Healthcare Programs workstream are heavily condensed into early 2017/18 for execution. These timeframes are possible given that a number of the opportunities identified are non complex and relatively quick and easy to execute.

Change/Introduce Deductible for Cancer Drugs to Align With Other Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $4.5M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	The objective of this opportunity is to align Manitoba's policy on deductible for cancer drugs in line with other provinces.
Benefit	• Reduction in costs though the introduction of a deductible.
In-scope/Out of Scope	• **Out of scope:** All other cancer treatments not within the scope of the deductible.
Key Assumptions	• Deductibles apply only to specified and agreed cancer drugs used by patients outside a hospital setting. • Reinvestment to increase coverage of cancer drugs. • Reduction in administrative cost of services provided by CCMB staff.
Governance	• MHSAL, ADM, Provincial Policy and Programs.
Project Management	• Under Provincial Policy and Programs, assume 0.1 FTE in MHSAL to progress. Significant impact to the Communications and Correspondence stream.
Communication Strategy	• A policy change in this area is highly likely to be controversial given that it relates specifically to cancer drugs. A careful communications strategy would need to be developed stressing alignment with other provincial jurisdictions.

Risks

- Potential public and patient complaints with the potential for sustained campaign of opposition.
- Physicians may raise concerns about the lack of access to medically necessary home based equipment, particularly for patients require Bi-PAP support.
- Patients, particularly low-income patients, those without third party insurance, and those not on EIA, may the deductible challenging.
- Increase in 3rd party insurance costs (would hit government through HEPP coverage).

Interdependencies

- Deductible models applying to other drugs.
- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.

Change/Introduce Deductible for Cancer Drugs to Align With Other Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $4.5M
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Receive Government approval to implement.
- Receive approval of amended policy.
- Development of a Business Case (Risk analysis) including jurisdictional analysis.
- Cost/Benefit analysis.

Outputs:

- Approval to implement.
- Business Case to support deductible model.
- Cost/benefit analysis.

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 from the deductible 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 c-payment on revenue, 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.

Assess Cost Improvement Opportunities for Home Care Housekeeping Services

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $4.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	This opportunity relates to assessing the scale of cost improvement in relation to a) implementing a means test for housekeeping services in the Home Care program and b) the elimination from the Home Care service of Light Housekeeping. WRHA has completed a study that suggests savings of up to $6.6m annually if light housekeeping and laundry services are ceased completely. Manitoba and Quebec are the only provinces in Canada who do not apply means testing or a co-payment model for Home Care services.
Benefit	• Reduction in costs of the Home Care program through refocusing on those on low incomes and/or those with higher care needs.
In-scope/Out of Scope	• **Out of Scope:** all other health care and community care services.
Key Assumptions	• Analysis from Phase 1 HSIR report identified that significantly more recipients (when compared to Ontario) have lower care needs and therefore a significant proportion may be in receipt of housekeeping services.
Governance	• MHSAL, ADM, Regional Policy and Programs.
Project Management	• Under Regional Policy and Programs, assume 1 FTE in MHSAL to progress.
Communication Strategy	• Key messages in relation refocusing home care on those with the most significant care needs and/or those who can least afford to pay for Home Care. Strong communication strategy required.

Risks	Interdependencies
• Strong likelihood of a negative public reaction to loss of benefit/access. • Clarity required relatively quickly on whether the policy is implementing a means test or eliminating the service provision. • Potential loss of jobs / rescoping of current Job Descriptions for Home Care Staff.	• Provincial Clinical and Preventative Services Plan. • Core Clinical and Healthcare Services Work Plan in relation to refocusing home care services on reducing length of acute stays.

Assess Cost Improvement Opportunities for Home Care Housekeeping Services

Subtheme: Alignment with Canadian Standards | **Benefit Year: 2018/19 and Beyond** | **Est. Cost Improvement: $4.5M**

Implementation Duration: 1 year | **Implementation Effort: Medium**

2018/19

Q1

Key activities:

- Agree whether focus is means testing or removal of service.
- Development of a Business Case on means testing/elimination of service including:
  - Means test model development.
- Undertake cost/benefit analysis.

Outputs:

- Business Case to support means testing/elimination of service.
- Cost/benefit analysis.

Q2

Key activities:

- Receive Government approval to implement.
- Receive approval of new Homecare policy.
- Disseminate communication memorandums to stakeholders disclosing amended policy and effective implementation date.

Outputs:

- Issue guidance to RHAs.
- Issue internal and external communications on impact and implementation.

Q3

Key activities:

- Commence necessary technical and information system changes to implement the policy.
- Monitor impact of policy change in terms of changes in the number of recipients.

Outputs:

- Technical and information system changes made to support implementation.
- Develop any required mitigating actions if required.

Q4

Key activities:

- Evaluation of impact of policy change on access, numbers of recipients, cost/benefits.
- Agree any other policy adjustments or changes required for 2018/19.

Outputs:

- Assessment of impact of policy change against desired outcomes and benefits.
- Any required revised guidance for RHAs for 2018/19.

Consider Changes to Existing Income Based Pharmacare Deductible Program

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $4M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	The payment of benefits regulation made under the 'Prescription drugs cost assistance Act' is amended annually to implement any increase to the income based deductibles that beneficiaries must pay before the Pharmacare Program will cover the costs of their prescriptions drugs. This opportunity considers changes to this program to include options for purchasing additional coverage (optional basis) and increasing the deductible rate to be better aligned with other jurisdictions.
Benefit	Alignment with other jurisdictions, cost savings.
In-scope/Out of Scope	**In-scope**: all Pharmacare program participants.
Key Assumptions	Impact statement for program delivery is well defined.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Provincial Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Key messages would focus on the fact that the annual amendment is a normal process and that changes for 2017/18 are in the context of aligning Manitoba with other provincial jurisdictions.

Risks

- Public reaction to a perceived 'cut' in Pharmacare coverage and pushing coverage to private insurance plans.
- Ability of private insurance companies to react quickly to provide optional plans.

Interdependencies

- Overall Pharmacare coverage and benefits.
- Proposed changes to other benefits in relation to cumulative/overall impact on Manitoba residents.
- May require legislative amendments.

Consider Changes to Existing Income Based Pharmacare Deductible Program

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $4M
Implementation Duration: 1 year	Implementation Effort: Low	

2019/20

Q1

Key activities:

- Receive Government approval to implement.
- Development of a Business Case (Risk analysis) including jurisdictional analysis.
- Cost/Benefit analysis.

Outputs:

- Approval to implement.
- Business Case to support deductible model.
- Cost/benefit analysis.

Q2

Key activities:

- Disseminate communication memorandums to stakeholders disclosing amended program and effective implementation date.
- Make any necessary technical or information system changes.

Outputs:

- Communication Strategy.
- Technical/information system changes made.

Q3

Key activities:

- Monitor impact of program change in terms of income from the deductible 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 on revenue, and patient outcomes.
- Agree any other program adjustments or changes required for 2018/19.

Outputs:

- Assessment of impact of program change.

Implement Clinical Standards and Revise Funding Structure for Home Oxygen Program

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $4M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	This opportunity relates to implementing evidence-based, clinical standards already undertaken for portable home oxygen program including potential for deductible or funding limits.
Benefit	• Potentially more rapid provision of home oxygen service (with potential reduction of acute length of stay) and targeting of oxygen supply related to clinical need, alignment of benefit with other provinces.
In-scope/Out of Scope	• **Out of Scope**: Hospital/acute care based provision of oxygen services.
Key Assumptions	• That there is significant potential for improvement related to variation between service provision of home oxygen between RHAs and between leading clinical and service practice in other jurisdictions.
Governance	• MHSAL, ADM, Regional Policy and Programs.
Project Management	• Under Regional Policy and Programs including input from Provincial drug programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	• Development of the Home Oxygen Program based on leading clinical practice, alignment of benefit with other Canadian jurisdictions.

Risks

- Public reaction to deductible/funding limit.
- Access to accurate data on home oxygen use and ability to assess potential impact on Length of Stay.
- Potential for double payment.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.
- Current policies, process and clinical protocols/standards in relation to the Home Oxygen Program.
- Alignment with other policies in relation to deductibles.

Implement Clinical Standards and Revise Funding Structure for Home Oxygen Program

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $4M
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Refinement of Business Case on Home Oxygen Program.
- Jurisdiction scan of leading best practice.
- Cost/Benefit analysis.

Outputs:

- Approval to implement.
- Jurisdictional scan.
- Business Case to support deductible/funding limit.
- Cost/benefit analysis.

Q2

Key activities:

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

Outputs:

- Approval to implement.
- Approval of amended policy.

Q3

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.

Q4

Key activities:

- Monitor impact of policy change in terms of cost reduction.
- Evaluation of impact of policy change on cost reduction, and access.
- Agree any other policy adjustments or changes required for 2018/19.

Outputs:

- Develop any required mitigating actions if required.
- Assessment of impact of policy change.
- Any required revised guidance for RHAs for 2018/19.

Modify Orthotics Program to Reduce or Align Benefits with Other Canadian Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $2M
Implementation Duration: 3 years	Implementation Effort: Low	

Description	Modify Orthotics Programs to Reduce or Align Benefits with Other Canadian Jurisdictions.
Benefit	Reduction in expenditure on benefits.
In-scope/Out of Scope	All other benefits outside the scope of coverage of this program.
Key Assumptions	That there is the political appetite and willingness to reduce or eliminate coverage of ancillary benefits in the context of achieving fiscal sustainability of the healthcare system.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Elements of both Provincial Policy and Programs and Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	A careful communications strategy would need to be developed stressing the justification to better align Manitoba's benefits coverage with other jurisdictions in Canada.

Risks	Interdependencies
• Public opposition/protests to a loss of a benefit(s).	• Provincial Clinical and Preventative Services Plan. • Core Clinical and Healthcare Services Work Plan.

Modify Orthotics Program to Reduce or Align Benefits with Other Canadian Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $2M
Implementation Duration: 3 years	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Policy approval by government to proceed.

Outputs:

- Policy approval.

Q2

Key activities:

- Undertake a jurisdictional analysis in relation to each benefit.
- Develop business case and cost/benefit analysis.
- Identify any legislative changes required.
- Agree and announce policy change(s).

Outputs:

- Jurisdictional analysis.
- Business case and cost/benefit analysis.
- Confirmed legislative requirements.

Q3

Key activities:

- Prepare for this change internally, including development of a full implementation plan and a communication plan (to be developed in consultation with Communication Services Manitoba).

Outputs:

- Implementation and Communications Plan.

Q4

Key activities:

- Announce the change management and implement the plan.
- Commence necessary technical and information system changes to implement amended policy.

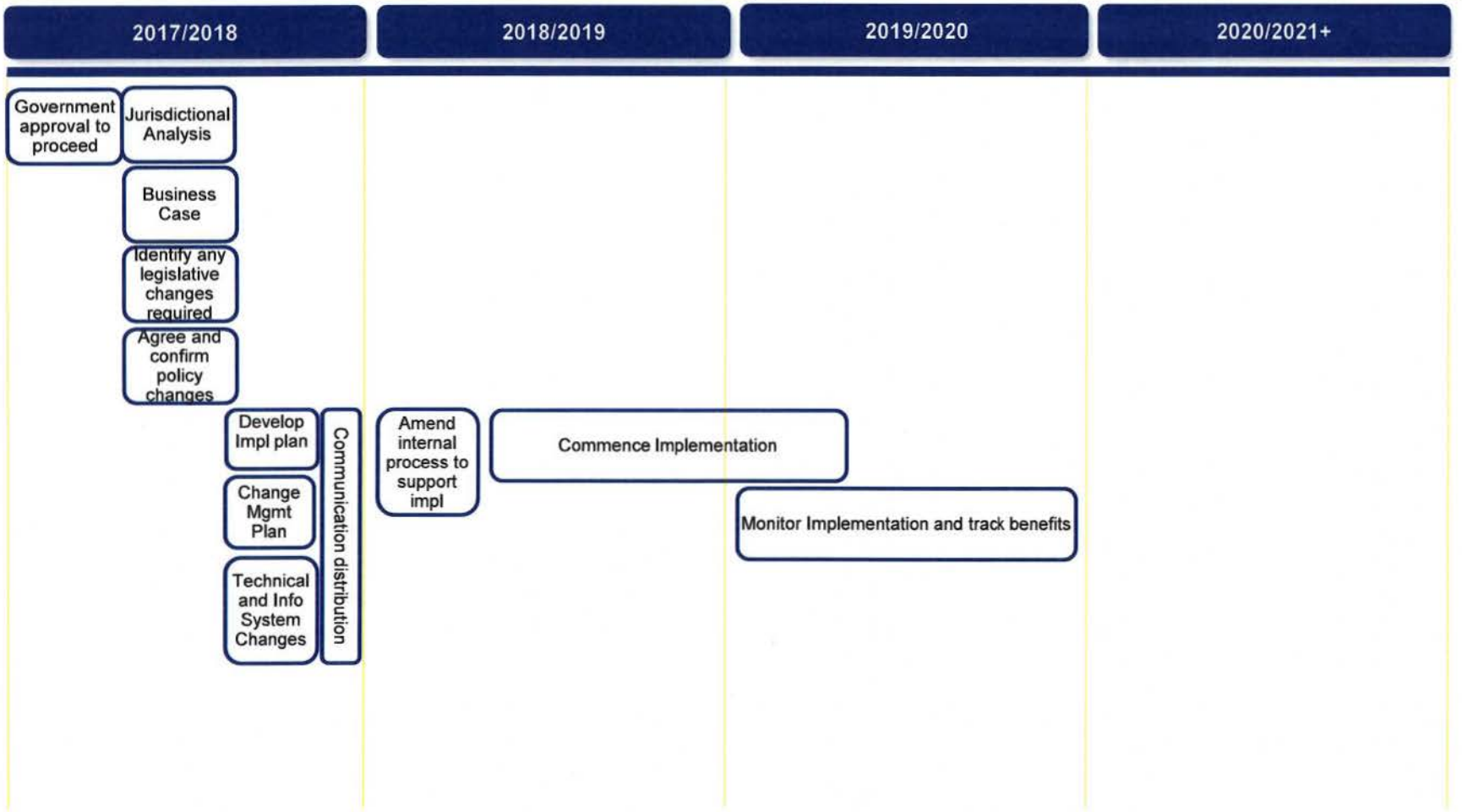
Outputs:

- Change Management Plan.
- Technical and Information system changes.

Modify Orthotics Program to Reduce or Align Benefits with Other Canadian Jurisdictions

Subtheme: Alignment with Canadian Standards | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: $2M**

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



Explore Options to Delist Supplies and Implement a Co-Payment Model for Sleep Apnea Patients

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $2.7M
Implementation Duration: 1 year	Implementation Effort: Low	

Description	Assessing options for introducing changes to the Sleep Apnea program through the delisting of sleep apnea supplies (equipment hosing, face masks, and filters) and the introduction of co-payments on Continuous Positive Air Pressure (CPAP) and Bi-level Positive Airway Pressure (Bi-PAP) equipment.
Benefit	Reduction in costs though delisting supplies/consumables and the introduction of co-payments for certain equipment.
In-scope/Out of Scope	**Out of scope**: All other healthcare services.
Key Assumptions	14,500 patients receive annual supply replacements at an average cost of $145 per patient; approximately 2,500 patients are added to equipment provision per annum; 7% of patient population requires Bi-PAP equipment; approximately 2,325 patients per annum receive CPAP equipment at average cost of $1,200 per unit; approximately 175 patients per annum receive Bi-PAP equipment at average cost of $4,000 per unit.
Governance	MHSAL, ADM, Regional Policy and Programs.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Key message is that it would align Manitoba with other provincial coverage for sleep supplies and equipment.

Risks

- Potential public and patient complaints.
- Physicians may raise concerns about the lack of access to medically necessary home based equipment, particularly for patients require Bi-PAP support.
- Patients, particularly low-income patients, those without third party insurance, and those not on EIA, may find cost of supplies challenging and go without treatment.

Interdependencies

- Co-payment models applying to other benefits.
- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.

Explore Options to Delist Supplies and Implement a Co-Payment Model for Sleep Apnea Patients

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $2.7M
Implementation Duration: 1 year	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Receive Government approval to implement.
- Receive approval of amended policy.
- Refinement of Business Case on delisting/co-payment model.
- Cost/Benefit analysis.

Outputs:

- Approval to implement.
- Business Case to support deductible/income limit.
- Cost/benefit analysis.

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 cost reduction, access by low income patients.

Outputs:

- Develop any required mitigating actions if required.

Q4

Key activities:

- Evaluation of impact of policy change on cost reduction, and access.
- 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.

Increase uptake of Direct Funding to for Self/Family Managed Care (SFMC)

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $2.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	This opportunity relates to increasing the uptake of Direct Funding to Families as opposed to eligible recipients receiving a home care service commissioned by the RHA.
Benefit	That the provision of Direct Funding to Families is more cost effective and results in improved outcomes of recipients of Direct Funding when compared to receiving traditional homecare services.
In-scope/Out of Scope	**Out of Scope**: Directly commissioned homecare services by RHA.
Key Assumptions	That there is sufficient potential to increase the provision of Direct Funding to younger disabled adults and potentially older people assessed as requiring homecare services.
Governance	MHSAL, ADM, Regional Policy and Programs, Self/Family Managed Care Working Group.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Promoting the positive benefits of Direct funding, extending choice of options to those assessed as requiring homecare, helping recipients remain living independently at home.

Risks

- Lack of access to payroll and employment support services.
- Ability to undertake comparative analysis between recipients of Direct Funded Services and those receiving Home Care commissioned by the RHAs to determine more accurate estimate of potential cost improvement.
- RHAs are challenged to offer Directly Funded Services given potential financial impact of committed homecare hours.
- Contractual arrangements on homecare hours.
- Appropriate level of auditing/review.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services.
- Current policies in relation to commissioning of homecare services.

Increase uptake of Direct Funding to for Self/Family Managed Care (SFMC)

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $2.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Development of a Business Case on expansion.
- Impact assessment on homecare staff hours.
- Estimate through data analysis financial benefits of expansion.
- Agree target client groups for increased take-up.

Outputs:

- Business Case.
- Staff impact assessment.
- Underpinning Cost/Benefit analysis.
- Agreed target client groups for increased take up.

Q2

Key activities:

- Develop any revised guidance to RHAs.
- Develop plan to increase access to employment support services/care brokerage.

Outputs:

- Issue revised guidance to RHAs including any targets on increased take up.
- Approved plan to increase access to employment support services/care brokerage.

Q3

Key activities:

- Monitor increased take-up by RHA and targeted client group and outcomes.
- Monitor increased access to employment support services/care brokerage.

Outputs:

- Developing required mitigating actions if off target (by RHA).

Q4

Key activities:

- Evaluation of increased take-up and validation of benefits achieved.
- Agree revised strategy for targeted increase for 2018/19.

Outputs:

- Validation of benefits (financial and outcomes) achieved for 2017/18.
- Revised guidance for RHAs for 2018/19.

Increase Uptake of Tenant Companion Services

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $2.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	This opportunity relates to increasing the uptake (following a previous small scale pilot) of Tenant Companion services to individuals at risk of moving into PCHs who can continue to live independently at home with support from the tenant companion as opposed to moving into a PCH. A previous WRHA pilot was conducted but not taken forward.
Benefit	That the provision of Tenant Companions to individuals is more cost effective and results in improved outcomes as opposed to being admitted to a PCH.
In-scope/Out of Scope	**Out of Scope**: Directly commissioned homecare services by RHA.
Key Assumptions	That, based on the outcomes of the pilot and evidence from other jurisdictions, Tenant Companionship is more cost effective and delays/prevents admissions to PCHs.
Governance	MHSAL, ADM, Regional Policy and Programs.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Promoting Tenant Companionship as a positive, home based alternative to admission to PCH and supporting independent living.

Risks

- Requirement to effectively re-launch the service across all RHAs.
- Ability to undertake analysis of cost effectiveness and evidence on delaying / preventing admission to a PCH.
- RHAs are challenged to offer Tenant Companionship given potential financial impact of committed homecare hours.
- Applying evidence to practice.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.
- Current policies in relation to commissioning of homecare services.
- Provincial Clinical and Preventive Services Plan.
- MCHP evidence (quantification of opportunities).
- Social Services – inter-sectoral linkages (i.e. Access Centres).

Increase Uptake of Tenant Companion Services

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $2.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Receive Government approval to implement.
- Receive approval of amended policy.
- Assess and review schemes from other jurisdictions.
- Review WRHA pilot.
- Development of a Business Case on service development + cost of support services required to implement.

Outputs:

- Business Case to support development of service across RHAs.
- Underpinning Cost/Benefit analysis to support service development.
- Agreed target service recipients by RHA.

Q2

Key activities:

- Disseminate communication memorandums to stakeholders disclosing amended policy and effective implementation date.
- Development of Tenant Companion services across RHAs.
- Implement marketing/promotion strategy to drive take-up.

Outputs:

- Issue revised guidance to RHAs in relation to Tenant Companion Service.
- Marketing/promotion approach to drive take-up.

Q3

Key activities:

- Monitor take-up against target.
- Monitor Tenant Companionship service in terms of quality and effectiveness.

Outputs:

- Developing required mitigating actions if off target (by RHA).

Q4

Key activities:

- Evaluation of take-up and validation of benefits achieved.
- Agree revised strategy for targeted increase for 2018/19.

Outputs:

- Validation of benefits (financial and outcomes) achieved for 2017/18.
- Revised guidance for RHAs for 2018/19.

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.

Modify Ancillary Programs to Reduce or Align Benefits with Other Canadian Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.2M
Implementation Duration: 3 years	Implementation Effort: Low	

Description	Modify the following ancillary programs to reduce or align benefits with other jurisdictions: • Eyeglass for Seniors Program • Orthotics subsidy program • Orthopedic Shoes for Children subsidy program • Telecommunications subsidy program • Personal Audiology Equipment specifically Children's Hearing Aids, Bone Anchored Hearing Implant Processors and FM Transmitters.
Benefit	Reduction in expenditure on benefits
In-scope/Out of Scope	**Out of scope:** All other benefits outside the scope of coverage of these programs.
Key Assumptions	That there is the political appetite and willingness to reduce or eliminate coverage of ancillary benefits in the context of achieving fiscal sustainability of the healthcare system.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Elements of both Provincial Policy and Programs and Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	A careful communications strategy would need to be developed stressing the justification to better align Manitoba's benefits coverage with other jurisdictions in Canada.

Risks	Interdependencies
• Public opposition/protests to a loss of a benefit(s). • Potential for perverse incentives through increasing demand for acute care. • Disproportionate impact on families/individuals on low incomes.	• Benefits coverage for other programs. • Provincial Clinical and Preventative Services Plan. • Core Clinical and Healthcare Services Work Plan.

Modify Ancillary Programs to Reduce or Align Benefits with Other Canadian Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.2M
Implementation Duration: 3 years	Implementation Effort: Low	

2018/19

Q1

Key activities:

- Policy approval by government to proceed.

Outputs:

- Policy approval.

Q2

Key activities:

- Undertake a jurisdictional analysis in relation to each benefit.
- Develop business case and cost/benefit analysis
- Identify any legislative changes required.
- Agree and announce policy change(s).

Outputs:

- Jurisdictional analysis.
- Business case and cost/benefit analysis.
- Confirmed legislative requirements.

Q3

Key activities:

- Prepare for this change internally, including development of a full implementation plan and a communication plan (to be developed in consultation with Communication Services Manitoba).

Outputs:

- Implementation and Communications Plan.

Q4

Key activities:

- Announce the change management and implement the plan.
- Commence necessary technical and information system changes to implement amended policy.

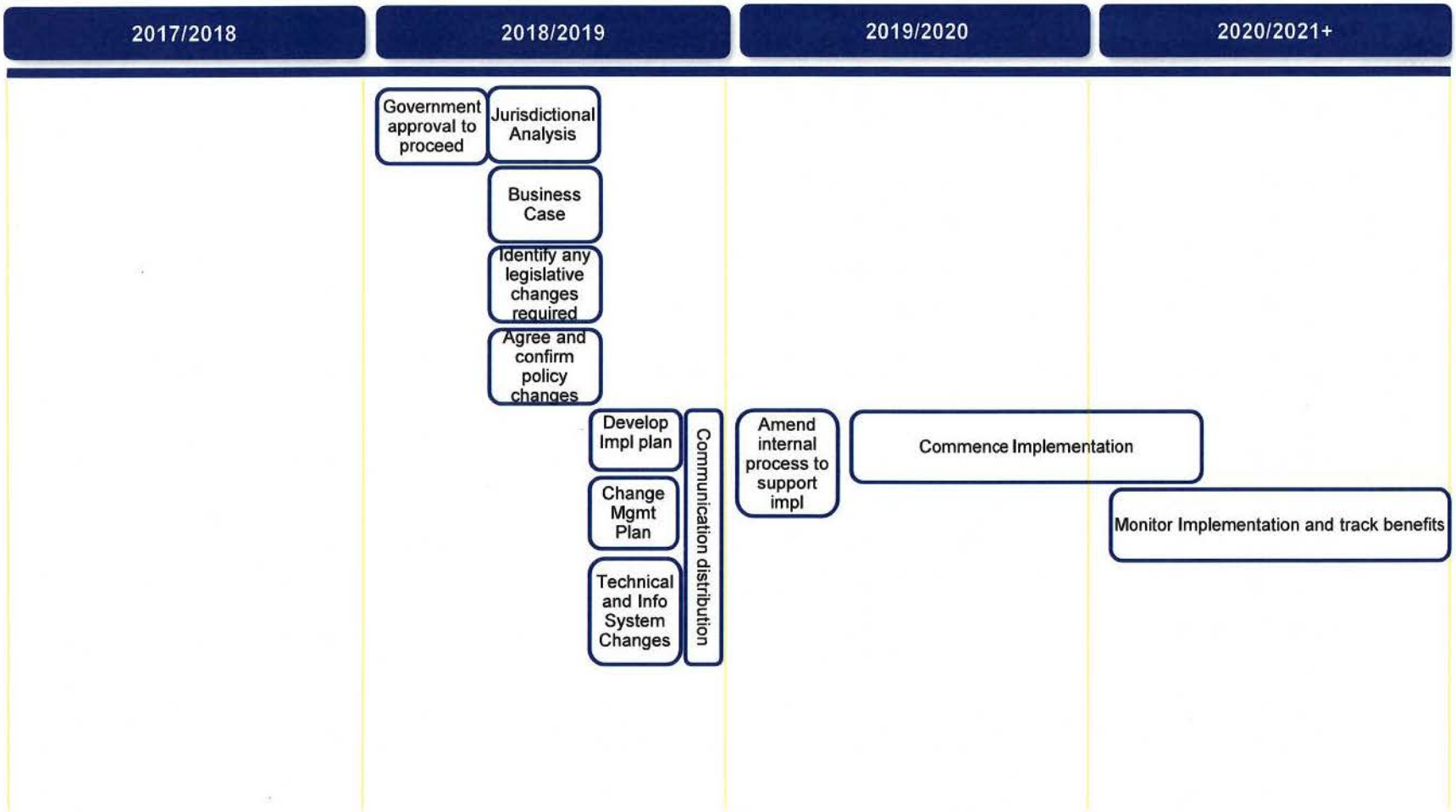
Outputs:

- Change Management Plan.
- Technical and Information system changes.

Modify Ancillary Programs to Reduce or Align Benefits with Other Canadian Jurisdictions

Subtheme: Alignment with Canadian Standards | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: $1.2M**

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



Reconfigure Funding Relationships with Adjacent Jurisdictions

Subtheme: Reviewing Inter-Jurisdictional Coverage	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.2M
Implementation Duration: 2 years	Implementation Effort: Medium	

Description	Review reciprocal billing arrangements with Saskatchewan, North West Ontario, and Nunavut to recover health care services accessed in Manitoba.
Benefit	Improved recovery of Out of Province/Territory (OP/T) revenue through better reciprocal billing arrangements of inpatient hospital services.
In-scope/Out of Scope	**In-scope**: Funding relationships with North West (NW) Ontario, Saskatchewan (SK), and Nunavut in relation to access, coordination of access and transfer, and funded services. **Out of Scope**: Altru delivery relationship.
Key Assumptions	That there is considerable scope to develop/improve reciprocal billing arrangements with North West Ontario, Saskatchewan and Nunavut.
Governance	MHSAL, ADM, Health Workforce Secretariat.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress. Will require support from HWS to progress.
Communication Strategy	The communication strategy would focus on Manitoba efficiently recovering all revenue owed by the other Provinces and Territories in relation to OP/T and that those costs are not borne by Manitoba.

Risks

- Loss of services/increased cost to MB.

Interdependencies

- Ongoing funding relationship review with NW Ontario.
- Funding for Performance Work Plan (patient volumes and funding support) opportunity.
- Notice from SK.
- Core Clinical and Healthcare Services Work Plan (capacity planning).

Reconfigure Funding Relationships with Adjacent Jurisdictions

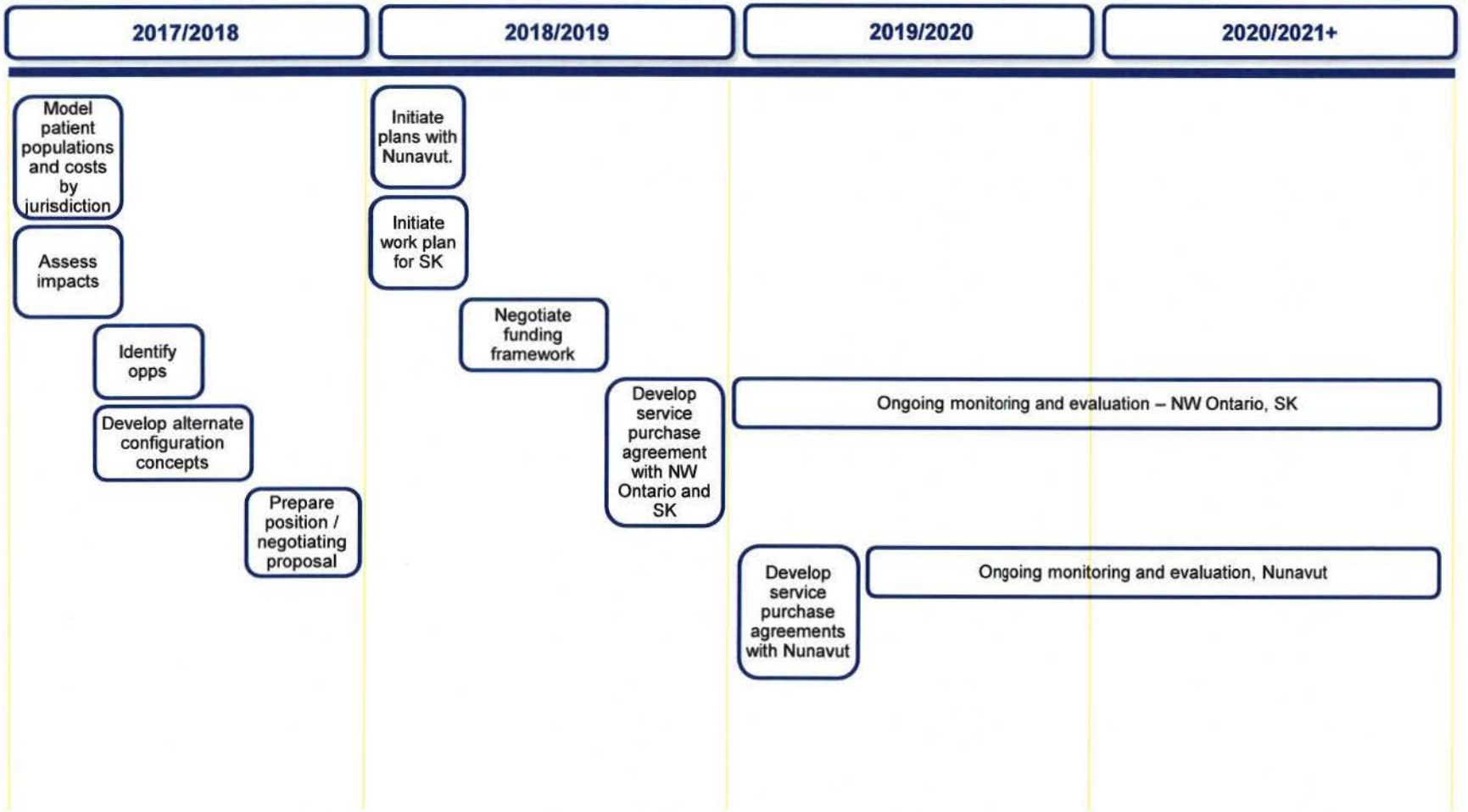
Subtheme: Reviewing Inter-Jurisdictional Coverage	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.2M
Implementation Duration: 2 years	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Model patient populations and costs by jurisdiction (SK, Nunavut). • Assess impacts of renegotiating with SK and determine whether to open agreement.	**Key activities:** • Identify opportunities. • Develop alternate configuration concepts with implications (i.e. service facilitators).	**Key activities:** • Continue to develop alternate configuration concepts.	**Key activities:** • Prepare position/negotiating proposal for Ministerial approval.
Outputs: • Additional analysis and modelling.	**Outputs:** • N/A.	**Outputs:** • Configuration concepts.	**Outputs:** • Position paper. • Decision on whether to re-open SK agreement.

Reconfigure Funding Relationships with Adjacent Jurisdictions

Subtheme: Reviewing Inter-Jurisdictional Coverage	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.2M
Implementation Duration: 2 years	Implementation Effort: Medium	



Eliminate Special Drug Program to Align With Other Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $0.9M
Implementation Duration: 2 years	Implementation Effort: Low	

Description	This opportunity looks to eliminate Manitoba's Special Drug Program (SPD), with the aim of individuals current under care realigning this to Canadian standards under the Pharmacare program.
Benefit	Reduced expenditure resulting from elimination of the SDP.
In-scope/Out of Scope	**Out of Scope**: All other drug programs.
Key Assumptions	• Members of the SDP have never paid a deductible, nor applied for Pharmacare. • This kind of change is best made at the very beginning of the fiscal year due to accruing drug expenditures through the course of the year. • SDP clients with high drug expenditures relative to family income levels can mitigate the transition to an annual Pharmacare deductible by applying to the Deductible Installment Payment Program for Pharmacare, whereby their Pharmacare deductible can be paid in monthly installments.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Under Provincial Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	A careful communications strategy would need to be developed as this will be perceived as a cut/loss of benefit. SDP clients have never been required to pay a deductible.

Risks	Interdependencies
• Public opposition/protests to a loss of a benefit. • Misalignment with CRA tax assessment timings.	• Pharmacare and overall provincial drug coverage. • Overarching policy in relation to out-of-country care. • Provincial Clinical and Preventative Services Plan. • Core Clinical and Healthcare Services Work Plan.

Eliminate Special Drug Program to Align With Other Jurisdictions

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $0.9M
Implementation Duration: 2 years	Implementation Effort: Low	

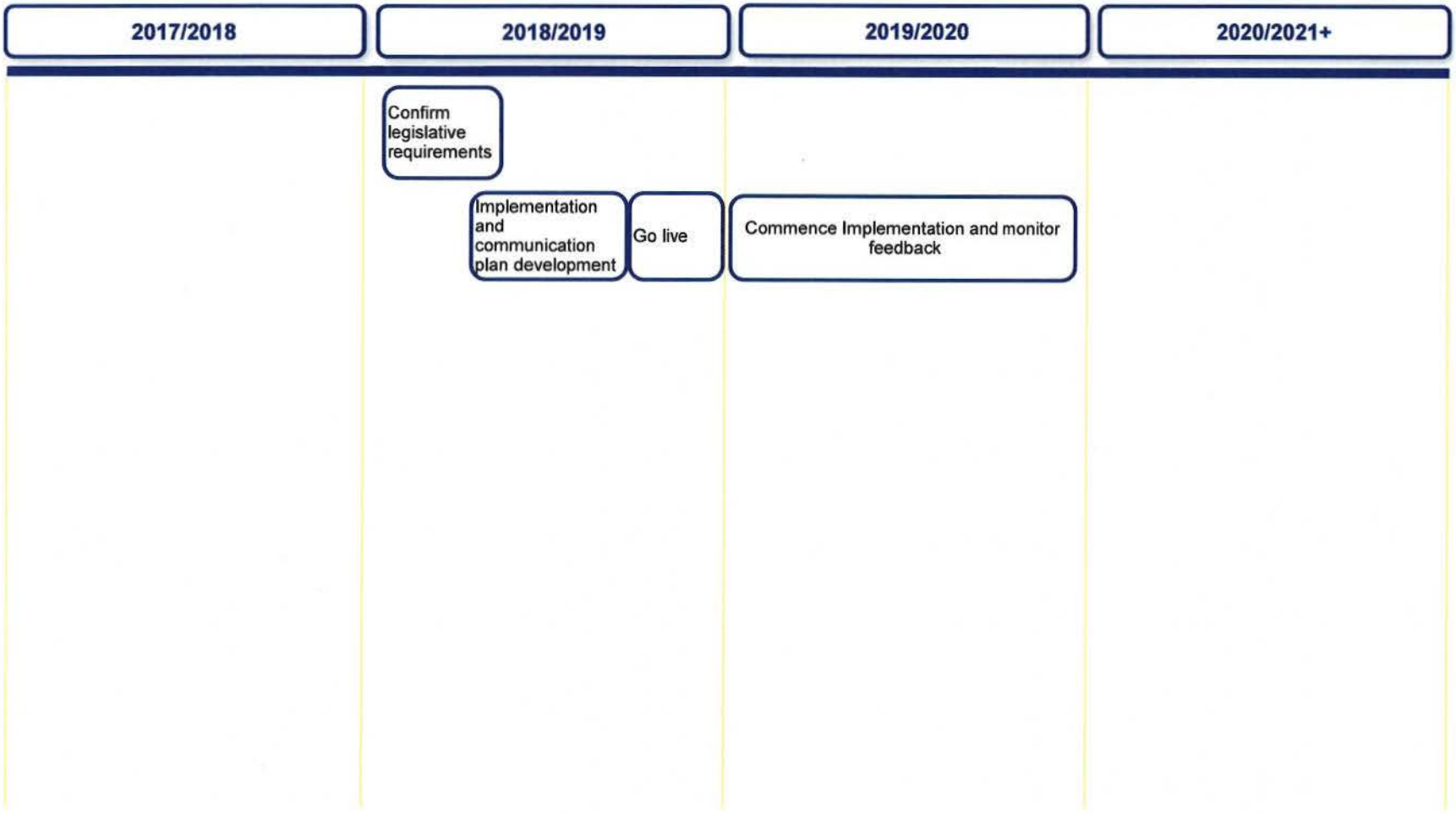
2018/19

Q1	Q2	Q3	Q4
Key activities: • Obtain legal advice to determine what legal challenges may arise and to determine what legislative options are available to action either alternative.	**Key activities:** • Prepare for this change internally, including development of a full implementation plan and a communication plan (to be developed in consultation with Communication Services Manitoba).	**Key activities:** • Announce the change management and implement the plan. • Commence necessary technical and information system changes to implement amended policy.	**Key activities:** • Amendment of internal processes to support implementation.
Outputs: • Confirmed legislative requirements.	**Outputs:** • Implementation and Communications Plan.	**Outputs:** • Implementation and Change Management Plan.	**Outputs:** • Implementation ready to 'go live'.

Eliminate Special Drug Program to Align With Other Jurisdictions

Subtheme: Alignment with Canadian Standards | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: $0.9M**

Implementation Duration: 2 years | **Implementation Effort: Low**



Increase Fees for Adult Day Centre Program

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $0.6M
Implementation Duration: 12 Months	Implementation Effort: Low	

Description	Implement an increase in fees for participants in the Adult Day Centre (ADC) Program for each RHA. Manitoba has one of the lowest participant fees in comparison with other jurisdictions.
Benefit	Increased revenue for RHAs.
In-scope/Out of Scope	• Only applies to participants in the Adult Day Care Centre Program for each RHA. • Income test limit could also be explored for 2018/19.
Key Assumptions	That there is data available from each RHA to estimate the financial impact from the fees increase.
Governance	MHSAL, ADM, Regional Policy and Programs.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Key message is that additional revenue in terms of fees are required to sustain the Adult Day Centre.

Risks

- Potential public and patient complaints in relation to fee increase.
- Participants particularly low-income patients, those without third party insurance, and those not on EIA, may find the fee increase challenging to pay and leave the program.

Interdependencies

- Other planned fee increases to other programs.
- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.

Increase Fees for Adult Day Centre Program

Subtheme: Alignment with Canadian Standards	Benefit Year: 2017/18	Est. Cost Improvement: $0.6M
Implementation Duration: 12 Months	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Receive Government approval to implement fee increase. • Disseminate communication memorandums to stakeholders disclosing fee increase and effective implementation date.	**Key activities:** • Monitor impact of policy change in terms of income increase from the fee increase and any impact on the number of program participants.	**Key activities:** • Monitor impact of policy change in terms of income increase from the fee increase and any impact on the number of program participants.	**Key activities:** • Evaluation of fee increase on revenue and numbers of program participants. • Agree any fee increases required for 2018/19.
Outputs: • Issue guidance to RHAs.	**Outputs:** • Develop any required mitigating actions if required.	**Outputs:** • Develop any required mitigating actions if required.	**Outputs:** • Any required revised guidance for RHAs for 2018/19.

Reposition Altru Clinics Delivery Relationship for SE Manitoba

Subtheme: Reviewing Inter-Jurisdictional Coverage	Benefit Year: 2017/18	Est. Cost Improvement: $0.5M
Implementation Duration: 12 Months	Implementation Effort: Low	

Description	This opportunity looks to decrease the delivery cost of SE Manitoban patients seeking Altru clinical services by encouraging services at a lower cost in Manitoba.
Benefit	Reduction in out-of-country expenditure.
In-scope/Out of Scope	**In-scope**: Only applies to Altru. **Out of Scope**: any other inter-jurisdictional agreements.
Key Assumptions	Manitoba residents with the primary residence in the RM of Piney and / or Buffalo Point FN who currently access specialist, non-emergency care at the Altru Clinics may need to be re-homed with Manitoba specialists. An effective communications and change management strategy will be required to ensure a seamless transition of care.
Governance	MHSAL, ADM, Health Workforce Secretariat.
Project Management	Health Workforce Secretariat, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	An effective communications strategy will need to be developed to stress that services that are currently being accessed at the Altru Clinics can be accessed in Manitoba, and that most patients attending the Altru Clinics also receive specialist care in Manitoba.

Risks

- Lack of effective communications means that this could be perceived as a cut or reduction in access to care.
- Lack of effective transition planning resulting in interruptions in accessing specialist care for patients.

Interdependencies

- Overarching policy in relation to out-of-country care.
- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.

Reposition Altru Clinics Delivery Relationship for SE Manitoba

Subtheme: Reviewing Inter-Jurisdictional Coverage	Benefit Year: 2017/18	Est. Cost Improvement: $0.5M
Implementation Duration: 12 Months	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Receive Government policy approval.
- Confirm agreement can be amended in the short term.
- Consultation with internal Department stakeholders and WRHA and Southern RHA.
- Development of Communication Strategy re notification of Manitoba residents, Roseau and Warroad Clinics.

Outputs:

- Issue guidance to RHAs.

Q2

Key activities:

- Development of rehoming strategy and transition planning and processes.
- Amendment of internal processes for additional scrutiny in the adjudication of out-of-country claims from Altru clinics.

Outputs:

- Rehoming and Transition Plan in place.
- Additional scrutiny processes in place.
- Develop any required mitigating actions if required.

Q3

Key activities:

- Monitor impact of policy change in terms of reduced out-of-country claims for the Altru Clinics.

Outputs:

- Develop any required mitigating actions if required.

Q4

Key activities:

- Evaluation of reduced out-of-country claims at the Altru clinics and rehoming strategy.

Outputs:

- Any required revised guidance for RHAs for 2018/19.

Introduce Co-Payment for Ostomy Consumables

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $0.5M
Implementation Duration: 12 Months	Implementation Effort: Low	

Description	Implementing an ostomy consumable co-payment in line with other provinces . Clients who are eligible to receive ostomy supplies currently receive: • Improved products as best practices become known and the RHA is able to provide these products; • Delivery and transportation of supplies as required; • Assistance with the use of supplies if necessary and; • Replacement of supplies damaged during normal operation.
Benefit	Implementing a co-payment plan will reduce supply costs across the Province.
In-scope/Out of Scope	**In-scope**: Only applies to consumables defined under the Home Ostomy Program policy.
Key Assumptions	• That there is a reasonable benefit to obtained. • Alignment with other jurisdictions.
Governance	MHSAL, ADM, Regional Policy and Programs.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Key message is that the number of clients with an ostomy has non increased significantly and Manitoba is the only province in Canada which provides fully funded support of ostomy consumable products for all clients regardless of their ability to pay and at any stage of intervention (i.e. temporary or permanent. Variations of co-payment programs exist across Canada. All provinces provide some level of provincially funded assistance and identify specific eligibility criteria.

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 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.

Introduce Co-Payment for Ostomy Consumables

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $0.5M
Implementation Duration: 12 Months	Implementation Effort: Low	

2018/19

Q1

Key activities:

- Receive Government approval to implement.
- Receive approval of amended policy.
- Development of a Business Case including jurisdictional analysis.
- Cost/Benefit analysis.

Outputs:

- Approval to implement.
- Business Case to support co-payment model.
- Cost/benefit analysis.

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 including inventory distribution and payment method.

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 from the co-payment 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 c-payment on revenue, patient access 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.

KPMG

Appendix 1: Insured Benefits Opportunities Not Yet Costed

Consider Advanced Benefit Programs for Health and Wellness Including Precision Drug Management

Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

Description	Consider options for establishing advanced benefit programs for health and wellness province-wide. This includes looking at incorporating information sources such as Fitbit information and genomics. Also, consider precision drug management, given the current pilot program in Manitoba for disease treatment and prevention that takes into account individual variability in genes, environment, and lifestyle for each person.
Benefit	Provision of advanced benefits to patients that are particularly susceptible to certain health complications before it becomes an issue. The benefit would also incentivize self-care and personal responsibility for preventative action. This helps reduce healthcare costs and demand down the line.
In-scope/Out of Scope	**In-scope**: Individuals willing to have their genome mapped in Manitoba.
Key Assumptions	Patients in-scope of this service need to have access at scale to genomics services.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Provincial Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Strong communication strategy for implementation focused on the benefits of this opportunity.

Risks

- Difficulties in being to accurately cost the benefit.
- Privacy issues in relation to genomic data.
- Maturity of precision drug management in Manitoba and ability to provide access at scale.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.
- Policies in relation to genomics.

Consider Advanced Benefit Programs for Health and Wellness Including Precision Drug Management

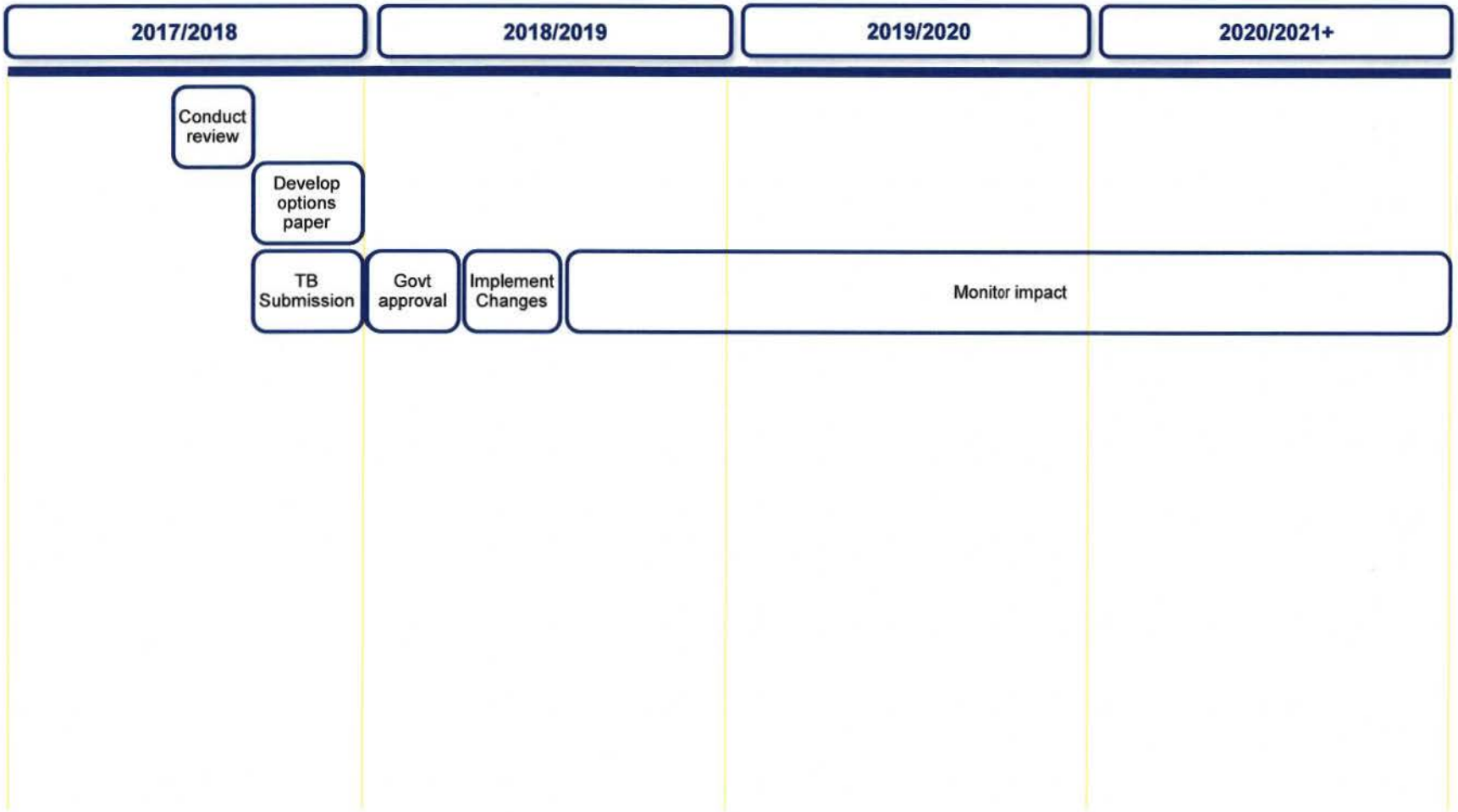
Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • N/A Q1.	**Key activities:** • N/A Q2.	**Key activities:** • Conduct review including jurisdictional scan of leading practices.	**Key activities:** • Options analysis. • Recommendation for potential 2018/19 Treasury Board Submission.
Outputs: • N/A Q1.	**Outputs:** • N/A Q2.	**Outputs:** • Identification of high level options for further consideration.	**Outputs:** • Option paper with recommended option. • Potential inclusion in 2018/19 Treasury Board Submission.

Consider Advanced Benefit Programs for Health and Wellness Including Precision Drug Management

Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	



Implement Program to Pay Families to Look After Patients in Special Care Scenarios

Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

Description	Explore options to implement a funding program for families to look after patients in recovery/rehabilitation/long term care scenarios to support care at home.
Benefit	This would allow for patients to stay out of hospital / long term care when it is not medically required with potential reductions in acute length of stay; in particular ALC and reductions in PHC admissions from hospitals. This also has significant benefits for patients to remain in a familiar, friendly environment for longer. Funding up front will have more significant cost savings than staying in-hospital. Multiple other jurisdictions (UK, Australia) provide a mix of supports to care givers both in the short-term and longer term.
In-scope/Out of Scope	**In-scope:** • Patients in recovery/rehabilitation/ requiring long term care at home. • Targeted short-term support. **Out of Scope**: Patients requiring long term care
Key Assumptions	That a funding would reduce/delay admissions to PCHs and potentially unplanned acute admissions. Decisions would be required in relation to applying an income limit or not.
Governance	MHSAL, ADM of Regional Policy and Programs.
Project Management	Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Strong communication strategy for implementation focused on the benefits of this opportunity.

Risks

- Having access to sufficient data to enable sufficient targeting.
- Public perception in relation to introducing a new benefit when others are being restricted or eliminated.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.
- Current policies in relation to commissioning of homecare services.
- SFMC Program.

Implement Program to Pay Families to Look After Patients in Special Care Scenarios

Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

2017/18

Q1

Key activities:

- N/A Q1.

Outputs:

- N/A Q1.

Q2

Key activities:

- N/A Q2.

Outputs:

- N/A Q2.

Q3

Key activities:

- Conduct review including jurisdictional scan of leading practices both within Canada and internationally.
- Current state assessment of current supports to families.

Outputs:

- Review outputs of the jurisdictional scan and current state assessment and develop high-level policy options.

Q4

Key activities:

- Options analysis including cost/benefit analysis for each option.
- Recommended option.

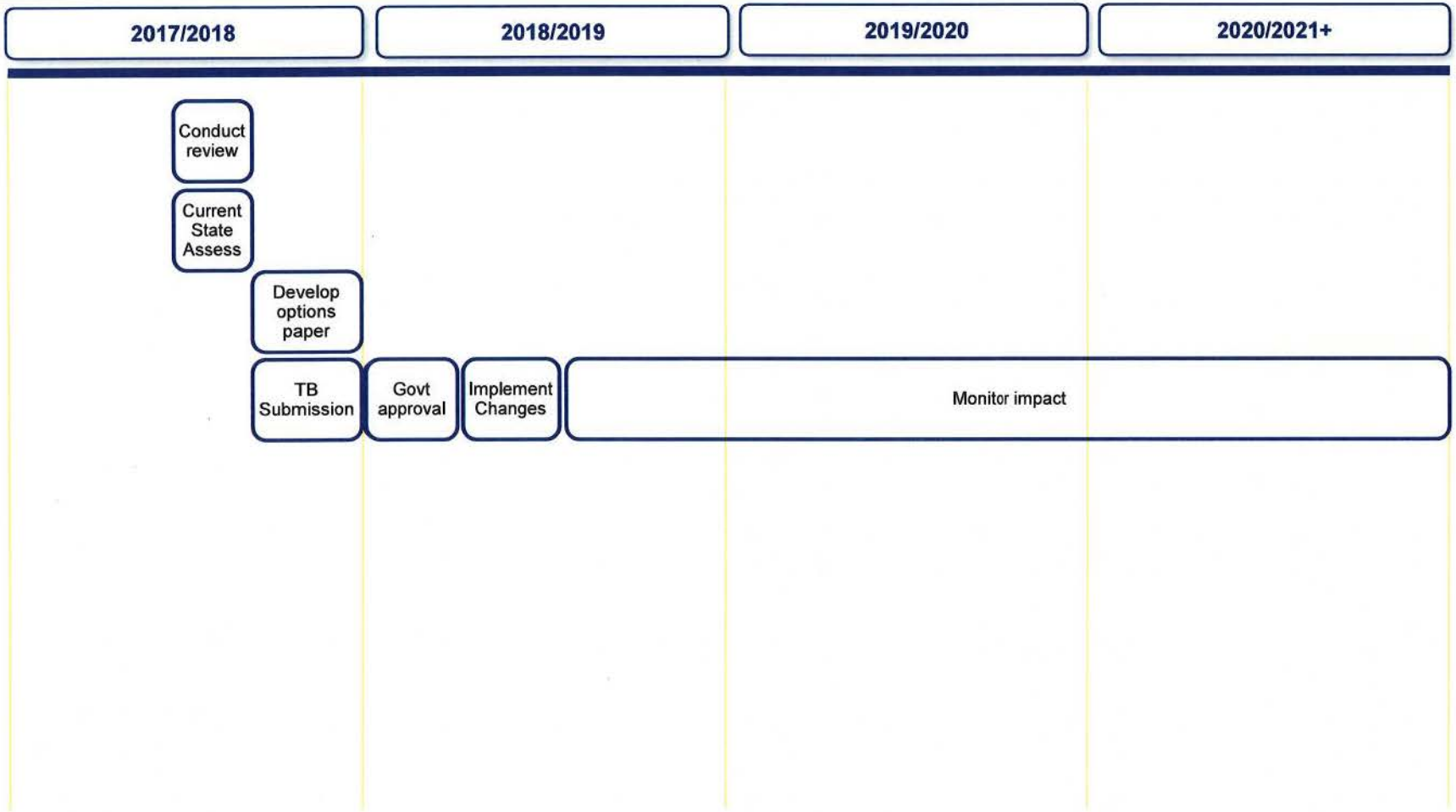
Outputs:

- Option paper with cost/benefit analysis.
- Potential inclusion of recommended option in 2018/19 Treasury Board Submission.

Implement Program to Pay Families to Look After Patients in Special Care Scenarios

Subtheme: Incentivizing Sustainability | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: TBD**

Implementation Duration: 18 Months | **Implementation Effort: Low**



Increase Respite Support for Primary Care Givers

Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

Description	Increase respite care support to provide better targeted support to informal care givers and maintain the primary care giving relationship. Respite support is typically capped at a set number of weeks in other jurisdictions.
Benefit	Increases short-term and time-limited breaks for families and other unpaid care givers of children with a developmental delay and adults with an intellectual disability and older adults in order to support and maintain the primary care giving relationship. The hard financial benefit would be a potential reduction in PHC admission rates over time.
In-scope/Out of Scope	**In-scope**: Primary care givers for adults/seniors and children requiring respite care.
Key Assumptions	That care givers would benefit from respite care and would be enabled to continue caring at home for longer.
Governance	ADM Regional Policy and Programs.
Project Management	Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Strong communication strategy for implementation focused on the benefits of this opportunity.

Risks

- Having access to sufficient data to enable sufficient targeting.
- Agreeing extent of the respite offer and is neither overly generous or insufficient to enable care givers to continue to provide care at home.
- Public perception in relation to introducing a new benefit when others are being restricted or eliminated.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.
- Current policies in relation to commissioning of homecare services and PCHs.

Increase Respite Support for Primary Care Givers

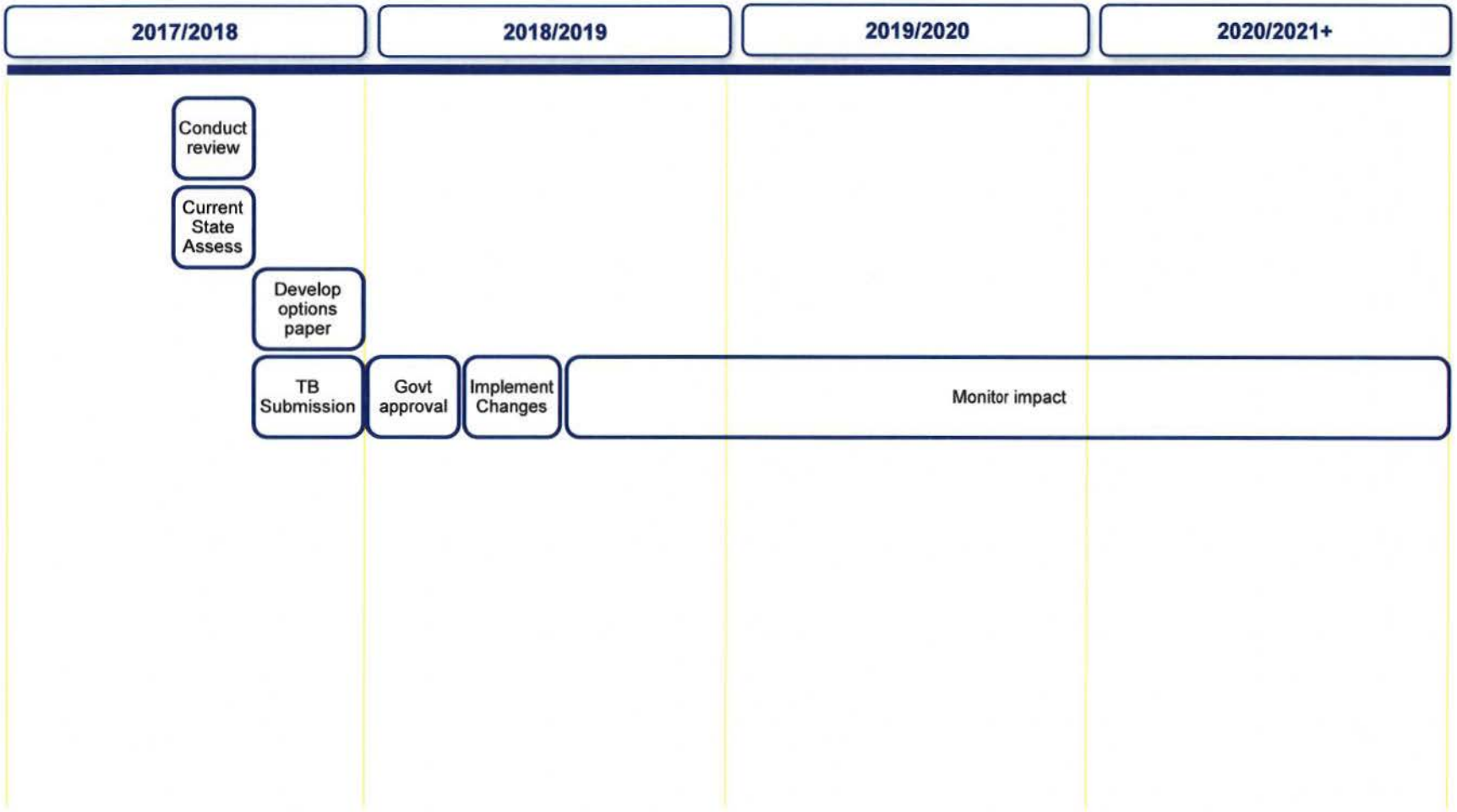
Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • N/A Q1.	**Key activities:** • N/A Q2.	**Key activities:** • Conduct review including jurisdictional scan of leading practices including both within Canada and internationally. • Current state assessment of supports to care givers.	**Key activities:** • Options analysis including cost/benefit analysis. • Recommended option.
Outputs: • N/A Q1.	**Outputs:** • N/A Q2.	**Outputs:** • Review outputs of jurisdictional scan and current state assessment and develop high-level policy options.	**Outputs:** • Option paper including cost/benefit analysis. • Potential inclusion of recommended option in 2018/19 Treasury Board submission.

Increase Respite Support for Primary Care Givers

Subtheme: Incentivizing Sustainability	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	



Incentivize the Provision of Self-Care Devices

Subtheme: Incentivizing Sustainability	Benefit Year: Beyond 2018/19	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

Description	Explore the development of a benefit that incentivizes the provision of self-care tools and devices including the potential 'social prescribing' of mobile applications to reduce reliance on system-wide healthcare providers.
Benefit	Reduces costs potentially through avoidable reductions in primary care and potentially ED visits for very minor conditions and reliance on healthcare providers and shift ownership to public citizens for the administration of self-care.
In-scope/Out of Scope	**In-scope**: • Diabetic patients. • Patients with other long term conditions or at risk through lifestyle choice through developing a long term condition • TBD.
Key Assumptions	That there is a sufficient evidence base both within Canada and internationally to support tangible cost improvements through reductions in avoidable access to healthcare services.
Governance	MHSAL, ADM, Provincial Policy and Programs.
Project Management	Provincial Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Strong communication strategy for implementation focused on the benefits of this opportunity.

Risks

- Sufficient and convincing evidence base to enable the development of a robust business case.
- May be viewed by sections of the public as substituting for 'cuts' elsewhere in the healthcare system.

Interdependencies

- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.
- Prescribing policy and rules applying to primary care physicians.

Incentivize the Provision of Self-Care Devices

Subtheme: Incentivizing Sustainability	Benefit Year: Beyond 2018/19	Est. Cost Improvement: TBD
Implementation Duration: 18 Months	Implementation Effort: Low	

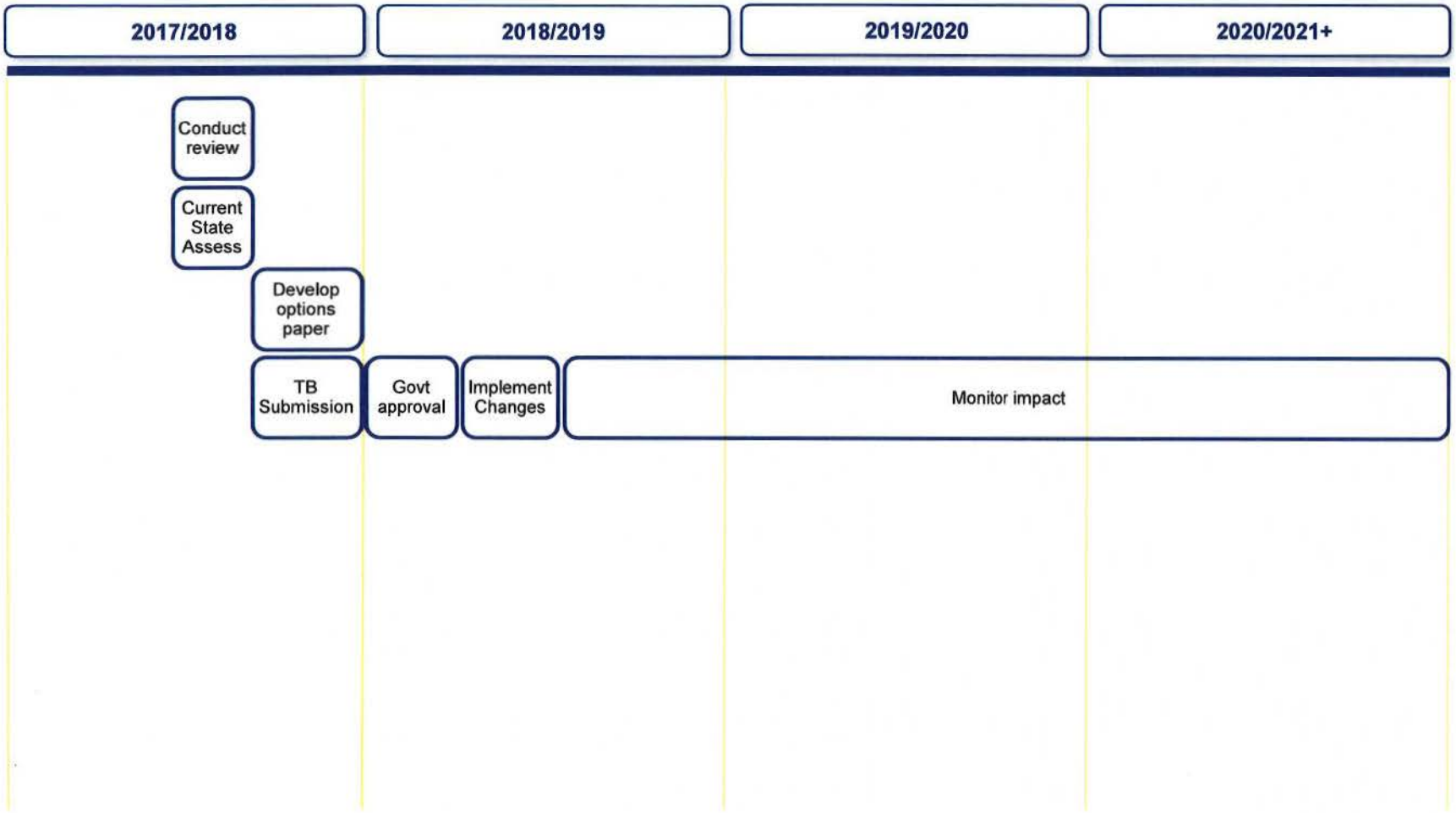
2017/18

Q1	Q2	Q3	Q4
Key activities: • N/A Q1.	**Key activities:** • N/A Q2.	**Key activities:** • Conduct review including jurisdictional scan of leading practices including both within Canada and internationally. • Current state assessment of current policy and supports.	**Key activities:** • Options analysis including cost/benefit analysis. • Recommended option.
Outputs: • N/A Q1.	**Outputs:** • N/A Q2.	**Outputs:** • Review outputs of jurisdictional scan and current state assessment and develop high-level policy options.	**Outputs:** • Option paper including cost/benefit analysis. • Potential inclusion of recommended option in 2018/19 Treasury Board submission.

Incentivize the Provision of Self-Care Devices

Subtheme: Incentivizing Sustainability | **Benefit Year: Beyond 2018/19** | **Est. Cost Improvement: TBD**

Implementation Duration: 18 Months | **Implementation Effort: Low**



Modify Processes to Manage the Supply of Community Equipment for Patients

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

Description	Identifying optimal processes for tracking/reclaiming equipment (such as walking aids) and devices issued to patients. The opportunity also involves assessing options for charging/co-payments for equipment and devices. Options for analysis are tracking system (barcode), retain model (issue voucher), financial deposit.
Benefit	Reduction in costs through the introduction of charging/co-payments for equipment and devices. Reduction in costs of equipment through being able to re-cycle reclaimed equipment.
In-scope/Out of Scope	**Out of scope**: Consumables / Disposables.
Key Assumptions	• That there is robust data/evidence that significant quantities of equipment and devices not reclaimed validating anecdotal evidence. • This only applies to equipment that can be reused. • Explore other jurisdictions that have in some cases have moved to a private sector model.
Governance	MHSAL, ADM, Regional Policy and Programs.
Project Management	Under Regional Policy and Programs, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	Key message is that it would align Manitoba with other provincial coverage in relation to reclaiming equipment and co-payments.

Risks

- Potential public and patient complaints in relation to co-payment
- Potential complexity in implementing a tracking system.
- 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.

Interdependencies

- Co-payment models applying to other benefits.
- Provincial Clinical and Preventative Services Plan.
- Core Clinical and Healthcare Services Work Plan.

Modify Processes to Manage the Supply of Community Equipment for Patients

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

2017/18

Q1

Key activities:

- Analysis of volume of equipment that could be reclaimed and charging models.
- Jurisdictional analysis.
- Option development
  - Tracking system (barcode)
  - Retain model (issue voucher)
  - Financial deposit
- Development of a Business Case.
- Undertake cost/benefit analysis.

Outputs:

- Business Case on reclaiming/tracking/charging.
- Cost/benefit analysis.

Q2

Key activities:

- Receive Government approval to implement.
- Receive approval of new policy and processes.
- Disseminate communication memorandums to stakeholders disclosing amended policy and effective implementation date.

Outputs:

- Issue guidance to RHAs.
- Issue internal and external communications on impact and implementation.

Q3

Key activities:

- Commence necessary technical and information system changes to implement the policy.
- Monitor impact of policy change in terms of changes in income and reclaimed equipment.

Outputs:

- Technical and information system changes made to support implementation.
- Develop any required mitigating actions if required.

Q4

Key activities:

- Evaluation of impact of policy change on access, numbers of recipients, cost/benefits.
- Agree any other policy adjustments or changes required for 2018/19.

Outputs:

- Assessment of impact of policy change against desired outcomes and benefits.
- Any required revised guidance for RHAs for 2018/19.

Increase Foot Care/Provide Free Foot Care to Designated Populations

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 2 years	Implementation Effort: Low	

Description	The objective of this opportunity is to identify the potential benefits of reducing avoidable access to acute care or premature admissions to Personal Care Homes (PCHs) by increasing access to foot or and/or providing free foot care to designated populations such as: • Patients living with diabetes due to the prevalence and complexity of foot ulcers. • Older people in relation to preventing avoidable fall resulting in acute admissions and admissions to PCH's.
Benefit	Reduction in avoidable ED attendances and acute admissions. Reductions in admissions to PCHs.
In-scope/Out of Scope	**Out of Scope:** Foot care not targeted at designated populations.
Key Assumptions	That, as suggested by Canadian and international research in other jurisdictions, that the benefits outlined above can be achieved in Manitoba. That there is appetite to fund 'invest to save initiatives' that have a strong evidence base and will contribute to the sustainability of the Manitoba healthcare system.
Governance	MHSAL, ADM, Regional Policy and Programs.
Project Management	Under Primary Health Care, assume 0.2 FTE in MHSAL to progress.
Communication Strategy	The communications strategy would stress that the government is now taking a proactive evidence-based, outcome based commissioning approach and is targeting resources on improving health outcomes for Manitobans.

Risks	Interdependencies
• Challenges in ability to directly co-relate the implementation of the policy to reductions in acute care and Personal Care Home admissions. • Ability to defend the policy in the context of other benefits being eliminate or facing deductibles/co-payments/charging.	• Benefits coverage for other programs. • Provincial Clinical and Preventative Services Plan. • Core Clinical and Healthcare Services Work Plan.

Increase Foot Care/Provide Free Foot Care to Designated Populations

Subtheme: Alignment with Canadian Standards	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 2 years	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Undertake a jurisdictional analysis.
- Develop business case and cost/benefit analysis.
- Identify any legislative changes required.
- Agree and announce policy change(s).

Outputs:

- Jurisdictional analysis.
- Business case and cost/benefit analysis.
- Confirmed legislative requirements.

Q2

Key activities:

- Prepare for this change internally, including development of a full implementation plan and a communication plan (to be developed in consultation with Communication Services Manitoba).

Outputs:

- Implementation and Communications Plan.

Q3

Key activities:

- Announce the change management and implement the plan.
- Commence necessary technical and information system changes to implement amended policy.

Outputs:

- Change Management Plan.
- Technical and Information system changes.

Q4

Key activities:

- Amendment of internal processes to support implementation.

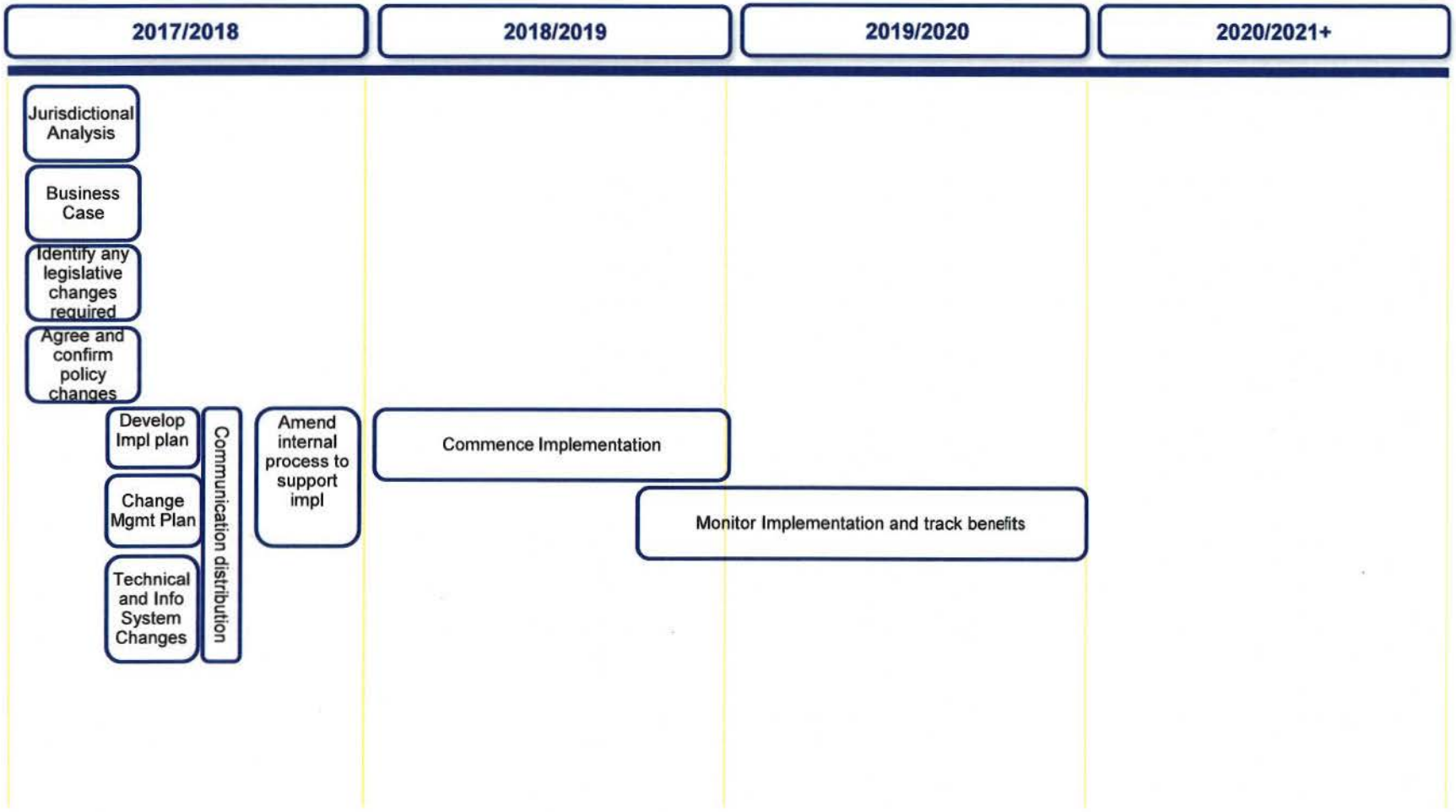
Outputs:

- Implementation ready to 'go live'.

Increase Foot Care/Provide Free Foot Care to Designated Populations

Subtheme: Alignment with Canadian Standards | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: TBD**

Implementation Duration: 2 years | **Implementation Effort: Low**



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Work Plan 3: Core Clinical and Healthcare Services

Notice

This Core Clinical and Healthcare Services Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

Core Clinical & Healthcare Services- Work Plan Summary

Core Clinical and Healthcare Services	
Project Summary	• The Core Clinical and Healthcare Services workstream includes reducing unit costs/rates; reducing variability of care/reduce length of stay; shifting care from acute to community settings; rationalizing and standardizing programs and services; and rationalizing staffing, scope of practice, and scheduling.
Objective & Scope	• Reconfigure healthcare delivery models to improve effectiveness of core service delivery and improve patient outcomes. • Shift the model of care away from acute care centered facilities to community and population-based care.
Interdependencies	• The Provincial Clinical and Preventive Services Planning for Manitoba report is recognized as a key dependency to transforming core clinical and healthcare services. It is anticipated that a provincial service plan will have a significant impact on drug wastage, capital costs, infrastructure to meet quality and safety standards (e.g. MDRD, systemic chemotherapy) following the recent completion of the Provincial Clinical and Preventive Services Planning report. • 2017/18 MSHAL Treasury Board Submission. • Wait Times Task Force. • Collective agreement rationalization; notice of change.

Summary of Opportunities

This table provides a summary of the total approximated cost savings for the Core Clinical and Healthcare Services Work Plan broken down by benefit year and sub category.

Sub Category	2017/18 Potential Cost Savings	2018/19 and Beyond Potential Cost Savings	Total
Shift care from acute to sub-acute/transitional and community settings	-	$67M	$67M
Rationalize staffing, scope of practice, and scheduling	$0.2M	$62M	$62M
Rationalize and standardize programs and services	$5.7M	-	$5.7M
Reduce unit costs/rates	-	$4.5M	$4.5M
Healthcare transportation	$3M	-	$3M
TOTAL	**$8.9M**	**$133.5M**	**$151M**

The following table provides an overview of each opportunity included in the Core Clinical and Healthcare Services Work Plan.

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Shift care from acute to sub-acute/ transitional and community settings	Reinvest in primary, community, and sub-acute care to reduce acute care utilization.	$67M	2018/19 and beyond	RHA-led	• Provincial Clinical and Preventive Services Plan. • RHA 2017/18 Plans to achieve Financial Balance. • Rationalizing Programs and Services workstream. • Home First Strategy. • Departmental policy alignment • Policy to align remuneration with strategic outcomes.	• System capacity. • Lack of investment in sub-acute care.
Rationalize staffing, scope of practice, and scheduling	Rationalize and reduce variation in staffing models.	$0.2M $62M	2017/18 2018/19 and beyond	MHSAL-led	• Health Workforce workstream • Bargaining unit restructuring. • Regulated Health Professions Act implementation. • Provincial Clinical and Preventive Services Plan. • WRHA Consolidation. • Collective agreement rationalization. • Matrix restructuring.	• Public, union, and regulatory college perception of reduced nurse-patient ratios. • Union action related to collective agreement rationalization.

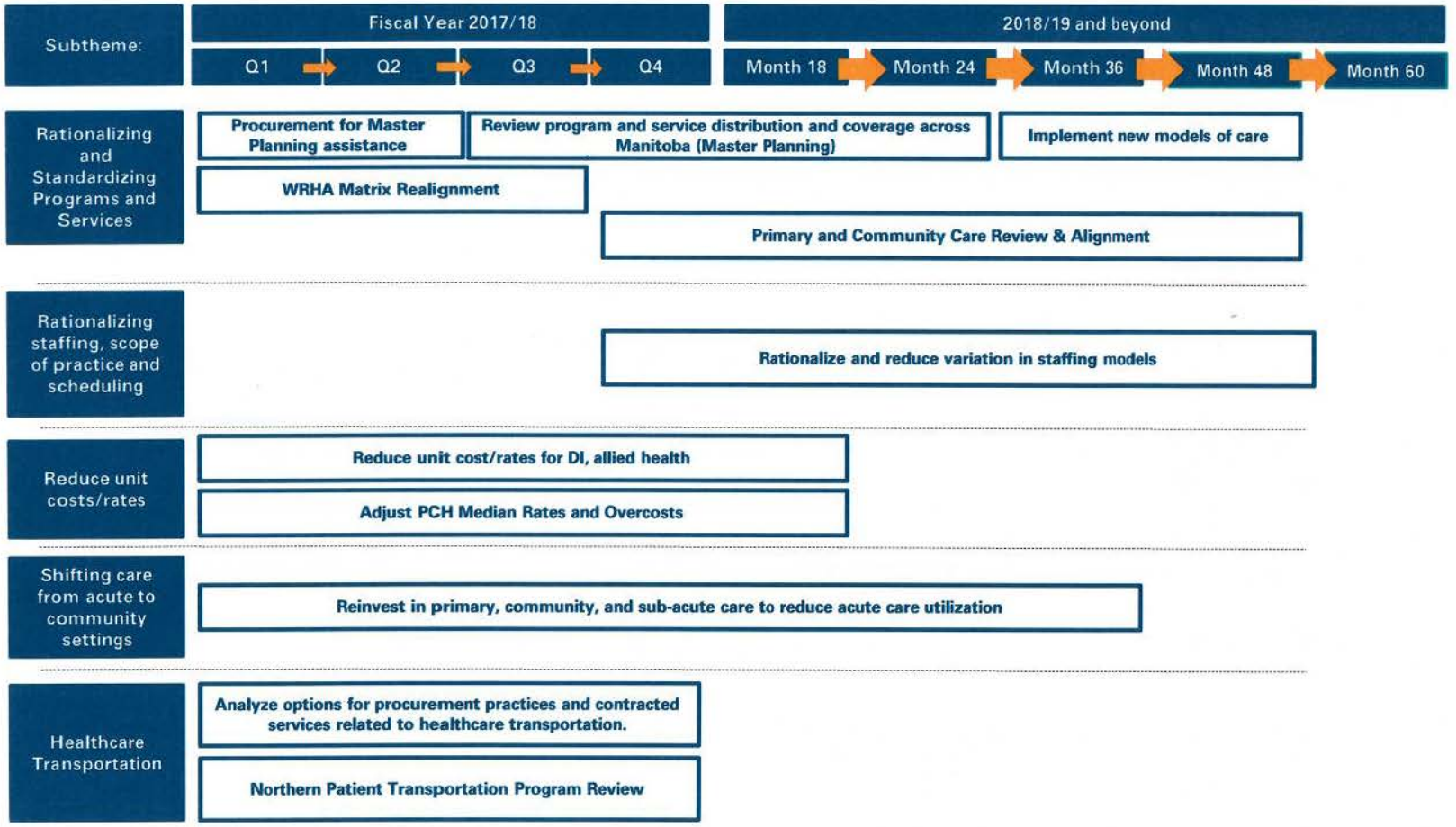
Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Rationalize and Standardize Programs and Services	Review program and service distribution and coverage across Manitoba (Master Planning).	*Enabler*	2018/19 and beyond	MHSAL-led	• Provincial Clinical and Preventive Services Plan. • RHA 2017/18 Plans to achieve Financial Balance. • Wait Times Taskforce. • Strategic System Realignment Work Plan.	• Number of concurrent initiatives / competing priorities within the department may inhibit capability and capacity to implement. • Interdependencies with Clinical Services Planning. • Public perception of changes related clinical service distribution.
	WRHA matrix realignment and consolidation (including review of bed map).	$5.7M	2017/18	WRHA-led	• Provincial Clinical and Preventive Services Plan. • RHA 2017/18 Plans to achieve Financial Balance. • Master Planning.	• Change management.
Reduce unit costs/rates	Reduce unit costs and rates for allied health, therapeutic services, laboratory procedures, and diagnostic imaging (provincial in-scope).	$3M	2018/19 and beyond	RHA-led	• Provincial Clinical and Preventive Services Plan. • Availability of ambulatory care. • Insured Benefits Work Plan. • System capacity for reablement/restorative care. • Public awareness.	• Engagement/change management with clinicians across multiple sites.
	Reduce PCH median rates and overcosts (WRHA).	$1.5M	2018/19 and beyond	WRHA-led	• Paneling process (home vs hospital).	• Capacity and capability of PCHs to execute cost optimization programs.

Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Healthcare transportation	Analyze options for procurement practices and contracted services related to healthcare transportation.	$1.5M	2017/18	MHSAL-led	• Air ambulance RFP. • Insured benefits workstream • Engagement with federal government.	• Completion of the procurement process by end of 2017/18.
	Implement centralized billing for ambulance/EMS.	$0.6M	2017/18	MHSAL-led	• Air ambulance RFP • Validity of NPTP review recommendations	
	Confirm Recommendations for Northern Patient Transportation Program are still valid.	$1.2M	2017/18	MHSAL-led	• Air ambulance RFP. • MHSAL Treasury Board Submission. • Provincial Clinical and Preventive Services Plan. • Provincial Emergency Consultation Service (PECS). • Federal relationship to find opportunities for savings • Communications to patients.	

Work Plan - High-Level Roadmap



Technical and Allocative Opportunities from Benchmarking Analysis

Health Sector	Technical Efficiency Opportunities	Allocative Efficiency Opportunities
Hospitals	**Emergency Department:** There are significant opportunities to reduce nursing labour hours per visit	**Emergency Department:** There are significant opportunities to reduce ED use in only one RHA. In the other RHA's ED use was low relative to comparator regions.
	Inpatient Units: There are significant opportunities to reduce nursing hour per day by optimizing nurse to patient ratio and reducing the number of beds in low occupancy units There are significant opportunities to reduce supplies cost per day (addressed in the Integrated Shared Services Work Plan)	**Acute Inpatient Admissions:** There are significant opportunities to reduce acute inpatient admissions in two RHAs by increasing the emphasis on hospital ambulatory and community based care.
	Operating Room and Day surgery: There are significant opportunities to reduce nursing labour hours per surgery There are significant opportunities to reduce supplies cost per surgery (addressed in the Integrated Shared Services Work Plan)	**Use of Day Surgery:** Manitoba hospitals typically make good use of day surgery to avoid inpatient admissions. Modest opportunities to improve the substitution of day for inpatient surgery were found for a few hospitals only.
	Diagnostic and Therapeutic Services: There are significant opportunities to reduce the use and cost of diagnostic and therapeutic services	**Inpatient Lengths of Stay:** Significant opportunities were found to reduce lengths of stay at all Manitoba hospitals. On average, Manitoba lengths of stay were 30 percent longer than at the comparator Ontario hospitals.
	All: There are significant opportunities to reduce staff overtime hours	
Personal Care Homes		**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.
Home Care		**Program Spending:** At the Ontario per capita spending rate, Manitoba would have spent significantly less one 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.
Physicians	Interprovincial comparisons imply that Manitoba has few significant efficiency opportunities in physician costs relative to other provinces.	
Drugs	Interprovincial comparisons imply that Manitoba has few significant efficiency opportunities in drug costs relative to other provinces.	

Implementation Plan: Methodology

The Implementation Plans for the Core Clinical and Healthcare Services Work Plan are based on leading practice in care system redesign.

Maximize Efficiency and Effectiveness

- Implementation of initiatives related to technical efficiency savings.
- Ensuring value for investment across the continuum, including primary care, private providers, non-contract activity.

Healthcare Workforce

Options Analysis and Business Cases

- Strategic options development (i.e. closure of capacity, shift settings of care, reduce demand, remove duplication, major pathway redesign).
- Evaluation, stakeholder engagement and additional modeling of options (i.e. clinical safety/viability, size of impact, achievability and affordability).
- Development of business cases.
- Legislative review (as required).

Contain Demand and Shift Care

- Implementation of options to shift care to lower-acuity settings.
- Reduction or reallocation in services of limited value.

"Right Size" Provision

- Reconfiguration of services across providers.
- Rationalization of physical capacity to optimize service configuration, reduce fixed costs, and shift demand.

Infrastructure Rationalization

Clinical Change Management Considerations

During a health system transformation, effective clinical engagement is a key component to success and effective change management should be employed across the initiatives highlighted in this work plan. The approach must be evidence based and grounded in robust data analysis. The key steps below show the key process to engaging clinicians in leading and owning sustainable change.

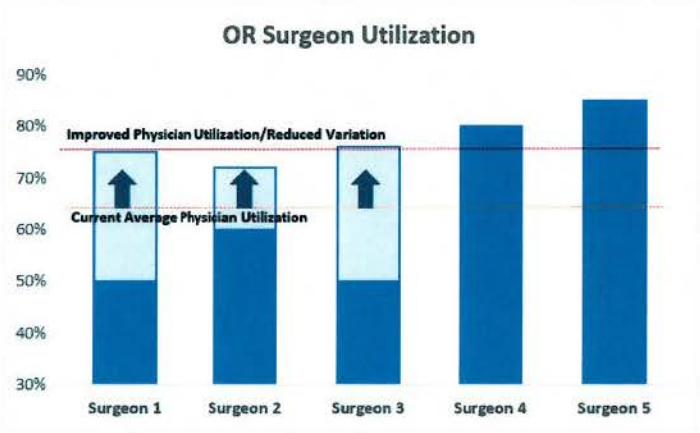
A Change Management Approach and Plan has been provided as part of the Phase 2 Report, which provides additional information and templates.

Evidence → **Moving from Engagement to Ownership** → **Creating Clinical Champions**

Driven by data analysis and an evidence based approach

Clinical accountability is key, which is ensured through appropriate engagement

Clinical Champions are the accountable owners and leaders of the change initiatives being implemented



Review Program and Service Distribution and Coverage Across Manitoba

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: Enabler
Implementation Duration: Immediate – 5 years	Implementation Effort: Medium	

Description	Rationalizing and standardizing programs and services includes maximizing efficiency and effectiveness in clinical organizational structures, aligning models of care, and consolidating programs/services to achieve greater value and patient access.
Benefit	• Improved integration of healthcare services across the continuum. • Improved patient flow. • 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**: Master Planning - Program reviews and planning; surgery distribution, ED (urgent care pathway) and critical care consolidation, capacity planning; review of specialist coverage in rural/remote areas. **Out of scope**: Integration of nursing and allied health. Home care should not be combined with long term care; works with community care. Repurpose around specialist dementia.
Key Assumptions	• Alignment with RHA plans.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks

- Number of concurrent initiatives / competing priorities within the department may inhibit capability and capacity to implement.
- Interdependencies with Clinical Services Planning.
- Public perception of changes related clinical service distribution.

Interdependencies

- Provincial Clinical and Preventive Services Plan.
- RHA 2017/18 Plans to achieve Financial Balance.
- Wait Times Taskforce.
- Strategic System Realignment Work Plan.

Review Program and Service Distribution and Coverage Across Manitoba

The benchmarking analysis undertaken in Phase 1 of HSIR found no evidence for economy of scale cost improvement in relation to Emergency Room (ER/ED) and Operating Room (OR) unit costs.

The benchmarking analysis undertaken in Phase 1 found significant cost improvement opportunities from reducing costs of these services as currently organized, such as ED and OR staffing costs (in particular, there are significant opportunities to reduce nursing labour hours per ED visit and per surgery). The benchmarking analysis also found the potential for cost improvement by reducing use of EDs.

Given these findings and the potential for disruptions from consolidations, the case to support consolidation is weak from a 1-3 year cost improvement perspective.

Opportunities in relation to achieving fixed cost reduction and developing an optimal configuration of acute services in alignment with leading clinical practice should be considered in the context of master services planning and to rationalizing acute care infrastructure.

	Potential Savings from Reducing Volumes	Potential Unit Cost Savings	Savings from Economies of Scale	Potential Service Disruption
Emergency Room	$5M	$24M	Low	High
Operating Room		$27M	Low	High
Diagnostic Imaging	$19M	$17M	Low	High

Review Program and Service Distribution and Coverage Across Manitoba

Consolidating Emergency Departments in Winnipeg Regional Health Authority

As shown in the table below, 46% of Emergency Department (ED) attendances in 2015/16 in the Winnipeg Regional Health Authority (WRHA) were CTAS 4s and 5s (less urgent and non-urgent).

There is a case for consolidation of EDs in the WRHA from a clinical quality perspective in terms of recommendations from Colleges on minimum volume thresholds (80,000+), clinical workforce planning and removal of fixed costs. However, given the fact of high numbers of CTAS 4 and 5 attendees at EDs and the high risk of shifting demand to other EDs, consolidation should be considered only in the context of medium to longer-term sustainability through undertaking a strategic, whole system reconfiguration of services including primary and community care services. This would need to be underpinned by the further development of the provincial clinical services plan and master services planning which is the recommended focus for 2017/18.

Hospital	CTAS 1 & 2	CTAS 3	CTAS 4 & 5	Total
Brandon Regional Health Centre	14%	32%	53%	27,037
Grace Hospital	19%	38%	43%	27,237
HSC Children's	9%	33%	56%	51,909
HSC General	16%	39%	44%	58,615
Selkirk & District Gen Hosp	9%	24%	67%	25,710
Seven Oaks General Hospital	14%	43%	42%	41,311
St Boniface General Hospital	26%	42%	31%	40,156
Victoria General Hospital	19%	45%	37%	31,079
Total	16%	38%	46%	303,054

Review Program and Service Distribution and Coverage Across Manitoba

Consolidating Proximal Small Rural EDs

The benchmarking analysis undertaken in Phase 1 examined the potential to improve resource use by consolidating proximal small rural EDs. The main findings included:

1. There are two potential sources of savings from consolidating EDs: (a) economies of scale in costs per visit; (b) reduction in the fixed costs by consolidating departments.
2. The analysis of unit costs at Manitoba's small rural EDs found no strong evidence for economies of scale in unit costs. Put differently, cost per ED visit did not decrease with ED total visits among small Manitoba EDs.
3. The analysis found that fixed cost savings from consolidations are likely negligible compared to those associated with the potential to reduce unit costs.
4. The results of all of the ED analysis imply the following prioritization: 1) improve ED unit costs; 2) reduce ED visits in Southern RHA taking account of the wider configuration of services; 3) after the first two priorities have been achieved, consider consolidating proximal small rural EDs.

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

Review Program and Service Distribution and Coverage Across Manitoba

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: Enabler
Implementation Duration: Immediate – 5 years	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Confirm scope of provincial consolidation/acute care rationalization and assess feasibility of including in broader master planning. • Assess internal capacity to complete master planning and initiate procurement process.	**Key activities:** • Initiate primary and community care supports review (i.e. Access Centres; QuikCare).	**Key activities:** • Develop scope and business case for master planning (models of care aligned to capacity and service distribution review).	**Key activities:** • Complete business case and work plan for primary and community care support realignment. • Initiate master planning: guiding principles; data analysis; clinical working group establishment.
Outputs: • Confirmed scope and services impacted by provincial consolidation. • Confirmed scope of Master Planning.	**Outputs:** • Review Framework: Primary and Community care.	**Outputs:** • Business Case: Master Planning.	**Outputs:** • Business Case: Primary and community care realignment. • Master Planning Methodology and Approach (scoping).

Review Program and Service Distribution and Coverage Across Manitoba

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: Enabler
Implementation Duration: Immediate – 5 years	Implementation Effort: Medium	

2018/2019

Key activities:

- Review and assess options for capacity and service distribution across Manitoba including rural/remote (master planning) with working groups.
- Recommend configuration of care.
- Realign primary and community care programming.

Outputs:

- Primary and community care operating model.
- Master Planning implementation plan.

2019/2020

Key activities:

- Implement new care configurations to shift care from acute to community.

Outputs:

- Finalized Master Plan.
- Re-aligned healthcare system operating model.

2020/2021+

Key activities:

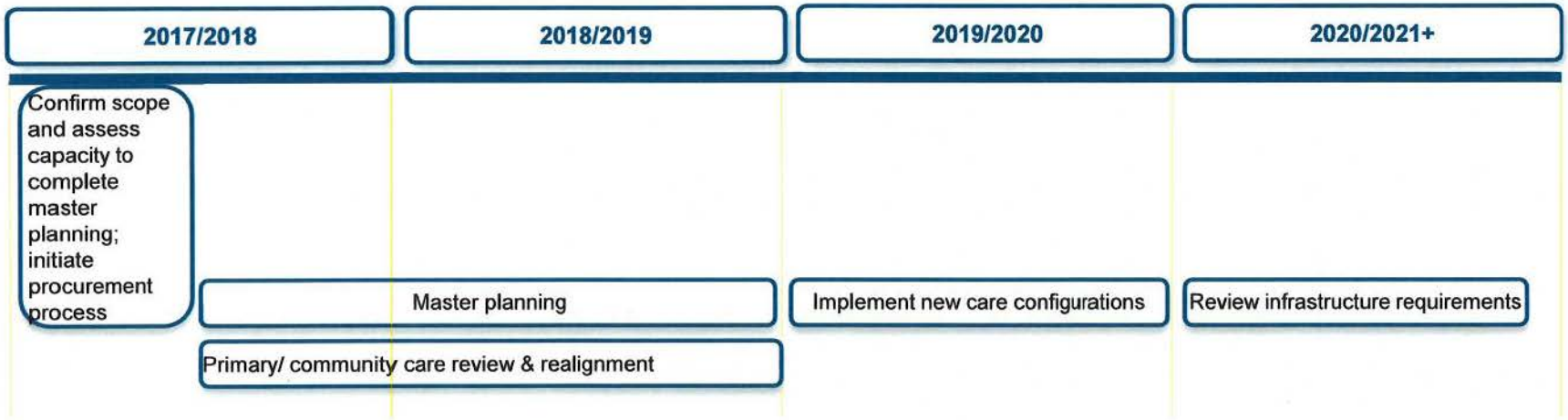
- Review infrastructure requirements (ongoing).

Outputs:

- Recommendations on aligning clinical service models to infrastructure requirements.

Review Program and Service Distribution and Coverage Across Manitoba

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: Enabler
Implementation Duration: Immediate – 5 years	Implementation Effort: Medium	



Master Planning & Care System Redesign

It is essential that Manitoba undertakes master planning to ensure consolidation and alignment to leading practice models of care and pathways.

Commissioning-based Approach

Provincial Clinical & Preventive Services Planning

Business Planning

Master Planning

High-Level Blueprint

- Population-based forecasting
- Development of Models of Care through stakeholder engagement
- Identification of population health & equity considerations
- Clinical governance models

Funding for Performance

- Emphasis on patient pathways, aligned with models of care ensuring a coordinated approach
- Aligned commissioner and provider priorities with shared savings introduced
- Longer term contracts to drive transformation and reduce costs
- A dual focus on quality and cost, leading to both improved patient outcomes and a reduction in system-wide costs

Activity and Capacity Modelling

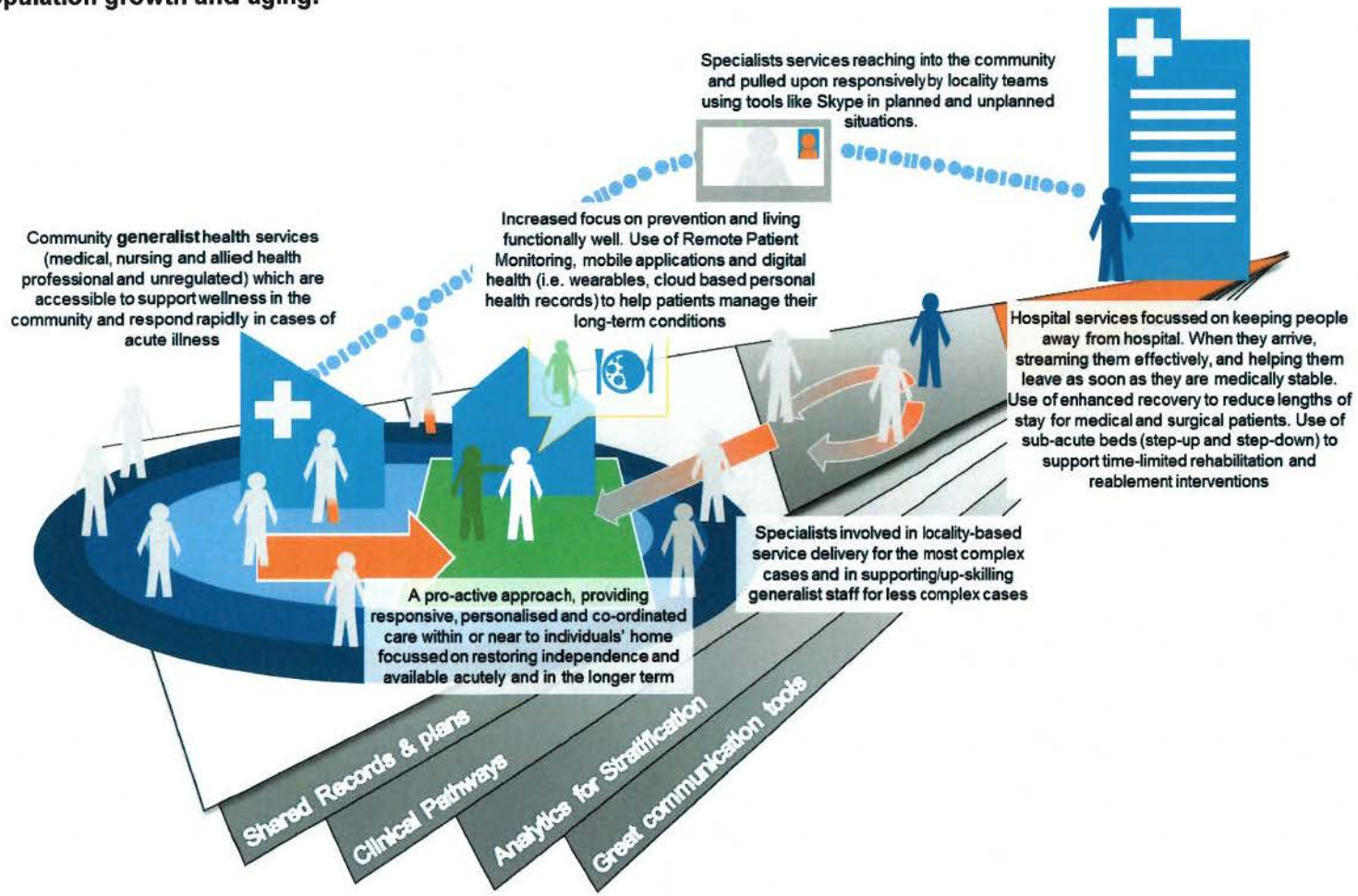
- Robust baseline and future forecasts prepared on a system-wide basis
- Priority pathways identified, providing a focal point to coordinate all stakeholders and an evidence base to facilitate change
- One version of the truth – assessment of system capacity, pathways, and providers
- Detailed support for operational level capacity planning

Care System Redesign

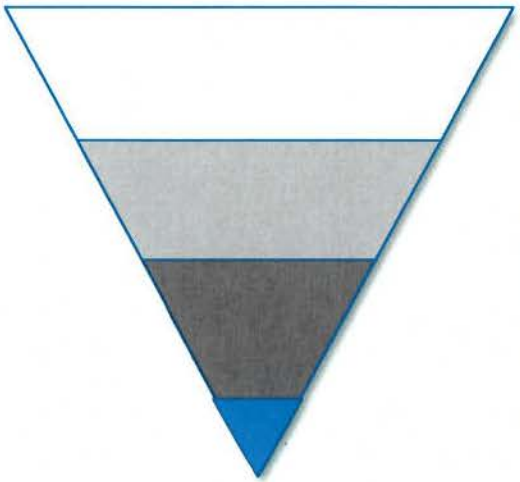
- Pace and momentum via a structured methodology to develop options with stakeholder buy-in and specialist independent challenge
- Future blueprint owned by system leaders and stakeholders
- Prioritized solutions agreed
- Impact quantified for all stakeholders on a system-wide basis

Elements of Effective Integrated Care

As part of the Phase 1 report, we benchmarked lengths of stay in Manitoba hospitals to Ontario peer hospitals, adjusting for differences in case mix using the CMG+ system which showed that lengths of stay in hospitals in Manitoba are typically significantly longer than the average of their Ontario peers. Improving lengths of stay to the average of Ontario peer hospitals through more effective bed management, integrating care and providing more care in community settings would reduce inpatient use by roughly 400 beds. 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 of roughly 8 years of population growth and aging.**



Two Patient Flows Combine for Effective Integrated Care

Unplanned	Stratification	Planned
Preventing patients getting to ED		Population health management & prevention
Turning patients around in ED		Patient self-management
Shortening the inpatient stay		Proactive disease management
Supporting Early Discharge		Interdisciplinary Case management

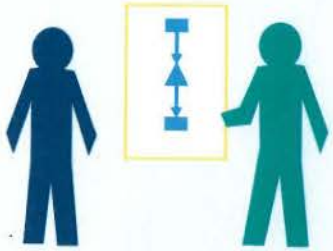
What would effective unplanned care involve?

Coordinated entry to services with effective triage

- A single telephone number (e.g., 111) to direct access to services acutely
- Walk in centres next door or at the front entrance to ED
- Primary Care Extended Hours, and the ambulance service considers itself part of the same system as ED (see and treat)
- Expanded in house primary care for acute patients (matching to demand)
- Crisis plans are accessible and activated if available
- Inter-disciplinary Rapid/Crisis Response Teams
- Direct admission to sub-acute beds

Preventing patients getting to ED

Ambulatory Care Pathways



- Pathways in place for the 49 Ambulatory Emergency Care (AEC) sensitive conditions
- Pathways written down/ formalised / followed (use is auditable)
- Patients can be redirected back to their primary care physician or referred directly to Rapid Response services
- Sub-acute step up beds are available for use (short term rehab)

Turning patients around in ED

Inreach services (management of patients rather than disease)

- Pro-active case-finding of patients for specialist input (e.g., Dementia)
- Presence of specialist teams e.g. Older Persons Assessment and Liaison Team, Rapid Assessment Interface and Discharge (mental health), Medication Use Review
- Ability to draw on specialist advice (as well as assessment)
- Provide education to staff (e.g., ward staff
- Enhanced Recovery for Medical and Surgical Patients
- Available within 24 hours of admission

Shortening the inpatient stay

Responsive stepped down care

- Service sub-specialised for Stroke and Frail Elderly and End of Life
- Assessment for need occurs before the patient is medically stable
- Able to pull patients into the community the same day as the patient is medically stable
- This fits with support in the community to prevent deterioration and rapid response.
- Sub-acute step down beds are available for use (short term rehab)

Supporting Early Discharge

What would effective planned care involve?

Carer support services

- Respite services are trusted
- Services are available locally
- Services are accessible
- Focussed on opportunities for social interaction rather than day centres
- Available on a scheduled and adhoc/emergency basis

Care planning
(including education, digital tools, support)

- Care plans are time limited and use agreed outcome measures to ensure progress is made
- Attendance is tracked to ensure patients receive messages
- Elements of the interventions are delivered via digital and online tools (e.g., depression)
- Good self management must include care planning for unexpected crises (eg. COPD)
- Patients can choose interventions which align with their care plan
- Use of Remote Patient Monitoring (RPM)

Access to specialists for advice and education

- Timely and appropriate response for advice (e.g., within 4 weeks)
- Available for all acute areas
- Senior physician-led
- Provides a treatment plan or access to hospital Medical Assessment Unit
- Facility for video assessment (Tele-consultation)

Reablement focussed home care

- Standardised electronic assessment and goal planning
- Pro-active assessment of patients (even if service isn't required, this begins to build a picture)
- Care commissioned on an outcome basis to incentivise exit from the service
- There is a commitment to increase the skill and experience of the workforce
- Innovation is encouraged in care plans and services that are delivered to achieve outcomes

Prevention | **Patient Self-Management** | **Pro-active Disease Management** | **Interdisciplinary Team Case Management**

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. Improve lengths of stay to the average of Ontario peer hospitals would reduce inpatient use by roughly 400 beds.
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 of roughly 8 years of population growth and aging.

			Average Length of Stay		Potentially Conservable Beds			
RHA	Hospital	Annual Admissions	Actual	Expected	Acute	ALC	Total	Potential Cost Improvement
Interlake-Eastern RHA	Selkirk & District General Hospital	1,801	7.4	5.0	9	3	12	$ 1.2M
Northern Health Region	Flin Flon General Hospital	909	4.9	4.6	1	0	1	$ 0.18M
	The Pas Health Complex	1,505	4.1	4.1	1	-1	0	$ 0.03M
	Thompson General Hospital	3,520	4.3	3.4	10	-1	9	$ 1.5M
Prairie Mountain Health	Brandon General Hospital	8,187	6.8	4.4	44	10	54	$ 7.2M
	Dauphin General Hospital	2,250	6.0	5.1	10	-4	5	$ 0.6M
Southern Health-Santé Sud	Bethesda Regional Health Centre	2,488	5.0	3.5	6	4	10	$ 0.9M
	Boundary Trails Health Centre	4,317	4.3	3.4	10	1	11	$ 1.0M
	Portage Hospital	2,180	7.5	4.1	10	10	21	$ 1.8M
WRHA	Concordia Hospital	3,781	9.6	6.8	24	5	28	$ 2.8M
	Grace Hospital	4,918	9.2	6.2	38	3	41	$ 4.4M
	Health Sciences Centre	27,202	5.6	4.5	87	-1	86	$ 13M
	Seven Oaks General Hospital	3,555	11.4	6.9	40	3	43	$ 4.8M
	St. Boniface General Hospital	23,331	4.9	4.6	24	-4	19	$ 3.0M
	Victoria General Hospital	3,972	10.1	6.9	31	4	35	$ 3.4M
Total		**93,916**	**6.2**	**4.8**	**346**	**30**	**376**	**$ 45.9M**

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. Southern RHA has Manitoba's highest use of ED care on a per capita basis and 46% more visits than expected at the peer region average age standardized visit rate. This finding implies significant opportunities to reduce use of EDs over time in Southern RHA whilst recognizing usage of EDs in the context of the configuration of services in Southern RHA.
2. Prairie Mountain had approximately 3% more ED visits than expected at the peer average age standardized rate and may therefore have some opportunities to reduce ED visits.
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. Interlake RHA had 22% fewer visits than expected at the peer region age standardized rate and therefore likely has few opportunities to significantly reduce ED use.

RHA	Annual ED Visits	Expected ED Visits	Potentially Avoidable ED Visits	Potential Cost Improvement	QuickCare Visits	Access Centres Visits
Southern Health-Santé Sud	115,141	79,061	36,080	$5.0M	10,307	
WRHA	266,640	309,428	0	$0M	63,265	28,867
Prairie Mountain Health	136,159	131,601	4,558	$0.6M		
Interlake-Eastern RHA	76,523	98,321	0	$0	12,192	
Total	**594,463**	**618,411**	**40,637**	**$5.6M**	**85,764**	**28,867**

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. Prairie Mountain RHA had 17% more acute admissions than expected at the peer average age standardized rate. This finding implies significant opportunities to reduce inpatient hospital resource use over time. The figures for Brandon General Hospital require further validation in Phase 2.
3. Southern RHA had 14% more acute admissions than expected at the peer average age standardized rate. This finding implies significant opportunities to reduce inpatient hospital resource use over time whilst recognizing usage of EDs in the context of the configuration of services in Southern RHA.

RHA	Hospital	Annual Admissions	Expected Admissions	Potentially Avoidable Admissions	Potential Cost Improvement
Prairie Mountain Health	Brandon General Hospital	4,610	4,042	568	**$ 1.7M**
	Dauphin General Hospital	1,547	1,229	318	**$ 1.0M**
Southern Health-Santé Sud	Bethesda Regional Health Centre	1,148	1,005	143	**$ 0.5M**
	Boundary Trails Health Centre	1,961	1,719	242	**$ 0.7M**
	Portage Hospital	1,342	1,164	178	**$ 0.5M**

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

- Public, union, and regulatory college perception of reduced nurse-patient ratios.
- Union action related to collective agreement rationalization.

Interdependencies

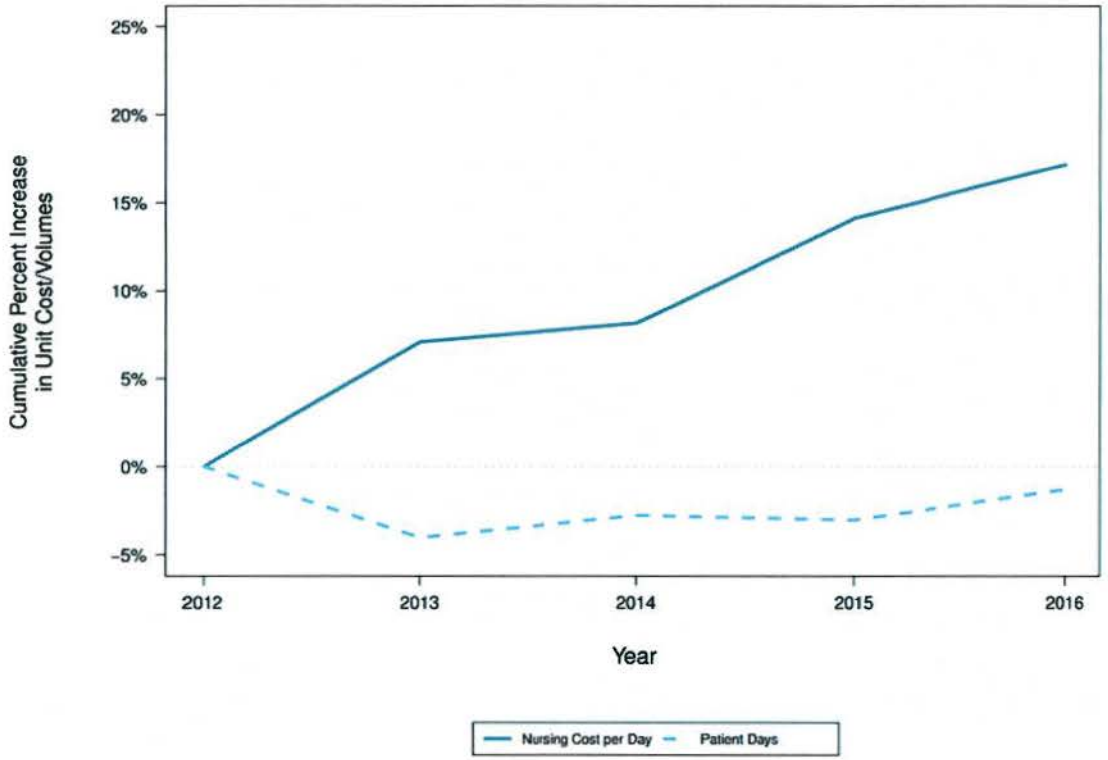
- Health Workforce workstream.
- Bargaining unit restructuring.
- Regulated Health Professions Act implementation.
- Provincial Clinical and Preventive Services Plan.
- WRHA Consolidation.
- Collective agreement rationalization.
- Matrix restructuring.

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. Northern Health Region hospitals nursing hours per patient day are 110% to 200% higher than Ontario peers.
4. Prairie Mountain Health hospitals nursing hours per patient day are 30% to 100% higher than Ontario peers.
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

Nurse Hours Per Patient Activity

		Medical Inpatient		Surgical Inpatient		ICU		Operating Room		Emergency Room	
		Nurse Hr / Day	% from Peer 40th PCTL	Nurse Hr / Day	% from Peer 40th PCTL	Nurse Hr / Day	% from Peer 40th PCTL	Nurse Hr / Case	% from Peer 40th PCTL	Nurse Hr / Visit	% from Peer 40th PCTL
Interlake-Eastern RHA	Selkirk & District General Hospital	8	10%	9	47%	-	-	8	13%	2.7	118%
Northern Health Region	Thompson General Hospital	14	111%	-	-	-	-	-	-	3.5	155%
	The Pas Health Complex	15	124%	-	-		-	-	-	3.8	180%
	Flin Flon General Hospital	21	204%	-	-	-	-	-	-	4.5	229%
Prairie Mountain Health	Brandon General Hospital	8	29%	10	32%	37	81%	12	120%	3.1	94%
	Dauphin General Hospital	8	16%	11	68%	31	103%	-	-	1.4	12%
Southern Health-Santé Sud	Portage Hospital	7	6%	11	56%	-	-	12	34%	2.3	55%
	Bethesda Regional Health Centre	7	6%	11	52%	-	-	11	26%	3.9	159%
	Boundary Trails Health Centre	7	5%	11	60%	-	-	14	59%	2.8	87%
WRHA	Seven Oaks General Hospital	8	20%	8	12%	31	33%	13	112%	3.9	121%
	Grace Hospital	7	7%	10	36%	33	42%	6	-6%	4.8	176%
	Victoria General Hospital	7	3%	11	41%	29	25%	8	33%	4.0	131%
	Concordia Hospital	7	0%	8	1%	24	3%	12	95%	4.1	135%
	Health Sciences Centre	11	55%	12	43%	27	0%	13	15%	4.3	134%
	St. Boniface General Hospital	10	42%	12	50%	38	43%	15	33%	4.8	165%

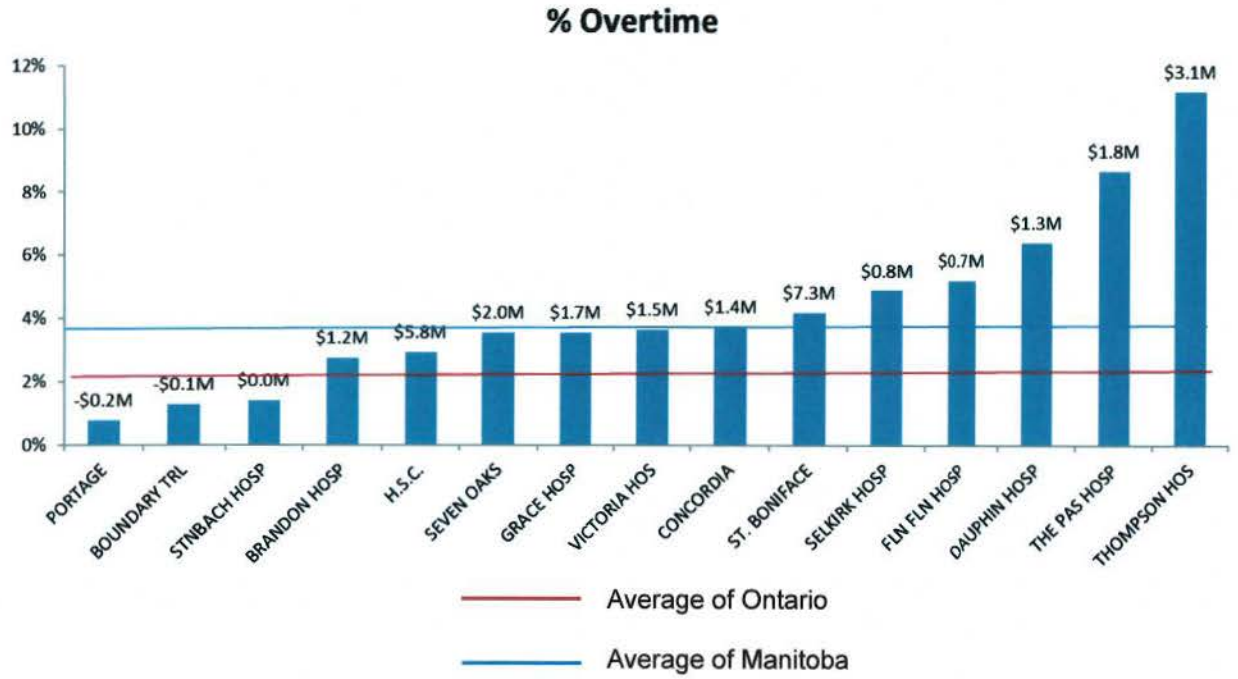
Rationalize and Reduce Variation in Staffing Models

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.

Realign WRHA Matrix

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2017/18	Est. Cost Improvement: $5.7M
Implementation Duration: >1 year	Implementation Effort: Medium	

Description	Address tactic opportunities to reducing length of stay, acute admissions, and ED visits through WRHA matrix realignment and consolidation (including review of bed map for WRHA facilities).
Benefit	• Reduction in administrative costs; and • Improved coordination of WRHA services.
In-scope/Out of Scope	**In-scope**: Acute care utilization demonstration projects; substitution of ambulatory for inpatient surgery. **Out of scope**: Province-wide consolidation.
Key Assumptions	• N/A
Governance	• WRHA-led.
Project Management	• WRHA-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks	Interdependencies
• Change management.	• Provincial Clinical and Preventive Services Plan. • RHA 2017/18 Plans to achieve Financial Balance. • Master Planning.

Realign WRHA Matrix

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2017/18	Est. Cost Improvement: $5.7M
Implementation Duration: >1 year	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Initiate realignment of WRHA clinical matrix and programs (consultation with province). • Initiate business case for WRHA consolidation.	**Key activities:** • Initiate WRHA bed map review. • Initiate WRHA consolidation business case and impact assessments.	**Key activities:** • Conclude WRHA clinical matrix realignment. • Develop consolidation work plan.	**Key activities:** • Initiate WRHA program consolidation activities. • Issue notice (90 days) as required to accommodate staffing requirements.
Outputs: • Work Plan: WRHA Clinical Matrix.	**Outputs:** • Progress Reports: Matrix Realignment. • Business Case: WRHA consolidation.	**Outputs:** • Progress Report: WRHA Matrix Realignment; Consolidation. • WRHA - revised clinical organizational structure. • Work Plan: WRHA consolidation.	**Outputs:** Progress Report: WRHA Consolidation.

Realign WRHA Matrix

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2017/18	Est. Cost Improvement: $5.7M
Implementation Duration: >1 year	Implementation Effort: Medium	

2018/2019

Key activities:

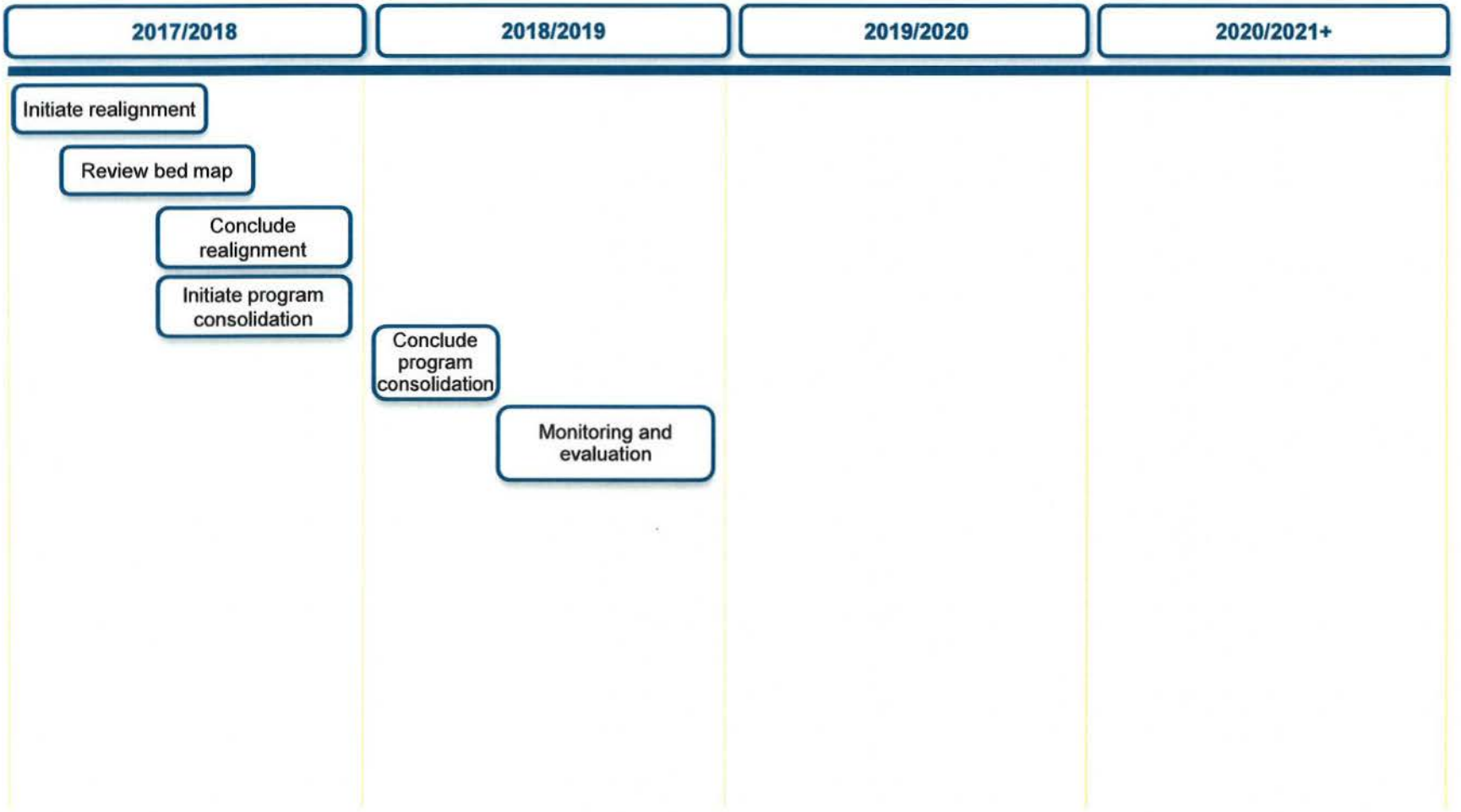
- Complete WRHA consolidation (including review of infrastructure requirements).

Outputs:

- Progress Report: WRHA Consolidation.

Realign WRHA Matrix

Subtheme: Rationalize and Standardize Programs and Services	Benefit Year: 2017/18	Est. Cost Improvement: $5.7M
Implementation Duration: >1 year	Implementation Effort: Medium	



Reduce Unit Costs/Rates for Allied Health, Therapeutic Services, Lab & DI

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 months	Implementation Effort: Medium	

Description	Identify and implement opportunities to reduce and standardize the cost per encounter for allied health/therapeutic services, laboratory procedures, and diagnostic imaging.
Benefit	• Reduction in costs; and • Redistribution of services to the most appropriate setting.
In-scope/Out of Scope	**In-scope:** Publicly-funded services provided in-hospital - allied health, therapeutic services, laboratory procedures, and diagnostic imaging procedures. **Out of scope**: Provider compensation; private DI/allied health centres.
Key Assumptions	• TBD
Governance	• RHA-led.
Project Management	• RHA-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks	Interdependencies
• Engagement/change management with clinicians across multiple sites.	• Provincial Clinical and Preventive Services Plan. • Availability of ambulatory care. • Insured Benefits workstream. • System capacity for reablement/restorative care. • Public awareness.

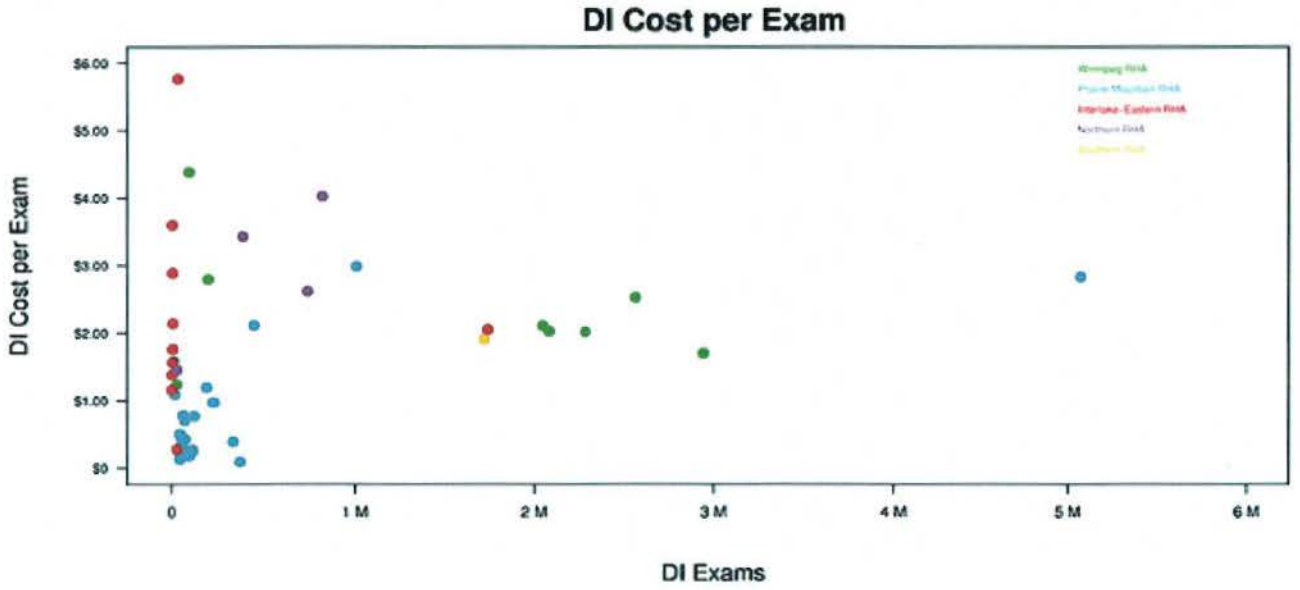
Reduce Unit Costs/Rates for Allied Health, Therapeutic Services, Lab & DI

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 months	Implementation Effort: Medium	

Diagnostic Imaging Opportunity

There is no evidence for increasing economy of scale in Diagnostic Imaging to reduce unit costs. The benchmarking analysis undertaken in Phase 1 found significant cost improvement opportunities from reducing costs of DI services as currently organized. The analysis also found the potential for cost improvement by reducing use of Diagnostic Imaging. Given these findings and the potential for disruption from consolidation, the case to support consolidation is weak from a 1-3 year cost improvement perspective.

	Potential Savings from Reducing Volumes	Potential Unit Cost Savings	Savings from Economies of Scale	Potential Service Disruption
Diagnostic Imaging	$19M	$17M	Low	High



Reduce Unit Costs/Rates for Allied Health, Therapeutic Services, Lab & DI

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 months	Implementation Effort: Medium	

Therapeutic Services Opportunity

The benchmarking analysis undertaken in Phase 1 compared the cost of an therapy attendance day (unit cost) and the number of therapy attendance days per patient day or visit (utilization) for each therapy department across Manitoba hospital and Ontario peer hospitals.

1. Cost improvement opportunities were found in Physiotherapy and Occupational Therapy.
2. There is high use of physiotherapy in outpatient clinics relative to Ontario peers.
3. There is a higher cost per attendance day in Occupational Therapy relative to Ontario peers.

RHA	Physiotherapy	Occupational Therapy	Respiratory Therapy
WRHA	$ 2.0M	$ 1.4M	$ 0.5M
Northern Health Region	$ 0.1M	$ 0.1M	$ -
Total	**$ 2.1M**	**$ 1.5M**	**$ 0.5M**

Reduce Unit Costs/Rates for Allied Health, Therapeutic Services, Lab & DI

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 months	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Define scope of encounters to be measured and analyzed. • Confirm current baselines by facility. • Establish target baselines (benchmarking). • Review acute and hospital capacity vs demand.	**Key activities:** • Review options for reducing costs (i.e. personnel, infrastructure, technology). • Select demonstration project services for unit cost reduction based on options analysis. • Define evaluation framework.	**Key activities:** • Monitor demonstration project services.	**Key activities:** • Monitor demonstration project services.
Outputs: • Cost optimization methodology and plan.	**Outputs:** • Demonstration project plan.	**Outputs:** • Quarterly performance update. • Communication/change management plan.	**Outputs:** • Quarterly performance updates.

Reduce Unit Costs/Rates for Allied Health, Therapeutic Services, Lab & DI

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 months	Implementation Effort: Medium	

2018/19

2018/19

Key activities:

- Re-evaluate first 6 months of demonstration projects.
- Develop implementation plans for cost optimization within other allied health/therapeutic/DI services.

Outputs:

- Quarterly performance update.
- Demonstration project evaluation.
- Implementation workplan.

2019/20

Key activities:

- Ongoing monitoring and evaluation.

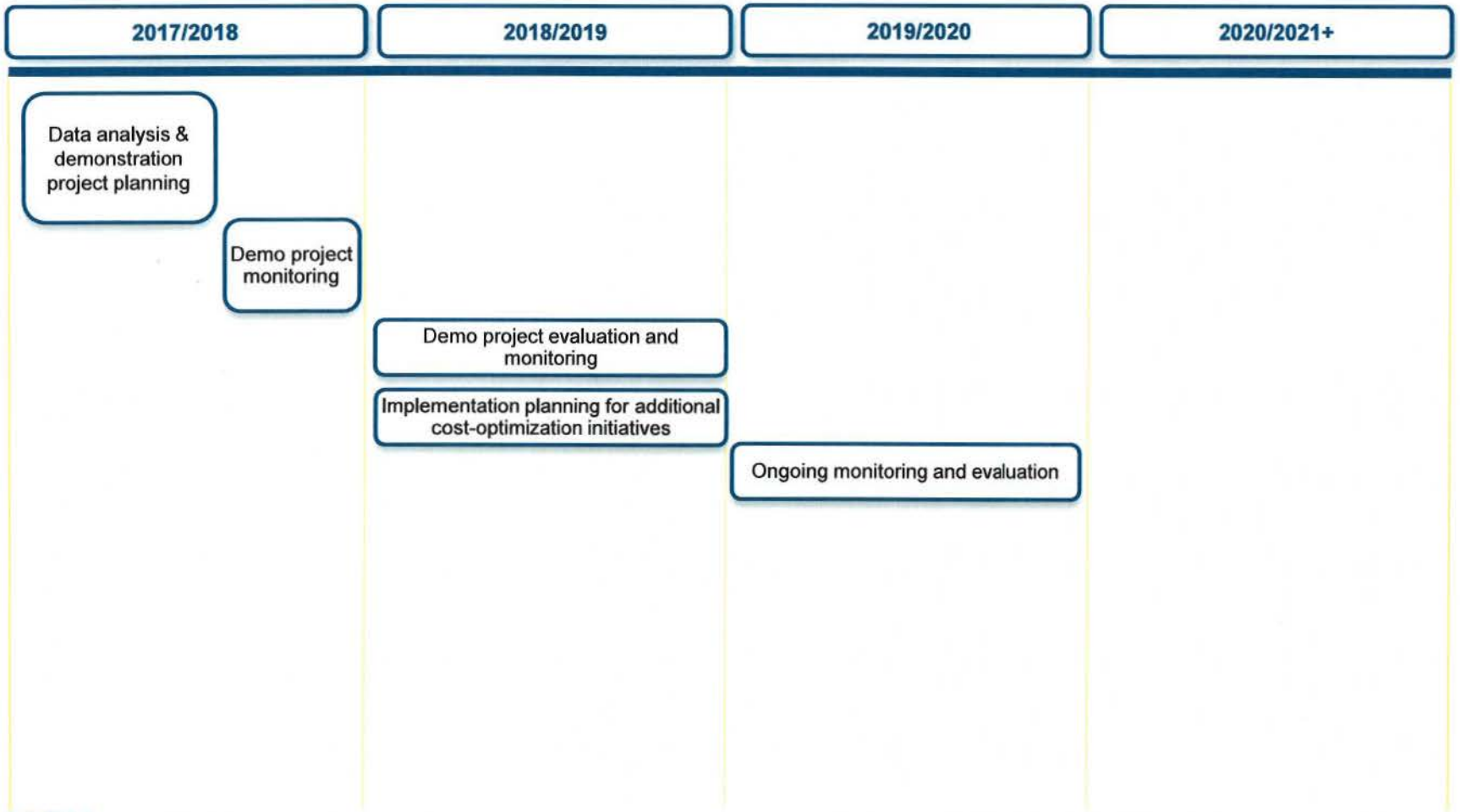
Outputs:

- Quarterly performance update.

Reduce Unit Costs/Rates for Allied Health, Therapeutic Services, Lab & DI

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 months	Implementation Effort: Medium	

2018/19



Adjust Median Rate & Reduce Overcosts for PCHs (WRHA)

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $1.5M
Implementation Duration: >1 year	Implementation Effort: Low	

Description	Adjust Median Rate and Overcosts for Personal Care Homes (PCHs) within the WRHA.
Benefit	• Reduction in costs; and • Redistribution of services to the most appropriate setting.
In-scope/Out of Scope	**In-scope:** PCH Median Rates and overcosts. **Out of Scope**: PCH bed use and supply.
Key Assumptions	• Implementation support for PCHs after new policies and payment structures implemented.
Governance	• WRHA-led.
Project Management	• WRHA-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks	Interdependencies
• Capacity and capability of PCHs to execute cost optimization. programs. • Stakeholder engagement across multiple PCH sites.	• Paneling process (home vs hospital).

Adjust Median Rate & Reduce Overcosts for PCHs (WRHA)

Subtheme: Reduce Unit Costs	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $1.5M
Implementation Duration: >1 year	Implementation Effort: Low	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Notify care homes of assessment and submit data request • Conduct study of rates across WRHA • Set target benchmarks	**Key activities:** • Validate overhead, back office, and supply chain costs • Measure costs against benchmarks • Develop options for median rate	**Key activities:** • Legislative review • Approval of new median rates/overcost guidelines	**Key activities:** • Implement new rates/overcosts
Outputs: • Implementation Work Plan	**Outputs:** • Options analysis & briefing note	**Outputs:** • Revised policies and PCH funding framework	**Outputs:** • Revised agreements with PCHs and ongoing implementation support

Review Contracted Transportation Services

Subtheme: Healthcare Transportation	Benefit Year: 2017/18	Est. Cost Improvement: $1.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Review healthcare transportation procurement and contracted services across the province.
Benefit	• Improved contracting and procurement processes, resulting in reduced costs.
In-scope/Out of Scope	• **In-scope**: Contracted healthcare transportation services. • **Out of scope:** Efficiency and effectiveness reviews (i.e. NPTP).
Key Assumptions	• RFP for basic air ambulance to be approved by 2017/18 Q2.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks	Interdependencies
• Completing the procurement process by end 2017/18.	• Air ambulance RFP. • Federal jurisdiction workstream. • Engagement of the Federal Government.

Review Contracted Transportation Services

Subtheme: Healthcare Transportation	Benefit Year: 2017/18	Est. Cost Improvement: $1.2M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Engage federal government to identify options for combined air ambulance contracting.	**Key activities:** • Release RFP for basic air ambulance. • Identify options for collaboration with federal government.	**Key activities:** • Select vendor for basic air ambulance. • Negotiate contract.	**Key activities:** • Monitoring and evaluation.
Outputs: • Air Ambulance contracting options analysis.	**Outputs:** • Federal Government contract agreements – options analysis.	**Outputs:** • Signed vendor agreement.	**Outputs:** • N/A.

Review Contracted Transportation Services

Subtheme: Healthcare Transportation	Benefit Year: 2017/18	Est. Cost Improvement: $1.2M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Validation of recommendations for the NPTP, following recent reviews.
Benefit	• Improved contracting and procurement processes, resulting in reduced costs.
In-scope/Out of Scope	**In-Scope:** Program review.
Key Assumptions	• RFP for basic air ambulance to be approved by 2017/18 Q2.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• Requirement to agree consistent and clear messaging.

Risks	Interdependencies
• Ability for the RFP to be approved by the second quarter of 2017/18.	• Air ambulance RFP. • MHSAL Treasury Board Submission. • Provincial Clinical and Preventive Services Plan. • Provincial Emergency Consultation Service (PECS). • Federal relationship to find opportunities. • Communications to patients.

Review Contracted Transportation Services

Subtheme: Healthcare Transportation	Benefit Year: 2017/18	Est. Cost Improvement: $1.2M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Review recommendations against current state. • Identify gaps.	**Key activities:** • Confirm release of air ambulance RFP. • Communicate to MLAs and RHAs.	**Key activities:** • Implement NPTP changes in alignment with air ambulance vendor decisions.	**Key activities:** • N/A.
Outputs: • Update to NPTP report.	**Outputs:** • Briefings with RHAs and region MLAs.	**Outputs:** • N/A.	**Outputs:** • N/A.

Implement Centralized Billing

Subtheme: Healthcare Transportation	Benefit Year: 2017/18	Est. Cost Improvement: $0.6M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Streamline information management processes to reduce risk of double-billing or errors.
Benefit	• Reduction in costs.
In-scope/Out of Scope	• In-scope: ambulance/EMS services.
Key Assumptions	• TBD.
Governance	• MHSAL-led.
Project Management	• MHSAL-led.
Communication Strategy	• Requirement to agree consistent and clear messaging. • Ensuring that there is clarity by all impacted staff in relation to new information management processes.

Risks	Interdependencies
• Ability to make required technical changes by end 2017/18.	• Air ambulance RFP. • Validity of NPTP review recommendations.

Implement Centralized Billing

Subtheme: Healthcare Transportation	Benefit Year: 2017/18	Est. Cost Improvement: $0.6M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Ambulance/EMS information management assessment and gap analysis (i.e. manual processes).	**Key activities:** • Evaluate options for ambulance/EMS. information management.	**Key activities:** • Develop business case.	**Key activities:** • Develop go-forward plan. • Treasury Board submission.
Outputs: • Ambulance and EMS Information management gap analysis.	**Outputs:** • Ambulance/EMS IM system – options analysis.	**Outputs:** • Business case.	**Outputs:** • Go-forward plan. • Treasury Board submission.

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Work Plan 4: Healthcare Workforce

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This Healthcare Workforce Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

Healthcare Workforce - Work Plan Summary

Healthcare Workforce	
Project Summary	• The Healthcare Workforce workstream includes: collective agreements; enabling efficient workforce composition; rationalizing healthcare employee benefits; and reviewing healthcare provider compensation levels and rates.

Objectives & Scope	• To improve the structure and cost effectiveness of Manitoba's healthcare workforce in all healthcare employment sectors:
	  • Reducing the complexity and number of the collective agreements in all employment sectors.
	  • Reviewing the effectiveness and cost competitiveness of the Health Employees Benefit Plan (HEBP) and Health Employee Pension Plan (HEPP).
	  • Evaluating opportunities to pursue the cost of Worker's Compensation Board coverage in healthcare by addressing inconsistencies in WCB practices for health worker claim approval and the potential for the healthcare system to self insure for work related injury claims.
	  • Introducing policy and legal changes that allow employers to enforce current employment practice violations between current health care employers in the short-term with an emphasis time and attendance, overtime and benefit accumulators between entities in the WRHA.
	  • Improving the overall framework and tools for managing the composition of the overall healthcare workforce.
	  • Strengthening the integration and models of professional provider compensation to achieve consistency with other jurisdictions and improve the relationship between provider compensation and system performance.
	  • Reviewing the accountability and processes for managing medical remuneration for all medical providers.
	  • Reducing or eliminating compensation to chiropractors by including it as an insured benefit. This practice is not consistent with other jurisdictions in Canada.
	  • Implementing changes to pharmacy compensation.

Healthcare Workforce - Work Plan Summary

Healthcare Workforce	
Interdependencies	• Regulated Health Professions Act. • Legislative and regulation review. • Provincial Clinical Services Plan. • Amendment to RHA Act and regulations. • Joint review by HEBP and HEPP trustees. • Collective agreements: rationalization, notice of change. • Recruitment strategy. • Negotiated agreements. • [redacted]

Summary of Opportunities

This table provides a summary of the total cost savings for the Healthcare Workforce Work Plan broken down by benefit year and sub category.

Sub Category	2017/18 Potential Cost Savings	2018/19 and Beyond Potential Cost Savings	Total
Rationalize Employee Benefits	$1.5M	$29.9M	**$31.4M**
Rationalize Provider Compensation	$28.6M	TBD	**$28.6M**
Adjust Workforce Composition	$4.5M	-	**$4.5M**
Rationalize Collective Agreements	-	$8.2M	**$8.2M**
TOTAL	**$34.6M**	**$38.1M**	**$72.7M**

The following table provides an overview of each opportunity included in the Healthcare Workforce Work Plan.

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Rationalize Employee Benefits	Eliminate/reduce pre-retirement leave bonus.	$26.7M	2018/19 and beyond	MHSAL 1 FTE	• Changes to the pre-retirement leave bonus may adversely impact the departments ability to negotiate during collective bargaining. • Potential change to retirement benefit plans (e.g. defined benefit → defined contribution). • Changes to pre-retirement leave bonus may adversely impact ability to negotiate other changes to total compensation.	• Failing to renegotiate the elimination of the bonus from collective agreements. • Politically sensitive, changing Legislation to supersede collective agreements could result in labour disputes. • May result in the "wrong" people retiring early to take advantage of the benefit before it is eliminated (presuming no grandfather clause). • Risk at targeting non union works when you need them to execute all the changes right now. • Risk is people at magic 80.
	WCB Prevention Initiative and Evaluation of Self Insurance Options.	$3.2M	2018/19 and beyond	MHSAL 0.5 FTE	• Occupational health and safety policies and procedures should be connected province-wide through provincial mandate and led at the provincial level; however, implementation should be managed outside of the Government Department (e.g. by WCB). • WRHA is reviewing self-insurance as a component of their managed to budget exercise.	• The cost increase at WCB to administer the self-insurance based model may outweigh the cost savings realized by the health sector. • Lobbying from remaining Class E premium category government employers as they may experience an increase in premium costs levied if the health sector abandons the Class E premium model. • Lobbying activities from other organizations (e.g. Manitoba Federation of Labour).

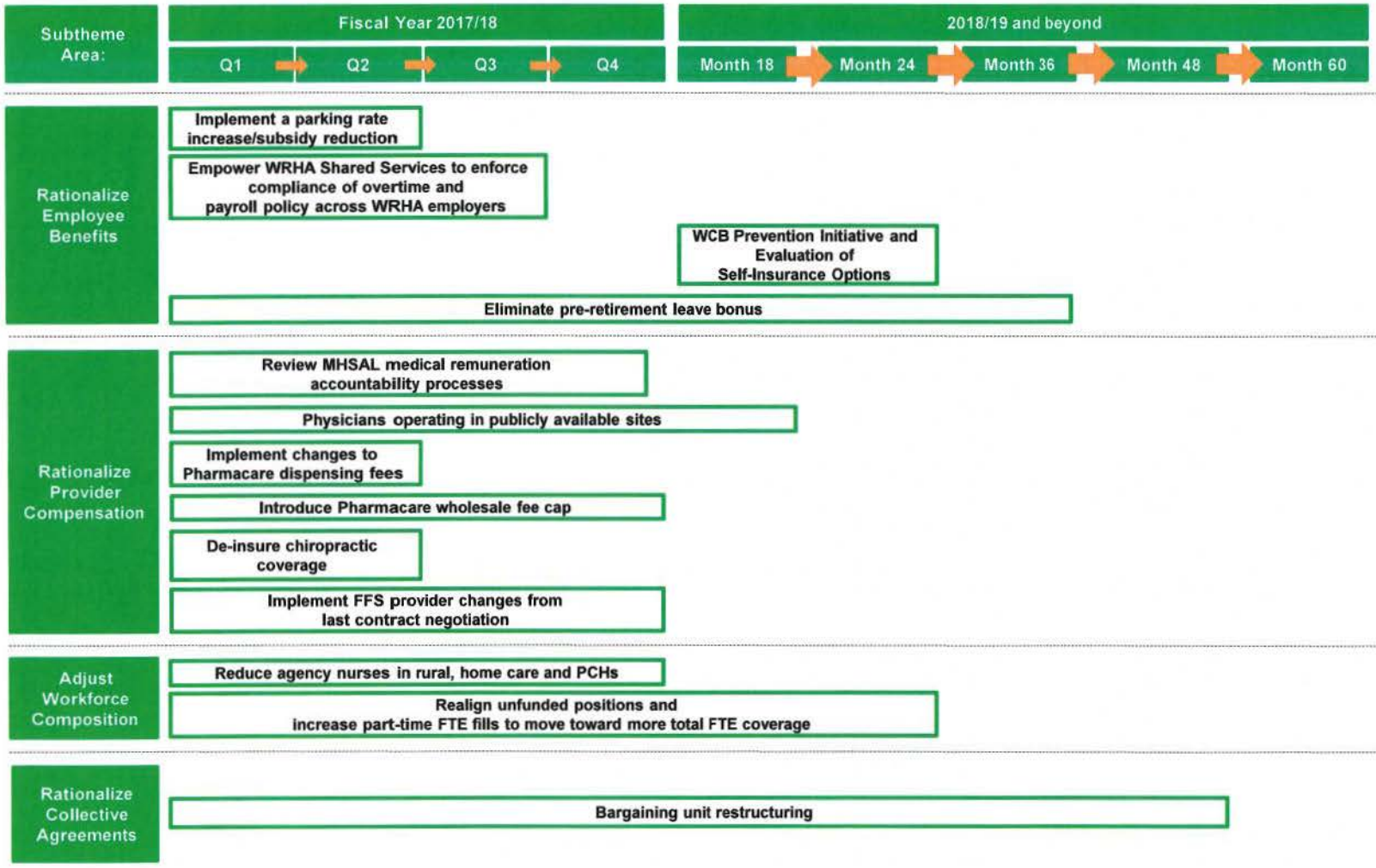
Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Rationalize Employee Benefits	Empower WRHA Shared Services to enforce compliance of overtime and payroll policy across WRHA employers.	$0.8M	2017/18	MHSAL 0.5 FTE	• Collective agreement bargaining process.	• Political risk with delegating WRHA the regions *"Employer of Record"*.
	Implement a parking rate increase/subsidy reduction.	$0.7M	2017/18	MHSAL 0.3 FTE	• Some organizations (e.g. DSM) are reviewing parking rates/subsidies as a component of their managed to budget exercise.	• May result in employee. grievances/complaints. • May result in parking customers seeking out parking in non-MHSAL parking lots resulting in lost revenues for MHSAL.
Rationalize Provider Compensation	Implement FFS provider changes from last contract negotiation.	$14M	2017/18	MHSAL 0.5 FTE	• Review MHSAL medical remuneration accountability processes. • Physicians operating in publicly available sites. • Provincial clinical services plan.	• Competitive nature of the employment market and within Canada.
	Implement changes to Pharmacare dispensing fees.	$5.5M	2017/18	MHSAL 0.5 FTE	• Introduction of Pharmacare wholesale fee cap	• Increased pressure to expand the scope of practice services that pharmacists currently offer in Manitoba. • Political risk.
	Introduce Pharmacare wholesale fee cap.	$5.5M	2017/18	MHSAL 0.5 FTE	• Implementation of changes to Pharmacare dispensing fees. • PCH Agreement and PCH Pharmacy Services RFP (for pharmacies delivering services to PCHs).	• Increased pressure to expand the scope of practice services that pharmacists currently offer in Manitoba. • Potential shut down of pharmacy.
	De-insure chiropractic coverage.	$3M	2017/18	MHSAL 0.3 FTE	• MPI – may have to take on charges.	• The Manitoba Chiropractors Association (MCA) may challenge the amended policy because it could be viewed as a breach in contractual obligation of the current agreement. • Adverse impact to access to chiropractic services.

Summary of Opportunities

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Rationalize Provider Compensation	Review MHSAL medical remuneration accountability processes.	$0.6M	2017/18	MHSAL 0.5 FTE	• Implementation of $50 million FFS provider changes from last contract negotiation.	• Potential negotiation uncertainty with Doctors Manitoba. • Potential public relations issues with individual doctors.
	Physicians operating in publicly available sites.	TBD	2018/19 and beyond	MHSAL 1 FTE	• Implementation of $50 million FFS provider changes from last contract negotiation.	• Access to services in rural regions. • Interaction with insured services administration may be cumbersome. • Potential negotiation uncertainty with Doctors Manitoba. • Potential public relations issues with individual doctors.
Adjust Workforce Composition	Realign unfunded positions and increase part-time FTE fills to move toward more total FTE coverage.	$3M	2017/18	RHAs 0.5 FTE	• Management of union expectations – bargaining unit restructuring.	• Management of front-line service delivery. • Political risk, heavy political decision. • Media management. • Significant public relations initiative – how not hurting front line services.
	Reduce agency nurses in rural, home care and PCHs.	$1.5M	2017/18	MHSAL 0.5 FTE	• Clinical services. • Management of overtime. • Staff scheduling initiatives in various healthcare delivery organizations.	• Service gaps. • May not be able to recruit for new relieve teams structure.
Rationalize Collective Agreements	Bargaining unit restructuring.	$8.2M	2018/19 and beyond	MHSAL 1 FTE	• Collective Bargaining. • Recommended future state employer structure from Work Plan 1 – Strategic System Realignment and Funding for Performance.	• Union strikes across collective agreement units. • Enacting new legislation which removes compensation/benefits from workers before negotiations are complete may negatively impact the government's ability to negotiate with collective agreement units

Work Plan - High-Level Roadmap



Eliminate Pre-Retirement Leave Bonus

Subtheme: Rationalize employee benefits	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $26.7M
Implementation Duration: 18 - 30 Months	Implementation Effort: High	

Description	MHSAL and WRHA staff are entitled to pre-retirement leave bonuses. The current pre-retirement leave bonus liability is estimated at ~$300 million. KPMG estimates this could be reduced by 30% through negotiation or cancellation of the benefit with employees. An attempt should be made to eliminate the bonus through negotiation. For unionized staff, collective agreements must be renegotiated and for non-unionized staff, contracts must be renegotiated. The government may also explore options to enact new Legislation which would supersede collective agreements and contracts (and the bonus benefit). Government may want to consider a "grandfather clause" for existing staff. The bonus should be eliminated for new staff.
Benefit	• Elimination of the bonus benefit.
In-scope/Out of Scope	• **In-scope:** employees include all healthcare employees entitled to the pre-retirement leave bonus.
Key Assumptions	• N/A
Governance	• MHSAL with oversight/implementation management provided by the central government.
Project Management	• MHSAL.
Communication Strategy	• For unionized staff, collective agreements must be renegotiated. • For non-unionized employees, contracts must be renegotiated.

Risks

- Failing to renegotiate the elimination of the bonus from collective agreements.
- Politically sensitive, changing Legislation to supersede collective agreements could result in labour disputes.
- May result in the "wrong" people retiring early to take advantage of the benefit before it is eliminated (presuming no grandfather clause).
- Risk at targeting non union works when you need them to execute all the changes right now.
- Risk is people at magic 80.

Interdependencies

- Changes to the pre-retirement leave bonus may adversely impact the departments ability to negotiate during collective bargaining.
- Potential change to retirement benefit plans (e.g. defined benefit → defined contribution).
- Changes to pre-retirement leave bonus may adversely impact ability to negotiate other changes to total compensation.

Eliminate Pre-Retirement Leave Bonus

Subtheme: Rationalize employee benefits	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $26.7M
Implementation Duration: 18 - 30 Months	Implementation Effort: High	

2017/18

Q1

Key activities:

- Assess the impact of pre-retirement leave on system budget (including forward looking impacts).
- Assess/develop options to eliminate/reduce/freeze the benefit.
- Assess practices used in the rest of Manitoba public sector.
- Recommendation to government on new short and long term policy.

Outputs:

- Alternative options to eliminate/reduce/freeze benefit.
- Review of pre-retirement benefit practices across Manitoba public sector.
- Memorandum detailing recommendation to government on new short and long term policy.

Q2

Key activities:

- Government decision.
- Notification process to all employers and unions for new policy eliminating benefit for new employees.
- Commence union negotiation process for unionized employees.

Outputs:

- Provide disclosure documents of policy change to employers and to unions to be used for negotiating purposes.

Q3

Key activities:

- Rollout new policy to eliminate benefit for new employees.
- Link to collective agreement bargaining for unionized employees.

Outputs:

- Provide disclosure documents of policy change to employers and to unions to be used for negotiating purposes.

Q4

Key activities:

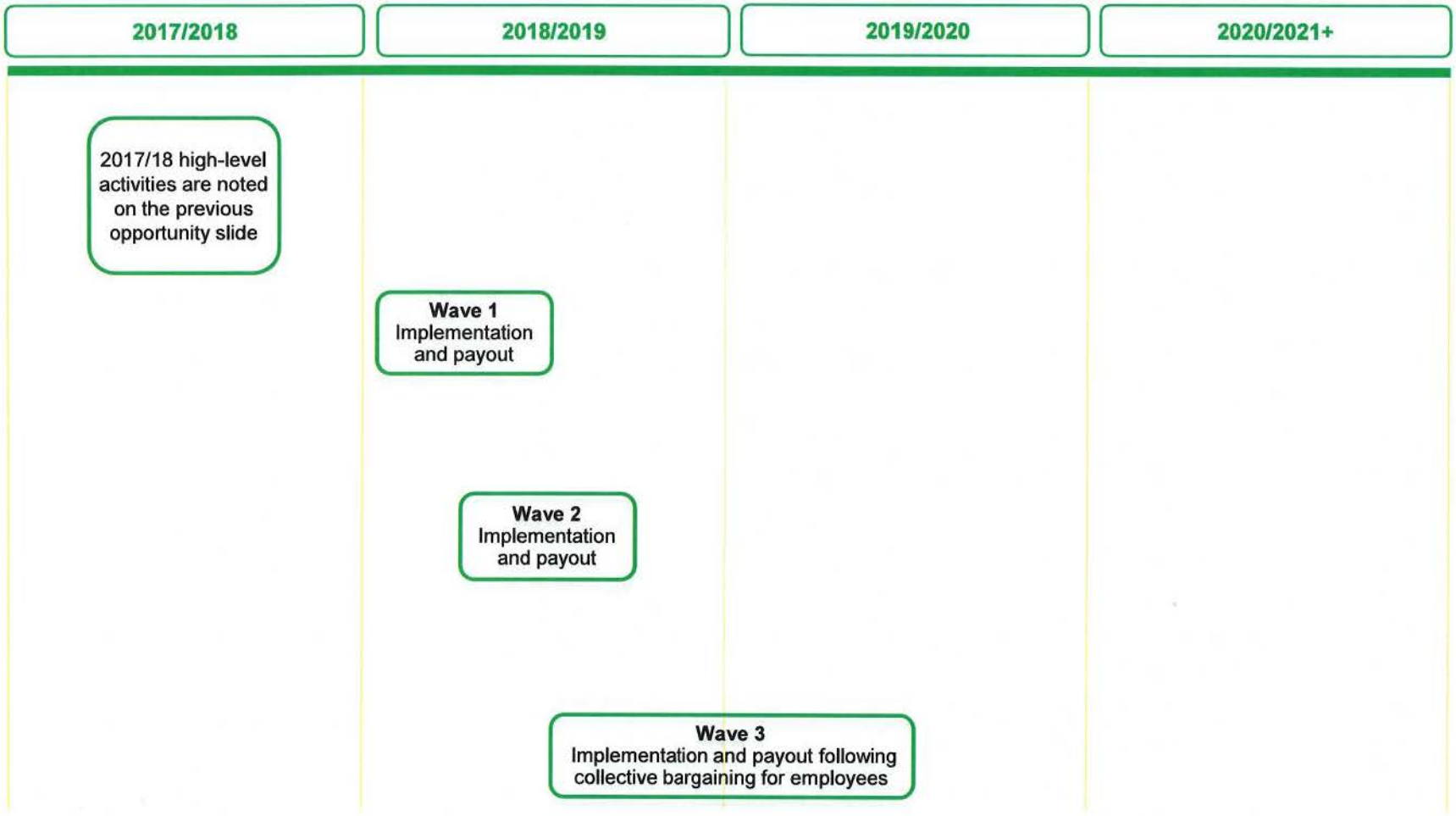
- Rollout policy to freeze benefit for existing recipients.
  - Approach.
  - Options.
  - Process to indicate preference.

Outputs:

- Memorandum detailing new policy and procedures for existing recipients impacted by the benefit freeze.

Eliminate Pre-Retirement Leave Bonus

Subtheme: Rationalize employee benefits	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $26.7M
Implementation Duration: 18 - 30 Months	Implementation Effort: High	



Implement FFS Provider Changes from Last Contract Negotiation

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $14M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	The majority of the Province's doctors are engaged as Fee-for-Service (FFS) providers that operate as private contractors within the system. Securing commitment for provider cost savings negotiated in the last contract in terms of compensation models and service integration over FSS providers.
Benefit	• Strengthening the integration and models of professional provider compensation to achieve consistency with other jurisdictions and improve the relationship between provider compensation and system performance.
In-scope/ Out of Scope	• FFS providers.
Key Assumptions	• Providers are willing to commit to the cost savings negotiated and will not leave the Manitoba market thus no impact to service delivery.
Governance	• MHSAL with oversight/implementation management provided by the RHAs and Doctors Manitoba.
Project Management	• MHSAL.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks	Interdependencies
• Competitive nature of the employment market and within Canada.	• Review MHSAL medical remuneration accountability processes. • Physicians operating in publicly available sites. • Provincial clinical services plan.

Implement FFS Provider Changes from Last Contract Negotiation

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $14M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Finalize written proposal to action items and savings areas.
- Complete discussions with Doctors Manitoba on proposed changes.
- Assess Doctors Manitoba options for cost improvements.
- Assess Doctors Manitoba options for implementation related activity.

Outputs:

- Written proposal with action items and savings areas.

Q2

Key activities:

- Complete discussions with Doctors Manitoba on proposed changes.
- Assess Doctors Manitoba options for cost improvements.
- Assess Doctors Manitoba options for implementation related activity.

Outputs:

- Assessment of Doctors Manitoba's discussions, and options for cost improvement.

Q3

Key activities:

- Implement changes to policy.

Outputs:

- Amended policy.

Q4

Key activities:

- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the change in policy detailing the financial impact.

Restructure Bargaining Units

Subtheme: Rationalize collective agreements	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $8.2M
Implementation Duration: 18 - 24 Months	Implementation Effort: High	

Description	Renegotiation of compensation (including benefits) in the 169 collective agreements (113 apply to the WRHA excluding Doctors Manitoba and PARIM) in place across the health sector. [redacted].
Benefit	• Improves the mobility of healthcare workers and promotes integration across the system. • Reducing the number of collective bargaining units and collective agreements. • Moving towards a single employer structure across all healthcare delivery organizations with standardized contracts, HR management and payment policies.
In-scope/Out of Scope	• **In-scope**: All collective agreements within the health sector.
Key Assumptions	• Scope assumptions include 7 bargaining units per entity based on existing regional health authority structure.
Governance	• MHSAL with oversight/implementation management designated by the Minister to an employer representation.
Project Management	• MHSAL and Provincial Labour Relations.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks

- Potential labour disruption.
- Enacting new Legislation which removes compensation/benefits from workers before negotiations are complete may negatively impact the Government's ability to negotiate with collective agreement units.

Interdependencies

- Collective Bargaining.
- Recommended future state employer structure from Work Plan 1 – Strategic System Realignment and Funding for Performance.

Restructure Bargaining Units

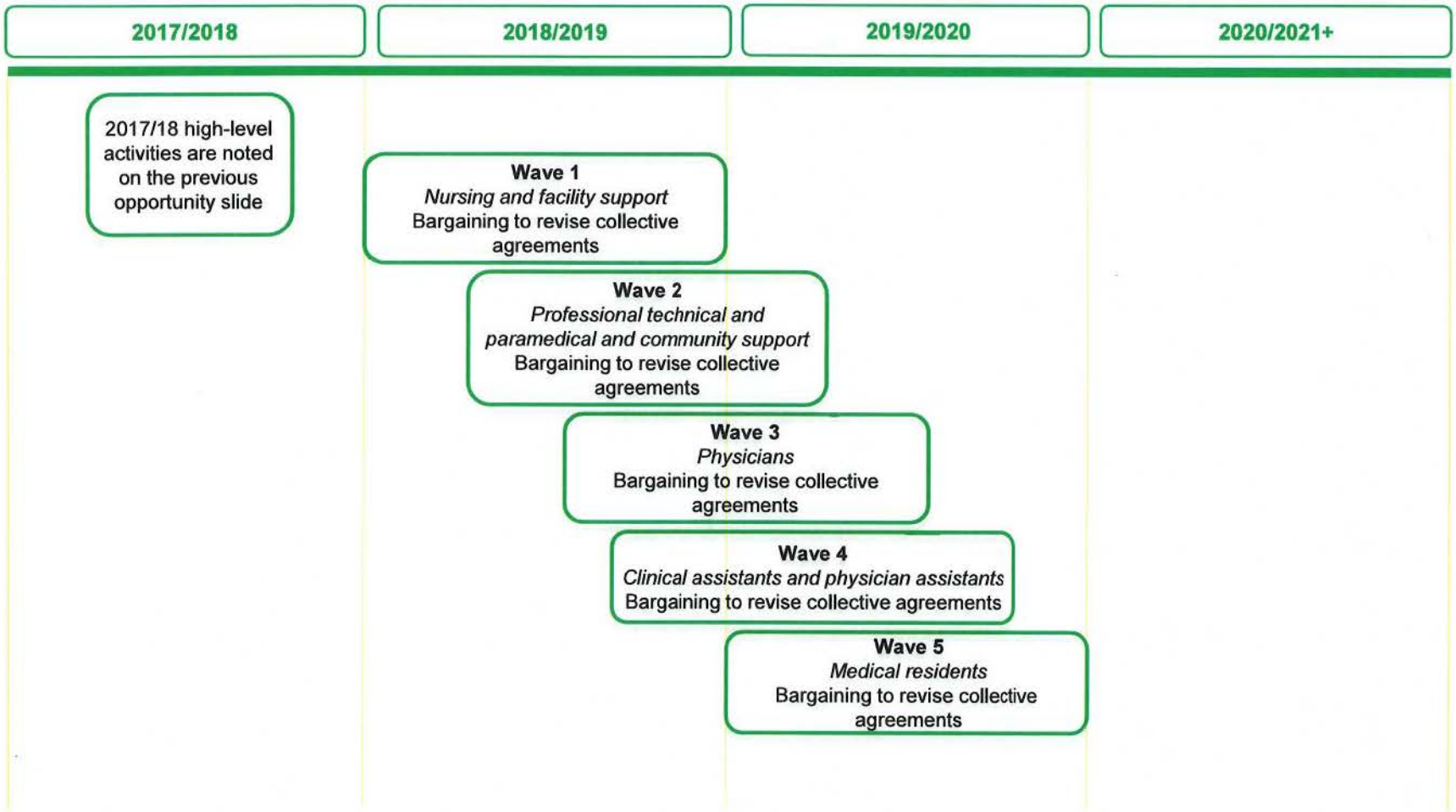
Subtheme: Rationalize collective agreements	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $8.2M
Implementation Duration: 18 - 24 Months	Implementation Effort: High	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Union Consultation. • Determination of composition of bargaining units. • Preparation of bargaining.	**Key activities:** • Proclamation of Legislation. • Slotting into bargaining units and determination of appropriate units.	**Key activities:** • Implementation of proclaimed Legislation. • Representation Votes. • Slotting into bargaining units and determination of appropriate units.	**Key activities:** • Bargaining to revise collective agreements. • Commence bargaining.
Outputs: • Draft desired future state of bargaining unit structure for unions.	**Outputs:** • Slotted bargaining units and final tally of appropriate units.	**Outputs:** • Finalize future state of bargaining unit structure for unions.	**Outputs:** • Draft desired future state of collective agreements.

Restructure Bargaining Units

Subtheme: Rationalize collective agreements	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $8.2M
Implementation Duration: 18 - 24 Months	Implementation Effort: High	



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

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.

Outputs:

- Amended policy documents.

Q2

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.

Outputs:

- Update DPIN with technical changes.
- Amended policy implemented.

Q3

Key activities:

- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the change in policy and the financial impact.

Q4

Key activities:

- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the change in policy and the financial impact.

Introduce Pharmacare Wholesale Fee Cap

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $5.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Manitoba is the only province without wholesale fee caps. Also, wholesale fees are calculated as a percentage of drug ingredient unit costs which results in disproportionately expensive wholesale fees for higher cost drugs relative to lower cost drugs. In the short-term, implement a general wholesale fee cap of 5% per drug ingredient – equal for generic & brand names. In the long term, develop a business case to implement wholesale fee caps for specific drug ingredient based on cost estimate leading practices from comparable jurisdictions.
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 including all pharmacies across Manitoba.
Key Assumptions	• Requires significant time investment in information and IT systems to re-code wholesale fee calculation formulae in DPIN.
Governance	• MHSAL with oversight/implementation management provided by the central government.
Project Management	• MHSAL.
Communication Strategy	• Disclosure to pharmacy wholesalers and 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. • Potential shut down of pharmacy.	• Implementation of changes to Pharmacare dispensing fees. • PCH Agreement and PCH Pharmacy Services RFP (for pharmacies delivering services to PCHs).

Introduce Pharmacare Wholesale Fee Cap

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $5.5M
Implementation Duration: 1 year	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 – 6 months. • 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:** • Technical changes implemented. • Amended policy implemented.	**Outputs:** • Ongoing reporting of the change in policy detailing the financial impact.	**Outputs:** • Ongoing reporting of the change in policy detailing the financial impact.

Evaluation of Self-Insurance Options

Subtheme: Rationalize employee benefits	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $3.2M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Review WCB Prevention Initiative Program to strengthen its focus on preventing workplace injuries/illnesses, returning injured workers to health and work more quickly. Conduct a safety review to identify root cause areas and improvement opportunities. Transitions WCB coverage from a Class E premium-based model to a self-insured model. The RHAs have put forward a proposal to convert to a self-insurance model under the existing definitions in the Legislation, estimating net cost savings of $2.6 million in 2017/18 and up to $6.4 million in reduced costs in 2018/19.
Benefit	• Preventing workplace injuries/illnesses, and returning injured workers to health and work more quickly. • Transitioning to the self-insurance model may result in an overall reduction in the cost of WCB claims.
In-scope/ Out of Scope	• **In-scope:** All healthcare delivery organizations.
Key Assumptions	• No Legislation changes are required. • Cost reduction is expected as a result of the actual costs of claims, together administrative and accrued liability costs, being less than the amount currently levied by WCB under the premium-based model.
Governance	• MHSAL with oversight/implementation management provided by the WCB.
Project Management	• MHSAL.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks

- The cost increase at WCB to administer the self-insurance based model may outweigh the cost savings realized by the health sector.
- Lobbying from remaining Class E premium category government employers as they may experience an increase in premium costs levied if the health sector abandons the Class E premium model.
- Lobbying activities from other organizations (e.g., Manitoba Federation of Labour).

Interdependencies

- Occupational health and safety policies and procedures should be connected province-wide through provincial mandate and led at the provincial level; however, implementation should be managed outside of the Government Department (e.g. by WCB).
- WRHA is reviewing self-insurance as a component of their managed to budget exercise.

Evaluation of Self-Insurance Options

Subtheme: Rationalize employee benefits	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $3.2M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/2018	2018/2019	2019/2020	2020/2021+
	Following on MNP Report, identify/target areas for joint action with WCB Establish working group Assess target areas for root cause and improvement opportunities		
	Establish/revise procedures Rollout procedural changes Communicate new procedures		
	Rollout remediation activities in waves. Develop business case for self insurance alternatives. Prepare recommendation for consideration of government. Commence union notification and negotiation process.		
	Monitor for implementation and results of policy change		

Realign Unfunded Positions

Subtheme: Adjust workforce composition	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 – 24 Months	Implementation Effort: Medium	

Description	Undertake process in all RHAs and health delivery organizations to eliminate unfunded positions and increase the FTE level of part-time roles in order to alleviate the current amount of overtime costs incurred.
Benefit	• Project will eliminate unfunded positions in all organizations by implementation of a leading practice. • Reconfiguring FTE levels (e.g. 0.3 to 0.6) may reduce overtime costs.
In-scope/ Out of Scope	• **Out of Scope**: Does not apply to protected positions.
Key Assumptions	• Initiative can be delivered tactically alongside of other workforce initiatives and collective agreement restructuring.
Governance	• Regional responsibility with progress reporting to MHSAL Workforce.
Project Management	• Regional responsibility.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks

- Management of front-line service delivery.
- Political risk, political decision.
- Media management.
- Significant public relations initiative.

Interdependencies

- Management of union expectations – bargaining unit restructuring.

Realign Unfunded Positions

Subtheme: Adjust workforce composition	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 - 24 Months	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Targeted initiative to review positions and roles.
- Identify opportunities to consolidate/collapse positions.
- Follow steps in Initiatives Letter.
- Provide notice to department.
- For unfunded positions, move forward to realign (do not need approval).

Outputs:

- Document detailing communication strategy.
- Conclusion of review of positions and roles along with opportunities to consolidate/collapse positions.
- Draft organizational charts for funded and unfunded positions.

Q2

Key activities:

- Confirmation of approval from government to consolidate/collapse positions.
- Develop new rotations/schedules.
- Notice to Unions – 120 days.
- Meaningful consultations.
- Terminate positions.

Outputs:

- Finalized rotations/schedules.
- Disclosure memorandums to unions.

Q3

Key activities:

- Initiate process to fill new positions (application and hiring process) - 3 month.
- Post new positions.

Outputs:

- Listing of new positions.

Q4

Key activities:

- Fill positions.
- Monitor for implementation and results of policy change.

Outputs:

- Final organizational charts for funded and unfunded positions, and part-time FTEs.
- Ongoing reporting of the change in policy detailing the financial impact.

Realign Unfunded Positions

Subtheme: Adjust workforce composition	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $3M
Implementation Duration: 18 - 24 Months	Implementation Effort: Medium	

2017/2018	2018/2019	2019/2020	2020/2021+
2017/18 high-level activities are noted on the previous opportunity slide	Fill new positions		

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	Interdependencies
• The Manitoba Chiropractors Association (MCA) may challenge the amended policy because it could be viewed as a breach in contractual obligation of the current agreement. • Adverse impact to access to chiropractic services.	• 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.

Reduce Agency Nurses in Rural, Homecare and PCHs

Subtheme: Adjust workforce composition	Benefit Year: 2017/18	Est. Cost Improvement: $1.5M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Focused initiative to review agency/relief practices and workforce with ultimate aim of reducing or eliminating reliance of agency/relief nurses. Focus on rural RHAs, personal care homes and home care. Initiatives would be undertaken as part of an coordinated program across all entities.
Benefit	• Elimination of agency nurses or lower costs based on reconfigured agency/relief nurse structures.
In-scope/ Out of Scope	• Focus on rural agency, personal care homes and home care service delivery.
Key Assumptions	• Initiative can be delivered tactically alongside of other workforce initiatives and collective agreement restructuring.
Governance	• Regional responsibility with progress reporting to MHSAL Workforce.
Project Management	• Regional responsibility.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks	Interdependencies
• Service gaps. • May not be able to recruit for new relieve teams structure.	• Clinical services. • Management of overtime. • Staff scheduling initiatives in various healthcare delivery organizations.

Reduce Agency Nurses in Rural, Homecare and PCHs

Subtheme: Adjust workforce composition | **Benefit Year: 2017/18** | **Est. Cost Improvement: $1.5M**

Implementation Duration: 1 year | **Implementation Effort: Medium**

2017/18

Q1

Key activities:

- Targeted initiatives in sector.
- Assess agency workforce use requirements.
- Assess agency cost structure and policies.
- Assess agency workforce composition.
- Evaluate contracts with agency nurses.

Outputs:

- Report detailing agency workforce use requirements, cost structure and policies, new and desired composition, and evaluation of agency nurse contracts.

Q2

Key activities:

- Staff mix and model.
- Evaluate scope of practice opportunities.
- Identify issues with collective agreements.
- Identify issues and opportunities for improvement.
- Recommendations to close agency positions with full time roles.
- Approval by MHSAL, RHA, delivery organization leadership.

Outputs:

- Conclusion of scope of practice opportunity evaluation.
- Collective agreement issues.
- Conclusion of issues and opportunities for improvement.
- Conclusion of agency position rationalization.

Q3

Key activities:

- Create alternate relief teams including policies, procedures, composition or compensation.
- Redefine relief team positions.
- Post new 1.0 FTE positions.
- Notice to agency nurses.
- Fill positions.

Outputs:

- Listing of new relief team positions.
- Listing of new 1.0 FTE positions.
- Disclosure documents to agency nurses.

Q4

Key activities:

- Activate transition strategy.
- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the change in policy detailing the financial impact.

Enforce Compliance of Overtime

Subtheme: Rationalize employee benefits	Benefit Year: 2017/18	Est. Cost Improvement: $0.8M
Implementation Duration: 9 Months	Implementation Effort: Medium	

Description	WRHA Shared Services currently monitors, through SAP, the scheduling of WRHA staff. WRHA suspect cases exist where overtime is paid when not warranted; cases include: staff are scheduled on overlapping shifts, back-to-back shifts with no travel time, calling in sick at one employer to work at another (while still being paid sick time), and picking up multiple casual assignment shifts that the system calculates as overtime (e.g. overtime reported when daily hours or pay period hours have not been exceeded). Empower the WRHA Shared Services to enforce compliance of overtime and payroll policy across WRHA employers to stop the above cases from occurring.
Benefit	• Mobilize WRHA Shared Services to enforce compliance of payroll and overtime policies across WRHA employers; • Mitigate cases as described above which result in overtime being paid when not warranted.
In-scope/ Out of Scope	• **In-scope**: All employers within the WRHA and their respective employees.
Key Assumptions	• WRHA Shared Services currently cannot legally enforce compliance with overtime and policies across WRHA employers. • This could be done by passing legislation to delegate the WRHA as the *"Employer of Record"* in the region.
Governance	• MHSAL with oversight/implementation management provided by the WRHA.
Project Management	• MHSAL.
Communication Strategy	• Disclosure to WRHA employees should be made to provide details of compliance with overtime and payroll policies, including potential disciplinary actions which may be levied on employees who breach policy, and any other relevant information.

Risks	Interdependencies
• Political risk with delegating WRHA the regions *"Employer of Record"*.	• Collective agreement bargaining process.

Enforce Compliance of Overtime

Subtheme: Rationalize employee benefits	Benefit Year: 2017/18	Est. Cost Improvement: $0.8M
Implementation Duration: 9 Months	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Develop report to analyze overtime and payroll policy breaches. Determine the nature, scope and magnitude of the various policy breaches. • Prepare a business case for action and recommendation on next steps, if appropriate.	**Key activities:** • Identify legal issues with empowering WRHA Shared Services with compliance enforcement accountabilities. • Develop approach/procedures to address legal issues. • Start development of new policy, plan and timing. • Serve notice of the change in policy indicating 120 days until enforcement.	**Key activities:** • Rollout remediation activities in waves. • Finalize new policy. • Communicate new policy.	**Key activities:** • Monitor for implementation and results of policy change.
Outputs: • A report describing overtime and payroll policy breaches. If possible, quantify the financial impact of the various policy breaches. • A business case with action items and recommendations. • Minister approval.	**Outputs:** • A report on legal issues with solutions to overcome. • Report detailing approach/ procedures, planning, timing, and new policy. • Memorandum disclosing change in policy indicating 120 days to enforcement.	**Outputs:** • Memorandum describing the planned remediation activities and the wave sequence.	**Outputs:** • Ongoing reporting of the change in policy detailing the financial impact.

Implement a Parking Rate Increase

Subtheme: Rationalize employee benefits	Benefit Year: 2017/18	Est. Cost Improvement: $0.7M
Implementation Duration: 6 Months	Implementation Effort: Low	

Description	Undertake a province-wide review of employee parking activity to understand the financial impact of parking activity in Manitoba by healthcare organization. Implement a new parking rate increase/subsidy reduction policy, whereby MSHAL specifically targets high demand organizations (e.g. MHSAL, WRHA).
Benefit	• Improve financial impact of providing parking services to healthcare employees by increasing parking revenue collected and/or decreasing parking subsidy expenses incurred.
In-scope/ Out of Scope	**In-scope**: • All healthcare employees, including employees of MHSAL, the RHAs, and other healthcare organizations (e.g. CancerCare, AFM). • Parking rate increases and/or subsidy reductions should be targeted to high demand organizations.
Key Assumptions	• Collective agreements do not prohibit a parking rate increase/subsidy reduction.
Governance	• MHSAL with oversight/implementation management provided by impacted organizations (e.g. MHSAL, WHRA, AFM, DSM, etc.).
Project Management	• MHSAL.
Communication Strategy	• Disclosure of the decision to implement a parking rate increase and/or a subsidy reduction should be communicated to employees. The disclosure should describe how employees may be impacted and should include the effective date of implementation.

Risks	Interdependencies
• May result in employee grievances/complaints. • May result in parking customers seeking out parking in non-MHSAL parking lots resulting in lost revenues for MHSAL.	• Some organizations (e.g., DSM) are reviewing parking rates/subsidies as a component of their managed to budget exercise.

Implement a Parking Rate Increase

Subtheme: Rationalize employee benefits	Benefit Year: 2017/18	Est. Cost Improvement: $0.7M
Implementation Duration: 6 Months	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Conduct a parking services review. Compile parking activity, rates, revenue and cost data at all organizations to understand system demand.
- Develop scenarios to evaluate alternate policy.
- Make decision to implement based on scenario evaluation.

Outputs:

- Identify high demand organizations driving parking revenue and/or costs.
- A range of scenarios detailing the financial impacts to parking revenue and/or costs based on alternate policy parking rates.

Q2

Key activities:

- Disclosure of policy change to staff of affected organizations including the effective implementation date.
- Implement changes to electronic parking control system and/or monthly pass processes.

Outputs:

- Disclosure memorandums of policy change for distribution to affected organizations.
- Updated electronic parking control system and/or monthly passes.

Q3

Key activities:

- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the policy change detailing the financial impact.

Q4

Key activities:

- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the policy change detailing the financial impact.

Review MHSAL Medical Remuneration Process

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $0.6M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	The FFS claims administration of medical remuneration should be centralized with the oversight and accountability processes also centralized. In the short-term, for fee-for-service, attention should focus on increasing audit frequency and tightening up claims administration. In the long term, amendments to legislation will provide the government more leverage in negotiating claims.
Benefit	• In the short-term, reduction in the amount of claims paid out because of tighter claims administration. • In the long term, sustained reduction in the amount of claims paid out because of amendments to legislation
In-scope/ Out of Scope	**In-scope:** • Opportunities within the structure of existing agreements, does not require CPS claims reconfiguration.
Key Assumptions	• Focus on opportunities with existing rules, prior rules, and review within structure of existing payment structure. • Tighten up on outliers. • No rate changes.
Governance	• MHSAL with oversight/implementation management provided by the RHAs and Doctors Manitoba.
Project Management	• MHSAL.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and provincial government.

Risks	Interdependencies
• Potential negotiation uncertainty with Doctors Manitoba. • Potential public relations issues with individual doctors.	• Implementation of $50 million FFS provider changes from last contract negotiation.

Review MHSAL Medical Remuneration Process

Subtheme: Rationalize provider compensation	Benefit Year: 2017/18	Est. Cost Improvement: $0.6M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Review/identify opportunities to streamline administrative enforcement of FFS claims. • Review compliance with existing agreements at RHAs, DSM, CancerCare. • Review alternate funding positions when positions for combination of salary and FFS. • Confirm opportunity areas. • Confirm opportunity areas collaboratively with the RHAs.	**Key activities:** • Develop integrated change proposal. • Confirm direction by Minister or delegate. • Negotiation/discussions with Doctors Manitoba on proposed changes. • Develop FFS adjudication rule changes.	**Key activities:** • Initiate changes to FFS. • Initiate changes to alternate funding. • Initiate compliance change.	**Key activities:** • Monitor for implementation and results of policy change.
Outputs: • Confirm alternative funding options. • Confirm compliance. • Confirm opportunity areas to streamline administrative enforcement of FFS claims.	**Outputs:** • Finalize new FFS adjudication rules to be implemented.	**Outputs:** • Rollout of changes in policy.	**Outputs:** • Ongoing reporting of the change in policy detailing the financial impact.

Reduce Costs of Physicians Operating in Publicly-Funded Sites

Subtheme: Rationalize provider compensation	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 12 - 18 Months	Implementation Effort: High	

Description	The practice of providing medical services in publicly available sites occurs across the system and applies to non-insured services. The magnitude of occurrences varies depending on the medical service provided (e.g. cosmetic surgery is flagged as a high occurrence medical service using publicly-funded facilities). In some cases, physicians are not charged for the use of equipment, supplies and staff when they are providing medical services in public available sites. Develop a business case to assess the usage of publicly available sites by physicians that are not currently being charged for equipment, supplies and staff. Quantify the existing cost borne by the system. Evaluate if policy should be changed to enforce payment for the use of publicly available sites along with the equipment, supplies, and staff resourced during medical service procedures.
Benefit	• Reduce cost borne by the system related to physicians providing services in publicly-funded facilities.
In-scope/Out of Scope	**In-scope:** • All non-insured medical services performed in publicly-funded facilities.
Key Assumptions	• All regions will approve and enforce the fee • Regions will collect fee ADT.
Governance	• MHSAL with oversight/implementation management provided by the RHAs.
Project Management	• MHSAL.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and provincial government.

Risks	Interdependencies
• Access to services in rural regions. • Interaction with insured services administration may be cumbersome. • Potential negotiation uncertainty with Doctors Manitoba. • Potential public relations issues with individual doctors.	• Implementation of $50 million FFS provider changes from last contract negotiation.

Reduce Costs of Physicians Operating in Publicly-Funded Sites

Subtheme: Rationalize provider compensation	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: TBD
Implementation Duration: 12 - 18 Months	Implementation Effort: High	

2017/18

Q1

Key activities:

- Assess scope of services delivered across all sites and regions.
- Determine scope of opportunity and priority areas.
- Assess impacts on facility availability.
- Assess service impacts in rural areas.

Outputs:

- Report detailing scope of services delivered across sites, priority areas, impact of imposing restrictions to facility availability and services in rural areas.

Q2

Key activities:

- Make decision on opportunity and priority areas.
- Obtain Minister approval.
- Initiate discussions with Doctors Manitoba on proposed changes – 6 months.
- Establish detailed implementation plan – 3 months.
- Develop new policy and charging model – 6 months.

Outputs:

- Minister approval.
- Detailed implementation plan.
- New policy and charging model.

Q3

Key activities:

- Disseminate new policy and revenue charging model to healthcare organizations. Allow time to integrate new policy and charging model into ADT system (and other relevant IT systems) to track policy change – 6 months.

Outputs:

- Documentation of new policy and charging model.
- Integration of new policy and charging model into ADT system (and other relevant IT systems).

Q4

Key activities:

- Undertake communication and education to providers.
- Monitor for implementation and results of policy change.

Outputs:

- Ongoing reporting of the change in policy detailing the financial impact.

Reduce Costs of Physicians Operating in Publicly-Funded Sites

Subtheme: Rationalize provider compensation | Benefit Year: 2018/19 and beyond | Est. Cost Improvement: TBD

Implementation Duration: 12 - 18 Months | Implementation Effort: High

2017/2018	2018/2019	2019/2020	2020/2021+
2017/18 high-level activities are noted on the previous opportunity slide	Complete ADT system update for new charging model		

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Work Plan 5: Integrated Shared Services

Notice

This Integrated Shared Services Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

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

This table provides a summary of the total cost savings for the Integrated Shared Services Work Plan broken down by benefit year and sub category.

Sub Category	2017/18 Potential Cost Savings	2018/19 and Beyond Potential Cost Savings	Total
ICT Support Services	-	$21.0M	**$21.0M**
Develop an integrated provincial supply chain	$1.4M	$12.5M	**$13.9M**
Administrative Support Services	$5.7M	-	**$5.7M**
Health Support Services	$0.5M	$2M	**$2.5M**
Transformation support services	-	-	-
TOTAL	**$7.6M**	**$ 35.5M**	**$43.1M**

The following table provides an overview of each opportunity included in the Integrated Shared Services Work Plan

Sub category	Opportunity	Est. Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
ICT Support Services	Medical engineering and MDR consolidation study.	$21M	2018/19 and beyond	RHA contribution with direct reporting to MHSAL	• This is not dependent on the delivery of the clinical services plan but there are some linkages. • ICT Services. • Transportation services.	• Capital or physical space may be required to support implementation.
	Develop a shared services business case and implementation plan for ICT service delivery.	Enabler	2017/18	PPP, with RHA Support	• Provincial Clinical and Preventative Services Plan.	• Barriers to implementation need to be understood and considered carefully in this phase.
Develop an integrated provincial supply chain	Reduce clinical consumables and review contractual arrangements.	$12.5M	2018/19 and beyond	RHA specific initiative with clinical support	• Provincial Clinical and Preventative Services Plan. • Clinical Standards. • Service purchase agreements. • MOU's. • Vendor management.	• Balancing single source vs scale and control.
	Ensure contract compliance opportunities are achieved in all entities.	$1.2M	2017/18	RHA specific initiative	• Dependent on the business case and implementation plan for administrative support services.	• Dependency of legal and regulatory compliance. • Provider preferences exist which need to be validated.

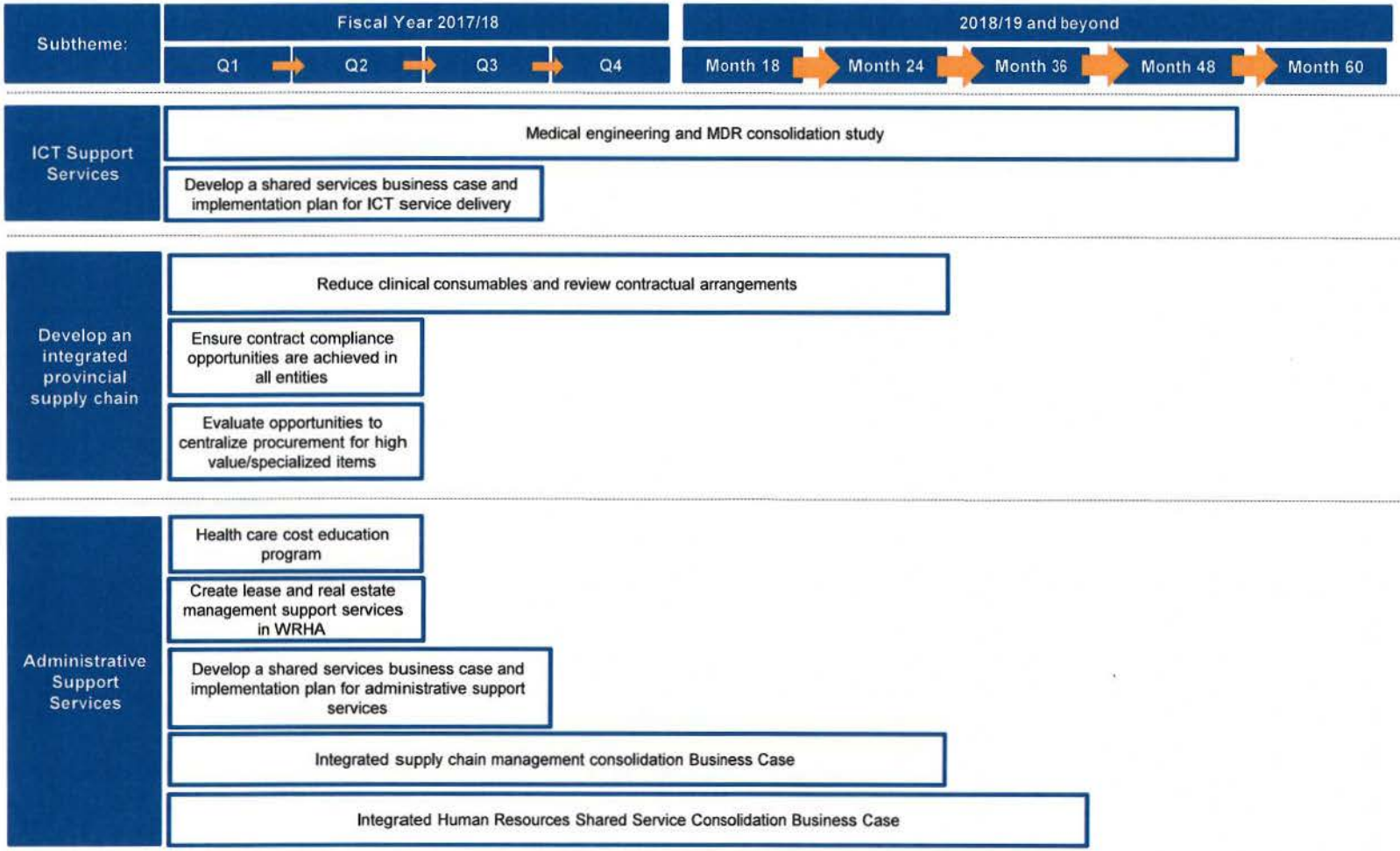
Summary of Opportunities

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.
Health Support Services	Expansion of WRHA RDF to support HSC and SBGH.	$1.4M	2018/19 and beyond	WRHA Capital Planning	• Signed of business case currently in motion. • Capital plan.	• Government doesn't approve current business case in motion. • Aging infrastructure is currently a problem.
	[redacted]	[redacted]	[redacted]	[redacted]	• [redacted] •	• [redacted]

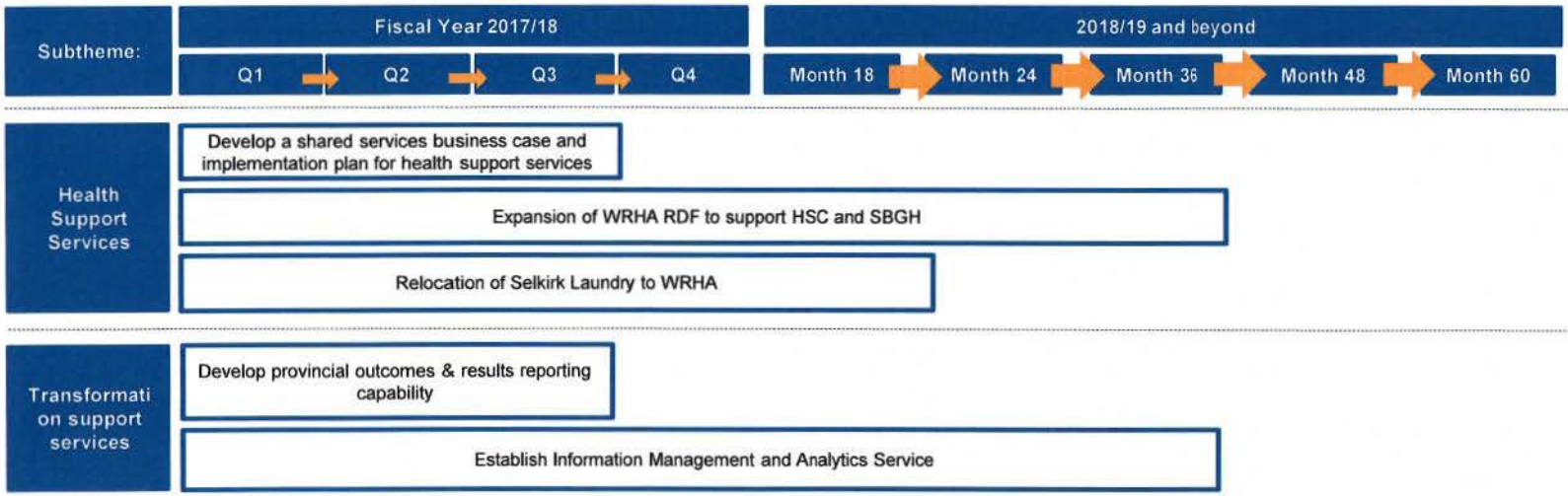
Summary of Opportunities

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



Medical Engineering and MDR Consolidation Study

Subtheme: ICT support services	Benefit Year: 2020/21	Est. Cost Improvement: $21M
Implementation Duration: 36 Months	Implementation Effort: Medium	

Description	Conduct a study to look at the ability to consolidate medical engineering and MDR facilities across the province and develop a new operating model.
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 provincial MDR sites. • Equipment service and maintenance agreements.
Key Assumptions	• TBD.
Governance	• MHSAL.
Project Management	• MHSAL with RHA support.
Communication Strategy	• Strong communications strategy and delivery that covers the impact of consolidating MDR sites across the province. Likely to be high profile coverage.

Risks	Interdependencies
• Capital or physical space may be required to support implementation.	• This is not dependent on the delivery of the clinical services plan but there are some linkages. • ICT Services. • Transportation services.

Medical Engineering and MDR Consolidation Study

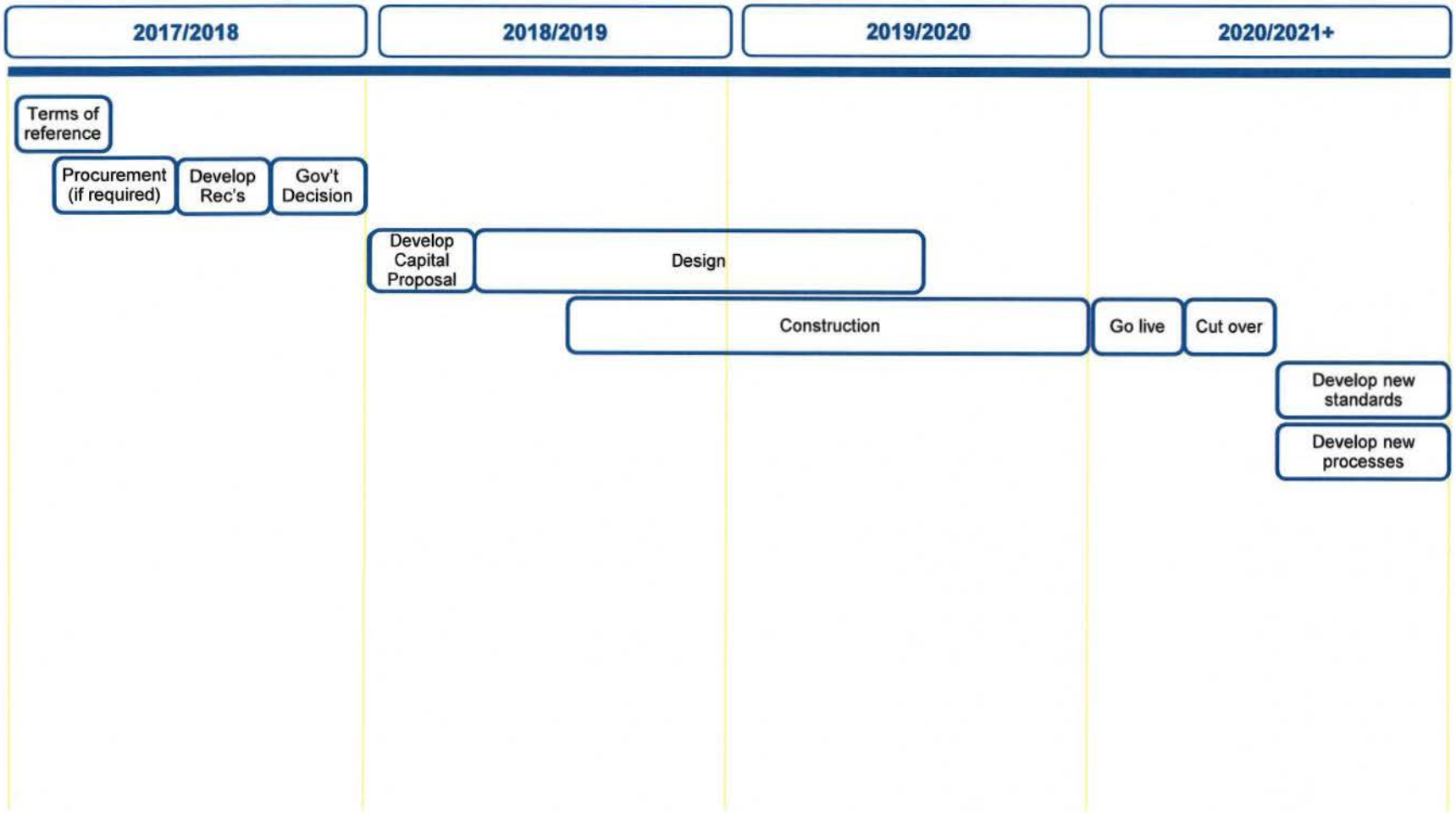
Subtheme: ICT support services	Benefit Year: 2020/21	Est. Cost Improvement: $21M
Implementation Duration: 36 Months	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Develop terms of reference. • Assess internal capacity and capability to complete study; consider procurement as required.	**Key activities:** • Develop recommendations. • Continue Procurement (if required).	**Key activities:** • Develop recommendations.	**Key activities:** • Decision by Government.
Outputs: • Terms of Reference (ToR). • Begin procurement for external support (if required).	**Outputs:** • Procurement outcome (if required).	**Outputs:** • Recommendation document.	**Outputs:** • Decision by Government.

Medical Engineering and MDR Consolidation Study

Subtheme: ICT support services	Benefit Year: 2020/21	Est. Cost Improvement: $21M
Implementation Duration: 36 Months	Implementation Effort: Medium	



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.

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	

2017/18

Q1

Key activities:

- Current state review including:
  - SKUs.
  - Establish/confirm standards under existing contracts.
  - Determine if rebates on specialized / high value items are being received.
  - Review policies and practices on stocking of supplies inpatient rooms.
  - Confirm compliance controls and measures.
  - Identify opportunities for other items to be included.

Outputs:

- Current state review.
- Opportunity analysis.

Q2

Key activities:

- Set targets for clinical supplies use in clinical / delivery units.
- Develop policies to reduce the use of clinical supplies.

Outputs:

- Set supply targets.

Q3

Key activities:

- Continue to develop policies to reduce the use of clinical supplies.

Outputs:

- N/A

Q4

Key activities:

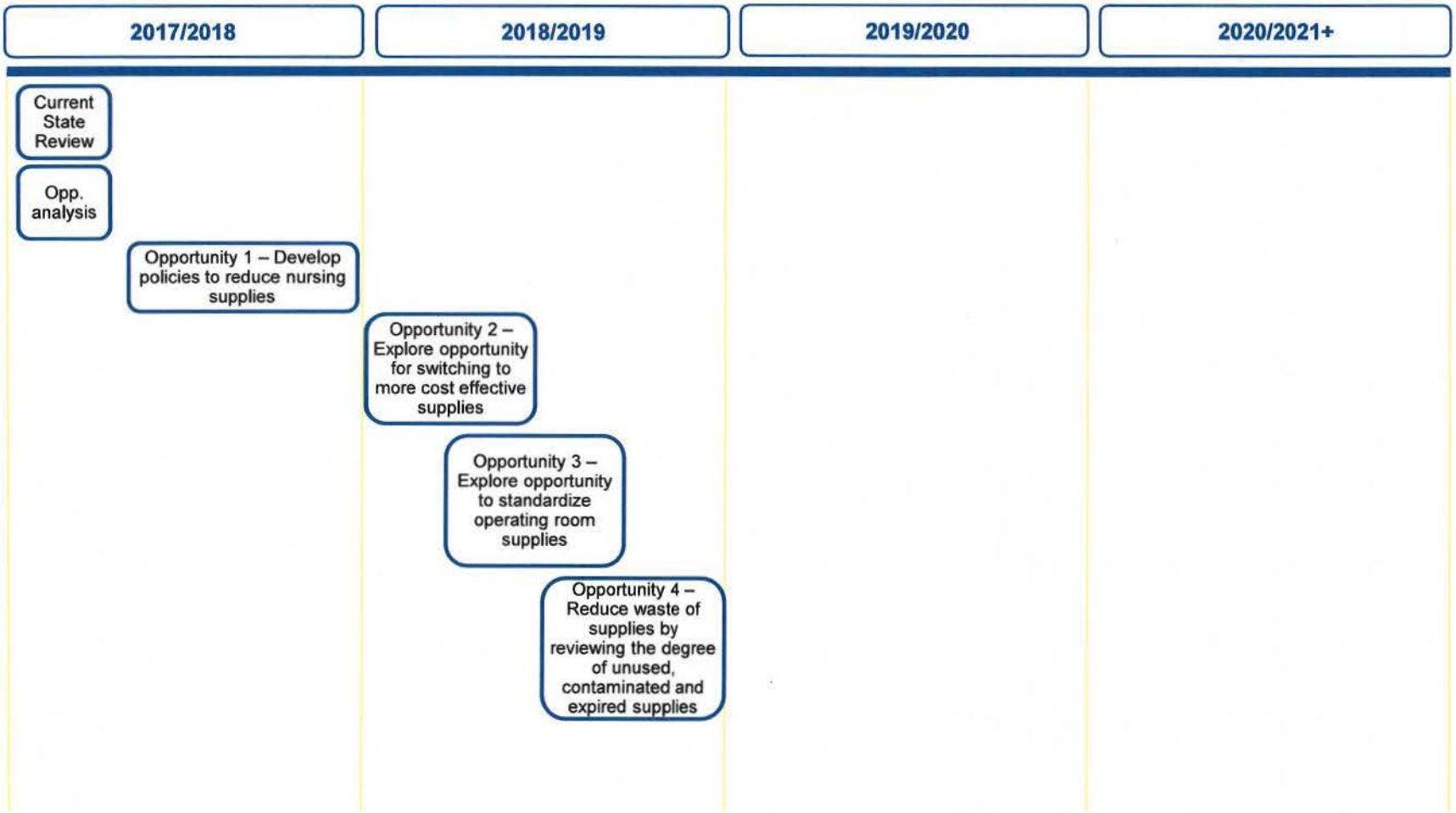
- Continue to develop policies to reduce the use of clinical supplies.

Outputs:

- Policies developed.

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	



Create Lease and Real Estate Management Support

Subtheme: Administrative support services	Benefit Year: 2017/18	Est. Cost Improvement: $5.7M
Implementation Duration: 1 year	Implementation Effort: Medium	

Description	Consolidation of real estate services in WRHA including accommodations management, capital planning, facilities management and housekeeping.
Benefit	• Leveraging WRHA 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**: • Assess requirements of rural RHAs for real estate and lease management support. • Identify options to leverage WRHA support capability.
Key Assumptions	• Small saving opportunity (to be confirmed with MHSAL).
Governance	• MHSAL, Provincial Policy and Programs.
Project Management	• Provincial Policy and Programs with RHA support.
Communication Strategy	• TBD.

Risks	Interdependencies
• TBD	• Interdependency on the continued provision of homecare services. • Infrastructure rationalization strategy. • Relationships with ASD.

Create Lease and Real Estate Management Support

Subtheme: Administrative support services	Benefit Year: 2017/18	Est. Cost Improvement: $5.7M
Implementation Duration: 1 year	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Assess requirements of rural RHAs for real estate and lease management support.
- Identify options for support from WRHA.
- Recommendation and decision by all RHAs and MHSAL.

Outputs:

- Requirements assessment.
- WRHA options support analysis.
- Recommendation.

Q2

Key activities:

- Consolidation of services.

Outputs:

- Consolidation of lease and real estate management services.

Q3

Key activities:

- Monitor for implementation.

Outputs:

- KPI Report.

Q4

Key activities:

- Monitor for implementation.

Outputs:

- KPI Report.

Expand WRHA RDF to Support HSC and SBGH

Subtheme: Health support services	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.4M
Implementation Duration: 36 Months	Implementation Effort: Medium	

Description	Expand the WRHA RDF to support HSC and SBGH under a shared services model. The current kitchens at HSC and SBH would be converted to receiving kitchens.
Benefit	• WRHA RFD would be refitted to support both hospitals. It is estimated that the kitchen at HSC could be reduced by 12,000 square feet and the SBH kitchen by 10,000 square feet. Both would be transformed to receiving kitchens. Conversion would increase current satisfaction rates, improve food quality, introduce advanced technology and introduce upgrades to the kitchens in a cost effective manner.
In-scope/Out of Scope	**In-scope:** • Implementation planning, WRHA RFD upgrade, HSC upgrade, SBHC Upgrade.
Key Assumptions	• Current RDF expansion proposal gets signed off. • Significant cost to transform current facilities to accommodate new arrangement.
Governance	• WRHA.
Project Management	• WRHA Capital Planning.
Communication Strategy	• Key Stakeholders may be concerned that shared services will threaten their business units ability to set and manage the strategic or operational direction of their department. Timely, clear and concise communications on benefits and timeframes to key stakeholders involved in this opportunity.

Risks	Interdependencies
• Government doesn't approve current business case in motion. • Aging infrastructure is currently a problem.	• Signed of business case currently in motion. • Capital plan.

Expand WRHA RDF to Support HSC and SBGH

Subtheme: Health support services	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: $1.4M
Implementation Duration: 36 Months	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Confirm business case:
  - Evaluate standard menus and dietary plans.
  - Expansion relocation options.
  - Options to create additional capacity for other users.
  - Options for potential provincial services provision.
  - Options for decommissioning.
- Develop capital investment proposal.
- Approval by WRHA Executive and Board.
- Develop HR change strategy.

Outputs:

- Signed off business case.
- Approval to proceed .

Q2

Key activities:

- Submission to MHSAL.
- Approval from Government.

Outputs:

- Approval to proceed from MHSAL.

Q3

Key activities:

- Design
- Tender/procurement

Outputs:

- Design documents finalized.
- Procurement period undertaken.

Q4

Key activities:

- Finalized procurement contracts.
- Permitting begins.

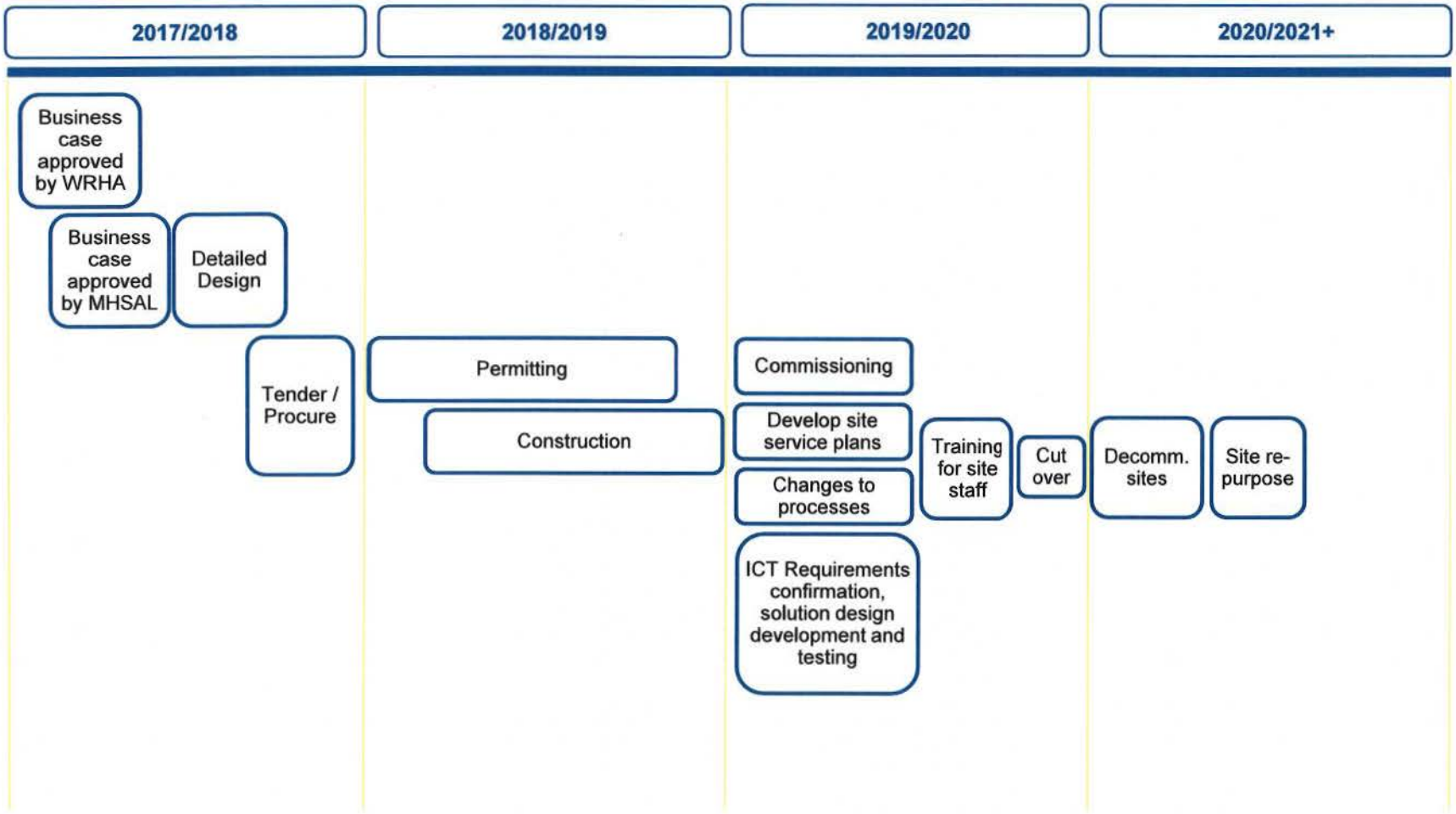
Outputs:

- Contracts
- Permitting begins

Expand WRHA RDF to Support HSC and SBGH

Subtheme: Health support services | **Benefit Year: 2018/19 and beyond** | **Est. Cost Improvement: $1.4M**

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



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.

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	

2017/18

Q1

Key activities:

- Current state review including:
  - SKUs
  - Establish/confirm standards under existing contracts.
  - Test whether all items that are purchased under Healthpro are actually owned by Healthpro.
  - Review whether or not rebates being received.
  - Identify opportunities for other items to be included.
- Identify opportunities for change.
- Finalize actions / decision.

Outputs:

- Current state review.
- Opportunity analysis.
- Decision

Q2

Key activities:

- Communicate changes to providers and sites.
- 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.

Relocate Selkirk Laundry to WRHA

Subtheme: Health support services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $0.7M
Implementation Duration: 20 Months	Implementation Effort: Low	

Description	A shared laundry service has been implemented in the WRHA since 2005. The facility has capability to support increased demand and discussions have been initiated with other areas including Selkirk Mental Health Center and Interlake Eastern RHA to provide laundry support services from this location. This opportunity looks to close the Selkirk Laundry site including operational transfer and equipment decommissioning to the Inkster Laundry site.
Benefit	• Closing the Selkirk site and consolidating operations at the Winnipeg site would maximize the use of space and the time available for increased laundry operation at the Winnipeg site.
In-scope/Out of Scope	**In-scope:** • Business case sign off, impact assessment, service delivery mapping, commissioning / decommissioning service.
Key Assumptions	• This should not require any capital investment. • Impact on the town of Selkirk to be taken into consideration.
Governance	• WRHA
Project Management	• WRHA
Communication Strategy	• Likely FTE reduction at Selkirk. Understand the impact sufficiently and communicated changes early.

Risks	Interdependencies
• That the impacts are fully understood of staff reductions.	• Interdependency on the continued provision of homecare services. • In line with the capital plan.

Relocate Selkirk Laundry to WRHA

Subtheme: Health support services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $0.7M
Implementation Duration: 20 Months	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Confirm business case:
  - Cost effectiveness analysis.
  - Jurisdictional scan.
  - Alternative service delivery options.
  - Decommissioning options analysis.
- Develop capital investment proposal.
- Develop HR strategy and plan.
- Approval by WRHA Executive and Board.

Outputs:

- Signed off business case.
- Approval to proceed.

Q2

Key activities:

- Submission to MHSAL.
- Approval from government.
- Develop communication strategy and plan.
- Notification for hiring / termination.

Outputs:

- Approval to proceed from MHSAL.

Q3

Key activities:

- Detailed design of future state.
- Site / facility design.

Outputs:

- Design documents finalized

Q4

Key activities:

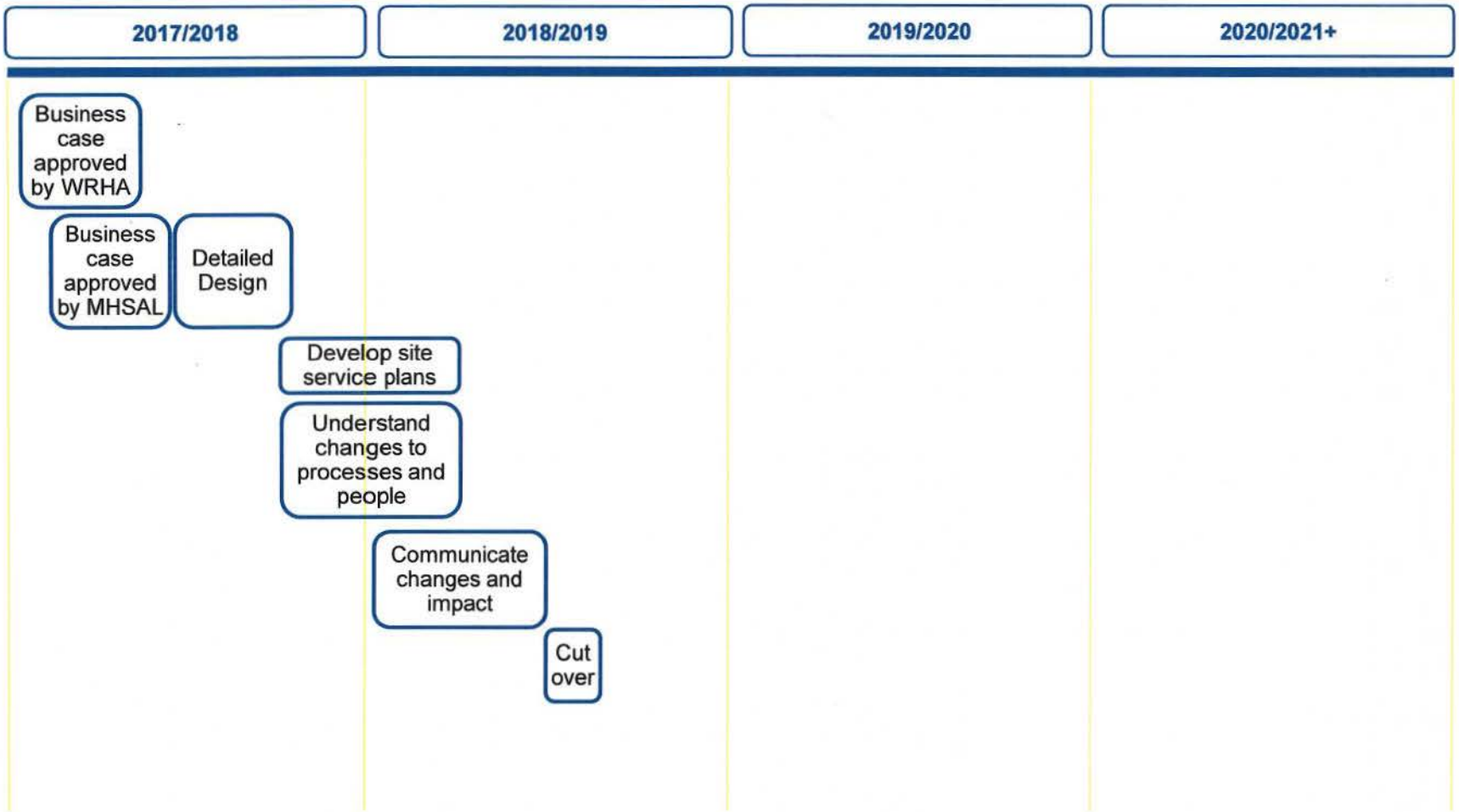
- Develop site service plans.
- Develop logistics plan.
- Understand changes to processes and people.
- Relocation exercise.
- Initiate decommissioning exercise.

Outputs:

- Site services plans.
- Impact assessment on people and process.

Relocate Selkirk Laundry to WRHA

Subtheme: Health support services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: $0.7M
Implementation Duration: 20 Months	Implementation Effort: Low	



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	

Description	Develop business case and implementation plan for the consolidation of health support services across the province including: • Dietary and food services; • Laundry; • Diagnostic Services; • Call Centre; and • Other clinical support services like medical device reprocessing.
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**: • Opportunity identification, costs of implementation, high-level timeframes, quantification of costs and benefits, recommendation. • Potential opportunity to include provincial transportation in-scope of this study.
Key Assumptions	• Governance backs this opportunity and is able to devote the time, support and input into the business case and implementation plan.
Governance	• MHSAL, Provincial Policy and Programs.
Project Management	• Provincial Policy and Programs with RHA support.
Communication Strategy	• To be developed as part of this opportunity.

Risks	Interdependencies
• Barriers to implementation need to be understood and considered carefully in this phase. Resistance to change, limitations of existing systems, executive commitment, change champions, expectation management, cross functional team.	• Provincial Clinical and Preventive Services Plan. • Provincial transportation opportunity.

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.

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Integrated Shared Services: Enabling Opportunities

Funding for Performance

Shared Services Business Case and Implementation Plan for Enhanced Admin Support Services

Subtheme: Administrative Support Services	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 9 Months	Implementation Effort: Low	

Description	Develop business case and implementation plan for the consolidation of administrative support services across the province including: • Finance including budgeting, cash management, comptrollership, reporting and performance management. • Real estate including accommodations management, capital planning, facilities management and housekeeping. • Legal including legislative and privacy compliance and commercial legal services. • Communications including public relations, advertising and production.
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**: • Opportunity identification, costs of implementation, high-level timeframes, quantification of costs and benefits, recommendation.
Key Assumptions	• Governance backs this opportunity and is able to devote the time, support and input into the business case and implementation plan. • Alignment/coordination with Provincial processes where appropriate. • Alignment with health workforce.
Governance	MHSAL, Provincial Policy and Programs.
Project Management	Provincial Policy and Programs with RHA support.
Communication Strategy	To be developed as part of this opportunity.

Risks	Interdependencies
• Barriers to implementation need to be understood and considered carefully in this phase. Resistance to change, limitations of existing systems, executive commitment, change champions, expectation management, cross functional team.	• Alignment/coordination with Provincial processes where appropriate. • Alignment with health workforce.

Shared Services Business Case and Implementation Plan for Enhanced Admin Support Services

Subtheme: Administrative Support Services	Benefit Year: 2017/18	Est. Cost Improvement: 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 initial analysis 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:

- Initial findings
- '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.

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.

Integrated Supply Chain Management Consolidation Business Case

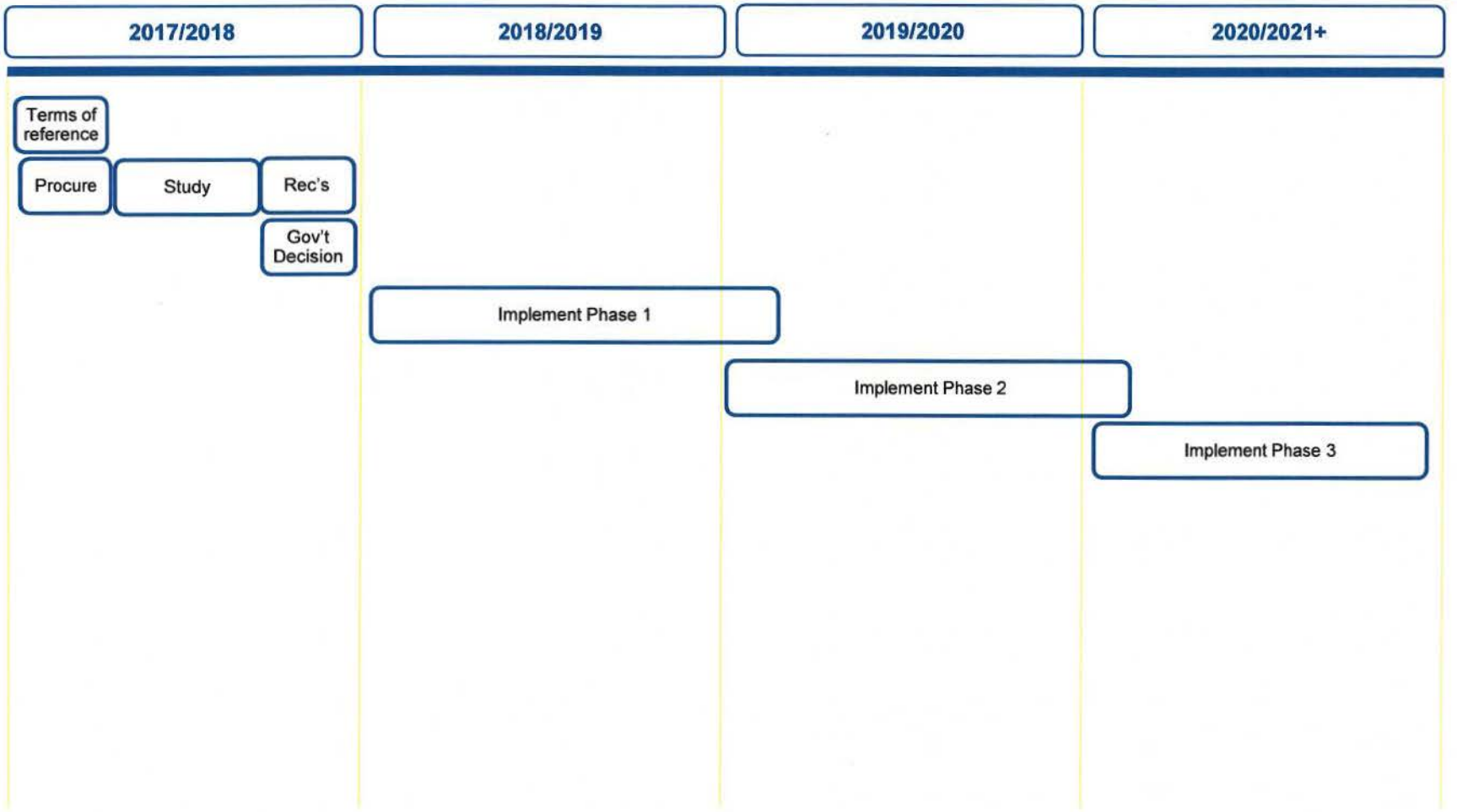
Subtheme: Administrative support services	Benefit Year: 2018/19 and Beyond	Est. Cost Improvement: Enabler
Implementation Duration: 36 Months	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Assess internal capacity and capability. • Identify and outline distribution and storage locations and processes.	**Key activities:** • Develop terms of reference. • Procurement (if required, may be internal capability or require external expertise).	**Key activities:** • Conduct business case and implementation plan. • Develop recommendations.	**Key activities:** • Proposal to Government. • Decision by Government.
Outputs: • Identify opportunities for change, consolidation, or reconfiguration.	**Outputs:** • Terms of Reference • Complete procurement (if required).	**Outputs:** • Business case and implementation plan. • Recommendations.	**Outputs:** • Decision by Government.

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	



Integrated Human Resources Shared Service 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 HR shared services across the province and develop a new operating model. This business case will make a decision whether or not the focus is solely on HR transactional payroll and benefits administration, or should also be expanded to include integrated workforce management service. In addition, this business case will evaluate the placement of the following functions: labour relations, recruitment, payroll/benefits administration, health workforce planning, medical staff administration (including support for credentialing), and workplace safety and health.
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:** • HRS/ERP system across all regions and PSOs. • Rationalization of sites. • Use and adaptation of integrated information system. • Rationalization/integration of services with HEBP/HEPP delivery. • Alignment with the Provincial Clinical and Preventative Services Plan.
Key Assumptions	• Alignment/coordination with Provincial processes where appropriate. • Alignment with health workforce.
Governance	• MHSAL, Provincial Policy and Programs.
Project Management	• Provincial Policy and Programs with support from RHA's.
Communication Strategy	• TBD as part of this opportunity.

Risks	Interdependencies
• Barriers to implementation need to be understood and considered carefully in this phase.	• Core dependency on Healthcare Workforce Work Plan. • Provincial Clinical and Preventative Services Plan.

Integrated Human Resources Shared Service Consolidation Business Case

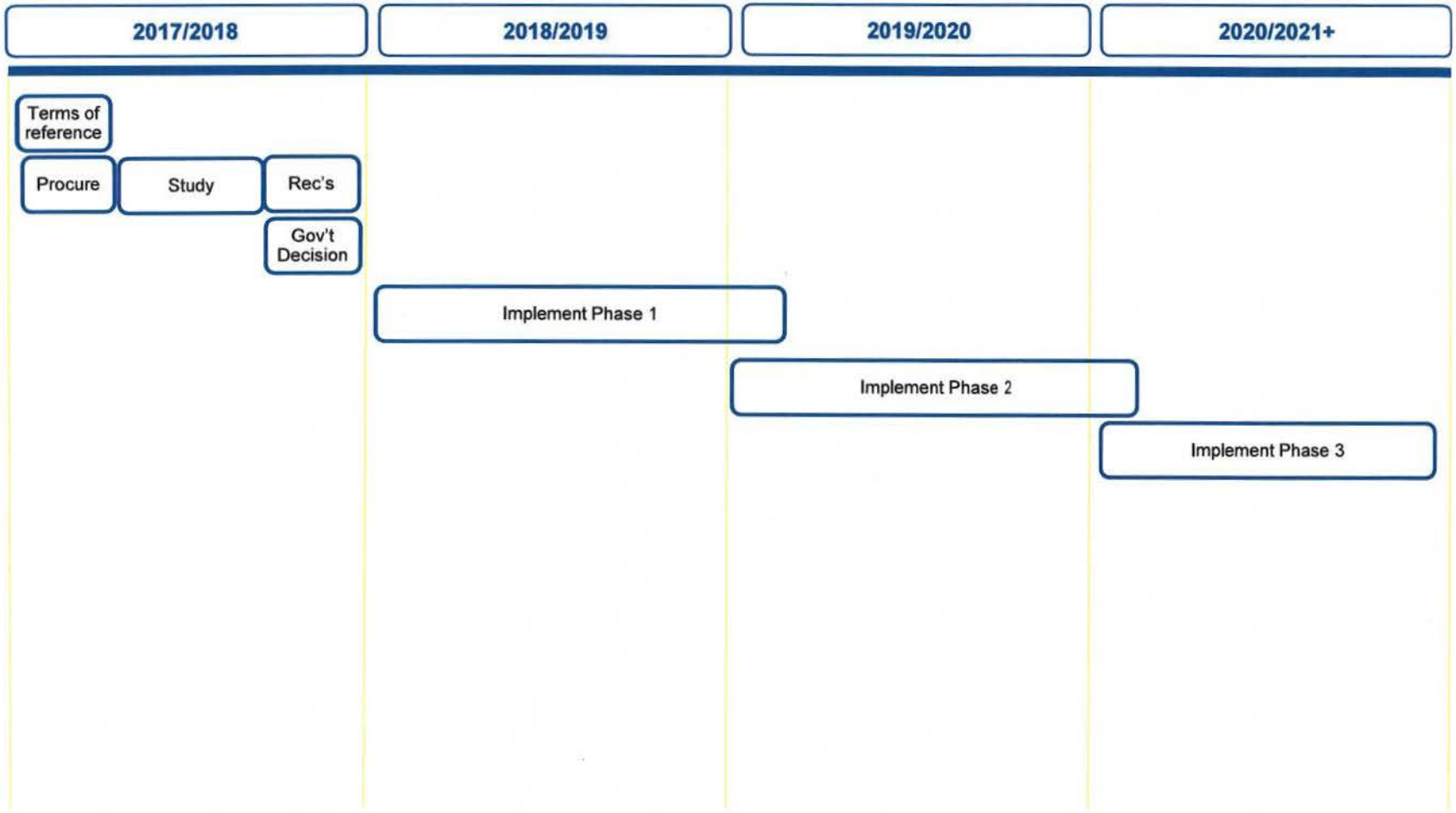
Subtheme: Administrative support services	Benefit Year: 2018/19 and beyond	Est. Cost Improvement: Enabler
Implementation Duration: 36 Months	Implementation Effort: Medium	

2017/18

Q1	Q2	Q3	Q4
Key activities: • Assess internal capacity and capability to complete. • Develop terms of reference. • Procurement (if required).	**Key activities:** • Start to conduct business case & implementation plan.	**Key activities:** • Continue business case. • Develop recommendations.	**Key activities:** • Proposal to Government. • Decision by Government.
Outputs: • ToR • Complete procurement (if required).	**Outputs:** • N/A	**Outputs:** • Business case & implementation plan. • Recommendation document.	**Outputs:** • Decision by Government.

Integrated Human Resources Shared Service Consolidation Business Case

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



Health Care Cost Education Program

Subtheme: Administrative support services	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 6 Months	Implementation Effort: Low	

Description	Conduct a healthcare cost education campaign for staff and management to educate and raise awareness on the true cost of healthcare.
Benefit	• Create a common understanding of healthcare cost including the benefits of 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:** • RHA's, MHSAL.
Key Assumptions	• Governance needs to lead the rollout of this campaign for it to be successful.
Governance	• MHSAL, Provincial Policy and Programs.
Project Management	• Provincial Policy and Programs with support from RHA's.
Communication Strategy	• Strong communication stream needs to be developed for this opportunity focusing on 'why' the campaign is taking place. Key messages need to be delivered from the top down.

Risks	Interdependencies
• No interdependencies with any other work stream. This is short-term tactical opportunity.	• Non reliant on the development of the Provincial Clinical and Preventative Services Plan.

Health Care Cost Education Program

Subtheme: Administrative support services	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 6 Months	Implementation Effort: Low	

2017/18

Q1

Key activities:

- Identify key issues to address.
- Identify key stakeholder groups.
- Develop communication plan.
- Develop communication aids and messages.
- Develop campaign structure and plan.

Outputs:

- Governance ownership.
- Communications plan and aids.

Q2

Key activities:

- Continue to develop campaign structure and plan.
- Launch campaign.

Outputs:

- Campaign structure and plan.
- Execution of campaign.

Q3

Key activities:

- Monitor spend to look for change.

Outputs:

- Monitor spend.

Q4

Key activities:

- Monitor spend to look for change.

Outputs:

- Monitor spend.

Shared Services Business Case and Implementation Plan for Consolidated ICT Service Delivery

Subtheme: ICT Support Services	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 9 Months	Implementation Effort: Low	

Description	Develop a business case and implementation plan for the consolidation of ICT service delivery across the province including: • Clinical ICT; • Administrative ICT; • Core ICT Infrastructure; • Medical Device Management; and • Clinical Engineering.
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**: • Opportunity identification, costs of implementation, high-level timeframes, quantification of costs and benefits, recommendation.
Key Assumptions	• Governance backs this opportunity and is able to devote the time, support and input into the business case and implementation plan.
Governance	• MHSAL, Provincial Policy and Programs.
Project Management	• Provincial Policy and Programs with support from RHA's.
Communication Strategy	• To be developed as part of this opportunity.

Risks	Interdependencies
• Barriers to implementation need to be understood and considered carefully in this phase. Resistance to change, limitations of existing systems, executive commitment, change champions, expectation management, cross functional team.	• Provincial Clinical and Preventative Services Plan

Shared Services Business Case and Implementation Plan for Consolidated ICT Service Delivery

Subtheme: ICT Support Services	Benefit Year: 2017/18	Est. Cost Improvement: 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

Develop Provincial Outcomes and Results Reporting Capability

Subtheme: Transformation support services	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 9 Months	Implementation Effort: Medium	

Description	Develop integrated provincial performance dashboard report applicable to all sites and programs for use as a system management tool across MHSAL, all RHAs and health delivery organizations. This is in an effort to accelerate the development of a province-wide outcomes and results reporting capability.
Benefit	• Critical enabler for more effective and efficient business and financial management, workforce planning, clinical performance, and patient outcomes and experience.
In-scope/Out of Scope	**In-scope**: • Review of existing measure for MIS, statistical key data. • Evaluate existing solutions southern health performance, PHSPIP, WRHA dashboard. • Ability to assess against external benchmarks (Other jurisdictions / other clinical guidelines). • Applicable across MHSAL, RHA's, CCMB, AFM, and DSM.
Key Assumptions	• Each health delivery organization has the resource available to learn and support the development and use of a provincial outcomes and results reporting dashboard. • Provincial priorities are defined. • Sufficient IM&A capability and capacity exists to monitor and govern ongoing dashboard quality. • Aggregated reporting data will not contain personal health information.
Governance	• MHSAL-led with support from RHA's, CCMB, AFM, and DSM.
Project Management	• MHSAL / eHealth with support from RHA's, CCMB, AFM, and DSM.
Communication Strategy	• Communicating the benefits of robust outcomes and results reporting dashboard. • Will be developed as part of this initiative to focus on specific audiences.

Risks

- Lack of input from each region to support the development of a provincial wide reporting dashboard.
- Inconsistency in the provision of data for provincial reporting dashboard.
- Discrepancies in data due to the current information system environment across the region make it difficult or impossible to develop and support a consistent provincial wide reporting dashboard.

Interdependencies

- 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.

Develop Provincial Outcomes and Results Reporting Capability

Subtheme: Transformation support services	Benefit Year: 2017/18	Est. Cost Improvement: Enabler
Implementation Duration: 9 Months	Implementation Effort: Medium	

2017/18

Q1

Key activities:

- Define/confirm list of critical measures.
- Review inventory of existing data and information.
- Identify delivery alternatives.
- Integrate key data sets from RHAs and health delivery organizations.
- Procurement step – Project development and funding proposal.

Outputs:

- List of measures.
- Provincial reports dashboard.
- Governance team set up.

Q2

Key activities:

- Continue procurement step.
- Design/develop integrated outcomes & results dashboard.
- Develop and implement a standardized data warehouse solution.
- Establish governance team to support the ongoing ownership of dashboard performance reporting.

Outputs:

- Standardized data warehouse.
- Governance team.

Q3

Key activities:

- Establish communication to communicate expectations.
- Deliver training to all RHA's and health delivery organizations on the new dashboard.
- Launch.

Outputs:

- Communication.
- Training.
- Go Live.

Q4

Key activities:

- Monitor quality of dashboard reporting.
- Annual refresh of data measures.

Outputs:

- Dashboard monitoring.

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.

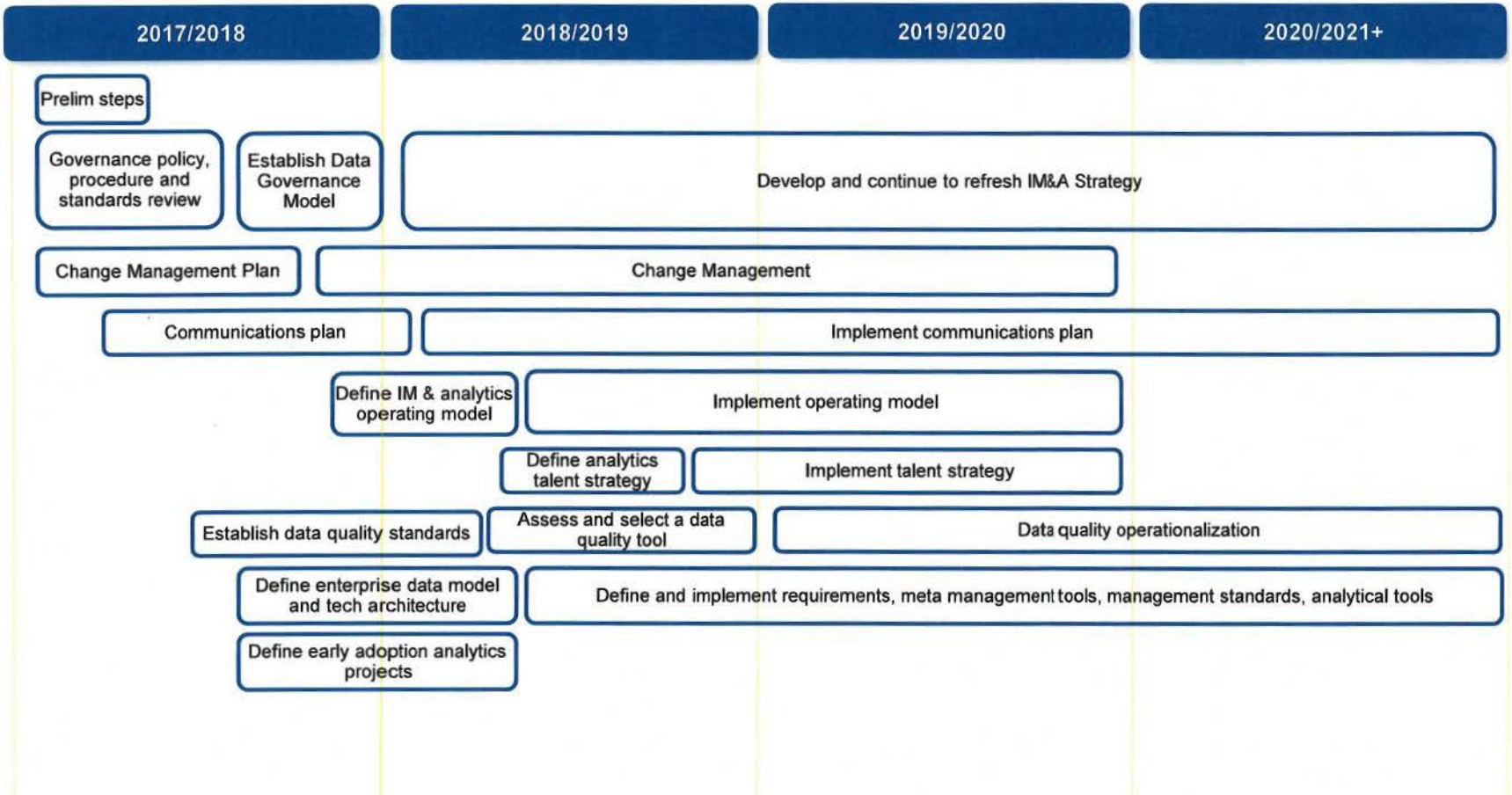
Outputs:

- 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**



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Work Plan 6: Infrastructure Rationalization

Notice

This Infrastructure Rationalization Work Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

Summary

This table provides a summary of the total cost savings for the Infrastructure Rationalization Work Plan broken down by benefit year and sub category.

Sub Category	2017/18 Cost Savings	2018/19 and Beyond Cost Savings	Total
Foundational - Capital Planning, Management and Delivery	$ 1.4 M	$ 21.8 M	$ 23.2 M
Implement new standards for infrastructure delivery	-	$ 24 M	$ 24 M
Capital Planning Optimization	-	-	-
Leverage external/ alternative funding and service delivery models	-	$ 16.5 M	$ 16.5 M
TOTAL	**$ 1.4 M**	**$ 62.3M**	**$ 63.7M**

The following table provides an overview of each opportunity included in the Infrastructure Rationalization Work Plan.

Sub category	Opportunity	Est Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Foundational - Capital Planning, Management and Delivery	Develop Long Term Infrastructure Strategy and Set Healthcare Priorities.	$1.4M $21.8M	2017/18 2018/19 and Beyond	MHSAL 1 FTE	• Government-wide capital improvement initiatives. • Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services plan. • Asset registry and market outlook.	• Resource shortage required to pursue the development of a high quality long term infrastructure strategy aligned with key interdependencies; • Resource shortage to determine where human resource capacity/skills gaps and shortages exist in the system; • Administrative disinterest in alternative construction funding methods (e.g., P3) because of an absence of familiarity to such methods; and • Depending on priority, possible transient reduction to delivery services. • Political risks.
	Develop a Health System Asset Registry and Market Outlook.	N/A	2017/18	MHSAL 1 FTE	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan.	• Lack of readily available information to conduct study. • Difficulty in gathering information to provide accurate, reliable registry/outlook. • Cost prohibitive to undergo process to conduct/contract out the work.

Summary

Sub category	Opportunity	EST Cost Savings	Benefit Year	Project Management Requirement	Key Interdependencies for Implementation	Key Risks for Implementation
Implement new standards for infrastructure delivery	Update and/or develop new MHSAL (and RHA) infrastructure delivery standards.	$24M	2018/19 and Beyond	MHSAL 1 FTE	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan.	• Lack of resources to pursue initiative to update policies/processes. • Administrative disinterest in P3 funding options given it is not a method traditionally used in the Province.
Capital Planning Optimization	Promote Greater Due Diligence in Upfront Project Planning.	N/A	2017/18	MHSAL 1 FTE	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan. • To be implemented in junction with "Post-project Funding Approval – Improving Project Oversight" opportunity (see joint implementation timeline).	• Lack of expertise and resources to pursue initiative to develop standard processes, identify required outcomes, etc., to increase the quality of the due diligence process that project planning should undergo.
	Post-project Funding Approval – Improving Project Oversight.	N/A	2017/18	MHSAL 1 FTE	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan. • To be implemented in junction with "Promote greater due diligence in upfront project planning" opportunity (see joint implementation timeline).	• May not have resources to monitor/track infrastructure performance measures needed for decision makers to evaluate the progress of the project. • Decision makers may not have the expertise to evaluate the infrastructure performance measures.
Leverage external/ alternative funding and service delivery models	Leverage federal government investment.	$16.5M	2018/19 and Beyond	MHSAL 1 FTE	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan.	• Negotiating investment from federal government may be time consuming and their investment interests may not align to the provinces.

Work Plan - High Level Roadmap

Subtheme:	Fiscal Year 2017/18				2018/19 and beyond				
	Q1	Q2	Q3	Q4	Month 18	Month 24	Month 36	Month 48	Month 60
Foundational – Capital Planning, Management and Delivery	Develop Long Term Infrastructure Strategy and Set Healthcare Priorities								
	Develop a Health System Asset Registry and Market Outlook								
Implement new standards for infrastructure delivery	Update and/or develop new MHSAL (and RHA) infrastructure delivery standards								
Capital Planning Optimization	Promote greater due diligence in upfront project planning								
	Post-project funding approval – Improving project oversight*								
Leverage external/alternative funding and service delivery models	Leverage Federal Government Investment for Northern Infrastructure Development								

Develop Long Term Infrastructure Strategy and Set Healthcare Priorities

Subtheme: Foundational - Capital Planning, Management and Delivery	Benefit Year: 2018/19 and Beyond	Cost Savings: $23.2M
Implementation Duration: >48 Months	Implementation Effort: High	

Description

MHSAL should plan and develop a long-term infrastructure strategy and set healthcare priorities. The strategy and priorities should align to Government-wide capital improvement initiatives, the healthcare strategic system realignment process and the provincial clinical services plan. While the time horizon of the overall strategy should reflect a long-term focus, tactful shorter term prerequisite activities, such as the development of a health system asset registry and market outlook (discussed in the next opportunity section), should commence in 2017/18.

Integral to the strategy is the amendment of, or development of new, MHSAL (and RHA) policies, processes, and procedures. Existing documentation, such as The Capital Planning Manual (1992), may be dated and potentially misaligned with the current infrastructure needs of the healthcare system. Policies, process, and procedures should be designed to incorporate broad healthcare reforms and desired outcomes (e.g., patient-centred design and performance specifications; shifting reliance from institutional to home care service delivery for long-term care patients), consider the use of technology to avoid/minimize capital-intensive needs, and reinforce long term sustainability (e.g., build flexibility where possible to share resources and/or address changing needs). MHSAL could consider leveraging guides from Canadian provinces as a starting point; Alberta's guidelines for continuing care facilities can be found at the following link: www.health.alberta.ca/documents/CC-Design-Guidelines-Facilities-2014.pdf.

The overall policies, processes, and procedures and strategy planning propose should consider factors such as:

- The need to own capital intensive assets versus lease and the appropriate balance of maintenance and new capital spend;
- Acuity reconfiguration and opportunities to reduce the overall footprint;
- Partnership opportunities (e.g., integrated services; sharing space);
- A broader toolkit of funding options for capital investments;
- Standard evaluation criteria to evaluate and prioritize project proposals (including alignment with population-based needs, and return on investment/value), prior to being considered for funding approval;
- The prioritization methodology should distinguish conceptual projects (in the early planning stages) from detailed projects (those that are ready for funding decisions, supported by a business case). Priority conceptual projects should be confirmed prior to spending significant funds on developing a functional program and/or design work; and
- Internal multi-year capital spending targets and project priorities.

Some initial priorities (in no particular order) are identified to include, but are not limited to, the following:

- Address the human resource capacity/skills shortages across the system to improve project management and spending;
- Explore and evaluate alternative construction funding methods for healthcare facilities (e.g., design-build, P3);
- Evaluate infrastructure needs for EMS service delivery across rural Manitoba;
- Evaluate infrastructure needs for rural pharmacy service delivery, focusing on specialized drug management;
- Evaluate infrastructure needs of Winnipeg hospitals to reduce primary care wait times in emergency departments, ICUs, etc.;
- Evaluate the closure of the four Winnipeg quick care clinic ***(potential immediate 2017/18 opportunity)***.

Net cost savings from these limited initial infrastructure priorities together are estimated to potentially reach $21.8 million.

Develop Long Term Infrastructure Strategy and Set Healthcare Priorities

Subtheme: Foundational - Capital Planning, Management and Delivery	Benefit Year: 2018/19 and Beyond	Cost Savings: $23.2M
Implementation Duration: >48 Months	Implementation Effort: High	

Benefit	• A long-term standard, consistent infrastructure strategy to help guide and prioritize capital investments within the system. • Concrete infrastructure priorities.
In-scope/Out of Scope	• MHSAL infrastructure assets (in-scope assets will vary depending on the priority).
Key Assumptions	• Ensure alignment with government-wide capital improvement initiatives, including the newly formed Deputy Minister committee (e.g., long-term capital planning and prioritization; alternative delivery models; asset management).
Governance	• MHSAL.
Project Management	• MHSAL with implementation management from the Infrastructure Secretariat and the Capital Planning Council.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks

- Resource shortage required to pursue the development of a high quality, long-term infrastructure strategy aligned with key interdependencies;
- Resource shortage to determine where human resource capacity/skills gaps and shortages exist in the system;
- Administrative disinterest in alternative construction funding methods (e.g., P3) because of an absence of familiarity to such methods; and
- Depending on priority, possible transient reduction to delivery services.
- Political risks.

Interdependencies

- Government-wide capital improvement initiatives.
- Strategic System Realignment Work Plan.
- Core Clinical and Healthcare Services Work Plan.
- Provincial Clinical and Preventative Services Plan.
- Asset registry and market outlook.

Develop Long Term Infrastructure Strategy and Set Healthcare Priorities

Subtheme: Foundational - Capital Planning, Management and Delivery	Benefit Year: 2018/19 and Beyond	Cost Savings: $23.2M
Implementation Duration: >48 Months	Implementation Effort: High	

2017/18

Q1

Key activities:

- Develop terms of reference for a review of healthcare policies, procedures, and processes while being aware of current infrastructure needs and key interdependencies. The review should include a current state analysis, gaps analysis to infrastructure needs and interdependencies, set priorities, and provide considerations to develop a desired future state of policies, procedures and processes to set a tone for a long term strategy.
- Propose closure of 4 quick care clinics in the WRHA to Government.

Outputs:

- Terms of reference and request for proposal.
- Proposals from procurement process.

Q2

Key activities:

- Commence procurement process of a review of healthcare policies, procedures, and processes.
- Finalize procurement process.
- Conduct review of policies, procedures and processes.
- Approve closure of 4 quick care clinics in WRHA.

Outputs:

- Obtain the review and evaluate considerations from the review.
- Close 4 quick care clinics in the WRHA.

Q3

Key activities:

- Develop business cases to implement considerations from the review, including amendments to policies, processes and procedures, the development of a long-term healthcare infrastructure strategy, and the identification and prioritization of initial infrastructure priorities.

Outputs:

- Various business cases covering topics listed above and associated proposals to government to implement various priorities.

Q4

Key activities:

- Develop business cases to implement considerations from the review, including amendments to policies, processes and procedures, the development of a long term healthcare infrastructure strategy, and the identification and prioritization of initial infrastructure priorities.

Outputs:

- Various business cases covering topics listed above and associated proposals to government to implement various priorities.
- Decisions by Government on business cases proposed during Q3 to be implemented.

Develop Long Term Infrastructure Strategy and Set Healthcare Priorities

Subtheme: Foundational - Capital Planning, Management and Delivery	Benefit Year: 2018/19 and Beyond	Cost Savings: $23.2M
Implementation Duration: >48 Months	Implementation Effort: High	

2017/2018	2018/2019	2019/2020	2020/2021+

Wave 1 - Development of infrastructure policies, processes, and procedures

Wave 2 - Address the human resource capacity/skills shortages across the system to improve

Wave 3 - Explore and evaluate alternative construction funding methods for healthcare facilities (e.g., design build, P3)

Wave 4 - Evaluate infrastructure needs for EMS service delivery across rural Manitoba

Wave 5 - Evaluate infrastructure needs for rural pharmacy service delivery, focusing on specialized drug management

Wave 6 - Evaluate infrastructure needs of Winnipeg hospitals to reduce care wait times in emergency departments, ICUs, etc.

The following timeline is for illustrative purposes. Actual timing of the waves will be dependent upon the completion of business cases, Government approval, and the setting of priorities.

Update and/or Develop New Healthcare Infrastructure Delivery Standards

Subtheme: Implement new standards for infrastructure delivery	Benefit Year: 2018/19 and Beyond	Cost Savings: $24M
Implementation Duration: 48 months	Implementation Effort: High	

Description	MHSAL (and RHAs) may wish to consider implementing new/updating standards for the consistent delivery and provision of healthcare infrastructure. The Province's existing standards for facility design and construction are not current with leading practices. This is particularly true for uses like long-term care (LTC) and mental healthcare where standards emphasize institutional standard structures and leading practice has moved to smaller supportive housing models. MHSAL should consider evaluating the infrastructure standard model alternatives for services such as, but not limited to, hospitals, LTC, community Quick Care clinics, labs and diagnostic services, special healthcare facilities, transportation and logistics, healthcare office, ALC, housing delivery programs, alternate non-clinical uses and Provincial Nursing Stations. There is an opportunity to modernize procurement processes and standards across the system to facilitate 'best value' decisions and greater value for taxpayer dollars. In line with leading practices, the evaluation process for large-scale, complex projects should be two-staged and project-specific; evaluation criteria should include consideration of supplier experience, performance history, demonstrated abilities, local knowledge, lifecycle cost considerations, and innovation. Other considerations include guidelines for conflict of interest, vendor debriefings and promoting fairness and transparency in procurement processes and decisions. Timely and efficient decision-making is needed as approved projects progress through key stages (proposal, functional programming, design, construction, etc.) to mitigate (potentially significant) unnecessary costs. Following standards for project evaluation and reporting should be mandatory for funding to be released. The estimated $24M cost savings is broken down as follows: 1. Evaluate LTC infrastructure model alternatives (2018/19 and beyond opportunity). $19.0M 2. Evaluate ALC infrastructure model alternatives for WRHA patients (2018/19 and beyond opportunity). $ 5.0M 3. Rationalize community Quick Care clinics (2017/18 opportunity). $ 1.4M Evaluation of infrastructure standard models other than for LTC and ALC may yield additional savings.
Benefit	• Leading practice infrastructure delivery standards.
In-scope/Out of Scope	• The Capital Planning Manual (1992) and related documentation related to capital planning, management and delivery standards.
Key Assumptions	• Ensure alignment with government-wide capital improvement initiatives (e.g., long-term capital planning and prioritization; alternative delivery models; asset management).
Governance	• MHSAL.
Project Management	• MHSAL with implementation management from the Capital Planning Council.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks	Interdependencies
• Lack of appetite/resources to pursue initiative to update standards.	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan.

Update and/or Develop New Healthcare Infrastructure Delivery Standards

Subtheme: Implement new standards for infrastructure delivery | Benefit Year: 2018/19 and Beyond | Cost Savings: $24M

Implementation Duration: 48 months | Implementation Effort: High

2017/18

Q1

Key activities:

- Assess internal capacity and capability to complete.
- Develop ToR for business case development (develop business cases in 2 waves). Business cases should evaluate various infrastructure standard models for their impacts on the healthcare system. Business cases could review current state standards, develop desired standards based on leading practice and comparative study with select jurisdictions, provide options, and final recommendations.
- Procurement of services to complete study / issue RFP, if required.
- Wave 1 of business cases.

Outputs:

- Terms of Reference (ToR).
- Completed Wave 1 business cases.

Q2

Key activities:

- Wave 2 of business cases.
- Proposals to Government from Wave 1 business cases.

Outputs:

- Completed Wave 2 business cases.
- Decision from Government on Wave 1 business cases.

Q3

Key activities:

- Proposals to Government from Wave 2 business cases.
- Plan implementation of Government-approved standards from Wave 1 business cases.

Outputs:

- Decision from Government on Wave 2 business cases.
- Implementation plan details for Wave 1 business cases.

Q4

Key activities:

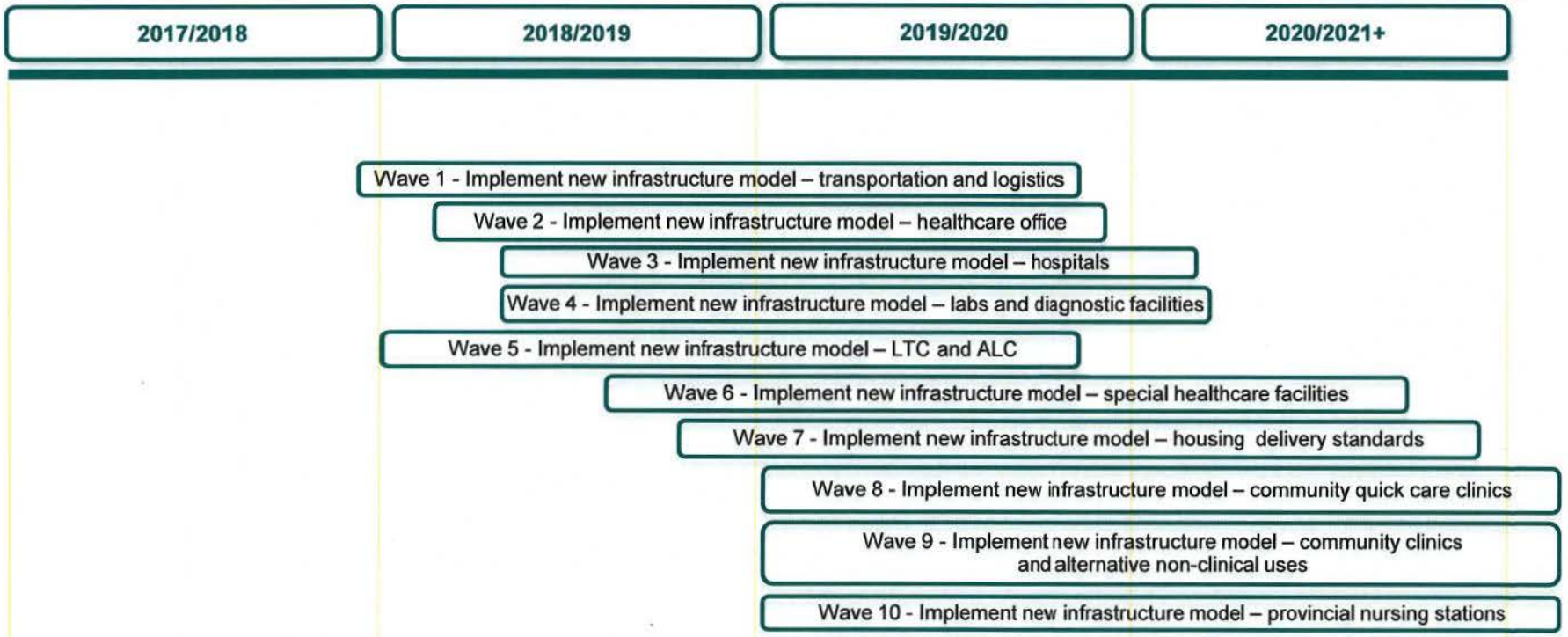
- Plan implementation of Government-approved standards from Wave 2 business cases.

Outputs:

- Various business cases to be implemented covering off infrastructure standards that are aligned to leading practices.

Update and/or Develop New Healthcare Infrastructure Delivery Standards

Subtheme: Implement new standards for infrastructure delivery	Benefit Year: 2018/19 and Beyond	Cost Savings: $24M
Implementation Duration: 48 months	Implementation Effort: High	



The following timeline is for illustrative purposes. Actual timing of the waves are dependent upon business case development which may warrant changing the order in which an activity is pursued because greater details (e.g., potential cost savings, steps to implementation, risks, benefits, implementation duration, etc.) may warrant pursuing specific activates earlier than others.

Leverage Federal Government Investment for Northern Infrastructure Development

Subtheme: Leverage external/alternative funding and service delivery models	Benefit Year: 2018/19 and Beyond	Cost Savings: $16.5M
Implementation Duration: >24 months	Implementation Effort: High	

Description	The following long term opportunity was identified in Phase 1; discussions during Phase 2 identified that the opportunities were not being pursued by MHSAL at the current time. These opportunities reflect potential investments made by the federal government in shared infrastructure projects as follows: 1. Leverage federal government investment in nursing station replacement for construction of northern support facilities with better coverage. $12.0M 2. Leverage federal government investment in transportation for construction of northern support facilities with better coverage. $ 4.5M Both opportunities carry noteworthy federal government investment estimates. MHSAL should consider revisiting the opportunities if they decide to investment in northern infrastructure for the aforesaid projects. MSHAL should also consider tracking opportunities globally and revisit in the context of new system opportunities wherein leveraging federal government investment may be advisable.
Benefit	• Making investment in northern support facilities while leveraging external federal government funding.
In-scope/Out of Scope	• Northern nursing station facilities and transportation facilities.
Key Assumptions	• Ensure alignment with government-wide capital improvement initiatives (e.g., long-term capital planning and prioritization; alternative delivery models; asset management).
Governance	• MHSAL
Project Management	• MHSAL with implementation management from the Capital Planning Council.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks	Interdependencies
• Negotiating investment from federal government may be time consuming and their investment interests may not align to the provinces.	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan

Leverage Federal Government Investment for Northern Infrastructure Development

Subtheme: Leverage external/alternative funding and service delivery models | Benefit Year: 2018/19 and Beyond | Cost Savings: $16.5M

Implementation Duration: >24 months | Implementation Effort: High

2017/18

Q1	Q2	Q3	Q4
Key activities: • Develop business case for leveraging federal government investment for new infrastructure projects.	**Key activities:** • Proposal to Government.	**Key activities:** • Negotiation with federal government for funding.	**Key activities:** • Finalize negotiation with federal government.
Outputs: • Business case.	**Outputs:** • Decision by Government.	**Outputs:** • N/A.	**Outputs:** • Federal government funding.

Develop a Health System Asset Registry and Market Outlook

Subtheme: Foundational – Capital Planning, Management and Delivery	Benefit Year: 2017/18	Cost Savings: N/A
Implementation Duration: 12 Months	Implementation Effort: High	

Description	Develop a health system asset registry and an overall market outlook. The asset registry should focus on healthcare infrastructure assets, specifically land and building, used for the purposes of providing healthcare to Manitobans. The health asset registry should include public sector (e.g., MHSAL, RHAs) healthcare infrastructure assets. The market outlook should include non-public sector healthcare provider infrastructure asset. MSHAL may consider contracting work through procurement. This opportunity is viewed as an initial enabling opportunity before assessing/developing future infrastructure opportunities.

Benefit	• Identify, in each community, key infrastructure information (own/lease, size, purpose, year built, current condition, current use, operating costs, etc.);
	• Identify surplus owned land that may be available for immediate sale (linkage to broad asset rationalization strategy); and
	• Develop a market outlook to identify health service providers/assets (e.g., private) to complement the system asset registry.
	• Assess the health system registry and market outlook against the Provincial Clinical Services Plan and identify:
	  • Critical information gaps and develop a strategy to address gaps;
	  • Potential infrastructure investment needs; and
	  • Potential opportunities for infrastructure rationalization (net of investments).

In-scope/Out of Scope	• All existing healthcare assets in the province, including public sector and non-public sector provider infrastructure assets.
Key Assumptions	• The health system asset inventory will be based initially on available information; costs/benefits will need to be assessed when considering data gaps. Efforts should be aligned with work already underway to develop a government-wide asset inventory. • Considerations for further work include: template to capture key information consistently government-wide, data capture (e.g., is it possible to leverage an existing enterprise IT solution, such as SAP?), data reliability, data comparability.
Governance	• MHSAL
Project Management	• MHSAL with implementation management from the Infrastructure Secretariat and designated work team.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks	Interdependencies
• Lack of readily available information. • Difficulty in gathering information to provide accurate, reliable registry/outlook. • Cost prohibitive to undergo process to conduct/contract out the work.	• Strategic System Realignment Work Plan. • Core Clinical and Healthcare Services Work Plan. • Provincial Clinical and Preventative Services Plan.

Develop a Health System Asset Registry and Market Outlook

Subtheme: Foundational – Capital Planning, Management and Delivery	Benefit Year: 2017/18	Cost Savings: N/A
Implementation Duration: 12 Months	Implementation Effort: High	

2017/18

Q1

Key activities:

- Develop terms of reference to develop a health system asset registry and conduct a market outlook. The registry should be segregated between asset classes and should include an inventory of MHSAL owned/lease space, size, purpose, year built, current condition, current use, operating costs, and if possible, an estimate of value (for owned properties), etc. The market outlook should focus on identifying private healthcare facilities capturing the same information as above, where possible.

Outputs:

- Terms of reference and request for proposal (if external assistance is required).

Q2

Key activities:

- Commence internal plan or procurement process to develop a health system asset registry and conduct a market outlook.

Outputs:

- Proposals from procurement process.

Q3

Key activities:

- Develop the health system asset registry and conduct a market outlook.

Outputs:

- N/A.

Q4

Key activities:

- Obtain the health system asset registry and the market outlook.

Outputs:

- Healthcare asset registry and market outlook.

Promote Greater Due Diligence in Upfront Project Planning

Subtheme: Capital Planning Optimization	Benefit Year: 2017/18	Cost Savings: N/A
Implementation Duration: 12 Months	Implementation Effort: High	

Description	Capital investment and/or rationalization decisions should be based on standard processes and aligned with population-based needs (current and future forecast). Projects should undergo more rigorous needs justification and required outcomes definition, and central challenge, within the context of health reforms in progress and as a long term capital plan. This should include consideration of non-capital intensive options, as well as an appropriate mix of service providers in the community (e.g., private, faith-based, charitable). There should be a mechanism to provide upfront government direction on priority conceptual projects, prior to RHAs spending significant funds on developing a functional program and design work. A business case should be the standard for all major government project funding decisions (starting with the 18/19 budget development process). Standard business case templates should be used that dictate the level of rigor and information requirement based on project value and risks. MHSAL expectations should be clearly identified (e.g., community contribution, lifecycle financial analysis, sources of revenues/funds, etc.). Project costs should identify capital (Class D at a minimum) and lifecycle (maintenance and rehabilitation) costs as well as program staff and operating costs. More comprehensive (MHSAL/RHA and central agency) analysis of a range of options to fund and/or deliver projects should be considered. This includes different funding sources (e.g., private, federal government, user pay, charitable) and models for owned assets (design/build, design/build/finance, design/build/finance/maintain).
Benefit	• Clearly defined project parameters including needs justification and required outcomes definition, and central challenge.
In-scope/Out of Scope	• All in progress and future capital projects.
Key Assumptions	• Ensure alignment with government-wide capital improvement initiatives (e.g., long-term capital planning and prioritization; alternative delivery models; asset management). • Standard assumptions should be used for costs where possible (e.g., construction inflation, contingency, annual maintenance).
Governance	• MHSAL.
Project Management	• MHSAL with implementation management from the Infrastructure Secretariat and the Capital Planning Council.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks

- Lack of expertise and resources to pursue initiative to develop standard processes, identify required outcomes, etc. to increase the quality of the due diligence process that project planning must undergo.

Interdependencies

- Strategic System Realignment Work Plan.
- Core Clinical and Healthcare Services Work Plan.
- Provincial Clinical and Preventative Services Plan.
- To be implemented in junction with "Post-Project Funding Approval – Improving Project Oversight" opportunity (see joint implementation timeline)

Post-project Funding Approval - Improving Project Oversight

Subtheme: Capital Planning Optimization	Benefit Year: 2017/18	Cost Savings: N/A
Implementation Duration: 12 Months	Implementation Effort: High	

Description	Key decision-making parameters should be identified for all approved/funded projects (desired program/client outcomes, budget, scope, schedule). A standard process should be in place to monitor changes to the key decision-making parameters for projects. Decision-makers should focus their attention on and revisit projects that are in jeopardy of delivering on the key decision-making parameters (due to more detailed planning, procurement results, etc.). Other projects that remain within key decision-making parameters should continue to progress through key stages.
Benefit	• Development a more efficient means of progressing approved projects through key stages once funding is approved.
In-scope/Out of Scope	• MHSAL infrastructure asset projects.
Key Assumptions	• Ensure alignment with government-wide capital improvement initiatives (e.g., long-term capital planning and prioritization; alternative delivery models; asset management).
Governance	• MHSAL.
Project Management	• MHSAL with implementation management from the Infrastructure Secretariat and the Capital Planning Council.
Communication Strategy	• To be determined concurrent to the initial opportunity work up for submission to the department and government.

Risks

- May not have resources to monitor/track infrastructure performance measures needed for a decision maker to evaluate the progress of the project.
- Decision makers may not have the expertise to evaluate the infrastructure performance measures.

Interdependencies

- Strategic System Realignment Work Plan.
- Core Clinical and Healthcare Services Work Plan.
- Provincial Clinical and Preventative Services Plan.
- To be implemented in junction with "Promote greater due diligence in upfront project planning" opportunity (see joint implementation timeline).

Promote Greater Due Diligence in Upfront Project Planning and Post-project Funding Approval - Improving Project Oversight

Subtheme: Capital Planning Optimization | Benefit Year: 2018/19 and Beyond | Cost Savings: N/A

Implementation Duration: 12 Months | Implementation Effort: High

2017/18

Q1

Key activities:

- Develop terms of reference to develop project evaluation standards. The evaluation standards should be designed to be used by MHSAL and Government to audit or vet proposed projects and their specific details for the purposes of either approving the project funding or reviewing in-progress project updates. Evaluation details should include needs justification, required outcome definitions, central challenge, etc.
- Commence procurement process to design the evaluation standards.

Outputs:

- Terms of reference and request for proposal.

Q2

Key activities:

- Select contractor to perform work.

Outputs:

- Obtain contractor work.

Q3

Key activities:

- Review considerations for the comprehensive project evaluation standards for implementation.

Outputs:

- List of standard considerations for approval from Government.

Q4

Key activities:

- Proposal to Government to implement new standards.

Outputs:

- Approval from Government to implement.

Opportunities removed from Work Plan

The Work Plan team reviewed the following immediate opportunities identified in Phase 1 and determined they were not rationalization opportunities and so should be removed from the Work Plan.

Subtheme: Rationale Facilities with System Demand	Benefit Year: N/A	Cost Savings: $0.3M
Implementation Duration: N/A	Implementation Effort: N/A	

Opportunity	Birthing Centre managed by the WRHA
Description	• Infrastructure repurposing is likely – the building is purpose built so tenant lease is not possible. • Continue to track opportunity globally and revisit in the context of the budget development process and/or completion of the Provincial Clinical Services Plan.

Subtheme: Rationale Facilities with System Demand	Benefit Year: N/A	Cost Savings: TBD
Implementation Duration: N/A	Implementation Effort: N/A	

Opportunity	Close Mature Women's Centre at Victoria Hospital (shift to primary care)
Description	• Infrastructure repurposing is likely (frees up beds for other acute care use). • Continue to track opportunity globally and revisit in the context of the budget development process and/or completion of the Provincial Clinical Services Plan.

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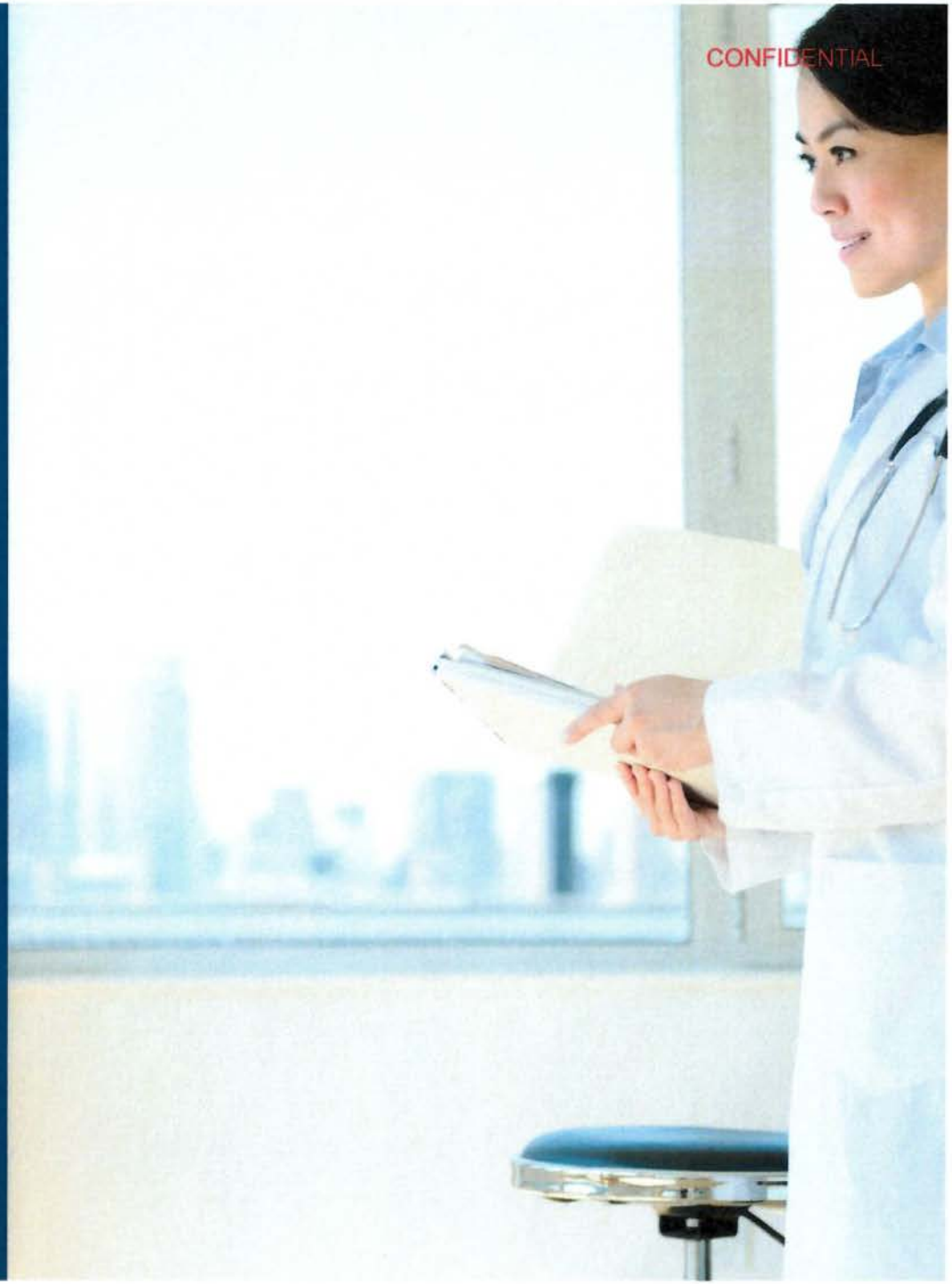
Health System Sustainability & Innovation Review: Phase 2 Report

Change Management Approach and Plan

March 31, 2017



Notice

This Change Management Approach and Plan (the "Document") 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. This Document is one part of the Phase 2 Review.

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

Our scope was limited to a review and observations over a relatively short timeframe, and consideration of leading practices. The intention of the Change Management Approach and Plan is to provide a consistent approach and general guidelines in change management implementation of cost improvement initiatives across the Department, the Regional Health Authorities, and other provincial healthcare organizations. We express no opinion or any form of assurance on the information presented in the Document and make no representations concerning its accuracy or completeness.

Table of Contents - Change Management Approach and Plan

1.1 Purpose

What is the purpose of this document?

This document provides the activities that Manitoba Health Seniors and Active Living (MHSAL or the 'Department') and the provincial health system may consider undertaking in order to develop a consistent, integrated approach to preparing for, executing and sustaining change across the Department, Health Authorities and Healthcare Organizations as the healthcare system commences cost improvement and transformative initiatives as part of the Health Sustainability and Innovation Review (HSIR). Change management is part of implementation of cost improvement initiatives and should be aligned with the Health Fiscal Performance Review Framework. This document is aligned with the Change Management Approach and Plan provided in Phase 2 of the Fiscal Performance Review for the whole of government. The document outlines an approach and general guidelines based on leading practices in change management, the typical stages and activities involved in managing change and accompanying templates and tools to support how to conduct the types of activities outlined.

Who is it for?

The intended audience for this document are change leaders, clinical leaders and change agents within MHSAL, RHAs, other Healthcare Organizations as well as individuals at all levels who have a role in preparing for and executing cost improvement change initiatives at a team, department and organizational level.

1.2 Health Fiscal Performance Review Framework

"Manitobans have a right to expect that their government uses public revenues effectively and efficiently to deliver high quality government programs and services at a reasonable and sustainable cost. Manitoba's New Government is working to fulfill that expectation by restoring fiscal discipline with a common sense approach to financial management. Common sense respects the value of taxpayers' money."

"A large part of restoring fiscal discipline is restraining the growth of spending – bending the cost curve – to ensure that spending does not outpace revenue growth. Manitoba's New Government is committed to ensuring that government programs and services become more effective and efficient."

Manitoba Budget 2016

The new Government of Manitoba has shown a strong commitment to the continuous improvement of programs and services delivered to Manitobans. Doing the right things, and doing them right by delivering quality services in the most efficient and effective way, while providing the highest value to taxpayers are central to this commitment.

The Manitoba healthcare budget for 2016/17 is approximately $6 billion, with an average annual increase of $223 million. The rate of actual spending growth is unsustainable - Manitoba faces specific challenges with the necessity to bend the cost curve and ensure that its health system is fiscally sustainable, while improving the quality of care and achieving better health outcomes. As Manitoba seeks greater efficiency and effectiveness, societal, demographic, and socio-cultural changes, as well as technological shifts should be considered:

- **Societal and Demographic Changes**. Manitoba has a unique population, with the majority of the population living in the single urban centre of Winnipeg. In addition, Manitoba has one of the highest indigenous populations in the country, a large number of citizens dispersed across rural and northern areas, and an ageing population. These social determinants of health play a critical role in how healthcare systems respond to population needs and allocate resources across the continuum of care.
- **Socio-cultural Changes.** The growth in consumerism, patient engagement, empowerment and participation means a profound shift from a provider centered healthcare system to one which is patient centered. This requires a pro-active healthcare system designed to help keep patients well in addition to reactively responding to healthcare needs.
- **Technological Development**. Healthcare is currently being impacted globally, and will continue to be impacted by disruptive innovation in technology: such as the growth in patient portals, wearables, remote patient monitoring, robots to genomics and personalized medicine. These technological developments will have a profound impact on care pathways and existing healthcare provider models – particularly to reach Manitoba's rural population.

1.2 Health Fiscal Performance Review Framework

Despite its high expenditures per capita, the second highest among Canadian provinces, and the highest proportion of provincial health expenditures to total government budget, there is significant evidence that existing funding and significant annual increases over the past decade have not translated into proportionate improvements in health outcomes. This suggests there are opportunities to improve technical efficiency within sectors, and allocative efficiency by reallocating dollars in an optimal manner across the care continuum, such as between acute care and community based care.

In response to the opportunities to improve the cost effectiveness of health service delivery (and as an aligned component of the wider Fiscal Performance Review already underway across all other core Departments), the Health Sustainability and Innovation Review (HSIR or the 'Review') has been established. The HSIR will review Manitoba's health system spending and performance, and provide confidential advice and recommendations to the Ministers of Finance and Health, Seniors and Active Living (MHSAL) for consideration during development of the next and future provincial budgets.

The objective of the Review is to identify opportunities to improve the cost effectiveness and sustainability of Manitoba's Health Insurance Funds (HIF) and other MHSAL expenditures.

The scope of the Review is the Manitoba healthcare system and its interconnected facets and components. The Review will include population and public health, community health care, acute and specialty care, and residential care.

Specific components of the Review also include reviewing structures, roles and functions across the provincial health system to enable sustainable improvement and developing a new organization design and structure for the Winnipeg Regional Health Authority (WRHA).

The Review will also take account the alignment and potential synergies with the Fiscal Performance Review across other departments for provincial core government expenditures.

The Health Fiscal Performance Review Framework, which is designed to be supplemental to and align with the Fiscal Performance Review Framework (September 2016), provides a consistent, systemic framework that includes principles, guidelines and criteria for looking at spending across Government and at all levels, whether by Department, program, service, branch or unit.

1.2 Health Fiscal Performance Review Framework

The Health Fiscal Performance Review Framework provides assessment filters by which all Health programs, services and activities are evaluated across the provincial health system using efficiency and effectiveness criteria and lenses as illustrated below:

Efficiency Criteria and Lenses	
Lens	Criteria
Allocative Efficiency -- 'doing the right things'	Effectiveness – Intended outcomes and best allocation of resources across programs
Technical Efficiency – 'doing things the right way'	Economy and Efficiency – Affordability and optimal cost of delivery of programs and services

The application of the Health Fiscal Performance Review Framework can have multiple uses across the provincial health system such as:

- An assessment tool to measure effectiveness, efficiency and value-for-money of how Government dollars are spent on HIF clinical programs and services
- Demonstrating whether HIF investment and funding is translating into improved health outcomes for Manitobans
- Aligning programs and policies to intended healthcare outcomes and measuring performance across the provincial health system
- A tool to assist MHSAL and Treasury Board in their annual Budget preparation process, particularly in a move towards more performance-based budgeting of healthcare programs and services
- To use analysis and evidence to better inform healthcare policy, investment and program choices and prioritize fiscal and operational resources.

The consistent, systemic application of the Health Fiscal Performance Review Framework can effectively change culture across the provincial health system and the way all spend is looked at.

1.2 Health Fiscal Performance Review Framework

The Manitoba healthcare budget for 2016/17 is approximately $6 billion, with an average annual increase of $223 million. The rate of actual spending growth is not sustainable - Manitoba faces specific challenges with the necessity to bend the cost curve and ensure that its health system is fiscally sustainable while improving the quality of care and achieving better health outcomes. The Health Fiscal Performance Review Framework provides principles and guidelines to place attention and fiscal discipline on all spending, and on the provision of efficient and effective HIF programs and services to improve health outcomes for Manitobans and ensuring a sustainable health system.

The framework further guides a process for MHSAL of providing better information and evidence on the performance of the healthcare system and health outcomes for decision-makers.

Shifting to a Health Fiscal Performance Review Framework will have a transformative impact on MHSAL and the provincial health system. It will require a fundamental change in the behaviours, the culture, and the approach to decision-making across MSHAL, to Health Authorities, to providers, to Treasury Board, to the ultimate decision-makers in Cabinet. As such, getting a strong commitment to the Health Fiscal Performance Review Framework at the most senior levels of Government is crucial.

1.2 Health Fiscal Performance Review Framework

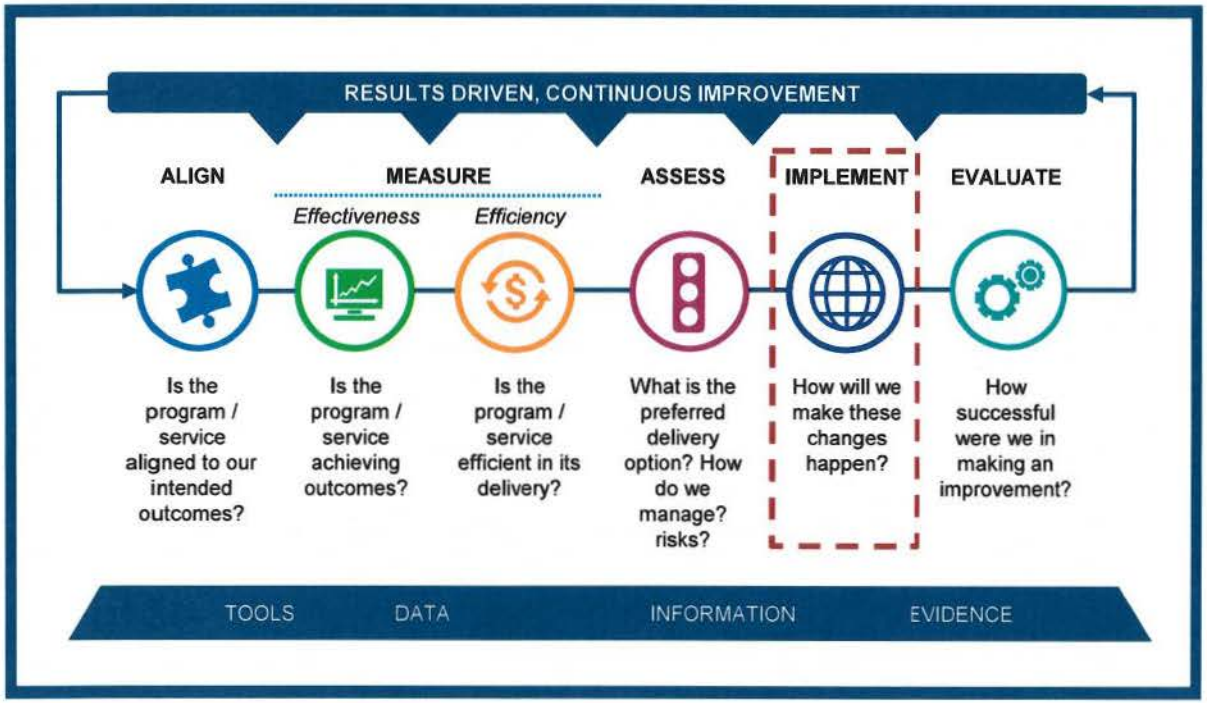
Ultimately the goals of the Health Fiscal Performance Review Framework, aligned with goals of the fiscal performance review framework for the whole of government, are:

Understanding of performance and confidence in decisions to achieve Government's objectives	MSHAL decision-makers have a more robust and deep understanding of the financial, operational, and performance results that drive outcomes, and can make more confident decisions about changes required to achieve Government's objectives. Decision-makers need to have line of sight between the case for change, the analysis and options related to the change, and the final benefits that will be realized. This requires information and evidence for the decision-maker to consider at a level that is necessary to reliably make a decision.
Transparency of performance	To closely examine how every HIF dollar is spent across the provincial healthcare system, MHSAL and decision-makers will be better able to identify the link between the clear objective of the healthcare programs and clinical services and the evidence of its performance both in terms of efficiency and effectiveness. To enhance transparency and public accountability, greater clarity of performance is also required for greater accountability, such that quantifiable metrics can be reported publically for clinical programs and Health Authorities.
Greater collaboration between Departments	The requirement for information and evidence to support HIF funding and prioritization decisions means that MHSAL will have a better understanding of financial controls, operational performance, and achieving better outcomes. Leading practice from high performing healthcare systems from across the globe clearly shows that sustainability and improved health outcomes can only be achieved though better integration of healthcare services with other government services such as housing, family services - and within health services – both horizontally in relation to integrated acute services to achieve optimal volumes – and vertically between acute, community and primary care.
Greater alignment between fiscal imperatives and the priorities of Government	A key attribute of the framework is that decisions on programs and services are driven by the achievement of desired outcomes and the effectiveness and efficiency in which this can be done. The framework will provide a clearer understanding of the link between healthcare policies, HIF investments, and health outcomes, which in turn can support decisions to align fiscal priorities with results.

1.2 Health Fiscal Performance Review Framework

The Health Fiscal Performance Review Framework is being applied in MHSAL and consists of a series of steps and questions that decision-makers are expected to ask, and provides a guide for how analysis should be approached and evidence-built. The use of this evidence, supported by standards and tools, will drive the successful application of this framework.

The following Change Management Approach and Plan is triggered during the *Implement* step of this framework.



In addition, two key components of the Framework include continuous improvement and results-driven. Continuous improvement takes the learnings and informs changes to drive consistently better and better outcomes. "Results driven" refers to a set of common Government outcomes that should be considered in all decisions.

1.2 Health Fiscal Performance Review Framework

The Change Management Approach and Plan, as previously indicated, should be applied during the *Implement* stage of the Heath Fiscal Performance Review Framework.

Implement	
Overview	**Questions to be Answered**
In this step, an implementation plan is developed. This includes the key steps, roles and responsibilities, milestones, and timelines. The plan should outline the full cost of the preferred option and include actions related to managing risk, reporting on progress, and include a project implementation plan outlining the benefits to be realized, expected costs, roles and responsibilities, and actions to implement the project. The necessary changes to implement the preferred option are then initiated.	This step defines how the changes to programs / services will be made. Specifically the following questions should be asked: ❑ How will you manage and implement the change? ❑ What are the key tasks and milestones? ❑ What is the total approved budget for the change? ❑ How will you report on the progress of implementation? ❑ What benefits both should be expected and when will these be realized? How will you report on these?
Standards	**Tools**
This standard has been met when the changes to be made have been broken down into a set of key milestones to be achieved. Consideration for the benefits has also been documented and reporting has been agreed upon.	❑ Cost Accounting ❑ Project Implementation Plan ❑ Change Management Plan ❑ Benefits Tracker ❑ Risk Assessment

2.1 Setting the Change Management Context

Change Management Context

— The Government is committed to placing attention and fiscal discipline on all spending with a desire to bend the cost curve in healthcare spending, while also ensuring programs and services are efficient, effective in improving heath outcomes for Manitobans and deliver value for taxpayer dollars. This represents a significant transformation and culture shift.

Parts of the Current Culture of the Healthcare System	Desired Culture
▪ SILOED	▪ ALIGNED
▪ ACUTE CARE CENTRED	▪ INTEGRATED
▪ PROVIDER CENTRED	▪ FOUSED ON IMPROVING EFFECTIVENESS AND EFFICIENCY
▪ LACK OF PERFORMANCE MANAGEMENT	▪ RESULTS DRIVEN WITH ALIGNED INCENTIVES
▪ MISALIGNED	▪ PATIENT CENTERED
▪ DUPLICATION OF EFFORT	▪ ACCOUNTABILITY FOR OUTCOMES
▪ LACKING FOCUS ON OUTCOMES	▪ EVIDENCE BASED
▪ DESIRE FOR CHANGE	▪ CONTINUOUS QUALITY IMPROVEMENT
▪ MANAGEMENT BY ISSUE	

— Change Management can be one of the toughest paths on the transformation journey. We have leveraged our experience and proven methodologies to develop this Change Management Approach and Plan to assist MHSAL and the provincial health system with their transformation efforts.

— The Change Management Approach and Plan is designed to provide a concise, consistent approach and general guidelines for change management, with flexibility for MHSAL, RHAs and Healthcare Organizations to work with and ensure alignment with MHSAL and Government directions in the implementation of cost improvement initiatives.

— The Change Management Approach and Plan considers the following key steps: alignment with MHSAL and Provincial Government direction and the Health Fiscal Performance Review Framework; confirming the transformation vision; understanding where there are gaps; mobilizing leaders, clinicians and plans; acting out the vision and desired culture; showcasing success; and monitoring progress and adjusting plans where necessary.

2.1 Setting the Change Management Context

To bring the MHSAL Change Management Approach and Plan to life, it has been organized around the following key aspects:

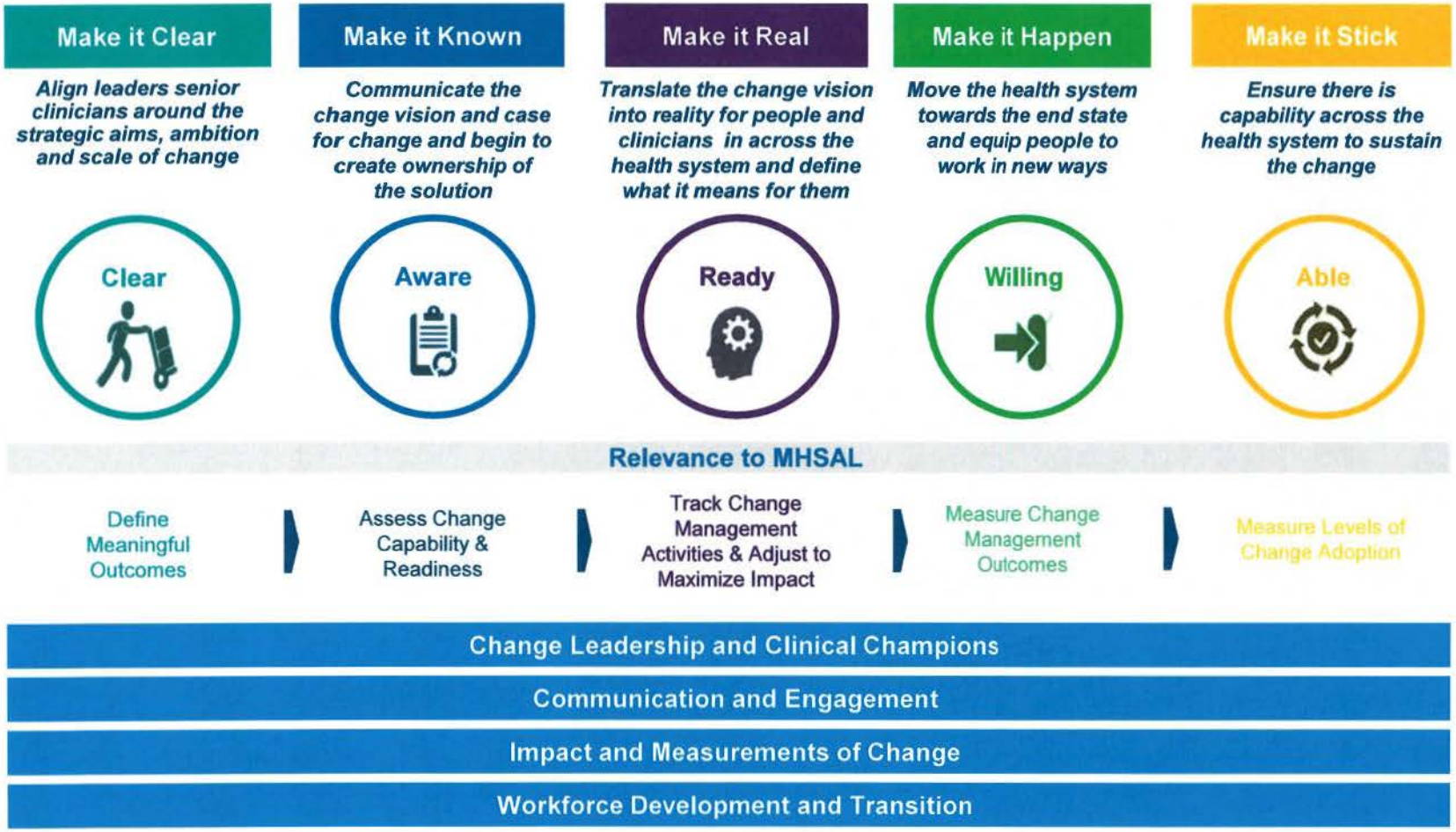
- **Change Planning and Management** – how you set the context for change management and understanding gaps.
- **Change Leadership** – how you mobilize leaders to the change and help them to disseminate communication and manage staff and stakeholder reactions to the changes.
- **Change Strategy** – how you align change strategy and create action plans.
- **Change Networks** – understanding the role of change networks, change agents and clinical champions, including mobilizing them, and helping staff and clinicians develop new capabilities or learn the new ways of working as a result of the change.
- **Communications and Engagement** – how you help staff, clinicians and stakeholders move along the change continuum from awareness, understanding, buy-in and advocacy for the changes, and measuring and reporting on progress.

Change Management Implementation

- The following approach is focused on positively influencing staff and clinician acceptance for change and mitigating resistance. This methodology pragmatically and proactively manages risks to drive desired business benefits. Adoption of organizational and system change, and ensuring the benefits realized are sustainable, are achieved through a focus on effective Change Management.
- To execute on this plan, a strong Change Management methodology should be leveraged. By proactively understanding: (1) the magnitude of the specific change effort; and, (2) the capacity of MHSAL and the provincial health system for change, the approach can be applied in a customized manner.
- A made-for-MHSAL approach:
  - Focuses on changing behaviours, of individuals, clinicians and teams, to help deliver sustainable cost improvement in performance.
  - Develops change strategies based on robust diagnosis and hard evidence based on data analysis to mitigate the critical people risks associated with change.
  - Helps to drive the performance required for delivery of benefits and results.
  - Develops change leadership capability and creates momentum for sustainable performance improvement.
  - Understands change management as an iterative, rather than a linear process.

2.2 Change Management Approach

During a health system transformation, Change Management can not be overlooked as a key component to success. Following a known set of principles and applying the appropriate tools will ensure MHSAL and the health system's workforce and clinicians are first engaged and then appropriately empowered to obtain the new vision. The five steps identified below are the overarching structure to engaging the workforce and clinicians in sustainable change.



2.2 Change Management Approach

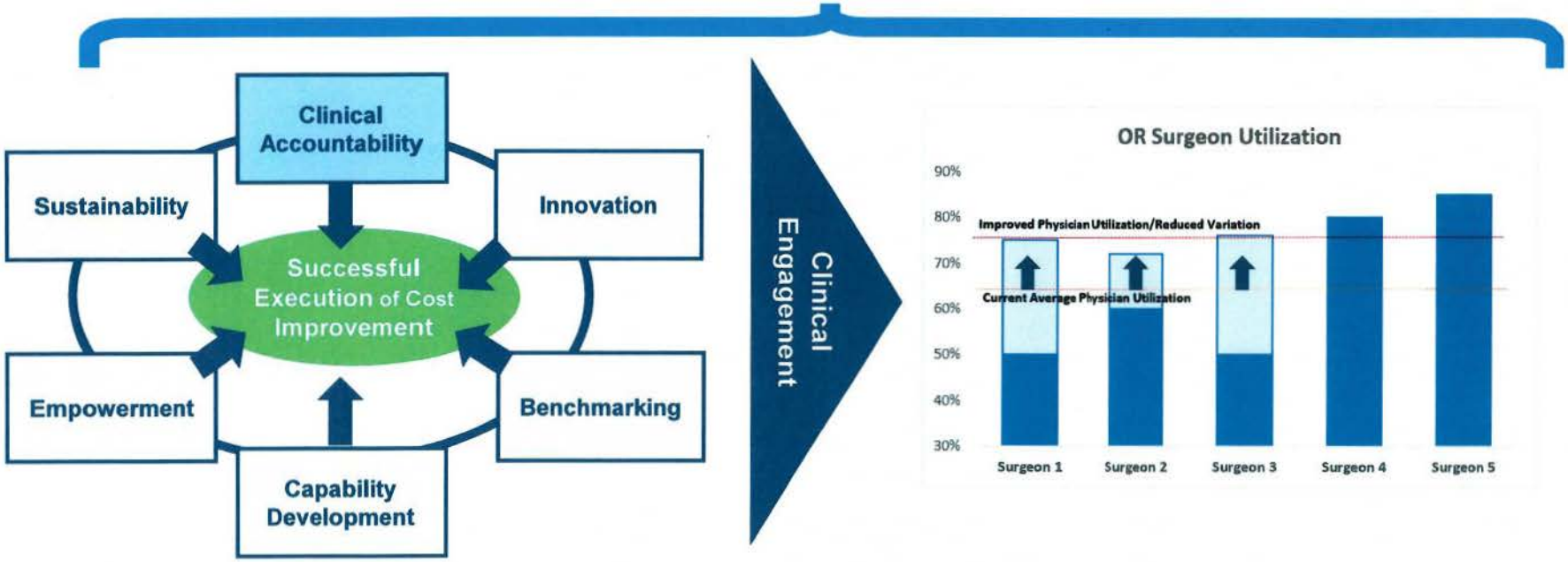
During a health system transformation, effective clinical engagement is a key component to success. The approach must be evidence based and grounded in robust data analysis. The key steps below show the key process to engaging clinicians in leading and owning sustainable change.

Evidence → **Moving from Engagement to Ownership** → **Creating Clinical Champions**

Driven by data analysis and an evidence based approach

Clinical accountability is key, which is ensured through appropriate engagement

Clinical Champions are the accountable owners and leaders of the change initiatives being implemented



2.2 Change Management Approach

The following critical success factors will support MHSAL and the wider provincial health system as it prepares for, executes and sustains change efforts moving forward

- **Early engagement** is key to address resistance early on and invite the people to contribute to the change.
- **Transparent and robust implementation plans** will help ensure the transparency of progress against them.
- **One size does not fit all.** Each of the changes to be implemented will require a tailored and fit-for-purpose change management.
- **Change leadership** is no longer optional. Sponsorship is not enough, and the owners of this change need to be at the right levels.
- **Change is personal.** Aligning the people levers in the organization is key to reach individuals.
- **Change is a capability** that can be developed, not just a work stream.
- **Measure change**, and look beyond the finish line to sustainability.
- **Learn from the past**. Do, or do not, let history repeat itself and recognize that old approaches do not work anymore.
- **Drive for a systemic approach**. See the forest, not just the trees.
- **Ongoing interactive communications** are key throughout. Modern day technologies facilitate critical engagement.
- **Plan to be agile.** A successful change management approach will remain flexible throughout its course.

2.3 Change Management Plan

The following represents the typical activities that comprise a change management plan. This approach to change management is under-pinned by these activities:

Make it Clear | Preparing for Change

— Involves outlining the business case, the case and reasons for change as well as the alignment of the change relative to the organization and a shared vision

Make it Known | Planning & Building Support for Change

— Analyzes the change readiness of MHSAL and Healthcare Organizations as well as any potential risks and issues that may arise during the implementation

Make it Real | Pre-Implementation Support

— Identifies key stakeholders to engage as well as a plan around how to properly engage them

Make it Happen | Go-Live Implementation & Stabilization

— Involves the implementation of the changes and the transition to operations

Make it Stick | Cementing & Reinforcing the Change

— Involves evaluating the benefits from the change as well as assessing lessons learned and recognizing success

2.3 Change Management Plan

For the HSIR, six work streams (and supporting work plans) have been organized to bring about the necessary changes to create a more sustainable health system in Manitoba. Outlined below are several key activities to be considered in the development and execution of a more robust change management plan, based on past experience with the change management as part of cost improvement initiatives. This assumes a linear flow to activities, however work streams may need to address different change requirements at different times.

In the initial phases, the work will be common across all work streams. As implementation progresses, further change strategies / activities may be needed. It will also be important to consider the best approach for change management activities for staff, clinicians and others who will be impacted by multiple work streams – where possible a single / coordinated approach should be used.

	2017 / 18		
Transformation Work Streams	**Q1**	**Q2**	**Q3**
	Make it Clear	**Make it Known**	**Make it Real**
Strategic System Realignment and Funding for Performance Insured Benefits and Funded Health Care Programs Core Clinical and Healthcare Services Healthcare Workforce Integrated Shared Services Infrastructure Rationalization	Develop case for change for HSIR, outlining the need for each change Identify change leaders Conduct a visioning workshop to align all on necessary changes and plans Conduct a change leadership workshop to outline roles and actions Develop change leadership plans Identify and analyze stakeholder perceptions	Assess stakeholder and organizational change readiness against each work stream Identify key stakeholder (e.g. staff, clinicians, leaders, patients, public, etc.) impacts and change risks Identify mitigating actions to address changes risks Develop detailed change management plan and integrate with overall work plan and implementation plan Identify and orient change networks, change agents and clinical champions	Identify individual communication requirements for each work stream Develop integrated communications plan for HSIR Identify individual training requirements for each work stream Develop integrated training plan for HSIR Identify individual stakeholder engagement requirements for each work stream Develop integrated stakeholder engagement plan for HSIR Execute stakeholder engagement and communications plans

2.3 Change Management Plan

Transformation Work Streams

- Strategic System Realignment and Funding for Performance
- Insured Benefits and Funded Health Care Programs
- Core Clinical and Healthcare Services
- Healthcare Workforce
- Integrated Shared Services
- Infrastructure Rationalization

2017 / 18	2018 / 19	
Q4		
Make it Happen		Make it Stick
Execute change management plan and activities Continue to execute communications plans Continue to execute stakeholder engagement plans Conduct roadshow to roll-out changes to be made and timing to staff, clinicians and others Provide ongoing support to change leaders, change agents, and clinical champions	Manage and report on implementation progress as required Monitor change risks and stakeholder feedback and impacts from change agents / clinical champions Address new change risks as required Capture and report out on successes and recognize key teams / individuals	Provide ongoing support to staff, clinicians, patients and others to sustain and reinforce the change Measure and report on benefits realized Define and implement and continuous improvement process Conduct an evaluation of changes implemented / completed Report on lessons learned and successes achieved

3.1 Readiness for Change

Change readiness and impact analysis activities examine the scope, depth and overall size of the change the initiative will result in. When preparing for change, two critical assessments are needed at the onset:

- An assessment of the change itself (i.e. how big is it), and
- An assessment of the healthcare organization and others organizations that are impacted by the change (i.e. how ready are they).

Specific items to be addressed by this activity include:

- Scope and scale of the change, including capacity for change
- Leadership support and engagement (level and degree to which senior leadership / clinicians are involved and support the change)
- Middle-management's predisposition to change (in many healthcare organizations middle managers have a high degree of control over their peers and employees – they will play a significant role in the change process)
- Engaging frontline clinical staff directly
- Number of employees and clinicians impacted, types of roles impacted
- Type of change (process, technology, organization, job roles)
- Employee readiness for change, and
- How clearly defined the project vision is and whether it is understood.

3.1 Readiness for Change

The measurement of change readiness is important to every change initiative as it directly impacts the ways in which those impacted by change are engaged.

By understanding the individual, team, clinicians, departmental and organizational readiness for change, the scale, type and frequency of communications with each impacted stakeholder group can be selected more accurately.

3.2 Handling Change Resistance

As part of preparing for change, it is essential to take the necessary time to understand levels of actual or perceived resistance from stakeholder groups impacted or influenced by the change.

RESISTANCE TO CHANGE

"I've been doing things this way for a long time and it's always worked – I don't see the **need for change**."

"My **manager** hasn't changed her behaviour...I don't see why I should!"

CONFUSION AND ANXIETY

"I **don't know** what I'm meant to be doing..."

"How does this **change** affect me personally?"

"Do all these changes mean I'm going to **lose my job**?"

FALLING EMPLOYEE ENGAGEMENT

"I'm **confused** and **de-motivated**, I'm going to start looking for another job!"

"I will do the **minimum possible** and see what happens."

3.3 RACI Matrix Creation

A key component of positioning MHSALs and the provincial health system's leaders to effectively prepare, execute and sustain change is to support change leaders (and others across the provincial health system) with the appropriate level of transparency by developing a decision making accountability framework.

The RACI matrix underpins the ability of MHSAL, RHAs and other healthcare organizations to have an effective mechanism to understand how key decisions will be made as part of change initiatives.

What is a 'RACI'?

What does it stand for?

The four letters represent four different roles in relation to a task:

- **Responsible: (Performs the task)**
  - Individual / clinician who owns the activity, clinical process or implementation.
  - Responsibility can be shared across clinicians and managers
  - Level of responsibility is determined by the individual / clinician designated with the "A".
- **Accountable: (Is held accountable for the results)**
  - Individual with the ultimate yes/no authority.
  - Who signs off or approves work.
  - Only one "A" can be assigned to a function.
- **Consult: (Is in the loop and provides input)**
  - Individual / clinician has information or capability to complete work.
  - Involved prior to decision or action.
  - Requires two-way communications.
- **Informed: (Is kept in the picture)**
  - Individual / clinician is notified of decision or action so that they can fulfill their tasks.

What is a RACI chart?

It is a model that is used to identify and clarify roles and responsibilities within an organization. It can be used to re-design a process, re-align an organization, or manage a function.

- It is responsibility plotting.
- It helps to identify functional / clinical areas and activities.
- Assists in re-designing processes and clinical services by highlighting decision points.
- Identifies redundant, overlapping, inconsistent responsibilities.
- Defines structure and distributes responsibility, accountability, and authority.
- Creates clear lines of communication.

What are the benefits?

- Streamlines the organization by placing accountability where required.
- Clarifies roles and responsibilities for individuals, clinicians RHAs, Healthcare Organizations and MHSAL.
- Increased productivity through well-defined accountabilities.
- It eliminates misunderstandings.
- Reduces duplication of effort.
- Results in better communication.

4.1 Understanding Change Leadership

Change leadership is about mobilizing, activating and leveraging a group of committed individuals who can work across the provincial health system, its staff and stakeholders to bring about the required changes. For the Government of Manitoba, change leadership will mean:

- Supporting the DM and ADMs to communicate to their teams and stakeholders;
- Supporting clinicians and physician leaders to lead changes on clinical behaviours, roles and behaviours and;
- Supporting Middle Managers and Line Managers to communicate to their staff and stakeholders.

The approach to delivering Change Leadership

Prepare leaders to lead the change	*Work with senior leaders / clinicians to prepare them to lead and sponsor the change*
Equip strong and engaging managers and clinicians	*Strong middle management and clinicians to lead the frontline to be ready, willing and able to implement changes*
Mobilize dynamic change clinical networks and teams	*Establish a clinical change champions network to oversee and drive sustainable change*
Build change capability and capacity	*Build a culture where employees feel involved in and responsible for change. Help people became more change-able and change ready*

4.1 Understanding Change Leadership

Preparing the leadership group to lead the transformation is critical to sustainable change. Many times quality improvement and change management are seen as "common sense". Change management is a learned, structured set of skills.

Prepare leaders to lead the change

Work with senior leaders / clinicians to prepare them to lead and sponsor the change

Build change capability and capacity

Equip strong and engaging managers and clinicians

Mobilize dynamic clinical change networks and teams

The change leadership approach strengthens **leaders** ability to:

— Consistently **role model** new ways of working and demonstrate this through their behaviors

— **Reinforce new ways of working** amongst their teams

— **Communicate effectively** throughout the change process

— Effectively **manage key stakeholders**, and understand what actions and behaviors they can adopt to overcome resistance to change within the organization

— **Unblock** barriers to change

— Build **change capability** across and at each level across organizations within the provincial health system

— Demonstrate **visible leadership and accountability** throughout the transformation programmed

— Keep what is working, **holding true to the organization's and health system purpose and values**

4.1 Understanding Change Leadership

During a health system transformation, Change Leadership cannot be overlooked as a key component to success. The five steps identified below highlight the typical activities that it is advised change leaders focus on as part of change management initiatives within MHSAL, RHAs and other Healthcare Organizations across the provincial health system.

	Make it Clear Creating clarity	Make it known Creating awareness	Make it real Creating readiness	Make it happen Creating willingness	Make it stick Creating ability
Leadership and Vision	— Define how MHSAL and the provincial health system needs to transform to survive and grow — Create accountability and ownership for the vision and reason for change — Define what does good look like and how to measure it	— Communicate and manage expectations of the journey — Understand and accept role within change and create time for it — Identify change leaders at all levels	— Be clear on what change really means — Be open about the impact of transformation on individuals and the organization — Identify any potential blockers and sticking points — Empower and delegate authority — Be visible — Be active with middle management	— Role model new behaviours — Correct unacceptable behaviour — Unblock and address barriers — Stay the course as performance and productivity may dip — Create space for managers and clinicians — Prepare to be agile — Stay in tune with the business and across functions	— Don't skip meetings — Have presence on the floor and the ward — Deliver against Leadership Action Plans — Role model new behaviours
Communication and Engagement	— Plan how to engage — Co-author individual leadership action plans	— Sit with teams to explain change and solicit feedback on how to make it happen: — Create open feedback channels	— Adhere to governance model and cascade communications — Articulate guiding principles for design and implementation — Increase conversation about new ways of working	— Remind people of the vision, benefits, and case for change — Be open and honest about rationale for change and what's happening — Be visible and present — Continuously communicate what is happening when — Actively work with and communicate with middle management and clinicians	— Manage expectations of the journey and maintain focus — Sustain energy — Opportunistically communicate — Reinforce the case for change
Workforce Transition	— Establish plan to manage	— Identify influencers/detractors,	— Be vocal about what needs to change at a behavioural level including clinical behaviours — Close the door to exceptions	— Make and support difficult decisions around people changes, sticking to the principles/vision objectives	— Retain focus until complete (don't shift to the next new thing too soon) — Hold people to account — Realign the way performance is managed
Measurement	— Define what needs to change	— Understand resource planning, barriers and enablers	— Set the example for timely decision making	— Monitor measurement and act — Highlight progress and wins — Hold people accountable for actions	— Keep monitoring communications, ROI and resources — Know when to exit and celebrate close — Institutionalize lessons learned

4.2 Change Leadership Behavioural Diagnostics

Prepare leaders to lead the change

Work with senior leaders to prepare them to lead and sponsor the change

The best way to prepare a leader to lead change is for them to understand where their strengths and opportunities for development are. The key four functional areas for leaders to understand and make happen are:

1) Setting direction
2) Mobilizing action
3) Building capability
4) Acting with courage

4.3 Change Management Plan Risk Analysis

With any change initiative there are inherent risks associated. They can be as extreme as a risk to MHSAL's, RHA's and Health Care Organization's across the province ability to deliver on their service offerings.

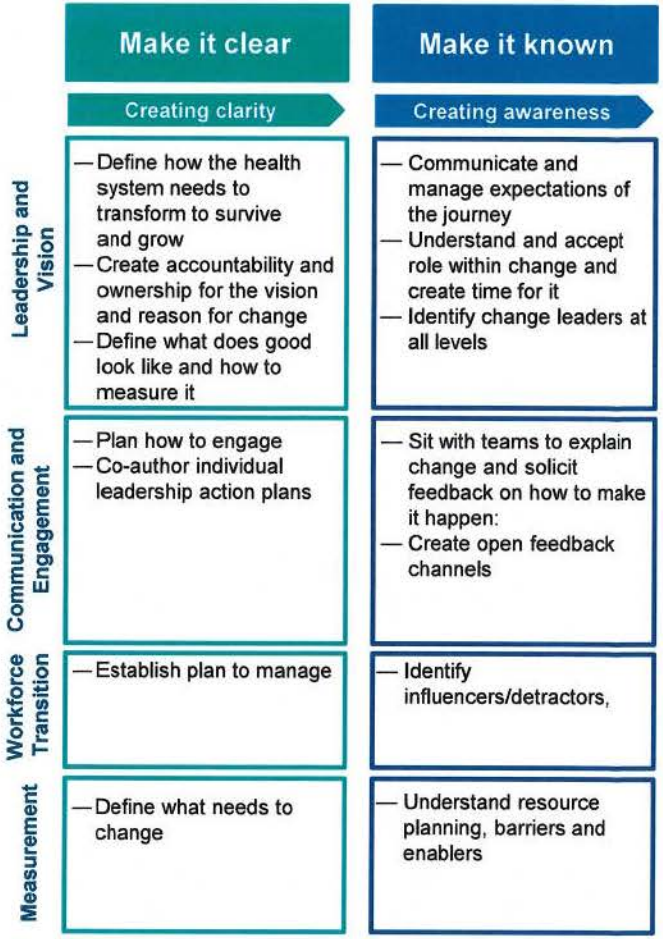
The key to managing risk is identifying the potential of the risk as soon as possible.

The three key questions to ask about risk are:

1) What is the likelihood that the action could happen?
2) How severe would it be if it did happen?
3) Could we identify that it is going to happen before it does (predictive measurement)?

Once decisions are made on considerations outlined in the Work Plans that have been created for MHSAL, an engagement plan should be created. When these plans are being created each line of the engagement plan should also be accompanied by the previous three questions. When risk is identified then part of the engagement plan should include the risk mitigation.

Some of the risk mitigations are how you "make it clear" and "make it known".



4.4 Leadership Action Plans

The personalized leadership action plan is an accumulated document encompassing all the tasks required by the individual or clinician to lead their assigned change.

Leadership Action Plan

- Develop customized leadership development plans and measures to invite and encourage leadership's visible support and commitment
- Match leaders to a coach for personal monitoring and guidance

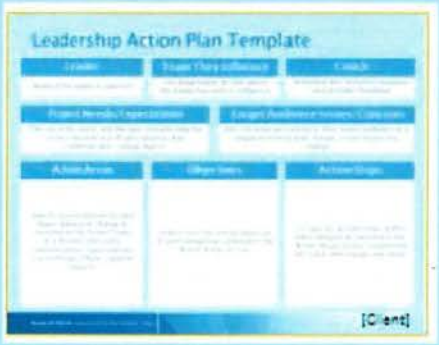
Purpose

- Define the actions leaders need to take and the results they must achieve to successfully implement the change
- Identify potential obstacles to change that require close scrutiny and management
- Help key stakeholders and clinicians understand what they can do to champion change

Questions for Consideration

- In which areas can the leader provide the most beneficial impact?
- In what way does the leader typically interact with his or her teams?
- Which peers does the leader respect and feel comfortable?

Example



4.5 Change Management Action Plan

Change management requires an actionable roadmap that defines the specific tactics and levers that will be used to help transition MHSAL and the provincial health system in a tailored, integrated fashion to achieve the intended benefits associated with the change.

- ✓ Documents the project-specific approach to proactively manage the changes and transition leaders, clinicians and staff effectively.
- ✓ Defines the guidelines and structure to proactively address known challenges while continuing to identify new challenges so they may be quickly addressed.
- ✓ Identifies the areas and components of change that need the most attention and effort in order to manage resources most effectively.
- ✓ Helps create leadership understanding and alignment for how the change and people impact can be managed proactively.
- ✓ Demystifies change management and provides a conceptual methodology into distinct components that can be monitored, measured, and assessed.

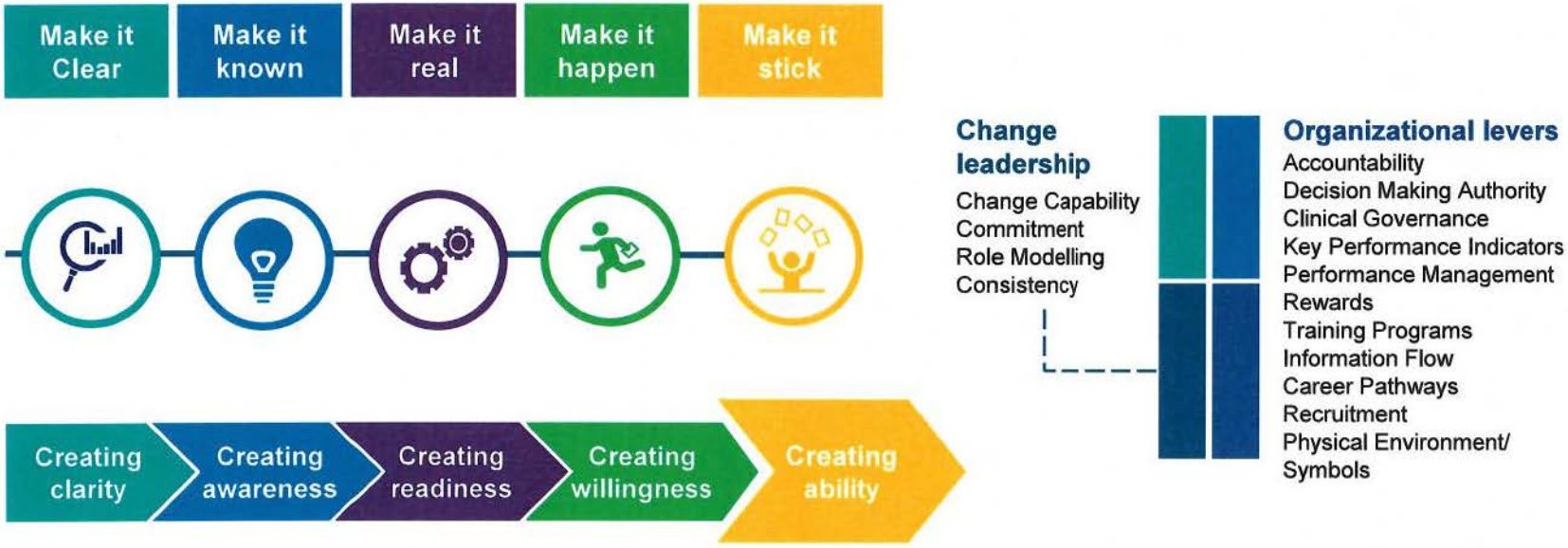
5.1 Understanding the Role of Change Networks

To support MHSAL and the provincial health system with the execution of and ability to sustain change efforts, the role of Change Networks is critical.

Change Networks are comprised of individual "change agents / clinical champions" who will enable teams that span divisions or units of MHSAL, an RHA, or a hospital or hospitals to bring together leaders who can help to tackle communications and engagement.

Change Networks will help to provide a feedback loop to the change owners within MHSAL, RHAs and other Healthcare Organizations and help to inform the types of change challenges being experienced as well as the tools that are needed to address such challenge or resistance.

The role of the individual change agent / clinical champions is also critical because of their ability and personal commitment to creating long term, systemic change. Several potential change agents have been identified for various cost improvement initiatives.



5.2 Change Agent / Clinical Champion Skill Set Requirement

In general, Change Agents / Clinical Champions should be high performing individuals and are respected as leaders by their peers with the following characteristics:

Influential	Realistic	Supportive	Good communicator	Open and positive
— Is respected amongst peers, staff, and senior leaders — Has credibility within clinical speciality work area or function — Understands the bigger picture including the wider transformation agenda for health — Is not necessarily "the boss" — Is someone with whom others trust and feel comfortable	— Flexible — Good problem solver — Pragmatic and resourceful — Recognizes and addresses barriers	— Is personally supportive of the initiative — Listens and learns — Respects differences — Builds genuine relationships — Follows through — Takes role and relationship seriously	— Able to clearly convey messages both written and verbal — Functions as a bridge between views — Acts as an interpreter — Is a confidant — Respects confidentiality — Perceptive qualities to monitor and provide feedback on areas of change resistance	— Works to change attitudes — Provides a sense of possibility — Offers encouragement — Is inclusive, accessible and engaged — Early adopter; able and willing to adapt to rapidly changing circumstances

5.3 Change Network Mobilization Strategy

Make it happen

Creating willingness

Leadership and Vision

- Role model new behaviours
- Correct unacceptable behaviour
- Unblock and address barriers
- Stay the course as performance and productivity may dip
- Create space for managers and clinicians
- Prepare to be agile
- Stay in tune with healthcare and across functions

Communication and Engagement

- Remind people of the vision, benefits, and case for change
- Be open and honest about rationale for change and what's happening
- Be visible and present
- Continuously communicate what is happening when
- Actively work with and communicate with middle management and clinical leaders

Workforce Transition

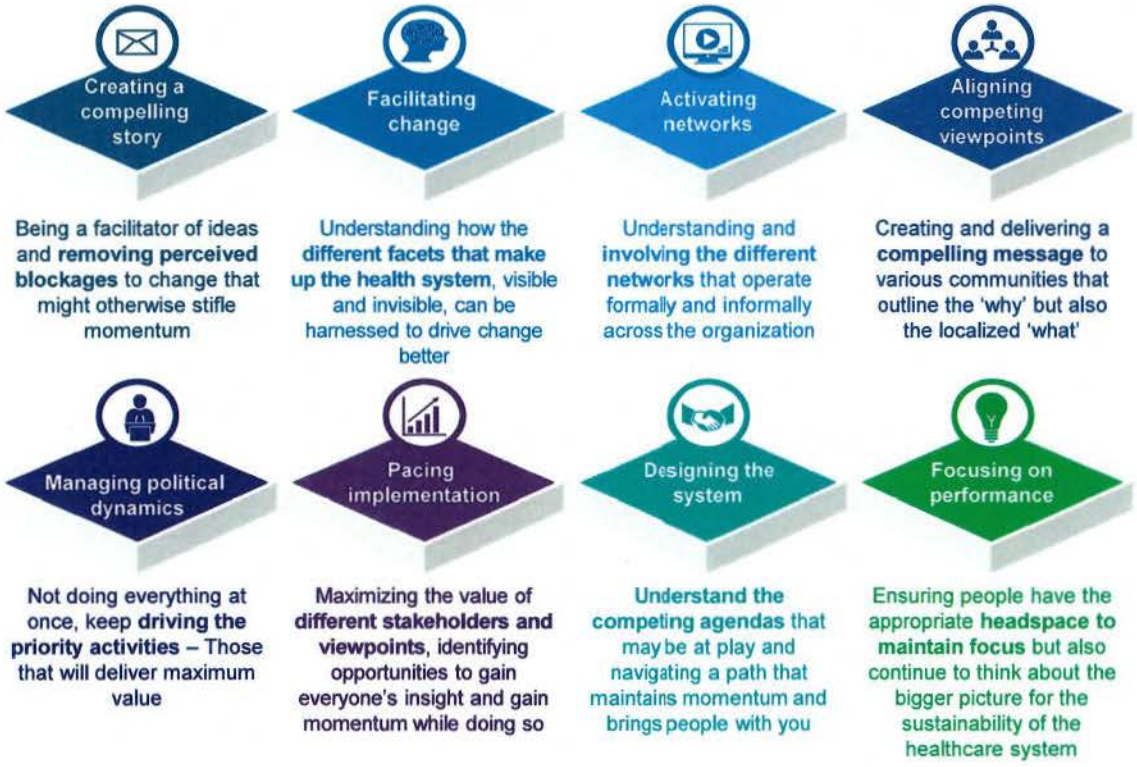
- Make and support difficult decisions around people changes, sticking to the principles/vision objectives

Measurement

- Monitor measurement and act
- Highlight progress and wins
- Hold people accountable for actions

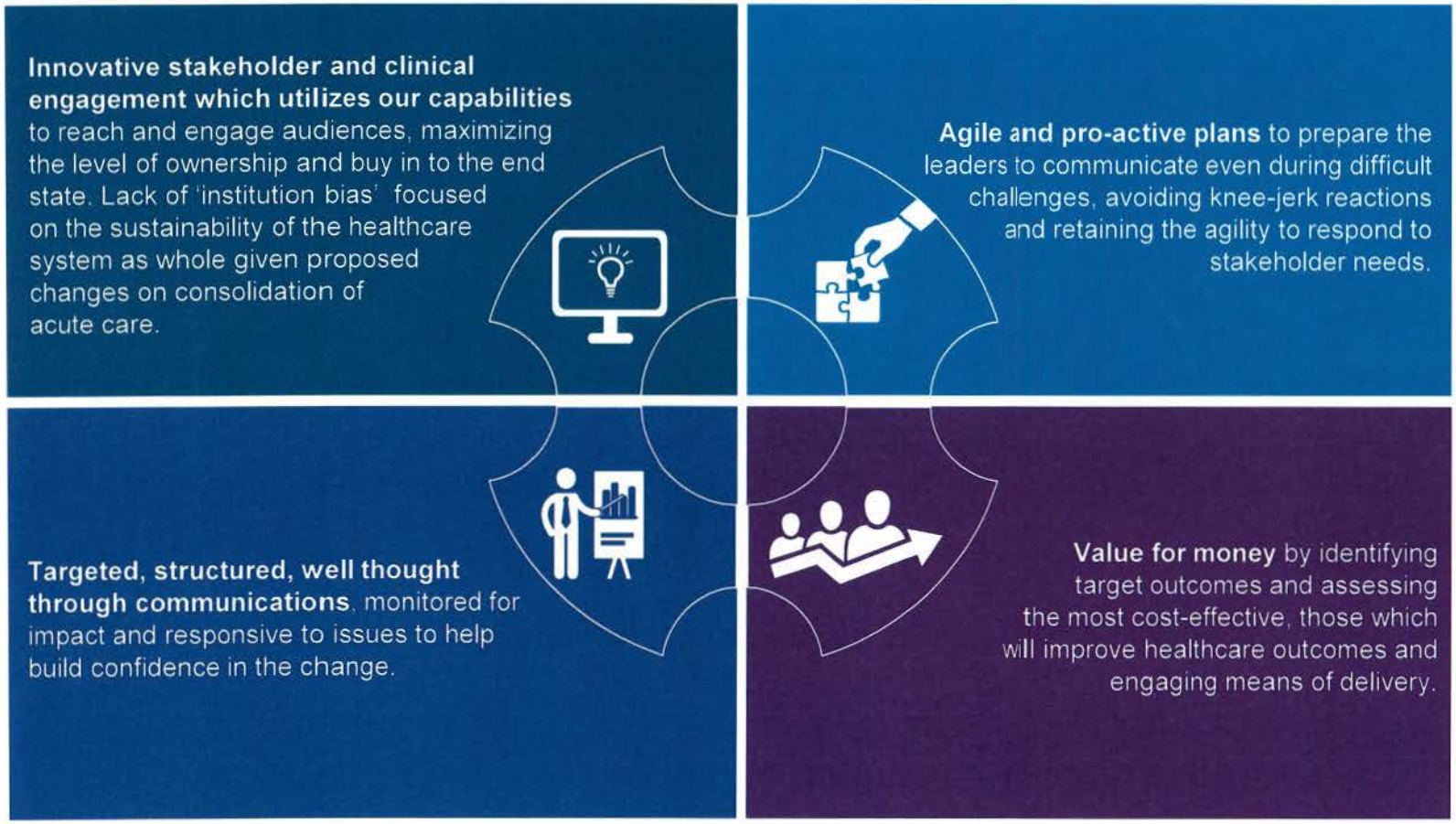
The mobilization strategy is to:

1) Identify the Change Agents / Clinical Champions who will comprise the Change Network
2) Build their capacity for change
3) Engage them in the Change Plan
4) Support the Change Agents / Clinical Champions from the leadership group



6.1 What Needs to Be Communicated and to Whom

Our approach to communications and engagement



6.2 Identification of Key Communication Activities

Change is largely about communicating to staff and stakeholders about the changes and what they should expect. The Communications Strategy and Plan is essential in supporting MHSAL and leaders across the health system to effectively deliver and manage change.

- A Communications Strategy provides a clear statement of the approach to be used for the development and execution of all communication activity and defines the parameters for delivering key messages to stakeholders both internal, patients and the public.
- The Communications Plan serves as an effective mechanism to plan and deliver communications to all internal and external (if required) stakeholders.

Communications should be:

- Clear and direct in their purpose and intent;
- Consistent messaging;
- Should provide facts;
- Help to answer frequently asked questions; and
- Connect to those affected through various mediums.

6.2 Identification of Key Communication Activities

The process has **four key elements** to follow:

1. Build the Communications Strategy, the plan should be designed to be creative in nature and utilize out of the box channels and vehicles for delivering the key messages and themes outlined in the Communications Strategy.

2. Build the Communications Plan.

3. Design and evaluate effectiveness of communications. Socialize the Communications Plan so stakeholders across the provincial health system know what to expect and that the key messages are being delivered.

4. Implement the Communications Strategy and Plan throughout the project:
   - ✓ The Communications Strategy is developed based on a communications assessment to articulate the vision, clearly set out the strategic priorities and identify the specific communication needs of the stakeholder groups.
   - ✓ The Communications Strategy and Plan allows key stakeholders to understand the case for change in relation to the provincial health system, the desired end state and what the organization will do to move toward the new vision via a communications front.
   - ✓ The Communication Plan is built early in the project and then refreshed throughout. It is intended to deliver communications across the lifespan of the project or the project phase.
   - ✓ In case the initiative's scope is adjusted the plan should reflect the audience's needs.
   - ✓ The plan should reference the findings of the communications assessment and refer to the Communications Strategy to maintain consistent guidance.

6.2 Identification of Key Communication Activities

Effective communication and clinical engagement is an essential element of a successful cost improvement and transformation program. Research shows that organizations where senior leaders communicate openly and across the organization about the transformation's progress, respondents are eight times more likely to report a successful transformation.

The communications approach has to be designed to bring staff and clinicians on the journey and ensure they understand what achieving financial sustainability means, how it will impact them and how they can be involved and committed. As staff move along the continuum, they will gain:

- Clear, shared understanding of the change process and the health system's key aims and objectives;
- Clarity regarding implementation plans, reducing misunderstanding and misinformation;
- Reduced anxiety; and
- Opening up of channels for staff to contribute to influencing the future direction of the provincial health system

Communications teams within healthcare organizations often have inadequate experience to translate complex change messages, or the capacity to deliver the sustained support that is required. Transformative change needs a specific communications perspective and the leadership team need strong counsel on messages. Principles that should guide this include:

- Communicate early and often to provide a consistent narrative, incorporate views and secure buy in and support.
- A lack of information is often worse than hearing bad news; honesty engenders trust and support which is vital for transformation.
- Focus on conversation rather than communication; encouraging conversation and making stakeholders part of the solution will engender greater engagement and in turn greater loyalty and productivity.
- Senior leaders must be able to paint a compelling vision of the root cause of the issues. Once performance is improving and a clear vision and implementation in place, it is vital that this is communicated in a clear and engaging way to ensure that all stakeholders are behind the plan.

The next page shows how the execution of leading practices can be taking forward based on the three key principles of effective communication: Informing, Listening, and Engaging.

6.2 Identification of Key Communication Activities

The diagram below shows how the execution of leading practices can be taking forward based on the three key principles of effective communication:

INFORMING — LISTENING — ENGAGING

AWARENESS | UNDERSTANDING | ACCEPTANCE | INVOLVEMENT | COMMITMENT

AT OUTSET

Key Principles

- Start early and communicate often
- Understand stakeholders perceptions
- Establish key messages

Questions/actions

- Does everyone understand the HSIR goals?
- Have we been candid about the situation and challenges?

FIRST 3 MONTHS

Key Principles

- Tease out implementation pain points
- Articulate critical path and key milestones
- Understand stakeholders perceptions
- Establish key messages

Questions/actions

- Have you communicated a compelling vision of the future
- Focus on actions to be taken

3 to 6 MONTHS

Key Principles

- Ensure credibility and consistency

Questions/actions

- Have you ensured multiple opportunities for two way dialogue
- Continue to communicate to support implementation and change

ONGOING

Key Principles

- Amplify the narrative

Questions/actions

- Have you created opportunities for involvement, feedback and regular, clear and consistent communication with stakeholders ?

ONGOING

Key Principles

- Reinforce change story and build momentum

Questions/actions

- Have you ensured that you have built a long term communications program that continues to support the sustainability of the Manitoba Health System.

6.3 Create Communication Activities

The Communications Plan will help by providing set targets and defining responsibilities to build and maintain understanding and accountability throughout the project for staff, clinicians, patients and the public. The plan should answer a number of questions including: who needs to be involved in the communication process, what needs to be communicated, when does the communication take place and what are the most suitable methods of communication. The plan essentially lists communication activities and events to bring the Communication Strategy to life while taking into account the risks and barriers identified through the Communications Assessment.

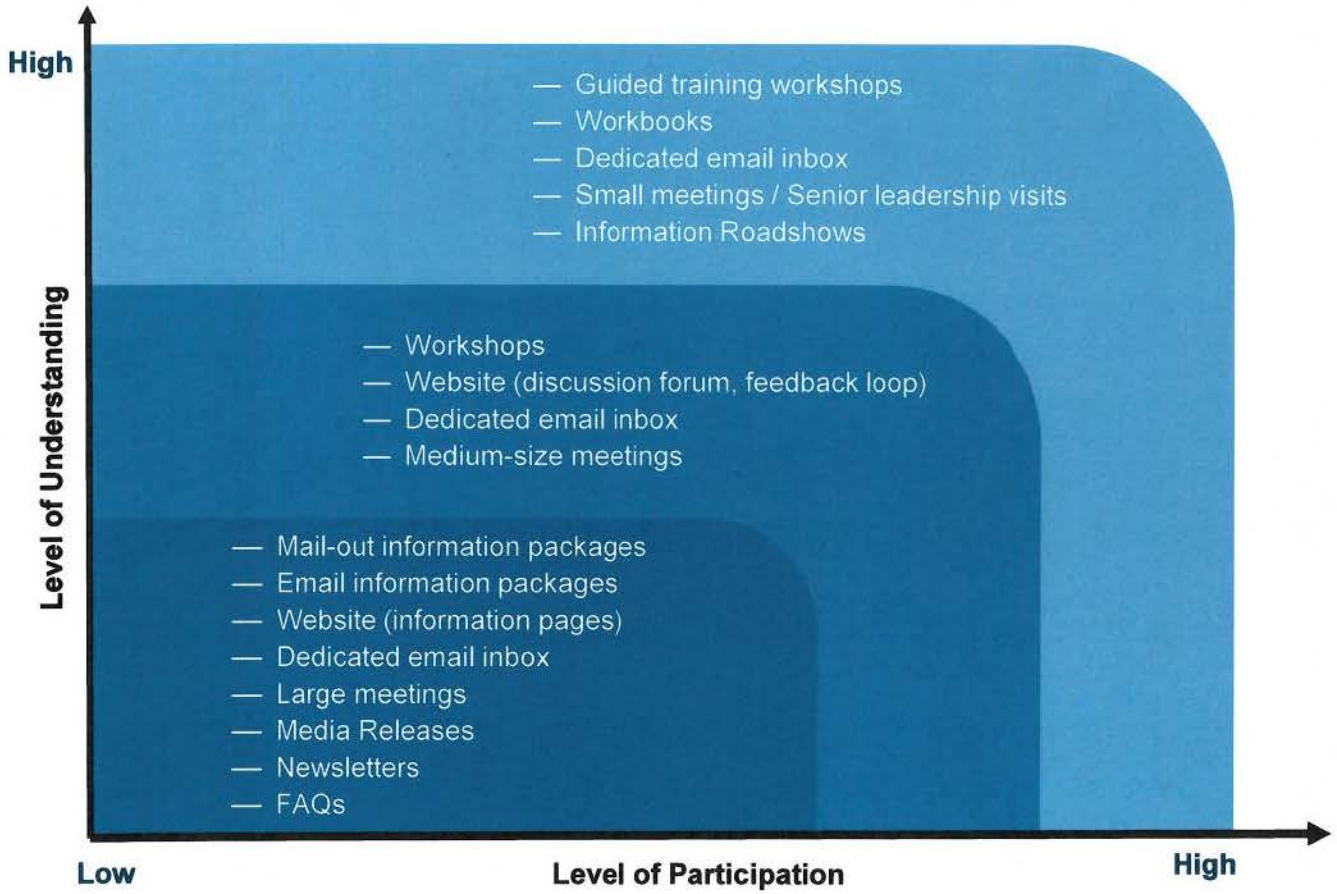
Outlined below are the practical steps required to create and execute a targeted tactical and operational Communications Plan.

	Communications Assessment	Develop Strategy, Plan, & Calendar	Develop Communication Review Process	Establish Feedback Mechanisms	Develop Communication Materials
Activities	▪ Identify Stakeholder Needs ▪ Identify Communications Channels ▪ Identify Key Messages / Themes	▪ Define strategic objectives for communications activities ▪ Define communications activities and timeline ▪ Determine Roles & Responsibilities	▪ Identify internal communications requirements ▪ Identify internal review requirements and processes ▪ Coordinate with internal communications team	▪ Identify and establish communications mechanisms ▪ Embec feedback in communications plan	▪ Develop draft materials ▪ Submit draft materials to review process
Output	▪ Stakeholder Analysis ▪ Vehicle Analysis ▪ Key Messages / Themes	▪ Communications Plan ▪ Communications Calendar	▪ Communications Review Process Guidelines	▪ Regular and formal feedback mechanisms	▪ Final approved Communications Materials

6.4 Communication Channels

A variety of potential communication tools and channels can be used as part of MHSAL's change management initiatives depending on the level of understanding and participation required of stakeholders affected by changes.

The range of communication options range from low-touch to high-touch, and can be customized to resonate with their intended audiences along with the practical steps required to create and execute a targeted tactical and operational Communications Plan.



KPMG

Appendix A - Templates

Template - Change Readiness Areas of Investigation

Area	Purpose / Use
Compelling Case for Change	— What is the stakeholders' current understanding of the program or initiative? — Do stakeholders understand the clinical case for change and cost drivers? — Do stakeholders believe the change is needed? — Are stakeholders comfortable with the new processes? — Do stakeholders believe the processes and application will improve the situation? — What concerns do stakeholders have?
Resources	— Are effective support tools and resources in place? — Where are the gaps? — Are there common challenges? — What additional support and resources do stakeholders need?
Leadership	— Do leaders appear committed to the project goals and aligned to project plans? — Are leaders providing active and visible sponsorship for project efforts?
Effective Communications	— What communications have stakeholders received? — Which communication events have stakeholders attended? — Which channels are or are not working well?

Template - Change Readiness Sample Question Categories

Category	Question	1	2	3	4	5
Satisfaction	How satisfied are you with…?	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied (or Neutral)	Satisfied	Very Satisfied
Agreement	Please state your level of agreement with…?	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Extent	To what extend do you…?	Not at all	To little extent	To some extent	To a moderate extent	To a large extent
Helpfulness	How helpful is…?	Not at all helpful	Not so helpful	Neither	Somewhat helpful	Very helpful
Interest	Please indicate your degree of interest in…?	No interest	Little interest	Some interest	Moderate interest	Considerable interest
Relative Quantity	Should … do less or more of…?	Much less	Somewhat less	Fine as is	Somewhat more	Much more
Importance	How important to you is…?	Very Unimportant	Somewhat Unimportant	Neither Important or Unimportant	Somewhat important	Very important
Quality Rating	Please rate the quality of…?	Poor	Below Average	Average	Above Average	Excellent

Template - Change Leadership Behavioural Diagnostics

Leadership Diagnostic Questionnaire

Change Leadership Guidance

Change leadership can be defined as:

"Behaviour and actions that mobilize committed and capable people from their current situation to a successful future."

There are four key behaviours that do this:

1) Sets direction
2) Mobilizes action
3) Builds capability
4) Acts with courage

A key part of change leadership is to understand where their skills in these key areas are. This will help to determine areas of strength that may be beneficial during the change.

Change Leadership Behaviours	Rarely	Some-times	Often	Don't know
Sets Direction				
Based on knowledge of provincial priorities, determines and communicates priorities for attention				
Sets, shapes and corrects direction in which people are to move				
Communicates clear, challenging but fair individual accountabilities for each direct report				
Mobilizes Action				
Anticipates and thinks through other's possible responses and adapts own approach to speak to their interests or concerns in explaining new directions				
Takes action in group situations (even if not the official leader) to make sure people work effectively together				
Respects the contribution of others, seeking out strong people for the team and giving them freedom to act				
Consciously keeps an open mind when listening to others' ideas; going out of the way to hear contrary opinions in order to avoid 'groupthink' and land on the best decision				
Builds Capability				
Notices others' learning needs and takes personal action to provide feedback, coaching and training				
Creates challenging learning opportunities that stretch the person's ability to experience and think				
Looks for development opportunities for others (assignments, job moves, training etc)				
Acts with Courage				
Sets personal stretch goals and takes informed risks to achieve them				
Raises issues honestly and directly with the people involved and works to resolve them				

Template - Leadership Engagement Plan

Leadership Engagement Plan

HSIR Leadership Engagement Plan				
Purpose: Plan and track activities needed to ensure impacted leaders are ready, willing, and able to make the necessary changes.				
Who	**When Launch**	**How**	**Resources**	**Responsibilities**
*Leader Name or Leadership Group	*Date (Month YYYY)	*Listing of activities and cadence	*Deliverables to be created for stakeholders	*Individual(s) responsible for execution

Template - Leadership Action Plan

Leadership Action Plan Template – Sample

Leader	Team They Influence	Coach
Name of the leader in question	The department over which the leader has control/influence	Individual who monitors progress and provides feedback

Project Needs/Expectations	Target Audience Issues/Concerns
The role of the leader and the type of leadership the project requires (e.g., Project Sponsor, Key Communicator, Change Agent)	Key risk areas pertaining to their target audience (e.g., negative history with change, recent leadership change)

Action Areas	Objectives	Action Steps
Specific responsibilities for each major category of change as identified by the Project Team (e.g., Business Decisions, Clinical Change, Communications Opportunities, Current Project Phase, General Support)	Underscores the overall objective of each category as outlined in the Action Areas section	List specific actions steps within each category as outlined in the Action Areas section (monitored by Coach, will change over time)

Template - Change Action Roadmap

The Change Impact Action Plan is created using the information created by the sequentially collected information on change including the change plan, risk analysis and leadership action plans. The roadmap identifies specific interventions needed to address impacts. It also establishes accountability by identifying the owner for each intervention.

Benefits
✓ Identifies specific actions required to prepare stakeholders ✓ Creates formal accountability by assigning the appropriate stakeholders to be responsible for taking the necessary actions

Understanding Change Impacts

Degree of Impact

Degree	Description
R "Big"	— This is significant change compared to how things are currently done. — Majority of stakeholders will be impacted. — Very visible to internal customer. — At least somewhat visible externally (customers or suppliers).
Y	— A change that has some impacts, but may only impact a few departments. — Somewhat visible to internal customer. — Limited external impact (customers or suppliers).
G	— Not a significant area of change. — Only a small number of people impacted. — No internal customer or external stakeholder impact.

Perception of Impact

Degree	Description
R "Difficult"	— This is a change that would not be favorably received. — Resistance is expected from a large portion of people impacted. — Increases work effort, has impact on internal customers that they would consider negative or at least neutral.
Y	— Those impacted would not view this negatively or positively.
G	— This is a change that would be welcomed by the majority of those impacted. — Potentially reduces work effort, provides better information, or has positive impact on internal customer. — The change would not be viewed as a threat, but as a way to make work easier or work product better.

Template - Change Action Roadmap

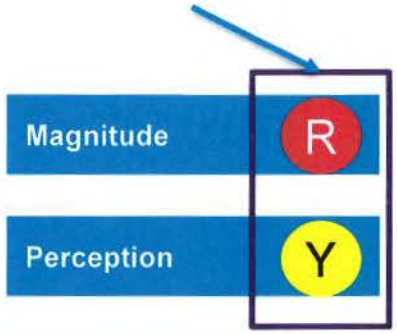
Use the previously created documents to gather and enter the key impacts in the action plan template and develop recommendations to address the change impacts. Add due dates if necessary.

Example

Impacted Division, Function or Change Dimension: [Function]

Summary: [Summarize the change initiative]
- [Text]
- [Text]
- [Text]

Summarize the level of impact based on Magnitude and Perception



Key Impact	Recommendation	Owner
— List the key impacts from the Change Impact Summary report	— List recommendations to address the impacts. — Recommendations should be timely and actionable using existing resources.	— Assign owner to address recommendation

Template - Change Action Gantt Chart

The Gantt chart is a visual tool that will allow all parties involved to know where they are, what tasks are coming up, and what is to be expected in the future.

This visual communication tool is one of the risk mitigation steps required.

The Gantt chart will influence:

- Staff involvement
- Questions asked
- Timely progress

Estimated Change Action Gantt Chart

Estimated timing for assessment of progress to plan.

Template - Change Agent Selection Matrix (Risk Analysis)

Skills and Attributes

- *Customer Advocacy:* should understand that customers (both internal and external) are always the final judges of service quality.
- *Passion:* passion gives fortitude to persevere, even when the going may get tough.
- *Change Leadership:* change agents and change leaders have a way of accomplishing positive change while engendering support for the change.
- *Communication:* understanding the various needs of audience members and tailoring the message to address their concerns is the mark of an effective communicator.
- *Business Acumen:* the ability to display the linkage between projects and desired business results.
- *Project Management:* knowledge of project management fundamentals and experience managing projects are essential.
- *Team Player and Leader:* must possess the ability to lead, work with teams, be part of a team, and understand team dynamics (forming, storming, norming, performing).
- *Result Oriented:* are expected to perform and produce tangible results.
- *Fun:* should enjoy their jobs if they are passionate about them.
- *Trust and Integrity:* these are requirements and are non-negotiable.
- *Been There, Done That:* typically a team gives credibility to a change agent that has "been through it."
- *Diverse Work Experience:* a diverse background can help one appreciate change and issues more holistically

Scoring a potential change agent – 1 = no experience, 3 = applied experience, 9 = proven experience (score each skill/attribute)

A score of 36 or higher would indicate a change agent capable of leading the change

Template - Sample Communication Plan

Communication Activity	Timing	Target Audience	Message Objectives	Vehicles	Sender	Responsibility	Status	Feedback Mechanism	Action
Joint Mobilization Meeting	2/9	Core Team, Advisors and Sponsors	—Introductions —Project Background —Overall vision —Initial mobilization activity —Logistics	Meeting			Complete	On-going dialogue	
Project Team Core Kickoff Meeting	2/25	Project Leadership and all Team Leads	—Kickoff Workshop format —Project Business Case and Vision —Scope and Objectives —Approach —Breakouts covering Critical Success Factors & Action Plans	Kickoff Meeting (off-site)			Complete	Q&A/Parking Lot	
Manager Pre-notification	2/26	Key managers affected by new roles on project with people reporting to them	—Organizational Announcement —Clarify new role on project for affected managers —Announce any backfill or transition plans as appropriate	Email			Complete	Points employees to manager for additional clarification	
Stakeholder Executive Interviews	3/18 – 4/5	Executive Leadership	—Discuss and identify areas of change, complexity and change readiness	Individual Meetings			Complete	Individual Meetings	
Create Vision	3/22	Project Leadership	—Clearly layout project vision and scope	Meeting			Complete	Steering	
Roadmap	3/22	Executive Leadership and eventually all involved departments	—Layout timeline on how we expect to accomplish scope and objectives —Clearly identify what will and will not be delivered	Meeting Presentation			Complete		

Template - Sample RACI Chart

R = Responsible (for executing or "doing the work")
A = Accountable (for outcomes of the decisions, "the buck stops here")
C = Consulted (involved in the process, but not decision makers)
I = Informed (communicated on the outcome of a decision)

Deliverables	Deputy Minister	ADM	Manager
On-going			
Monthly or Biweekly Status Reports	C, I	R	I
Advisory Committee Update Reports	C, I	R	I
Updated plan, estimate, and budget to complete the remaining phases	C, I	R	I
Start-up			
Project Team Structure and RACI	C, I	R	
Quality Plan	C, I	R	
Validation Workshops Schedule	R	C, I	
Kick-off Meeting Deck and Execution	C, I	R	
Provisioned to execute remaining phases	R	C, I	
Chart of Accounts Design	A, C	R	
High Level Health System Design and Role Definitions	C, I	R	
Consolidated Reporting Inventory currently used by the Finance Organization	C, I	R	
Stakeholder Analysis	A, C	R	
Future State Close-out Process	C, I	R	

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