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Advisory Panel on Health System Structure Saskatchewan Ministry of Health
3475 Albert St. Regina, Saskatchewan S4S 6X6

Saskatchewan RHA Review Advisory Panel Written Submission Form

Name

Linda Wasko-Lacey, President, SRNA

Do you represent an organization or are you making a submission on behalf of an organization?

Yes - Saskatchewan Registered Nurses' Association (SRNA)

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SRNA Background

The Saskatchewan Registered Nurses' Association (SRNA), established in 1917 by the *Registered Nurses Act*, *1988,* is the profession-led regulatory body for the province's Registered Nurses (RNs) and Registered Nurse-Nurse Practitioners [RN(NP)s]. The SRNA is accountable for public protection by ensuring members are competent in providing the services that society has entrusted to them. Individual members are personally accountable for their professional nursing practice through adherence to the code of ethics, practice standards and maintaining competence.

The SRNA is also the association for RNs and RN(NP)s in the province; promoting the professional interest of its members in the public interest. This role includes working with our members and partners to influence healthy public policy and support quality practice environments. The association also implements strategies to support ongoing education of our members and promote evidence-based nursing.

SRNA Mission: RNs and RN(NP)s are leaders in contributing to a healthy population.

Membership: At the end of 2015, there were 11,285 practicing RNs, of which 213 were RN(NP)s. The SRNA is the largest health professional regulatory body and association in the province.

SRNA Submission

We are pleased to advise that the SRNA solicited member involvement to provide input on our submission through a webinar and an online survey. A total of forty-three SRNA members participated.

Their feedback has been integrated with the perspective of the SRNA President, Council and Executive Director and summarized in the submission below.

Mandate #1

Recommend a structure with fewer regional health authorities to achieve administrative efficiencies as well as improvements to front-line service delivery.

1. What are the strengths of the current 12 RHA structure?
    a. Local representation on boards – local decision making by people in/from the community.
    b. Focus and attention on understanding as well as addressing local issues.
    c. One approach often doesn't work across different areas (such as urban and rural). Ability to adapt and update strategies with less bureaucracy and influence from other stakeholders.

2. What are the weaknesses of the current 12 RHA structure?
    a. Twelve boards striving for access to provincial funding – difficult to navigate through challenging economic times.
    b. Lack of standardized, evidence based policies / leading practice guidelines.
    c. Duplication of similar work at times – an example would be 12 different policies/procedures can be developed where one provincial policy/procedure may work.
    d. Many lessons learned not effectively shared across all health regions.
    e. Perceived turf protection and needless competition between regions at times.
    f. Changes in one region may have a negative effect on the programming/services in another so it is difficult to think and make decisions provincially.
    g. Twelve RHAs makes development and implementation of new models of care difficult on a provincial basis. For example, Nurse Practitioners could be utilized in many more areas to meet local patient needs but some policy/financial barriers limiting spread of these services across 12 different health regions.
    h. Transfers between facilities and RHAs create vulnerable transition/failure points in communication and coordination resulting in increased risks to patients and families. Difficult to develop strong teamwork strategies and expectations across twelve RHAs.
    i. Direct care providers often not asked for meaningful input on local issues and changes for improvement.
    j. Patients sometimes experience needless duplication of procedures/lab tests.
    k. Insufficient transparent accountability for the performance of the applicable region.
    l. Some patients do not know how to influence the delivery of their healthcare services.
    m. Some key services such as Physical and Occupational Therapy not easily accessible in rural areas.
    n. The competencies of health system leaders vary significantly across and within the RHAs. Insufficient investment to date in developing and supporting leaders.

3. What factors should be considered in defining RHA boundaries?
    a. Travel / referral patterns for outpatient and inpatient care.
    b. Centralization of tertiary centres as hub sites and the distance that must be travelled to access these services.
    c. Availability of services.

d. Geography.
e. Ability of Board members and management to engage with patients and providers locally to understand their perspective and challenges.
f. Holistic approach – ensure silos do not negatively impact patients and families.
g. Use resources (HR, Facilities, Financial) to move to a more balanced approach between illness and health promotion focus. Be in the business of health through effective primary health care.

4. How can we ensure local community / regional needs are represented with fewer RHAs?
    a. Design RHA structure to spread governance and decision making power across the province. Include defined mechanisms for regular community input to the board.
    b. Absolutely essential that managers with decision making authority are in place at the local level to adjust/support programming to meet local needs.
    c. Ensure representation from rural communities, some members could be appointed, some elected - much like the health self governing boards. The elected reps could be determined through the municipal election process.
    d. Ensure full participation and representation of Indigenous people in community development decisions and board governance. This should include more than one Indigenous person becoming a board member according to the population of the RHA and the appointment should be made by the local Indigenous groups.
    e. Ensure that each RHA has representation from rural municipalities.
    f. Enable diverse public/patient/family advisory panels/groups with direct reporting/communication to governance of each region.
    g. Ensure that the new regions must meet minimum service level requirements for their population.
    h. Incorporate rigorous population health assessments into strategic planning cycles.
    i. Engage local volunteers in the transition discussions and ensure that strong support mechanisms for volunteer engagement exist in the new RHA(s).
    j. Services should be brought to patients, clients and residents as much as possible. With the technological advancements that have occurred, this goal should be achievable in more areas of the province.

5. What about the current regional structure limits innovation across the system?
    a. LEAN initiative viewed by some as ineffective and some direct care providers experiencing challenges with accessing needed supplies.
    b. Insufficient investment in local leaders to develop expertise in innovation.
    c. Insufficient investment in education and simulation to improve teamwork within interdisciplinary care teams.

6. Is there a logical configuration of RHAs? Why?
    - Recommend three to five RHAs to ensure that North, Central and South areas of the province have their own governance to enable effective community partnerships; strong local leadership; and, staff, physician, patient and family engagement.

- A large northern RHA could be better positioned to provide specialty services within the region.

7. What administrative efficiencies can be achieved through fewer RHAs? What type of administrative structure do you recommend?
    a. Administrative efficiencies may not occur through fewer RHAs.

8. What improvements to patient care can be achieved through fewer RHAs?
    a. Fewer and larger RHAs enables each to have a greater infrastructure for prioritizing the needs of their population, providing the applicable education and resources to deliver the targeted services as well as evaluate the impact. Each region would be better positioned to establish and/or support their centres of excellence for identified services based on the needs of their population.
    b. Standardized provincial guidelines.
    c. Standardized provincial nursing orientation programs for specialized services such as critical care, emergency, labour & delivery, etc.
    d. Improved workforce planning and workforce distribution based on broader assessment of needs across larger health regions. For example, RN shortages in rural and northern areas should be addressed through a provincial / regional partnership. Another example would be NP led clinics as proof of concept has been established in rural and small urban areas in Ontario/Manitoba however Saskatchewan has been slow to add this service that has delivered improvements in patient health outcomes at stable cost.
    e. Shared records/forms/documents.
    f. Potential for a more effective, coordinated strategy for research and innovation.
    g. Potential ability to leverage patient safety expertise in some of the regions to systematically improve the ability to understand the root causes of adverse events/critical incidents. Targeted strategies for improving the quality of care (and reducing the risk to patient safety) will be more effective.
    h. Potential to support the development of physician leaders and enhance medical quality review/improvement mechanisms.
    i. Potential to support the development of RN and RN(NP) leaders across all levels and sectors in order to enhance the quality of nursing care.
    j. RNs are the largest group of regulated health professionals in the province therefore it is important to ensure that new RHA(s) have a Chief Nurse Executive on the RHA Executive Team. He or she would be integral to ensuring that RNs, other nursing professionals and members of the inter-disciplinary team are evidence based and supported to implement best practice.

9. Do you have advice on steps to be taken when moving to fewer RHAs?
    a. In view of the significant disruption and distress related to health system restructuring, approach this health system restructuring with the goal that it will not occur again unless it is community initiated. Take the time to design and finalize a coordinated transition to the new structure.
    b. Build on the strengths of our people and communities.

c. Ensure that new management structure and all support services are in place on the first day of the new structure. Explain the methodology / rationale for the design transparently.
d. Span of control for management must be feasible to ensure all employees have the guidance and support to deliver safe and effective health care services.
e. Communicate and engage with public, patients/families, staff and physicians before, during and after each step in the transition to the new structure.
f. Ensure regulatory bodies and union representatives are engaged early in the discussions and decisions.
g. Ensure that new structure has explicit and mandated requirements for coordination and/or delivery of primary care within the region. This would include a focus on holistic, collaborative, culturally competent health care and a health promotion and prevention approach. A comprehensive approach such as this would positively impact the social determinants.
h. Ensure that community development hubs are established to support local community engagement and participation. Provincial standards and consistency can still occur.
i. Incorporate a requirement and mechanism for the new health regions to work with all health and human services such as the Education, Justice and Social Services.
j. Design and enable a much more comprehensive approach to the delivery of home care services, including palliative home care services.
k. There is strength and diversity in our province. The new structure needs to reflect this diversity.
l. Review the evidence arising from regional changes in other provinces and incorporate what has been successful.
m. Incorporate leading change management principles into the establishment of the new structure.
n. There are many people in our province living in fear of the future and we know that fear negatively impacts teamwork, patient care and staff engagement. The transition process and structure will need to pay attention to these people and support them through this change.

Mandate #2

Consider opportunities to consolidate clinical or health system support services currently delivered by regional health authorities or other health care agencies that may be more effectively delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services.

1. Are there non-clinical and support services currently managed by RHAs that could be more effectively delivered on a provincial basis? Support services are those services and activities that are necessary to run any business including health care but are not health care services themselves – for example: procurement, information technology, payroll, etc.
    a. Yes.
        i. Efficient expansion and support of the electronic health record (all providers and patients should be on a single system)
        ii. Information Technology
        iii. Human Resources
        iv. Occupational Health & Safety
        v. Financial / Budget Support
        vi. Contract Services for Capital investments as well as expansion of bulk purchasing of drugs, medical/surgical supplies
        vii. Consider leveraging Quality Improvement / LEAN expertise on a provincial basis with dedicated resources locally

2. Are there clinical services that could be more effectively delivered / managed on a provincial basis that would improve patient care? Clinical services can include, for example: • Diagnostics and laboratory • Ambulance • Highly specialized medical services • Public health • Other?
    a. Yes.
        i. Ambulance
        ii. Public and Population Health (share the expertise and standardized best practices)
        iii. Lab/DI
        iv. Credentialing of physicians
        v. Consider leveraging Infection Prevention and Control expertise provincially with dedicated resources locally
        vi. Consider leveraging Mental Health Services provincially with dedicated programming and resources locally

3. What governance model do you recommend would be best to provide oversight to a provincial health authority? For example: • Crown corporation • Provincial Authority with a Board reporting to the Minister • CEO reporting to the Deputy Minister rather than to a Board • Private enterprise • Other?
    a. Clinical services such as lab must be linked to the local clinics/hospitals to meet local needs and ensure effective utilization.

b. Whatever governance model that is selected provincially must have an explicit and visible relationship to a structure within each region. Coordination and delivery of these services must be seamless in each region.
c. Recruit CEOs or board members early in the process that have expertise in developing and implementing large complex services so they can guide the creation of the new system.

4. Do you have advice on steps to be taken to consolidate provincially delivered or managed services?
    a. Ensure that applicable models in other provinces and countries are assessed for their effectiveness and ability to deliver efficiently then bring this knowledge to Saskatchewan. Carefully plan out how to make any transitions within the province without disruption to patient care.
    b. Design the model to share key expertise equitably across the province.
    c. Base these decisions on well developed business cases with input from patients, families and providers.

Mandate #3

Review current legislation and processes to ensure they adequately establish: the roles of health systems boards; their composition; structure and reporting relationship to achieve appropriate accountability. In 2002 The Regional Health Services Act was proclaimed into force and the current 12 regional health authorities were established. A board comprised of up to 12 members is appointed by government to plan, organize, deliver and evaluate health services within the region. Roles, responsibilities and accountability are outlined in the Act.

1. What are the strengths of the current board model?
    a. Local community leaders as leaders in delivering local health care services.

2. What are the weaknesses of the current board model?
    a. Appointed and given direction by the Ministry, not given clear parameters to govern locally.

3. Is there clarity of the role, mandate, accountability and relationship with the Ministry in the current board model?
    a. No.
        i. It is essential that board members be appointed with greater expertise in the design of leading health systems, quality improvement, patient and family centred care, health economists and the delivery of care. The breadth and depth of expertise required of the board members should be formally specified prior to the health system restructuring.
        ii. There should be greater clarity of the role, mandate and accountability of the health regions.
        iii. There should be greater clarity of the role, mandate and accountability of the Ministry.

4. How can the interests of Indigenous people be represented within a board structure?
    a. The obvious answer is that each board must have at least one member from an Indigenous background but all board members must also have, or be supported to attain, an in depth understanding of the Indigenous cultures in Saskatchewan, their health outcomes and applicable relationship to the social determinants of health in Saskatchewan.
    b. Consider a formalized relationship/mandate and/or role with First Nations governing bodies.
    c. Ensure broad engagement now, including with Elders, to design the new structure and then maintain strong partnerships on an ongoing basis.

5. Does current legislation limit a board's or the health systems' ability to innovate and to ensure open channels of communications across the health system? If so, what recommendations for change do you offer?
    a. There is an opportunity to establish a structure with provincial mechanisms for a smaller number of RHAs to formally learn and innovate together. An example would be a

provincial initiative to reduce hospital readmissions for patients with Congestive Heart Failure. Patients and families could be engaged with direct care providers, managers and physicians to transparently share lessons learned across the province.

6. With fewer regions, what must be considered in board structure, composition and accountability to ensure your community interests are represented?
    a. Incorporate a process to increase patient/family voices for change. Right now boards hear patient and family stories but we need to ask how we can leverage the patient and family centred care perspective to advance and enable these changes.

Mandate #4

Identify processes to enhance management information to improve and observe on performance management of the health care system.

1. What type of information is required to make informed decisions about health system performance and to report on variances in performance (e.g. between similar facilities, region to region, etc.)?
    a. Transparent and accessible objective data on the performance of the health system that is obtained from the EHR or another repository.
        i. Patient/family experience and satisfaction
        ii. Staff and Physician engagement surveys
        iii. Wait times for mental health services, surgery, access to specialists, Emergency, access to primary care clinics, etc.
        iv. Emergency visits for non-urgent care
        v. Infection rates
        vi. Utilization rates
        vii. Chronic disease management indicators
        viii. Key clinical outcomes such as 30 day-mortality following a myocardial infarction and readmission rates to hospital.
        ix. Nursing sensitive indicators (such as falls, urinary tract infections, decubitus ulcers)
        x. Safety indicators at various touch points along the continuum of care such as transitions, access points (navigation failures), etc.
        xi. Use patient safety and other quality measures to design, implement and evaluate staffing models to ensure that there are an appropriate number of RNs and RN(NP)s coordinating, implementing and evaluating the delivery of health care services.
        xii. Better use of Health Indicators to guide Primary Health Care needs/directions
        xiii. Regularly seek to answer the question “Are the services offered what the local population needs to improve their health?”
    b. Ongoing and effective public, patient/family, staff and physician participation in surveys and health advisory panels.

2. Is this information currently available – in other words, what is the gap in information?
    a. No
        i. Very little information on health system performance is currently available.
        ii. More frequent, well designed and easily understandable reports are required for improvement of the system.
        iii. All areas of the province should be required to report on standardized quality indicators.
        iv. Direct care providers and patients should directly receive/have access to this information and not be the last to know.

3. How can these gaps in information be addressed?
    a. One EHR for all providers and patients
    b. Access to remote technology in more areas
    c. Look for established and credible sources of data, including the Canadian Institute for Health Information and Long Term Care (MDS/RAI)

Any other comments you want to share with the panel.

a. Importance of the RN and RN(NP)s in the acute, long term and community settings

"RNs and RN(NP)s are uniquely prepared to safely and effectively provide nursing expertise and support to Saskatchewan residents across the continuum of care, regardless of how complex or unpredictable their injury or condition. From primary care to critical care, RNs and RN(NP)s play a vital role in helping to keep our elderly safely in their home, assisting those of all ages to recover from injury and illness as well as leading health promotion and illness/injury prevention programming. Meaningfully engaging RNs and RN(NP)s in the transition to fewer RHAs will help to ensure a successful outcome."

Linda Wasko-Lacey, RN, President, SRNA

b. Importance of coordinated and integrated Health Human

"At a time when healthcare needs are becoming increasingly complex and healthcare services must become more efficient, Saskatchewan needs a proactive, coordinated and integrated provincial health human resource plan to inform and support the transition to fewer RHAs."

Carolyn Hoffman, RN, Executive Director, SRNA

c. Meaningful and sustained positive change

"I would like to share that it is my hope that decisions are made thinking about the health strategy of people in our province and that politics and finance are not the drivers of the change."

Quote from an SRNA Member