Overcapacity and Productivity
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Overview

The major health care restructuring that occurred in Canada throughout the 1990s produced a sustained impact that continues to reduce the quality of care delivery. Although improvements in technology, surgical technique, etc. have meant appropriate reductions in lengths of stay (LOS) in hospital, poor understanding of nursing care processes and huge pressures to cut costs have resulted in two major problems:

- Hospitals functioning over acceptable capacity
- Rates of nursing productivity/utilization above safe levels

Overcapacity

As there are routinely ebbs and flows in the need for acute care, often affected by seasonal activities or illnesses, it has long been accepted operating practice to aim to operate hospitals at less than 100 per cent capacity. For example, the UK government target for bed utilization is 82 per cent, but with high patient admission rates together with bed reductions, 71 per cent of health trusts have exceeded this target.1 Similarly, in BC, acute care beds were reduced substantially in 2001/02 even though many viewed the system as already very lean. The result has been years of hospitals working at over 100 per cent2, sometimes going as high as 120 per cent. Despite spending over a number of years on a myriad of minor initiatives aimed at easing the situation, the problems persist.

Hospital emergency departments (EDs) have become the public face of the system working over capacity, with approximately 14 million Canadians visiting an ED every year. A 2006 study by the Canadian Agency for Drugs and Technologies in Health3 found that 62 per cent of respondents in an ED director survey reported overcrowding as a major or severe problem in 2004 and 2005. Most respondents (85 per cent) pointed to a lack of admitting beds to be a major or serious cause of the overcrowding.

Canada is not alone in experiencing ED overcrowding, and the problem appears to exist independently of the type of health system, whether private, public or a mix. Numerous interventions have been undertaken,4,5 but there are no magic bullets, and high quality evidence evaluating the effectiveness of these measures is lacking. For example, in the

2 Bed shortage so severe it’s ‘appalling’ Globe and Mail Wed 05 Nov 2008 p A4
3 Rowe, B.H. et al (2006) Emergency department overcrowding in Canada: what are the issues and what can be done? [Technology overview no 21]. Ottawa: Canadian Agency for Drugs and Technologies
4 Ibid p 9
CADTH study, 98 of 158 Canadian ED directors reported having tried at least one intervention to address overcrowding and 29 indicated the intervention was unsuccessful.⁶

**Impact**

The following list of the effects of emergency department overcrowding have been suggested (although research-validating, these are not substantive):

- Public safety risk
- Prolonged pain and suffering
- Dissatisfied patients
- Ambulance diversions
- Decreased physician productivity
- Violence
- Negative effect on teaching missions in academic medical centres, and
- Miscommunication⁷

Nurses, as the first contact with patients entering emergency departments, are badly affected, both by their inability to provide optimum care and as the target of much of patients’ dissatisfaction. A study in Alberta found that ED staff stress resulted from the inability to achieve desired standards of care.⁸ Similarly, in the CADTH study, 82 per cent of ED director respondents perceived that overcrowding increases stress among nurses, and 68 per cent felt it makes the recruitment and retention of nurses more difficult.⁹

At a Canadian Patient Safety Institute Board meeting in September 2008, a presentation on overcapacity in hospitals was given by Kaaren Neufeld and Joanna Pawlyshyn. Following the presentation, the Board discussed safety issues related to overcapacity¹⁰ but no information has been published related to the issue.

**Towards a Better Workplace**

*Overcapacity Protocol (OCP)*

In BC, in 2006, in response to severe ED crowding, health authorities put in place Overcapacity Protocols (OCP) to be used as short-term responses to gridlock conditions. The intent of these protocols (also referred to as decongest policies, Code Purples, etc.) is to offload admitted patients from EDs to wards and other areas of the hospital, which may include hallways or closets. It causes transfers within units, with subsequent increased nursing workload, and threatens infection control, for example when MRSA-

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⁶ Rowe, B.H et al (2006) op cit
positive patients can not be isolated. It also has a knock-on effect to all parts of the healthcare system as there is huge pressure to discharge patients into the community or back to residential care facilities, where staffing levels are not sufficient to cope with the increased demand.

In response to this untenable situation, the BC Nurses’ Union council endorsed a position statement on overcapacity protocols (see related media) and devoted targeted resources to ensure that nurses were informed about OCP and that they could act upon the impacts in their workplace. This could include filing Professional Responsibility Forms (PRF), grievances, or incident reports and taking up their concerns with managers and others who could influence policy.

This initiative did educate many nurses, and subsequently PRFs were filed. Again, health authorities tried numerous initiatives but because of the systemic nature of the problem they continued to be “band-aid” approaches. In recognition of these broader issues, the OCP campaign transformed into a Repair the Care initiative which encourages nurses to examine the underlying links to a privatization agenda as the public system becomes destabilized.

Patient flow
Much of the current literature on emergency department crowding discusses patient flow, not only in the ED but throughout the hospital.11,12

Two BC health authorities, Fraser and Vancouver Coastal, have implemented a process called iCare which aims to “decongest” the acute care system, improve patient flow and improve the quality of care. Specific goals include:

- Reduce inpatient occupancy
- Reduce intra-hospital transfers
- Reduce non-residential Alternate Level of Care (ALC) rates
- Reduce and discontinue the need for OCP

Reports indicate that the program is successful in achieving these goals. For example, in one facility, ward occupancy rates went from 106 per cent to 99 per cent. Nurses at another facility report that OCP has all but been eliminated.

The concept involves daily rounds with a core inter-professional team which usually includes a physician, registered nurse (sometimes referred to as utilization clinician), occupational therapist, physiotherapist, social worker, patient care coordinator, and discharge coordinator. The team sets care planning and discharge goals for each patient and integrates their work to meet the goals.

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Although iCare has produced positive results within the hospitals where it has been implemented, several concerns have been expressed, which will need to be monitored. One is that earlier discharge may increase the workload of nurses in the community and over-burden informal care providers. Another is that early discharge may result in readmissions, which are not tracked if a patient returns to hospital with a different yet related medical diagnosis than that which was recorded on the previous admission.

*Nurse productivity*

As hospitals function over optimum levels of bed occupancy, so too do nurses function beyond optimum productivity. In the Canadian healthcare system, nurses receive paid breaks equivalent to about 7 per cent of their work hours. Therefore, the maximum capacity of these nurses is 93 per cent. At 93 per cent there is no flexibility to meet unanticipated demands or respond to increased patient acuity. In a major study involving cardiac and cardiovascular units of six hospitals in Ontario and New Brunswick with resulting 727 nurse questionnaires and 8,113 patient days of data, it was found that on 46 per cent of days evaluated, units worked beyond 93 per cent, and on 61.5 per cent of the days, units worked beyond 85 per cent.\(^\text{13}\)

The study recommended that nursing unit productivity/utilization levels should target 85 per cent, plus or minus five percent because levels higher than this create higher costs, poorer patient care and poorer nurse outcomes, such as retention and sick time. The authors suggest that appropriate productivity targets can be met by enhancing nurse autonomy, reducing emotional exhaustion, and having enough staff, carrying out work appropriate for scope of practice, to cope with changing patient needs.\(^\text{14}\)

The issue of nurse autonomy has been examined in relation to nurse satisfaction and retention for many years and forms one of the key factors in Magnet Hospitals that differentiates high performing organizations from others. The original magnet research study identified fourteen characteristics in hospitals that were best able to recruit and retain nurses during the shortages of the 1970s and 80s.\(^\text{15}\) These characteristics became the American Nurses Credentialing Centre Forces of Magnetism and are used in their Magnet Hospital Recognition Program.

Force 2, Organizational Structure, requires a system of shared decision-making. Force 9, Autonomy, requires “the ability of a nurse to assess and provide nursing actions as appropriate for patient care based on competence, professional expertise, and knowledge.”\(^\text{16}\)

A recent Robert Wood Johnson Foundation publication looking at nurse staffing policy highlighted the importance of increasing nurses’ authority, reporting that “Some nursing

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\(^{14}\) Ibid p ii


\(^{16}\) Forces of Magnetism – American Nurses Credentialing Centre at [www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx?cs](http://www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx?cs)
advocates believe that, even if staffing policy is implemented, if nurses are not given enough decision-making authority, the policy may not work well.17

Moving Forward

Two examples of initiatives which embody the front-line empowerment necessary to achieve nurse autonomy are the BCNU workload/staffing plan project and the Releasing Time to Care program which was developed in the UK but is quickly spreading to other countries, including Saskatchewan where a pilot is proceeding.

**BCNU Workload/Staffing plan project**

As part of bargaining for the 2006-2010 BCNU Provincial Collective Agreement, language was negotiated in an attempt to deal with the pressing issue of nurses’ workload. In recognition of the fact that Workload Measurement Systems have been found wanting, for the most part due to their failure to accurately reflect the depth of what nurses actually do, a process based on front-line empowerment is being tested at eight work sites throughout BC. The sites include two units in acute care hospitals, two residential facilities, two community mental health sites and two community health units.

The purpose of the project is to engage nurses (RNs, RPNs, LPNs) and other relevant care providers in discussions related to their work environment with the aim of making decisions for change and then to implement safe and effective staffing plan processes. The work requires input from all members of the care team and relies upon leadership from both project teams and managers at the selected sites.

A project manager and two nurse consultants work with site-based teams to analyze data (which might come from staff surveys), then develop action plans to address targeted issues. They then help the team to work through a patient/resident/client classification exercise in order to make recommendations about staffing.

At the end of the project, a report with recommendations will be presented to senior healthcare executives regarding implementing standardized staffing plan processes for care staff across BC. (See Appendices I & II)

**The Productive Ward - Releasing Time to Care**

The Productive Ward program was designed by the National Health Service (NHS) Institute for Innovation and Improvement in Coventry, England. Utilizing principles from the LEAN model of work organization, the program empowers nurses to look at how their wards are organized and make changes that allow them to spend more time with patients. It was piloted in four NHS Trusts and about 80 per cent of Trusts have now signed on.

Pilots showed the Productive Ward can:

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• Dramatically increase the amount of time nurses spend on patient care
• Cut handover time by a third
• Reduce medicine round time by 63 per cent

The strength of the approach is that it gives ward staff the information, skills and time they need to regain control of their ward and the care they provide.18

To implement the Productive Ward, there needs to be strong leadership support. It is resource intensive in the initial stages and can take up to a year before positive returns are achieved. For example, at Middlemore Hospital, Waitemata District Health Board, New Zealand, utilizing the “releasing time to care approach” staff spent the better part of a year successfully plotting how to remove five corridor beds.19 The program will be implemented in other Health Board facilities. One charge nurse manager described it as a program “run by the nurses, for the nurses…we can work smarter rather than harder and it enables us to provide greater quality care with less stress and without any additional resources.”20 More information can be found at www.institute.nhs.uk.

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18 NHS Institute for Innovation and Improvement (2008). Briefing note for Jamie Cowling, Treasury, Productivity and Reform Team
19 Hospital removes beds from corridors. Sept 26, 2008 New Zealand Herald www.nzherald.co.nz
APPENDIX I
MEMORANDUM OF AGREEMENT
STANDARDS FOR MEASURING NURSE WORKLOAD AND APPLICATION OF NURSE STAFFING PLANS IN BRITISH COLUMBIA

Context

It is agreed that nursing is a fundamental element of British Columbia’s health care system. Patient safety and positive patient outcomes are dependent upon having appropriate staffing plans which provide reasonable workloads for nurses.

It is also recognized that nursing workload is a significant issue that needs to be addressed. The literature suggests that continual excessive workload can lead to an overly stressful work environment and may result in poor decision making by care givers, high staff turnover, recruitment problems, increased use of medical disability programs and absenteeism, and the need to pay overtime in order to fill the subsequent vacancies.

Variables which need to be considered in developing appropriate staffing plans include:

- Patient/resident/client clinical acuity;
- Nature and complexity of care provided;
- Functionality of the capital facility;
- Location of facility or service;
- Workforce Resources (FT/PT/Casual and scheduling options, etc).

It is understood that it is a vital task of the parties to provide quality patient care and optimize nurses’ working conditions in order to ensure a robust public health care system for the people of B.C.

Implementing Appropriate Workload Measurement Tools and Nurse Staffing Plan Processes

The parties agree that workload measurement tools are a means to facilitate informed discussion and decision-making about safe workloads for nurses, rather than being an end in themselves. While workload measurement tools have undergone advances in recent years they are not yet fully developed outside of the acute care and residential care setting. Principles that should be met in determining appropriate workload measurement tools and nurse staffing plans should be:

- Evidence-based;
- Based on patient/resident/client needs, acuity and outcomes.

The Deputy Minister, Ministry of Health and the Health Authorities commit to cost share the implementation of a workload measurement system to facilitate workload measurement and staffing plan processes.
Provincial Nursing Workload Committee

Upon ratification of the Nurses’ PCA, a joint Provincial Nursing Workload Committee (PNWC) shall be formed. The PNWC shall consist of three senior representatives from the Nurses’ Bargaining Association and three senior representatives from the Health Authorities and will be chaired by the ADM – Clinical Innovation and Integration (Chief Nurse Executive). An NBA representative will be the vice-chair of the PNWC. The PNWC shall seek to develop consensus and provide advice to Leadership Council (LC) on which indicators within a workload measurement tool should be used within the healthcare system.

The PNWC may seek the advice of experts and or add other personnel in order to provide expertise and guidance. Such additions shall be by mutual agreement among the regular members of the PNWC. Specifically, the PNWC will recruit the assistance of clinical nurse researchers including, but not limited to, a researcher associated with the CHSRF research project on nurse staffing conducted through the University of Toronto, to assist with the development and/or selection of the indicators and the assessment phases.

The Ministry of Health will provide financial and resource support for the work of PNWC. The PNWC will report directly to LC.

The PNWC will convene within thirty (30) days of ratification of the Nurses’ PCA and shall initially meet a minimum of once per month to seek to develop consensus on the workload measurement indicators and the selection of the initial areas where workload measurement tools and nurse staffing plan processes will be implemented. The PNWC will develop a timeline and target goals for its activities at its initial meetings.

Local Nursing Workload Committees (Regional Nursing Workload Committees)

Each Health Authority will form a Local Nursing Workload Committee (LNWC). The LNWC will consist of Health Authority (including CNO) and NBA representation and be chaired by a senior executive of the Health Authority. The Health Authorities will provide financial and resource support for the work of the LNWC. The LNWC will report to the Health Authority management and the PNWC. The mandate of the LNWC will be to advise Health Authority management and the PNWC on the appropriate implementation and tracking of the workload measurement indicators and staffing plan processes.

Immediate Response to Areas of Concern

The parties recognize that there are areas and/or units that have pressing workload concerns that need to be examined and addressed with necessary interventions in a timely manner. As a first step to inform its work and assist in resolving or ameliorating immediate workload concerns the PNWC will undertake a review of all outstanding Professional Responsibility Reports related to workload to be completed within three (3)
months of ratification. Based on this review the PNWC may make recommendations to LC. Additionally, the PNWC will inform the LNWC of the identity of key areas or units of concern and potential strategies that may be undertaken.

The LNWC will develop specific strategies and interventions to address workload in the key areas or units identified by the PNWC. In addition, the LNWC is not precluded from identifying areas or units of concern and developing strategies and/or interventions on its own. Such strategies may include the use of a Strategic Workload Analysis Team (SWAT) in each Health Authority. The SWATs will be composed of a Senior Health Authority management representative and an NBA representative and will have a Health Authority Executive sponsor. The SWATs may utilize other personnel as required. A framework regarding the composition, role and function of SWATs is attached to this MOA.

**Employer Objectives for Reasonable Workload**

The following articulates the elements to be brought into consideration in assessing and responding to workload issues:

- The staffing level should be aligned with the mix of patients being served
- Appropriate relief should be allocated to account for vacancies due to vacation, union leave, leave of absence, etc
- There should be an appropriate surge capacity available to deal with changes in patient load and acuity over the course of time
- There should be accessible, empowered, skilled frontline leadership
- Other key resources which can assist in the management of workload and may need to be made available include:
  a. Equipment
  b. Clerical support
  c. Allied health providers
  d. Patient transport support
  e. Information and communication technology

**Implementation of Workload Measurement Indicators and Staffing Plan Processes**

1. **Acute Care and Residential Care**

The implementation of workload measurement indicators and staffing plan processes will begin within six months of the PNWC first meeting and will be done in three phases:

**Phase 1:** The first phase of implementation will be for a minimum of four (4) agreed-upon areas, sites or locations (two (2) in acute care and two (2) in residential care) to apply and refine the workload measurement indicators, staffing plan processes and tracking of patient outcomes. Timeframe – Start up within 6 months.
The LNWC will provide ongoing advice to the Health Authority operational leadership and the PNWC on the implementation of workload measurement indicators and staffing plan processes in the selected areas/sites/locations.

Phase 2: The second phase will be the evaluation of Phase 1. Such evaluation will include the assistance of clinical nurse researchers including, but not limited to, a researcher associated with the CHSRF research project on nurse staffing conducted through the University of Toronto.  
Timeframe – To be determined by the PNWC.

Phase 3: The third phase will be the implementation of agreed-upon appropriate indicators, nurse staffing plans and tracking of patient outcomes on a province-wide basis.  
Timeframe – To be determined by the PNWC.

2. Community and Mental Health

Phase 1: The first phase will be the development/refinement of workload indicators, staffing plan processes and tracking of patient indicators.  
Timeframe – One (1) year.

Phase 2: The second phase of implementation will be for a minimum of four (4) agreed-upon areas, sites or locations (two (2) in community and two (2) in mental health) to apply and refine the workload measurement indicators, staffing plan processes and tracking of patient outcomes. 

The LNWC will provide ongoing advice to the Health Authority operational leadership and the PNWC on the implementation of workload measurement indicators and staffing plan processes in the selected areas/sites/locations.  
Timeframe – Start-up within three (3) months of the completion of Phase 1.

Phase 3: The third phase will be the evaluation of Phase 2. Such evaluation will include the assistance of clinical nurse researchers including, but not limited to, a researcher associated with the CHSRF research project on nurse staffing conducted through the University of Toronto who will be involved at the beginning of Phase 1.  
Timeframe – To be determined by the PNWC.

Workload Resolution Process
Any unresolved concerns regarding workload may be addressed through the Provincial Nursing Workload Committee.

This Memorandum of Agreement is in effect from April 1, 2006 to March 31, 2010.

ATTACHMENT TO APPENDIX O: Strategic Workload Analysis Team (SWAT)

- Established at Health Authority level.
- Composition: NBA representative, Health Authority management representative. Team will have a Senior Health Authority Executive sponsor.
- Team will be funded by the Health Authority.
- Team may access expertise and/or resources (staff, equipment, expertise in hiring, recruitment, scheduling, environmental knowledge, clinical, professional practice, facility knowledge, etc) as appropriate.
- Factors that may be identified for SWAT response include:
  - Persistent overcapacity;
  - Vacancy rates;
  - Inability to maintain baseline staffing;
  - Closures of service;
  - Overtime;
  - Sick time;
  - Professional responsibility forms
  - Lack of access to vacation/leaves/breaks
- May need to limit number of units reviewed in order to maximize team effectiveness.
- The Team will develop recommendations and strategies and assist in their implementation.
- Recommendations and strategies will be focused on solutions that will have an immediate impact in the short term and are designed to show indicators of success within 6 months.
- Recommendations and strategies will include a wide variety of designs including Responsive Shift Scheduling, non-nursing duties, Innovation fund, etc.
- The Team will follow-up with an informal evaluation: Plan, Do, Study, Act – what worked, what didn’t;
- The Team will communicate with the Local Nursing Workload Committee (LNWC) and share solutions with other Health Authority SWAT Teams.
APPENDIX II

Provincial Nursing Workload Committee Demonstration Projects — Background and Progress to Date (October 2008)

Part of the Provincial Nursing Workload Committee’s work, as outlined in Appendix O of the NBA and HEABC 2006-10 Provincial Collective Agreement, is to implement workload and nurse staffing plan process projects at eight health care sites within BC.

Background
Heavy nursing workloads result in job strain and nursing burnout (Baumann et al., 2001). One way to address nursing workloads is to critically examine nurses’ staffing plan processes. Positive staff and patient outcomes are dependent upon having appropriate staffing plan processes in place which provide reasonable workloads for those who provide care (Canadian Health Services Research Foundation, 2006).

Recent nurse staffing plan projects in the United States and Canada have demonstrated that appropriate staffing can be achieved through decision-making processes that involve nurses. The research evidence shows that those who provide care are vital to staffing discussions. Nurses are knowledgeable about their own practice environment, and they know what is necessary to safely and effectively respond to their patients’ care needs (Canadian Nurses Association, 2004; Parsons, 2004). In fact, recent operations research has shown that the most effective nursing workload measures begin with the development of professional judgment (nursing) patient acuity models. These models are qualitatively developed through discussions with front-line nurses. Components of this project, particularly the development of patient/resident/client classification systems, are taken from this research (The Advisory Board Company, 2007).

Earlier work of O’Brien Pallas et al (1997) demonstrated that “a gold standard process” for determining nursing resource intensity (workload) includes encouraging nurse caregivers to interpret objective workload data from the perspective of their actual frontline experience (Canadian Nurses Association, 2003). Some examples of such objective data sources that will be used in this project include care staff workload survey information, nurse-sensitive patient indicators, and human resource data.

Purpose
The purpose of this project is to engage nurses (RNs, RPNs, LPNs) and other caregivers (e.g., Care Aides, Mental Health Workers) in discussions and decisions related to their work environment and to implement safe and effective staffing plan processes within their specific practice sites. While NBA members and their managers are leading this project, it is recognized that staffing plans cannot be developed in isolation. Therefore, at each of the project sites, all members of the care team will be involved at some level. What we learn from these demonstration site projects will help develop standardized staffing plan processes for care staff in other healthcare sites across BC.
Objectives
The primary objective of this project is to facilitate nurses’ capacity to systematically examine factors that are relevant to their workloads. Project teams comprised of front-line leaders and care staff members will use site-specific data to support decision-making processes aimed at addressing factors critical to effective staffing and workload management. This project is not intended to develop a traditional, quantitative nursing workload measurement system, or WMS, such as GRASP or ERIC. Rather, it is meant to provide a workload measurement process where front-line staff and leaders work together to analyze their environment, patient needs, and the care that staff provide and then develop and implement action plans and recommend how to best organize and deliver services. Although progress has been made in refining WMSs, traditional systems still fail to capture the actual work done by nurses and other caregivers, and often neglect to consider important patient and environmental characteristics that influence workload (Baumann et al, 2001; CNA, 2003).

Specific project objectives will be to:
Form a staff Project Team of up to 6 members, comprised of nurse leaders, nursing and other care staff where appropriate.
Identify practice environment factors that negatively impact workload, and where feasible and in consultation with management, develop action plans to address these issues
Classify patient/resident/client caseload according to levels of acuity
With the aid of a staffing plan toolkit and assistance from an external Project Manager, pilot a nursing staffing plan process designed to address each site’s unique concerns
Employ patient-sensitive measures at pre-intervention and post-intervention points to determine whether the workload intervention process positively influences selected patient and staff outcomes

Over the one year duration of the project, the Project Team members will meet with the Project Manager and Nurse Consultant for monthly full-day working sessions, and will work together with their Team colleagues on a regular basis in order to achieve their objectives. Funding is provided to cover each Project Team staff member’s time, to a maximum of 0.2 FTE over the one year project’s duration.

The project work has begun at 2 residential care sites and 2 acute care sites:
Brock Fahrni Pavilion, Vancouver, Vancouver Coastal HA (June, 2008).
Yucalta Lodge, Campbell River, Vancouver Island HA (July, 2008).
Richmond Hospital – 6 North, Vancouver Coastal HA (March, 2008).
Cowichan District Hospital, Duncan – 2 South, Vancouver Island HA (June, 2008).

Dr. Maura MacPhee is an Assistant Professor of Nursing at UBC and is the Lead Researcher for this project and on a Canadian Health Service Research Foundation study on nursing leadership development. She has extensive research experience and has done team process facilitation with nurse-led project teams at a number of hospital sites.

The Project Manager also provides much needed skill for this project. Andrea Wardrop has a B.A. in Psychology and is currently completing her M.A. in Counselling Psychology at SFU. She brings to the project experience in group facilitation, research and project management.
Project Teams begin with an assessment of factors they consider to contribute to excess workload, with a view to enhancing the quality and safety of patient care delivery and the workplace. Workload management strategies are individually designed based on the needs and interests of each unit. For example, one project team is auditing standards of care, such as wound care management. Interventions selected by each Project Team will be evaluated to ascertain their effectiveness in reducing workload and improving staff and patient satisfaction.

The PNWC has recently reviewed Expressions of Interest in order to expand the workload project to community health and community mental health services sites, which may include Mental Health clinics, Primary Health Care Clinics, Home and Community Care Services, and Population and Preventive Health Services. Two community mental health sites (one from Northern Health and one from Fraser Health) and one community health site from Fraser Health have been selected. Another community health site selection will be completed shortly. First visits to the four new sites are expected to occur in October/November, 2008.