# Health Accord
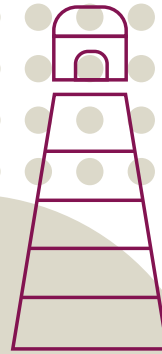## for Newfoundland & Labrador

## Our province.
## Our health.
## Our future.

A 10-Year Health Transformation

## THE REPORT

17 February 2022

**The Honourable Andrew Furey**
*Premier of the Province of Newfoundland and Labrador*

The Office of the Premier
Confederation Building, East Block
P.O. Box 8700, St. John's, NL A1B 4J6

**The Honourable John Haggie**
*Minister of Health and Community Services*

Department of Health and Community Services
Confederation Building, West Block
P.O. Box 8700, St. John's, NL A1B 4J6

Dear Premier Furey and Minister Haggie,

On 05 November 2020, you announced that we had been appointed as the Co-Chairs of Health Accord NL. We were given responsibility for developing a 10-Year Health Accord for Newfoundland and Labrador that comprises actions and recommendations in strategic areas of health and health care to be implemented throughout the life of the Health Accord. We forwarded to you an Interim Report outlining the first phase of our work on 16 April 2021.

We are pleased to present the completed Health Accord NL Report (February 2022): *Our province. Our health. Our future. A 10-Year Health Transformation.* This Report is built on significant engagement with the people of the province, use of the existing evidence, and the focused work of six strategy committees and four working groups led by a broadly representative Task Force. We also forward to you a Summary of the Report.

Lower life expectancy, worse health outcomes compared with other provinces, major mental health concerns, stark demographic changes, the inability to recruit and retain needed health professionals, unsustainable services in some regions, a challenging fiscal situation, a climate emergency, and ongoing impacts of the COVID-19 pandemic together spell out a compelling case for change.

The conclusion of the intensive engagement and research conducted for this Report is that we can significantly improve the health of the people of our province over the next ten years. We can achieve Health Accord NL's vision of improved health and health outcomes of Newfoundlanders and Labradorians by accepting and intervening in social determinants of health, and by designing a higher quality health system that rebalances community, hospital, and long-term care services.

We will submit two further reports to you. The Implementation Blueprint will outline possible steps to be taken in response to the fifty-seven Calls to Action in the Report. We strongly encourage you to begin the implementation immediately. An online compilation of the extensive body of evidence which we used will complete the Report.

On behalf of the 126 members of the Task Force, strategy committees and working groups, we express gratitude for the privilege of carrying out this work on behalf of the people of Newfoundland and Labrador. We have been overwhelmed by the generosity of the members of the Accord in carrying out their difficult tasks and by the willingness of the public and the media to engage with us, openly and honestly, every step of the way.

Respectfully submitted,

Patrick Parfrey

Elizabeth M. Davis

# Abbreviations

**AAHP:** Association of Allied Health Professionals-NL

**ADHD:** Attention Deficit Hyperactivity Disorder

**ALC:** Alternate Level of Care

**ASL:** American Sign Language

**BIPOC:** Black, Indigenous, People of Colour

**CAYAC:** Children and Youth in Alternate Care Clinic

**CCB:** Canada Child Benefit

**CH:** Central Health

**CIHI:** Canadian Institute for Health Information

**CNS:** Centre for Nursing Studies

**CRNNL:** College of Registered Nurses Newfoundland Labrador

**CSH:** Comprehensive School Health

**CSSD:** Department of Children, Seniors and Social Development

**CT:** Computerized Tomography (i.e., CT scan)

**CUPE:** Canadian Union of Public Employees

**CYCH:** Child and Youth Community Health

**EH:** Eastern Health

**EHR:** Electronic Health Record

**EMR:** Electronic Medical Record

**ELCC:** Early Learning and Child Care

**EVT:** Endovascular Therapy

**FP:** Family Physician

**GBI:** Guaranteed Basic Income

**GFW:** Grand Falls-Windsor

**GHG:** Greenhouse Gas

**HANL:** Health Accord NL

**HIS:** Health Information System

**HCS:** Department of Health and Community Services

**HSHS:** Healthy Students Healthy Schools

**HVGB:** Happy Valley-Goose Bay

**LGH:** Labrador-Grenfell Health

**LPN:** Licensed Practical Nurse

**MTAP:** Medical Transportation Assistance Program

**MUNFON:** Memorial University's Faculty of Nursing

**NAPE:** Newfoundland and Labrador Association of Public and Private Employees

**NL:** Newfoundland and Labrador

**NLCHI:** Newfoundland and Labrador Centre for Health Information

**NLMA:** Newfoundland and Labrador Medical Association

**NP:** Nurse Practitioner

**OECD:** Organization for Economic Co-operation and Development

**OHCOW:** Occupational Health Clinics for Ontario Workers

**ON:** Ontario

**PCA:** Personal Care Attendant

**PERT:** Premier's Economic Recovery Team

**PHA:** Provincial Health Authority

**PN:** Practical Nursing

**RHA:** Regional Health Authority

**RHC:** Regional Health Council

**RHSN:** Regional Health and Social Network

**RN:** Registered Nurse

**RNUNL:** Registered Nurses' Union NL

**RPM:** Remote Patient Monitoring

**SDH:** Social Determinants of Health

**UBI:** Universal Basic Income

**UNDP:** United Nations Development Program

**WH:** Western Health

**WHO:** World Health Organization

**WRSON:** Western Regional School of Nursing

# Health Accord
## for Newfoundland & Labrador

**Our Province. Our Health. Our Future.**

**A 10-Year Health Transformation:**

## THE REPORT

# Table of Contents

# Key Messages

★ Our health is not as good as the health of people in other Canadian provinces. We also have unfair and avoidable health differences among us for social, economic, age-related, or geographic reasons.

★ We can improve the health of the people of this province if we choose to do so.

★ Health is influenced by the conditions in which we are born, live, eat, exercise, learn, work, and play. It is influenced by our feeling respected and safe, and by our being able to age with dignity. To a lesser degree, it is influenced by our health system and our biology.

★ We can improve health for Newfoundlanders and Labradorians by (i) making changes in the social, economic, and environmental conditions that affect our health, and (ii) by rebalancing our health care system across community, hospitals, and long-term care.

★ Since November 2020, Health Accord NL has gathered evidence, focused its work in six committees and four working groups, and engaged with thousands of people across the province. It has developed 57 Calls to Action.

★ Health Accord NL wants action on improving specific social, economic, and environmental conditions affecting our health; providing better, more timely access to health care; and developing a more integrated, technologically enhanced, and sustainable health system.

★ Health Accord NL recommends that its 57 actions be implemented in the next five years. It will take ten years to see the greatest effects of the actions. We must evaluate all along the way.

★ There will be short-term costs to implementing Health Accord NL with longer-term efficiencies and better health outcomes. The cost of doing nothing will be far greater because our health outcomes will not improve and the health system will become even less sustainable.

★ We will know that Health Accord NL is working when we have better health outcomes; when there is health equity among us; when we have lower rates of chronic illness and fewer deaths from stroke, heart disease and cancer; and when the health of the people of our province is as good as the health of people in other provinces.

# 1

# Introduction
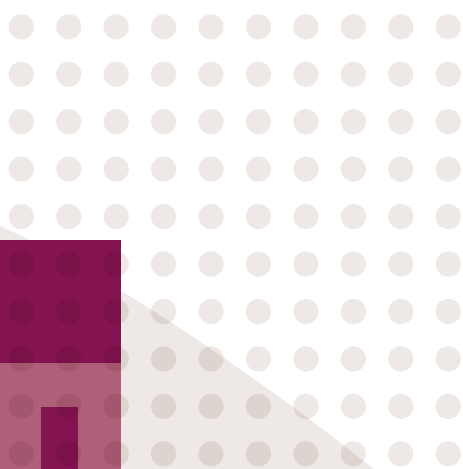
Health Accord NL was established in November 2020 by Premier Andrew Furey and Minister John Haggie (Department of Health and Community Services) as a Task Force to reimagine health and health care in this province. In Premier Furey's words, "The health of the people of our province is one of our greatest assets. Health care is our province's biggest annual investment. We created Health Accord NL to make certain that our health and social systems are working together in ways that lead to better health outcomes for people and families." See Appendix A for the terms of reference for the Health Accord.

There was a compelling case for change. Across the ten provinces, Newfoundlanders and Labradorians have worse health outcomes with (i) a higher rate of deaths from heart disease, cancer, and stroke, (ii) the lowest life expectancy of all the provinces, (iii) the highest level of complex health needs among children, and (iv) the highest proportion of older people with three or more chronic illnesses.

Connected to these direct health outcomes is the stark population decrease in most areas of the province over the past thirty years. In some areas, the population has decreased by more than 40%. This is made even more startling when we realize that some areas of the province have seen a decrease of over 70% in the number of children under the age of 15. The proportion of the population over the age of 65 years has at least doubled in almost every area of the province.

The climate emergency, experienced across the globe, is being felt most keenly in Labrador where steadily increasing temperatures are causing rising sea levels, the loss of sea ice, and new species in our waters. Extreme weather events, e.g., more intense hurricanes and rainstorms, are being experienced on the Island as well as in Labrador. The health implications of this climate emergency for individuals and for communities are becoming more evident globally and within our province.

The rapid onset of that population shift, linked with outmigration related to the cod moratorium in the early 1990s, was associated with a health system not built to cope with the shift from a focus on younger people with acute illness to older people with chronic illness. One of the effects has been a sustainability crisis, resulting in high numbers of vacancies for many health professionals, increased numbers of locum replacements for physicians, greater workplace stress and burnout for those working in the health system, and, reportedly, almost 20% of the population without access to a family physician.

How can Health Accord NL bring about the change needed in the face of these crises? Three elements seem to provide the key to the transformation.

▶ First is the focus on health, not simply health care. Social, economic, and environmental factors (i.e., the social determinants of health) have more influence on health (60%) than the health system (25%) or our genetic make-up and biology (15%). To bring about any change in the health of the population overall, we must acknowledge that this is so.

▶ Attention to these social, economic, and environmental factors combined with a rebalancing of the health system is the second element needed for a positive transformation. Giving attention to both while assuring that the social determinants find their rightful place and needed resources is essential if anything is going to change in a positive direction.

▶ The third element lies in how we go about finding the leadership and the energy to undertake the journey. The only way to be successful is to listen to the voices of the people for whom the health and social systems exist and to continually integrate the learnings from their lived experience with evidence and innovations. This means engagement with members of the public, with groups and organizations within the population, and with stakeholders who are more directly connected to health and health care. Multiple forms of engagement are needed, ensuring that people from all parts of the province and from all groups within the province can find the best ways to ensure that their input is welcomed and received.

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**Being transparent and involving key stakeholders will continue to be a huge piece of this puzzle.**

*– Engagement series 5 survey participant*

# Health Accord NL Structure
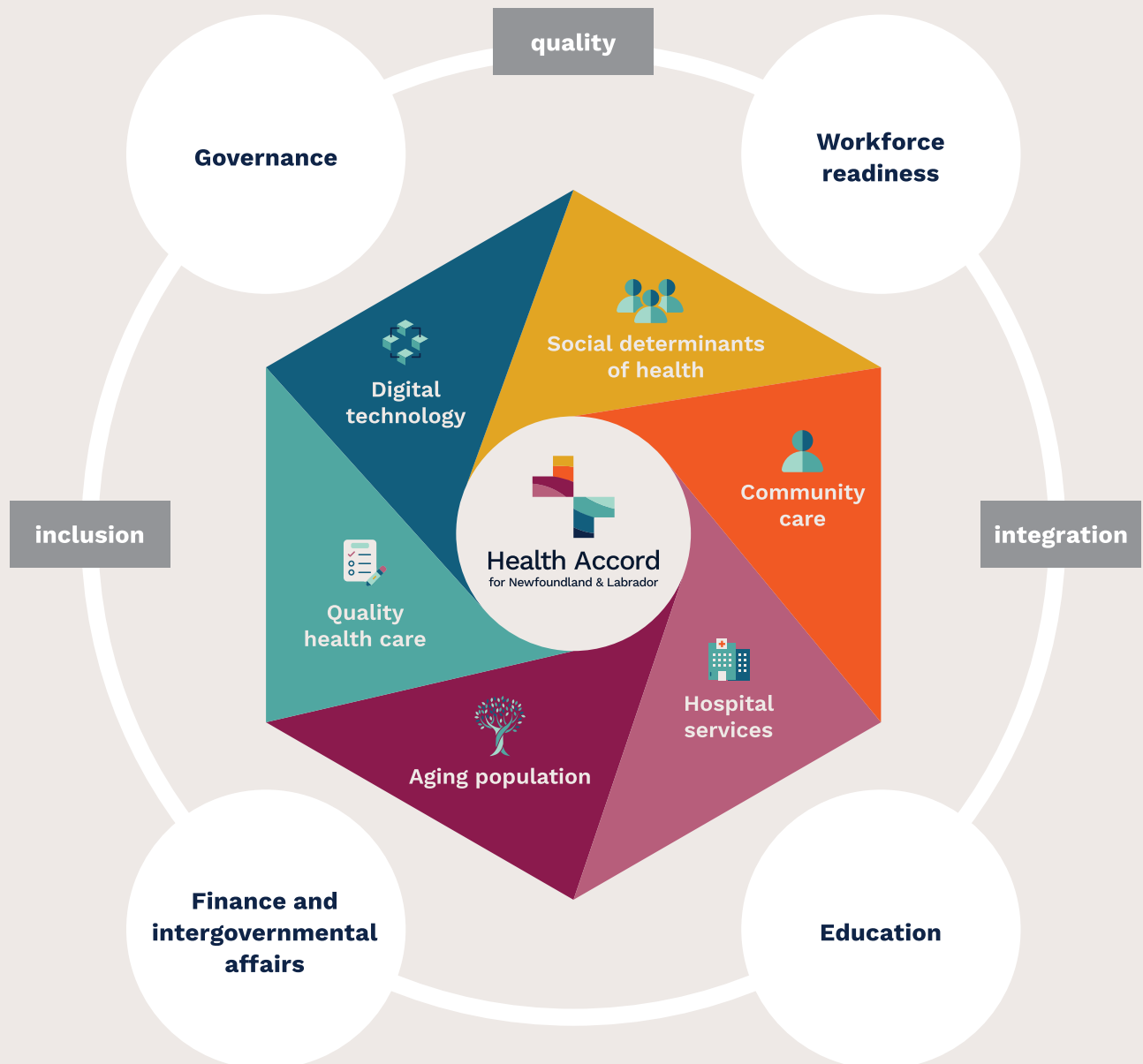
Health Accord NL was structured to make certain that all three elements were integral in the preparation for this transformation. To indicate the achievement of an accord, an agreement on the course to follow, the Task Force included members of the community at large, leaders of the five major health care provider organizations/unions, individuals appointed by our three political parties and the Indigenous peoples, leaders of other major stakeholders including health education institutions, the Chief Executive Officers of the four regional health authorities (RHAs), and the Deputy Minister of Health and Community Services.

Six strategy committees were established (social determinants of health, community care, hospital services, the aging population, quality health care, and digital technology) with broad representation from across the province. Four working groups were added on the advice of the members of the public (workforce readiness, education, governance, and finance and intergovernmental affairs). The Task Force oversaw the work of these ten groups, received their advice, and completed the mandate set by Premier Furey and Minister Haggie. See Appendix B for the list of the members of the Task Force, the strategy committees and working groups.

Three lenses have guided the work of the Health Accord: **inclusion** which is both a lens and a social determinant of health, **quality** related to both health and social services, and **integration** within the health system and across all organizations which influence health and health outcomes.

There are many existing strengths in Newfoundland and Labrador on which the Health Accord is building. People in all our health and social systems, people giving volunteer time and supporting community organizations, and officials in government departments seeking to implement new policy directions have been working tirelessly to bring about change. The provincial government has initiatives either in place or being developed to promote integration and breakdown silos to better support overall health and well-being. This includes a "health in all policies" approach, government-wide work on poverty reduction and well-being, and initiatives to address systemic barriers to homelessness.

Since 2006, Newfoundland and Labrador has had a Poverty Reduction Strategy which is now being re-energized with a focus on well-being. In 2019, government created a strong climate action plan. The All-Party initiative on mental health and addictions led to a *Towards Recovery Action Plan* now being implemented, a call for transformation with emphasis on health promotion and early intervention, and new energy with realigned resources to integrate these strengths into the new vision being implemented. *The Premier's Task Force on Improving Educational Outcomes: Now is the Time* (2017) called for better integration of health and

education to better respond to health literacy and health needs of children in the school system. What Health Accord NL adds is an overarching view of the whole picture, a vision for a comprehensive approach and integrated directions, a call for transformation with emphasis on health promotion and early intervention, and new energy with realigned resources to integrate these strengths into the new vision.

Health Accord NL is documenting its work in two phases. This Report summarizes the overall work of the Accord and identifies the directions needed to respond to social, economic, and environmental factors and to rebalance the health system. This Report also outlines the Calls to Action which will ensure that the directions are taken in a measured way over the next five years (see Appendix C for a list of the 57 Calls to Action). A second Report will present a blueprint for the implementation of these Calls to Action, showing the progressive timelines, estimating costs and sources of funding, and recommending integrating structures accountable for following this implementation blueprint. While the second Report allows for options in implementation, the first Report will succeed only if it is understood as a single, integrated, holistic, comprehensive approach.

Reimagining health in Newfoundland and Labrador means considering everything that affects our health from the social determinants that affect our health far more than the health system does, to the system we use to deliver health care, to the ways in which health care is delivered. Reimagining health means finding more creative, more realistic, more integrated, and more effective ways to improve health outcomes and health equity in our province. As you read the chapters which follow, we encourage you to become champions for this important task—bringing the Health Accord to life.
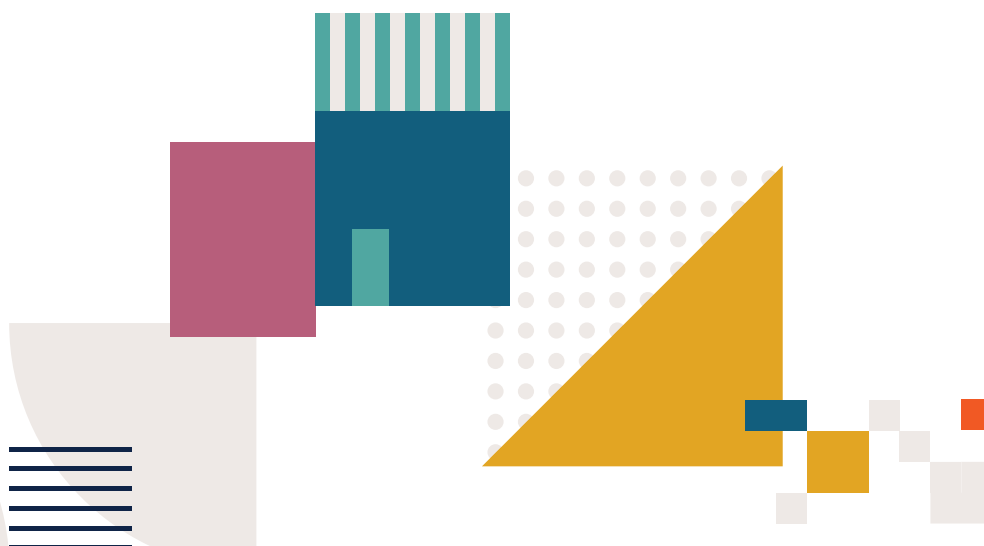
**2**

# A Compelling Case for Change

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**

Health outcomes, concerns about mental health and mental illness, demographic change, sustainability within the health system, the fiscal health of the province, the climate emergency, and the impact of the COVID-19 pandemic have come together to create the urgent basis for a thoughtful and far-reaching look at the health of the people of Newfoundland and Labrador. Health Accord NL is the response to the need to explore these seven realities within our province.

## Health Outcomes

On most indicators of the health of a population, Newfoundland and Labrador does not score as well as other provinces. Compared to the rest of Canada, people in this province have shorter lives, ranking tenth among all the provinces. **The life expectancy is 2.4 years lower than the Canadian average for males and 2.3 years lower for females.**
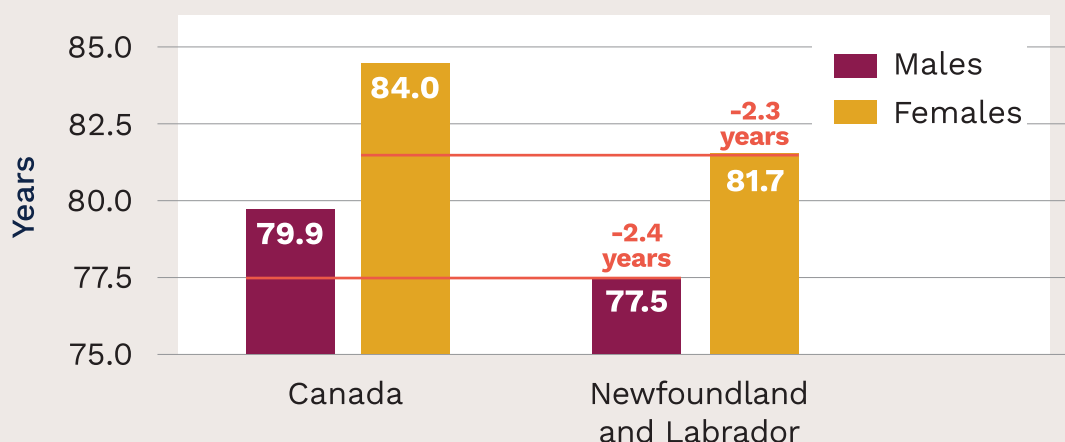


Life expectancy in NL was **2.4 years less in males and 2.3 years less in females** compared to Canada.

Life expectancy in NL was the **worst provincial life expectancy** in Canada.

**Fig 1: Life Expectancy in NL and Canada (2018)**
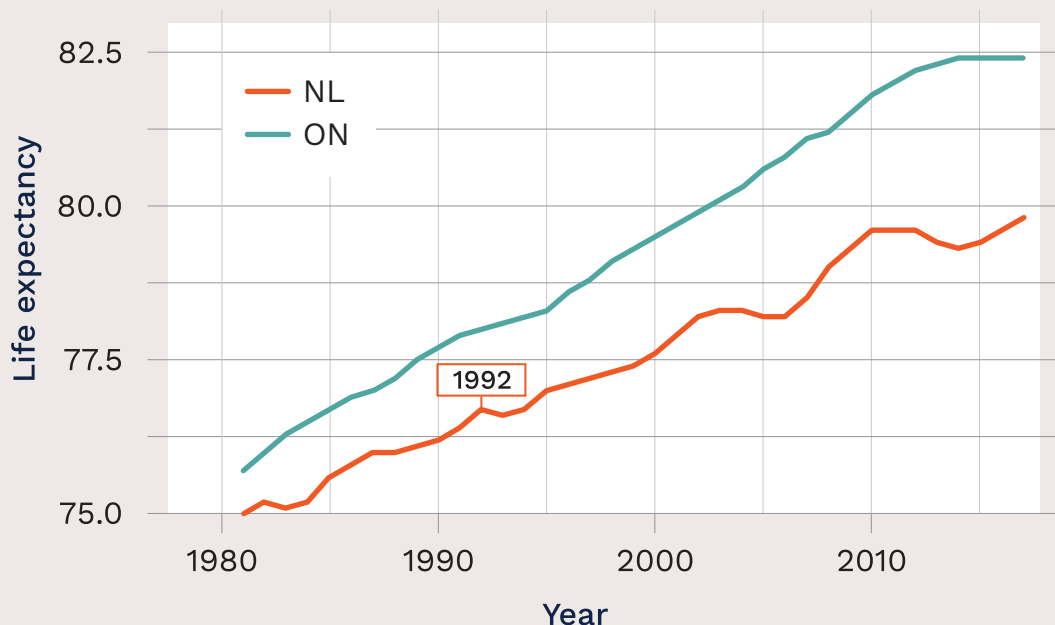
In **1980**, the life expectancy in NL compared to Ontario **differed by one year.**

Today, people in NL live **2.4 years less than people in Ontario.**

Source:
Dr. Dan Dutton

**Fig 2: Life Expectancy in Ontario and NL Over 40 Years**

What is even more troubling is the fact that in 1980 there was one year difference in life expectancy between our province and Ontario. While life expectancy in both provinces improved over the next forty years, by 2019, the difference between Ontario and Newfoundland and Labrador was 2.4 years. The divergence began in the early 1990s, coinciding with the cod moratorium and its impact on the province. Later in this chapter, we will examine more carefully the demographic impacts of the cod moratorium.

## Cancer Mortality

Age-standardized rate per 100,000 population

**Male** / **Female**

| | Canada | Newfoundland and Labrador |
|---|---|---|
| Male | 234 | 276 (+42), Provincial Rank = 10 |
| Female | 169 | 195 (+26), Provincial Rank = 10 |

## Cardiac Disease Mortality

Age-sex standardized rate per 100,000 population

| Canada | NL |
|---|---|
| 80 | 103, Provincial Rank = 9 |

## Stroke Mortality

Age-sex standardized rate per 100,000 population

| Canada | NL |
|---|---|
| 33 | 41, Provincial Rank = 8 |

Among the provinces, Newfoundlanders and Labradorians rank

**10th in deaths due to cancer**

**9th in deaths due to cardiac disease**

**8th in deaths due to stroke**

(Tenth being the least favourable rank).

**Fig 3: Mortality Rates for Cancer, Cardiac Disease, and Stroke (2018)**

When we look at deaths from chronic illnesses, we note again that the province does not do well. For both male and female residents, Newfoundland and Labrador ranks tenth among the provinces in deaths due to cancer (tenth being the least favourable rank). We rank ninth in deaths due to cardiac disease and eighth for deaths due to stroke.

**We have the highest rate of children and youth with complex health care needs, 53% higher than the national average.** Our province has one of the highest prevalence rates of children and youth in alternate care, and these children and youth are among the most vulnerable groups in our society. Root causes for children and youth in the care of the Department of Children, Seniors and Social Development (CSSD) include parental mental illness, domestic violence, and drug and alcohol abuse in the families of origin. Many children in this group have developmental trauma, complex mental health issues, learning and academic challenges, and significant medical diagnoses.
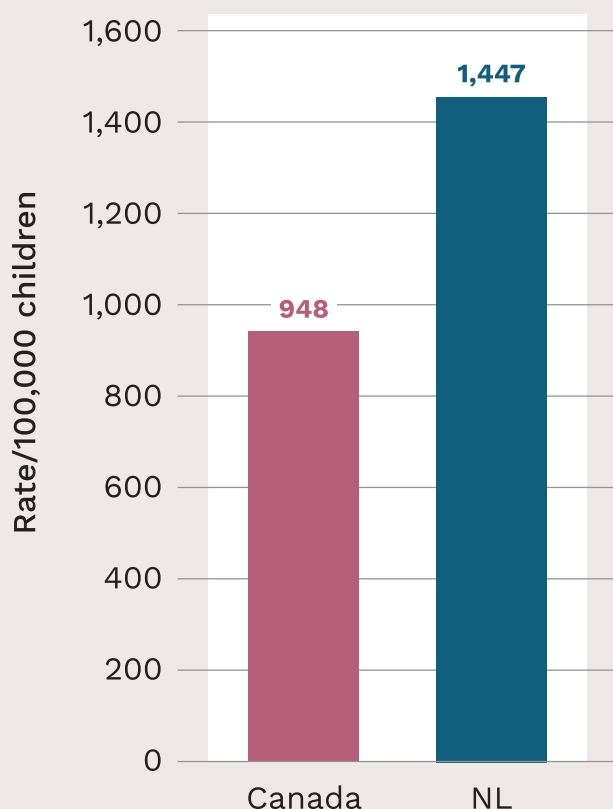
The rate of children with complex medical care needs is **53% higher in NL** than in Canada and **NL has the highest rate among the 10 provinces.**

**Fig 4: The Rate of Children with Complex Medical Needs/100,000 Children in NL and Canada (2015/16)**

## Mental Health Concerns

A special dimension of the compelling case for transformation of health and the health system in Newfoundland and Labrador is that of mental health. Throughout the Health Accord NL Report, "health" is an inclusive term, understood in accordance with the WHO definition as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Physical health and mental health are included within this definition.

Concerns about mental health were raised consistently in our engagement with the public through five series of town halls, through special symposiums including one with high school students, and through conversations with many organizations around the concept of inclusion. Mental health was consistently identified among their greatest health concerns, sometimes paired with addictions. It was noted that the suicide rate in Newfoundland and Labrador has tripled since the 1980s and is among the highest in Canada.

The Health Accord did not include an in-depth exploration of mental health and addictions in Newfoundland and Labrador because of an intensive study begun in 2015 and completed in 2017 by an All-Party Committee of Government. The Committee conducted a full review of the provincial mental health and addictions system to identify gaps in services and areas for improvement. The Committee heard from people throughout Newfoundland and Labrador who have experienced mental illness and addictions, their loved ones, advocates, community agencies, Indigenous communities, regional health authorities (RHAs), health care providers, and the public.

In March 2017, the All-Party Committee on Mental Health and Addictions released *Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador.* The Report outlined 54 recommendations that address service gaps and support what is currently working well in the mental health and addictions system in the province. On June 30, 2017, government released *Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador* and committed to immediately responding to all the recommendations. Government promised to implement a comprehensive, evidence-based, integrated, person-centered system that provides the right care, at the right time and in the right place, implemented in collaboration between community groups, government departments and the regional health authorities.

In its Interim Report released in April 2021, Health Accord NL referenced the directions outlined in the Towards Recovery strategy, adding its voice to the concerns expressed consistently by the people of the province and to the

expectations that the comprehensive, evidence-based, integrated, person-centered system for mental health will be implemented as quickly as possible.

Taken together, these few indicators show that health outcomes for the people of this province are below those for people in other provinces in Canada despite our sharing in the same universal Medicare program. In effect, the indicators point to ill health which relates more to the social, economic, and environmental factors which influence health rather than to the performance of the health system.

## Demographic Change

When we look more closely at the information for the 1990s, we note several startling facts. The outmigration from Newfoundland and Labrador from 1990 to 2000 (the years of the cod moratorium) was 57,114 persons—10% of the population. That loss of population is unprecedented in a developed country in modern times. Even more startling is the age groups who left the province during these years. By far the majority were between the age of 10 years and 35 years with a little more than half between 15 years and 24 years (with little difference between male and female numbers). See Fig 5 on page 14.

The impact of the outmigration of young people and young families was catastrophic in subsequent years. The Avalon Peninsula is the only region of the province to have experienced a population increase since 1990. The loss of population is most evident in rural and coastal communities, especially on the South Coast (a loss of 41%), the Northern Peninsula (a loss of 42%), the Burin Peninsula (a loss of 35%), and Notre Dame Bay (a loss of 34%). See Fig 6 on page 14.

Not unexpectedly, given the age groups of the people who left the province over these years, there has been a decrease in the percentage of children under 15 years of age and an increase in the percentage of adults over the age of 65 years. Even on the Avalon Peninsula where there has been a slight increase in population, the number of children has decreased by 34%. The areas with the greatest population loss have experienced an astounding decrease in the number of children: the South Coast (74%), the Northern Peninsula (75%), the Burin Peninsula (71%) and Notre Dame Bay (70%). Losses in other regions range from 36% to 59%. See Fig 7 on page 15.
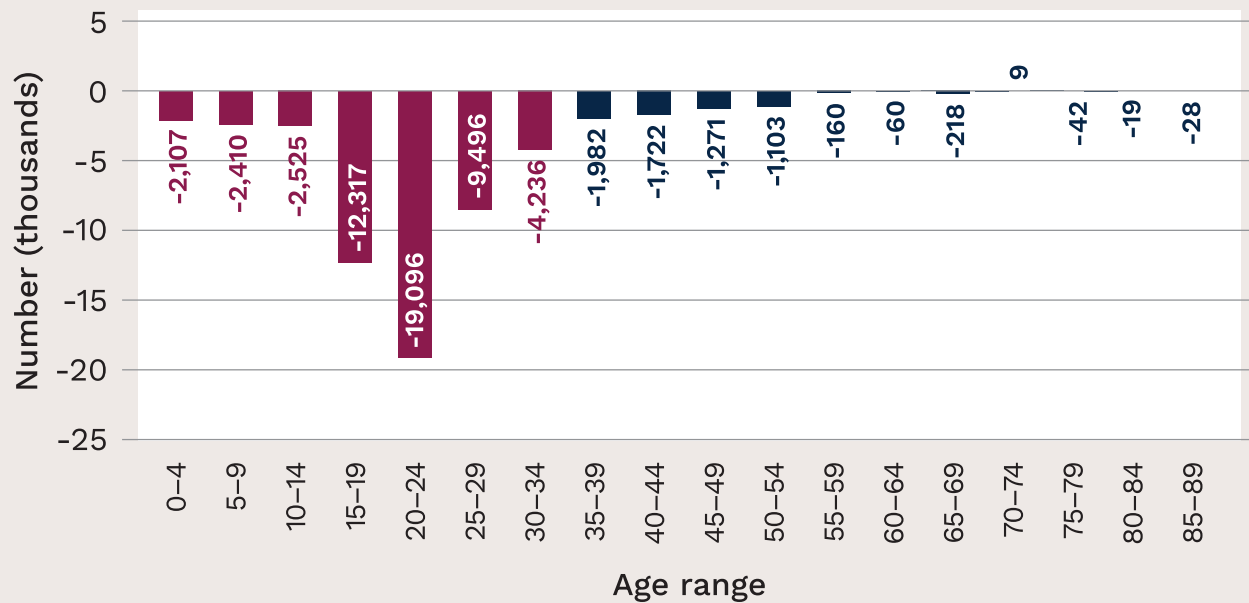
**Fig 5: NL Net Out-Migration Both Sexes by Age: 1990–2000 (Total -57,114)**

Source: Dr. Wade Locke

From 1990 to 2000, the net out-migration amounted to 57,114 people, of whom 12.3% were children younger than 15 years, **77.3% were young adults aged 15–34 years**, 11.0% were older adults aged 35–64 years, and 0.5% were 65 years or older.

**Of those people who left, approximately 91% (52,000) were under 35 years old.**
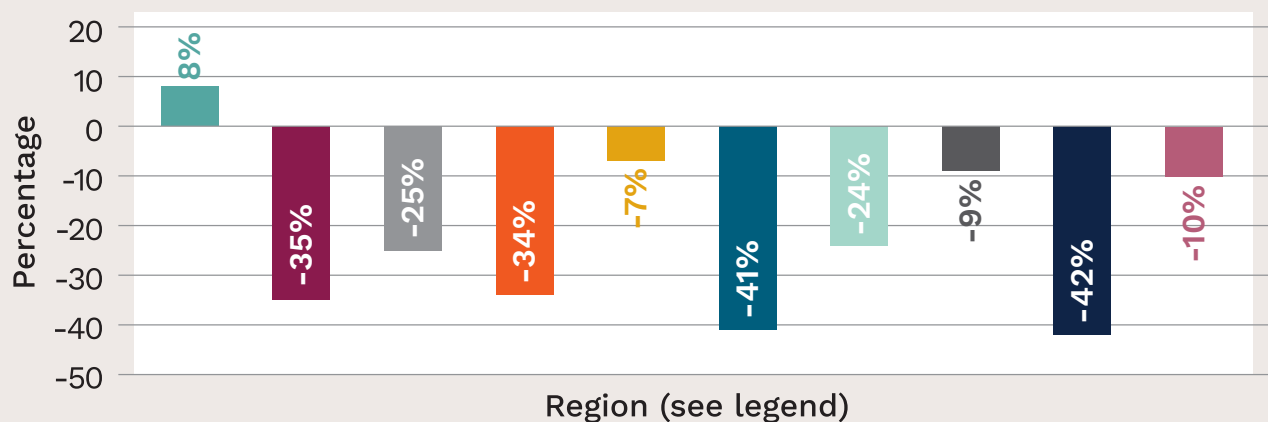


**Fig 6: Percent Change in Population by Region (1990–2020)**

Of the ten regions, only the Avalon had an increase in population. **The biggest reductions in population were the Northern Peninsula (-42%), South Coast (-41%), Burin (-35%), and Notre Dame Bay (-34%).** Within Labrador, increases in population occurred in Nunatsiavut and the Innu Nation, but there was a substantial decrease in South/Southeast Labrador.
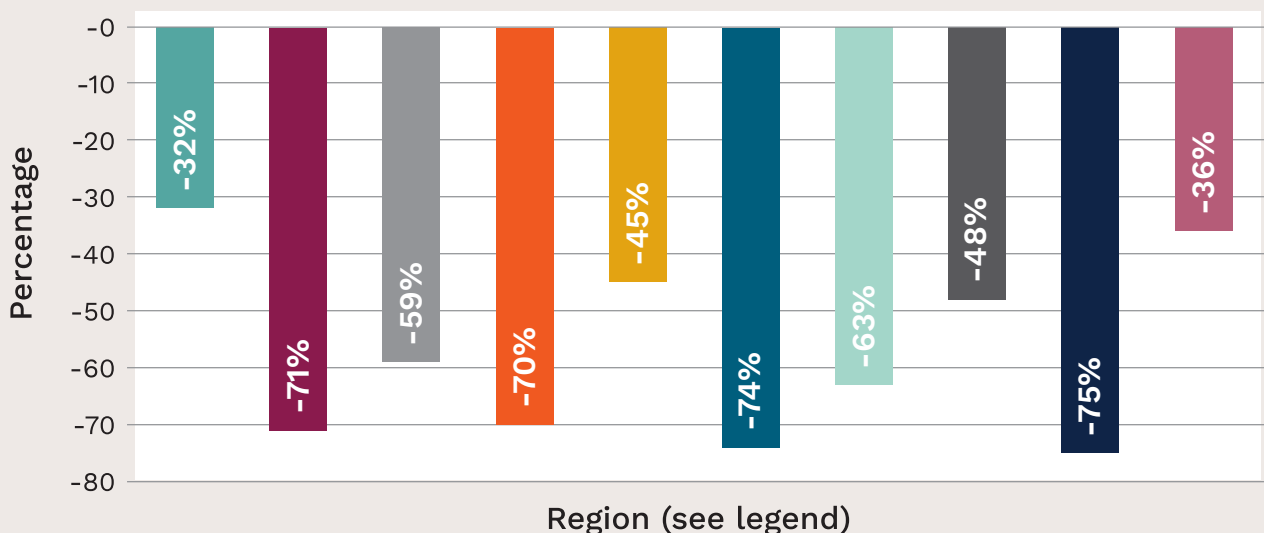
**Fig 7: Percent Reduction in Children Under 15 Years of Age by Region (1990–2020)**

**Massive reductions in the number of children** occurred in the Northern Peninsula (-75%), South Coast (-74%), Burin (-71%), and Notre Dame Bay (-70%). Even on the Avalon, the reduction in children was -32%.
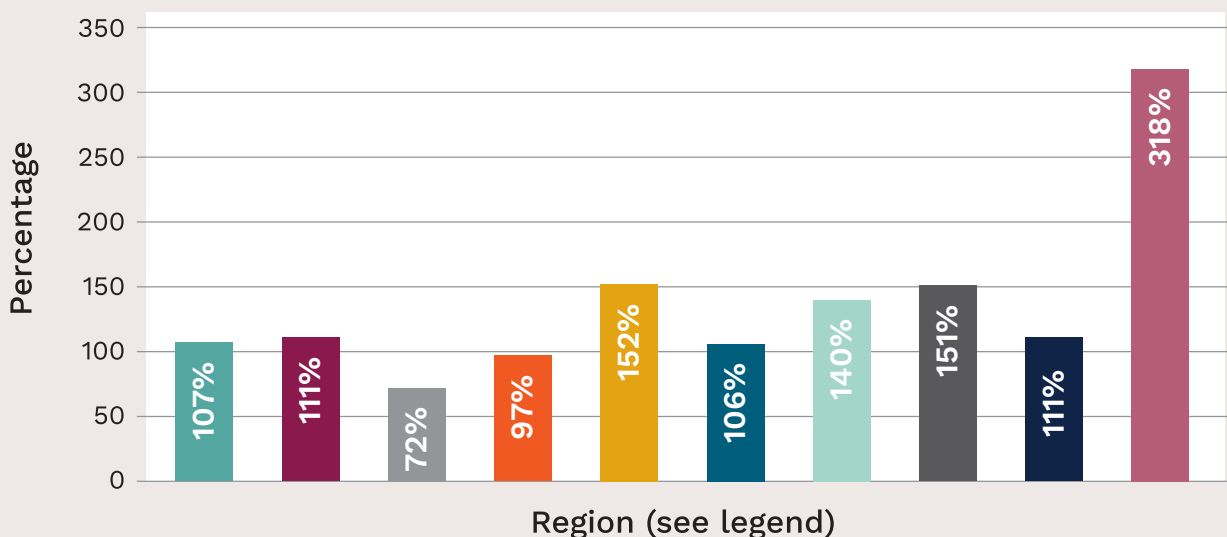


**Fig 8: Percent Increase in the Number of Seniors by Region (1990–2020)**

Every region of the province has had **massive increases in the number of seniors**, particularly Labrador (316%), Central (152%), and Humber (151%).

**Legend for Figures 6, 7 & 8. Data source: Dr. Wade Locke.**

| | | | | |
|---|---|---|---|---|
| Avalon | Bonavista/Trinity | Central | St. George's | Northern Peninsula |
| Burin | Notre Dame Bay | South Coast | Humber | Labrador |

The number of persons over 65 years of age has more than doubled over the past thirty years with increases from 107% in the Avalon region to 152% in the Central region. The lowest increase is in the Bonavista/Trinity area at 72%, and the greatest increase is in Labrador at 318% (even though the increase in Labrador was from a very small starting number in 1990). It is most likely that these numbers of persons over 65 years will continue to increase over the next 20 years. Advanced age is correlated with an increase in chronic illnesses which means that the demands on the health system are likely to grow for the foreseeable future unless drastic action is taken. See <u>Fig 8</u> on page 15.

## Sustainability

Sustainability includes the long-term ability of our health and social systems to recruit and retain needed professionals and other workers and to fund programs that are flexible and adaptable as the needs and demographics of our population change.

Sustainability is one of the primary factors in deciding the location of services within and among regions. Other factors taken into consideration are related to the needs of the catchment population, number of people, geography, and distance from other health services.

We are concerned about the current ability of our health system to recruit and retain health professionals and other workers. The concern is made more complicated by global shortages of health professionals and other workers which will further impede recruitment and retention efforts. This will require new ways of providing services across all dimensions of health care delivery.

At the time of writing of this report, there are many vacancies in nursing positions in hospitals and long-term care facilities across the province. In April 2021, RHAs experienced an 8.8% vacancy rate, the highest since standard reporting started seven years ago and double the average vacancy rate over this time period. The extended health sector and social sector are experiencing high vacancies. There are also indications of significant physician turnover rates in all regions of the province in both health facilities and in the community. Too many people report having no family physician or attachment to any health services in their community. Significant recruitment and retention challenges exist across many allied health professionals who will be critical to community teams as well as to sustainability within hospital services.

## A. The Turnover Rate* of Physicians in Hospitals in NL

Percent turnover

- St. John's: 13%
- Carbonear: 53%
- Clarenville: 56%
- Burin: 68%
- Gander: 47%
- GFW: 29%
- Corner Brook: 27%
- Stephenville: 25%
- St. Anthony: 75%
- HVGB: 64%
- Labrador City: 64%
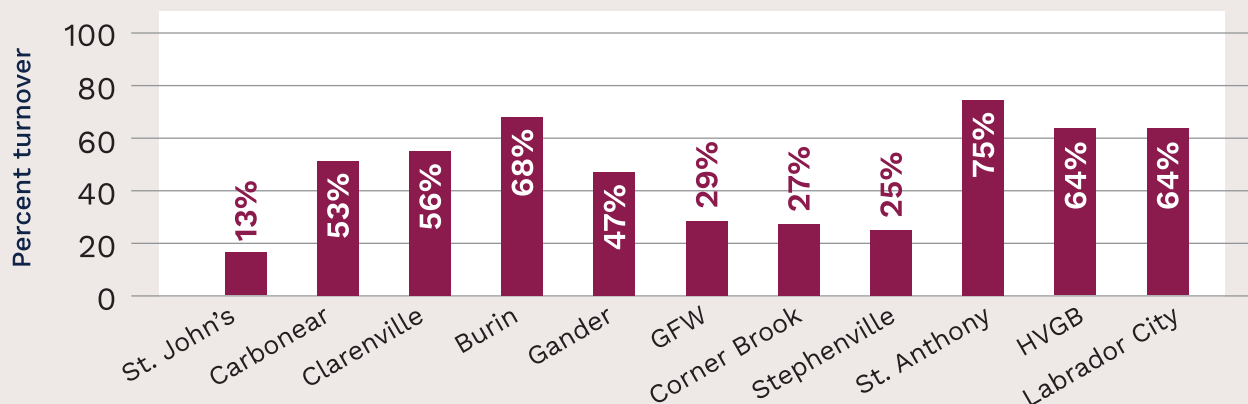
The turnover rate in six rural hospitals was greater than **50%**.

The turnover rate in the bigger hospitals ranges from 13% for the four in St. John's to around 29% in Grand Falls-Windsor (GFW) and Corner Brook, **but is high in Gander at 47%**.

## B. The Turnover Rate* of Family Physicians (FPs) Funded by the RHA by Region

Percent turnover

- St. John's: 26%
- Outside St. John's: 76%
- Gander: 36%
- Grand Falls-Windsor: 56%
- Rural Central: 71%
- Corner Brook: 43%
- Outside Corner Brook: 50%
- Labrador Grenfell Health: 113%

Legend:
- St. John's
- Gander
- Rural Central
- Outside Corner Brook
- Outside St. John's
- Grand Falls-Windsor
- Corner Brook
- Labrador Grenfell Health
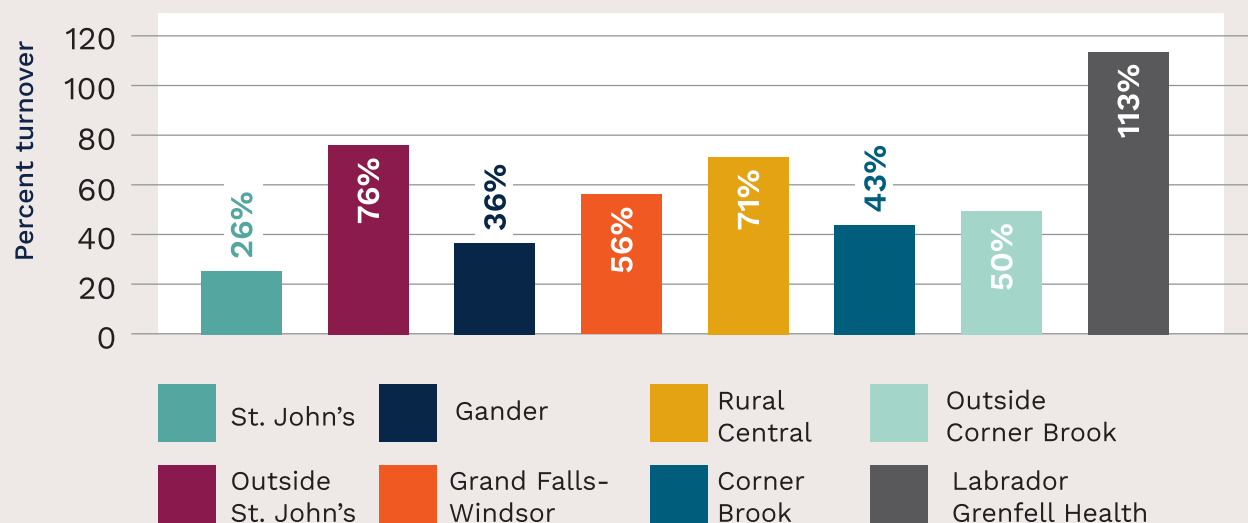
The turnover rate for FPs was **higher in rural than urban regions of the RHAs**. Even in urban regions, it ranged from 26% in St. John's to 56% in Grand Falls-Windsor.

## Fig 9: Turnover Rate for Physicians for 2018–2021

*Turnover rate: Number of new physicians + current vacancies over three years/number of physicians available, excluding sub-specialities. Data source: RHAs.

Vacancies for registered nurses (RNs) in Newfoundland and Labrador jumped from 287 in April 2020 to 480 in April 2021. In three out of four RHAs, RN vacancies more than doubled in the same one-year period—vacancies within Western Health (WH) more than tripled, jumping from 31 to 100. Newfoundland and Labrador has the highest rate of RN full time employment in the country at 73%, the second lowest rate of part time RN employment at 12%, and the second highest rate of casually employed RNs at 16%. Due to increasing stress and challenges within the workplace, many RNs perceive permanent employment as a risk versus an opportunity. As of March 2021, of those RNs who reported casual employment to the College of Registered Nurses of NL (CRNNL), 73% say it is their desired employment status.

Within the province, St. John's has the lowest turnover rate both for physicians in hospitals and for FPs funded by RHAs. As shown in Fig 9 on page 17, turnover rates for physicians in hospitals from 2018–2021 reached as high as 75% in St. Anthony, over 60% in the two hospitals in Labrador, and over 50% for Burin, Carbonear and Clarenville. For the same time period, turnover rates for family physicians funded by the RHAs were equally high with the highest rate in Labrador-Grenfell Health (LGH) (114%), followed by the rural areas of Eastern Health (EH) (76%) and rural Central Health (CH) (71%).

A second indicator of physician sustainability is the use of locums who serve as temporary physicians when there are vacancies or to fill in when the permanent physicians are unable to carry out their medical duties due to illness, vacation, or other leave. Often physicians are unable to get any leave if there is a lack of locum coverage.

In 2018 and 2019, the number of locum licenses given for hospital specialists were at 192% of active practitioners in LGH and 165% in CH with much lower percentages in WH and EH. Actual numbers of locums used in 2019 were as high as 425 in CH (260 in Gander alone), 381 in EH (115 in Clarenville), and 329 in LGH (152 in Happy Valley-Goose Bay). It should be noted that LGH has a number of long-term recurring locums who provide continuity.

Small sites with few physicians available to be on-call often place an undue on-call burden on physicians, especially when a vacancy occurs, and locums are unavailable. In these cases, the call frequency creates extraordinary pressure for coverage on the remaining physicians, creating a difficult environment for new recruitment and for retention of existing physicians.

Such high turnover and vacancy rates cause significant challenges for continuity of care for patients/clients/residents, for sustainability of specific programs, and for stability within the health care communities.
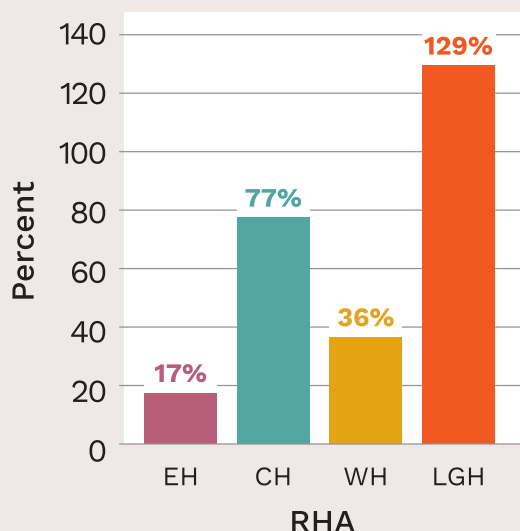


**Fig 10A: The Total Number of Locum Licenses as Percent of FPs Active in Practice by RHA, 2018 and 2019**



**Fig 10B: The Total Number of Locum Licenses as Percent of Hospital Specialists Active in Practice by RHA, 2018 and 2019**

The rate of locum licenses was high in CH (relative to the number of FPs active in practice): **77 locum licenses/100 physicians were provided over two years**. In LGH the rate was even higher.

The rate of locum licenses relative to the number of hospital specialists was **very high in CH and LGH.**

Data source: The College of Physicians and Surgeons of Newfoundland and Labrador
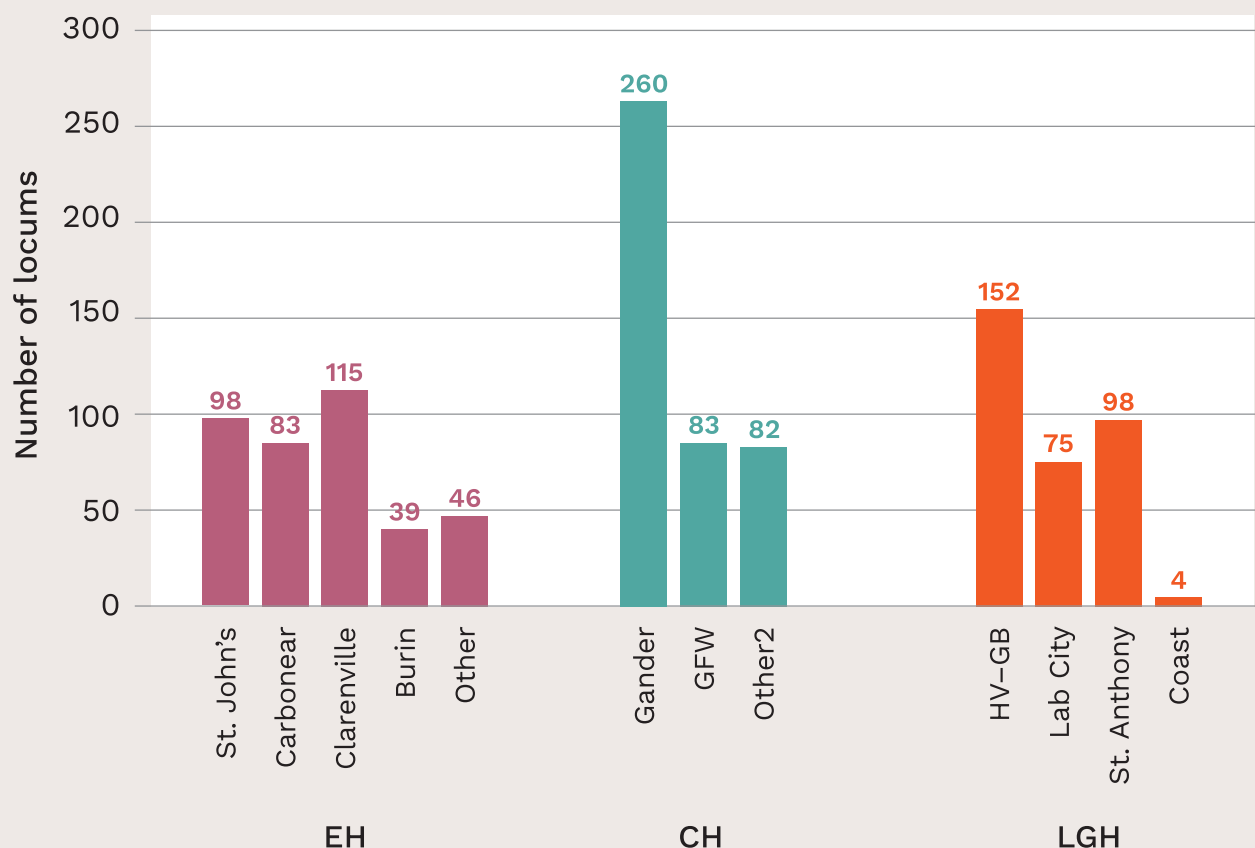
**Fig 10C: The Number of Locums by Site and Region, 2019**

In EH, there were a total of 384 locums in 2019, with the highest in Clarenville. By comparison, for the two fiscal years 2018–2020, the number of locum licenses (full or provisional) provided in EH was 188.

**Gander had more than threefold the number of locums** compared to GFW. The total for the region was 425. For two fiscal years 2018/19 and 2019/20, the number of licenses provided in CH was 170.

In the two fiscal years 2018/19 and 2019/20, the number of licenses provided in WH was 66.

**The total number of locums for LGH was 329, with the largest number 152 for Happy Valley-Goose Bay (HV-GB).** In the two fiscal years 2018/19 and 2019/20, the number of locum licenses provided was 68.

*Data source: RHAs. WH recorded locums in a different manner than the other RHAs. Therefore, its numbers are not included.*

Sustainability also becomes an issue when the number of patients requiring a specialty service is small. Small numbers do not support the basic number of specialists required in a specific discipline to ensure a call schedule rotation and a balanced work-life for the specialists and their families. Specialists who have trained for many years to build their competencies and skills will not be eager to move to a hospital to provide services if there are few patients to be treated or if their on-call burden is considered excessive. The challenge comes in finding the alternative solutions to ensuring that people in every part of the province from urban to rural to remote have appropriate access to medical specialist services.

In some instances, regulatory bodies or professional bodies provide standards showing acceptable levels of numbers of patients needed to sustain a practice. In other instances, objective and detailed decision trees must be designed to ensure quality services may be provided while also ensuring a work-life balance for the specialists.

A third issue relating to sustainability is the performance and cost of the health system itself. Studies undertaken by the C.D. Howe Institute and the Commonwealth Fund show that Canada is in the lowest tier of OECD (Organisation for Economic Co-operation and Development) countries in terms of health system performance. Within Canada, Newfoundland and Labrador is in the lowest ranking among the provinces in terms of its health system performance. In this context, performance encompasses care processes including preventive care, safe care, coordinated care, and engagement and patient preferences; access including affordability and timeliness; administrative efficiency; equity; and health care outcomes.

Newfoundland and Labrador has the highest per capita spending of all the provinces on its health system, 20.5% higher in 2019 than the average across all Canadian provinces.[1] While geography and distribution of population factor into the increased per capita spending, they cannot account for all the difference between this province and other provinces.

Over the past 38 years, the province has increased health system spending by 232% while social spending (excluding health and education) has increased by only 6%. The difference in increases in spending signals a policy and political context that has historically valued health care more than other determinants of health and has not yet rebalanced these priorities in light of available evidence.

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[1] It is noted that there is variation among the different elements of the health system. The two areas substantially over the Canadian average are hospitals and other institutions (e.g., long-term care), while spending on physicians and drugs is under the national average.
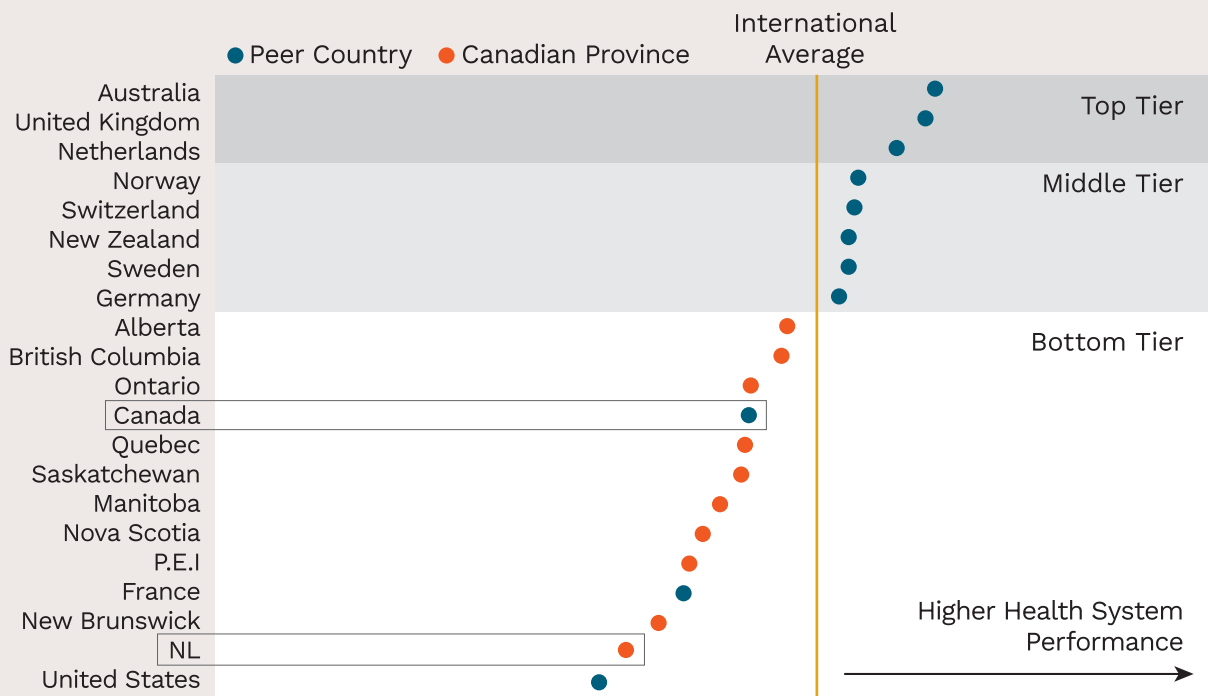
**Fig 11: Health System Performance in 11 OECD Countries and the 10 Provinces, 2016–2019**

Among 11 OECD countries, Canada ranks in the bottom tier for health system performance, as evaluated by the Commonwealth Fund. **Among Canadian provinces, NL ranked last.**



* Average
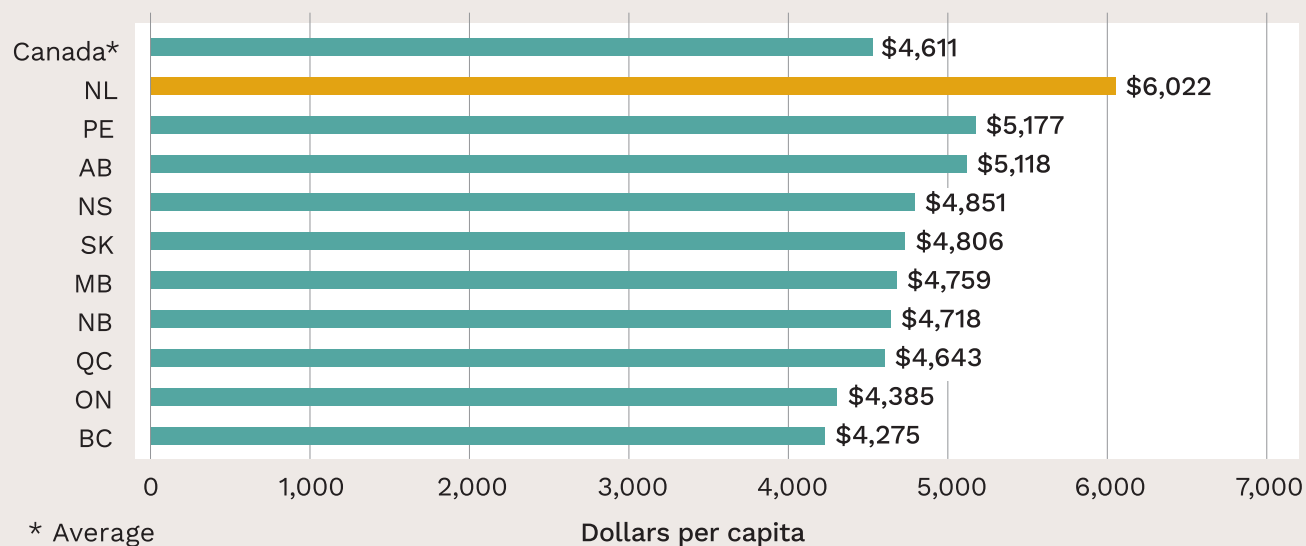
Dollars per capita

**Fig 12: Health Spending in the Provinces – Dollars per Capita, 2019/20**

**NL has the highest per capita spending in health among the 10 provinces.** Allied to the poor health system performance, NL provides poor value for its health spending.

**+232%**

**+101%**

**+32%**

**+6%**

Real spending per capita, $000

Year

NL Health Spending
Canada Health Spending
Canada Social Spending
NL Social Spending
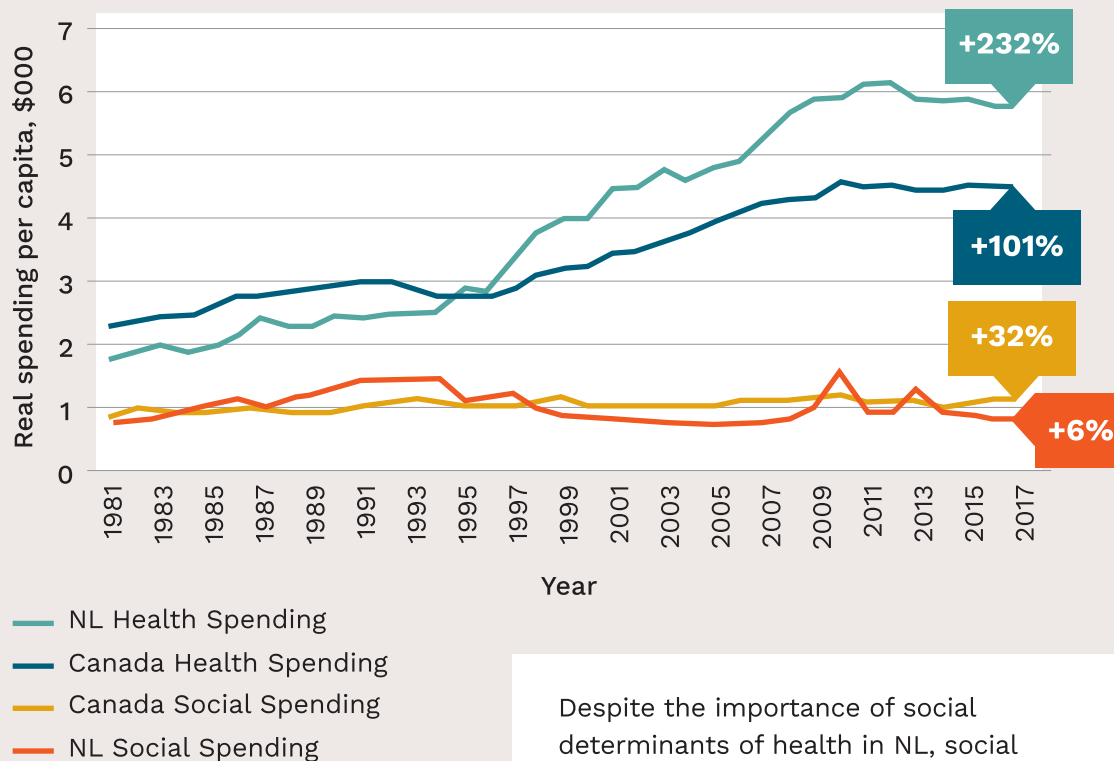
**Fig 13: Per Capita Canadian and NL Health and Social Spending, 1981–2017**

Despite the importance of social determinants of health in NL, social spending has been virtually flat since 1981, whereas **health spending has increased by 232%.** By comparison, social spending in Canada has increased by 34% and health spending by 101%.

## Fiscal Health of the Province

Health of the population and the fiscal health of the province go together. In the words of Michael Marmot, "Evidence from around the world shows that health is a good measure of social and economic progress. When a society is flourishing, health tends to flourish. When a society has large social and economic inequalities, there are large inequalities in health."[2]

[2] Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot Review 10 years on.* Institute of Health Equity. https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on.

The five statements in the image below summarize the connection between poverty and the economy.

**1** Poverty = ill health

**2** Poverty is very expensive

**3** Big public spending on consequences, not causes

**4** Child poverty is **unjust**. Its economic and financial costs **last a lifetime**

**5** Economic Development ~ Healthy Society
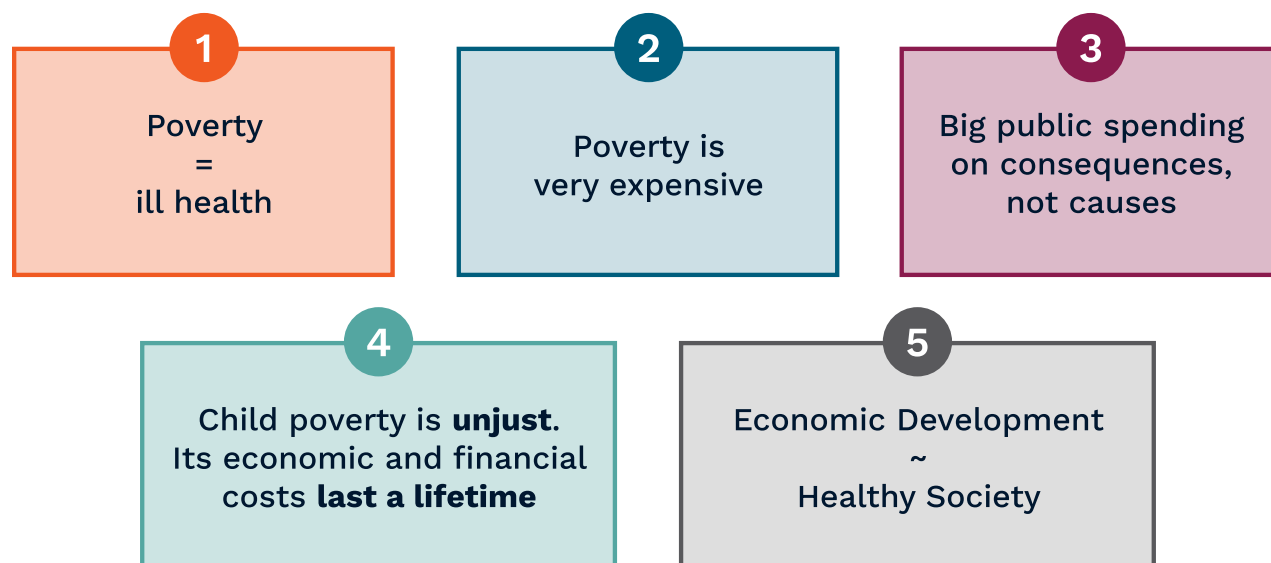
The fiscal situation of Newfoundland and Labrador is challenging. It has been said that, from 2012/13 to 2018/19, this province experienced "seven years of famine"[3] marked by falling oil prices, falling oil production, falling oil-related revenues, slowly rising government expenditures, and rising deficits and debts.

Premier Furey appointed the Premier's Economic Recovery Team (PERT) in October 2020 to explore growth sectors such as clean energy and investments in technology, and to review government expenditures, the province's fiscal capacity, and how services are delivered.

The PERT report, "The Big Reset," presented in May 2021, stated that the province's fiscal situation must be brought under control now.

▶ Over the past decade the provincial government has continued to borrow money to meet its annual expenditures.

▶ Newfoundland and Labrador has the highest per capita revenues, expenditures, deficit, and net debt of any province in Canada.

▶ The province has the oldest population, highest unemployment, highest per capita health care spending, and poorest health outcomes in the country.

[3] Locke, W., May, D. (2019, November 13). *Newfoundland and Labrador's Debt Management Strategy: Kicking the Can Down the Road While Waiting for a Saviour.* CARE Speaker Series, Memorial University of Newfoundland.

## The Fiscal Crisis in NL
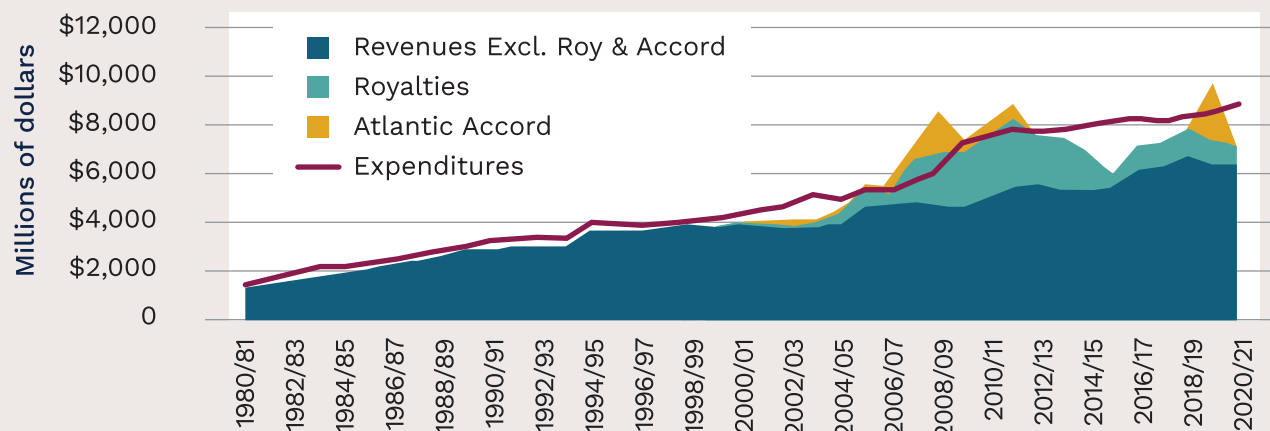


Except for seven years of the oil bubble and the 2019 Accord, NL expenditures **exceeded revenues**. Spending increased with revenue (mainly oil royalties), but **did not decrease** when revenues fell.

## Per Capita Debt Costs in NL and Canada
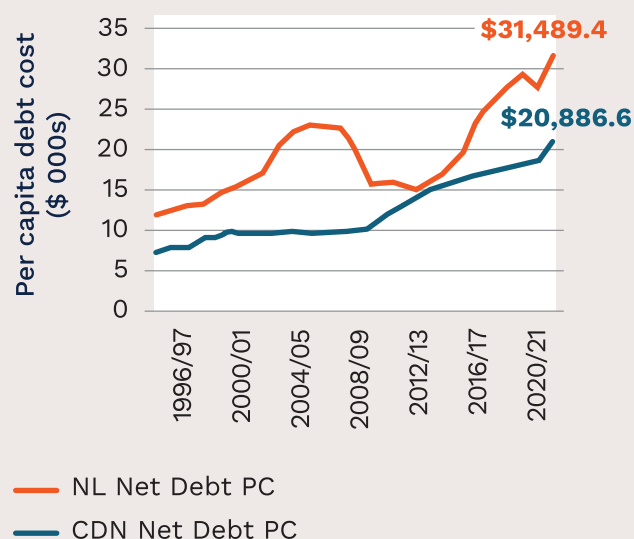


## Debt Cost as a Percent of Total Expenditure in NL and in Canada
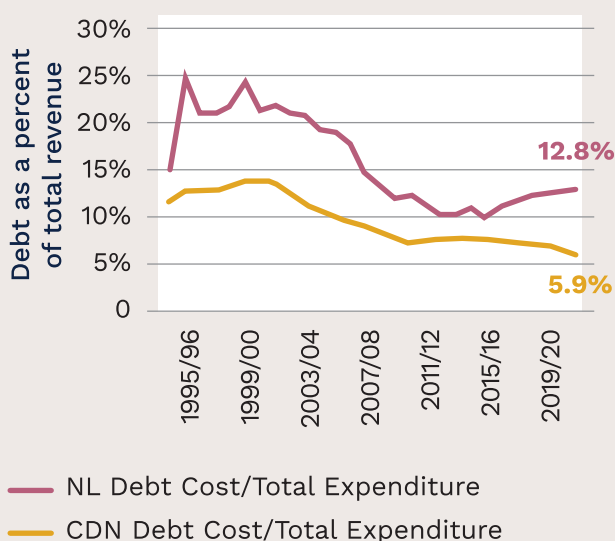


NL's net debt was **$16.4 billion** in 2020/21. Net debt per capita was $31,489, **51% higher** than for all Canadian provinces. NL debt costs as a percent of expenditure are more than **twice as large as the CDN average** (12.8% vs 5.9%).

## Fig 14: Economic and Fiscal Challenges

Source: Dr. Wade Locke

The mandate of Health Accord NL did not include the request to save money or reduce costs in the system. However, over the longer term, health transformation will help improve health outcomes—a healthier population will place fewer demands on the health system. Addressing the social determinants of health (SDH) and rebalancing the health system together are ways of strengthening the fiscal health of the province into the future.

## The Climate Emergency

The United Nations Framework Convention on Climate Change was held in Glasgow, Scotland from 31 October to 12 November 2021. Its four key goals were to secure by mid-century global net zero (a state in which the greenhouse gases going into the atmosphere are balanced by removal out of the atmosphere) and keep 1.5 degrees within reach (limiting the increase in temperature of the planet to 1.5 degrees), to adapt to protect communities and natural habitats, to mobilize finances of at least $100 billion in climate finance, and to work together to deliver. The hope was that the 197 countries gathered would finalize the Paris Rulebook (the rules needed to implement the Paris Agreement), accelerating collaboration between governments, businesses, and civil society to deliver on our climate goals faster.

> **Because everybody is hunting in the same areas, because they can't get where they want to get because of lack of sea ice—a lot of people are coming back with nothing. I was told many years ago that there's changes happening, but I never, ever dreamt that it would be happening as fast as it is.**
>
> *– A hunter and fisherman from Nain*

Source: Bird, L. (2021, March 24). *The sea ice in northern Labrador is thinning — fast. Here's why the Inuit are worried.* CBC News. https://www.cbc.ca/news/canada/newfoundland-labrador/labrador-nunatsiavut-sea-ice-1.5951551.

While the outcomes were not as comprehensive and integrated as many had hoped, the Glasgow Climate Pact was signed by the 197 countries, including Canada. Canada has increased its 2030 emission reduction target from 30% to 40–45% and adopted a 2050 net zero target, generally consistent with limiting warming to 1.5 degrees. Canada also announced a cap on oil and gas emissions and has committed to phase out coal by 2030 and achieve a 75% reduction in methane emissions by 2030. How Canada will do all of this is not yet clear since its current climate plan will not achieve these promised targets.

While the awareness of the health impacts of climate change is growing, in the Health Accord public town halls, this issue was not named frequently as a concern. However, the people of Labrador are seeing more quickly than they had ever imagined the effects of the climate emergency on their lives, their communities, and their very sense of identity. On Labrador's north coast, the sea ice is used as a highway system for connecting communities in the winter. When thin ice combines with unpredictable weather, it can make it dangerous for people to leave their homes. It stops trips to cabins and visits to lands where people were born—something Johannes Lampe (President of Nunatsiavut Government) said prevents spiritual nourishment, "That has impacted Labrador Inuit, mentally and physically and culturally, spiritually and certainly emotionally."[4]

The links between health and climate change are becoming clearer and more worrisome. In an article in the *Canadian Family Physician* in October 2021, the authors wrote, "Pathways to the health impacts of climate change are commonly grouped into three categories: direct effects from weather events, indirect effects from natural systems, and indirect effects mediated through human systems … the increasing social, economic, and environmental effects of climate change present major risks to health and care delivery … climate change will disproportionately harm people who have contributed least to, and benefited least from, climate-altering activities." They use specific examples in the Canadian context including one from this province, the impact of heat (increasing temperatures), which has resulted in "ecological grief experienced by the members of Inuit community living in Nunatsiavut."[5]

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4 Walsh, A. (2021, March 31). *As Labrador Inuit try to keep pace with climate change, adaptation takes a toll*. CBC News. https://www.cbc.ca/news/canada/newfoundland-labrador/sea-ice-labrador-inuit-adapt-climate-1.5954622.

5 Xie, E., Howard, C., Buchman, S., & Miller, F. A. (2021). *Acting on climate change for a healthier future: Critical role for primary care in Canada*. Canadian family physician Medecin de famille canadien, 67(10), 725–730. https://pubmed.ncbi.nlm.nih.gov/34649894/.
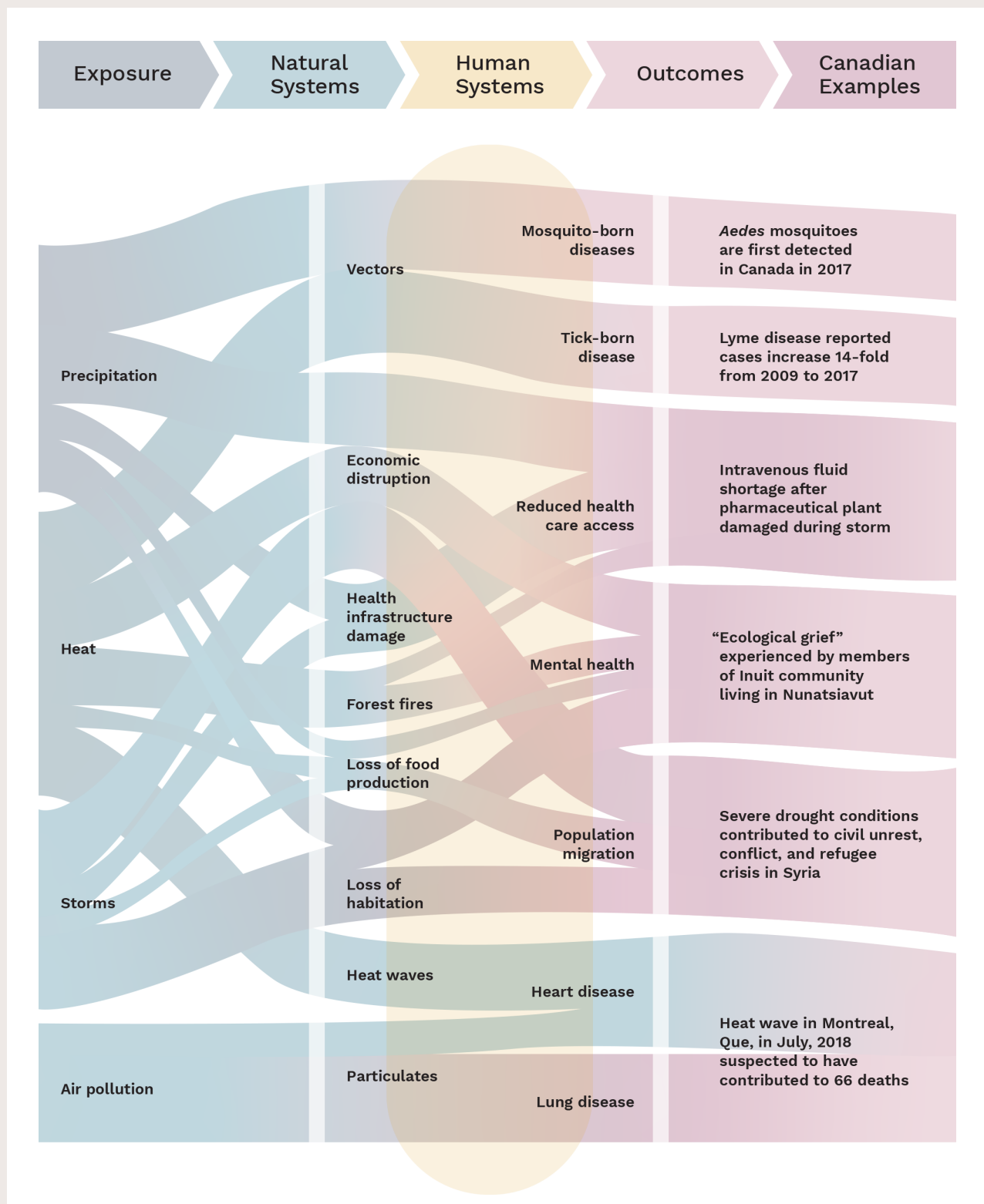
**Fig 15: Simplified Examples of Pathways Linking Climate Change Exposures With Health Outcomes and Canadian Examples:** *Direct and Indirect Effects Are Mediated Through Natural and Human Systems.*

## Impact of the COVID-19 Pandemic

Since early 2020, a global pandemic has intensified this compelling case for change. The emergence and spread of COVID-19 appear to be related to urbanization and global travel as well as environmental issues including habitat destruction, live animal trade, and intensive livestock farming. Evidence shows that, among groups living in vulnerable conditions, the pandemic substantially magnified the inequality gaps, with possible negative implications for these individuals' long-term physical, socioeconomic, and mental well-being. The pandemic has increased inequality in many other spheres of human activity—in the availability of vaccines; in economic growth; in access to education and health care; in the scale of job and income losses, which have been higher for women and low-skilled and informal workers; and potentially in losses to human capital caused by disruptions in education. The pandemic and the social response to the disease have led to behavioural and societal changes that may remain long after the pandemic.

All seven areas named above—lower health outcomes, mental health concerns, massive demographic change, concerns about sustainability, the current fiscal challenge, the climate emergency, and the impact of COVID-19—have impacts on the health of people. If any one of them exhibits serious challenges, the health of the people is at risk. All seven of them present serious challenges at this time in Newfoundland and Labrador. The health outcomes reported here reflect the health of the province and its people which is influenced far more by the SDH than by the health system. The health of the people of our province is at significant risk. This makes a compelling, time-sensitive case for a needed transformation if health outcomes are to be improved and if health equity is to be achieved. Health Accord NL is being built to respond to this compelling case.

# 3

# Creating the Health Accord Through Public Engagement

## The Health Accord

Health Accord NL is an agreement, a blueprint, and a commitment. It is an agreement among the people of Newfoundland and Labrador, all organizations and groups who have a vested interest in health and health outcomes, and the government that our health outcomes are not acceptable, that our health is not at a good place, and that we need to do something significant to change this; indeed, we must bring about a transformation. It offers a blueprint that would begin to improve these health outcomes and strengthen health equity within ten years, a blueprint which is detailed in the second volume of the Report. It is a commitment from the people, the stakeholders, and government to do what is needed to bring about this 10-year transformation in health in Newfoundland and Labrador.

The Health Accord process includes two distinct perspectives. Its vision is rooted in the belief that improved health and health outcomes of Newfoundlanders and Labradorians will only come from bringing together social, economic, and environmental factors (the social determinants of health [SDH]) with a rebalanced health system (community, hospital, and long-term care services). Its fundamental belief is that, to change the health of the people of the province, it is essential to engage with the people of the province.

## Our Province ~ Our Health ~ Our Say

The information arising from public engagement was linked with the information coming from the six strategy committees and four working groups, who used evidence derived from the province's health and social systems and from research and experience in other jurisdictions and countries.

The strength of Health Accord NL has been the diversity of lived experience, wisdom, and perspectives shared throughout the past year by members of the Task Force, members of the strategy committees and working groups, key persons and groups who brought expertise to our tables, stakeholders who reflected diversity in all its dimensions, and individuals from all walks of life in the province.

## Engagement

Health Accord NL placed a high priority on engagement from its very beginning. Engagement from stakeholders and the public was envisioned as essential to the development of the Calls to Action. A comprehensive engagement framework was developed to provide two-way learning opportunities on all levels.

The following guiding principle focused the engagement opportunities for the Health Accord:

**People and communities will decide how best to address these factors in ways that reflect their values, their perspectives, and their preferences—therefore, public engagement is key in bringing about culture change in understanding and supporting health.**

In delivering upon that guiding principle, we were steadfast in our commitment to undertake true engagement, not just consultation. We were not simply sharing information. We were speaking, and we were listening. We used multiple ways to ensure that as many people as possible could and would engage with us.

The phrase, "Nothing about us without us" is a familiar term that has its roots in disability activism in the 1990s. Over time, it has come to be used more broadly to ensure inclusion when discussing ideas that have the potential to truly impact lives and communities. The phrase gained a life of its own in our work as person after person and group after group shared experiences, stories and learnings that have helped shape the Health Accord. As a result, "Nothing about us without us" will be entrenched in the inclusion values of the Health Accord as a reminder of the necessity of true inclusive engagement in bringing about transformation in society.

The Health Accord NL Engagement Framework was built to accomplish the following:

▶ Offer multiple opportunities to learn together

▶ Appreciate that every person and every organization bring unique and valued insight

▶ Gain value from everyone's lived experience, both personal and professional

▶ Integrate learning to ensure a holistic picture

▶ Be transparent with ideas, processes, and decisions

**ENGAGEMENT STREAMS**

Public Forums
Submissions
Focus Groups
Virtual Symposium
Content Experts

**INTEGRATION**

Committees
Task Force
Working Groups

**FINAL REPORT**

**KEY INFORMANTS**

General Public   Indigenous Communities   Municipalities

Community Organizations with Health/Social Mandate   Health Education

Health Research Units   Self-Regulatory Bodies and Professional Associations

Individual Experts   Health Care Unions   Private Health Care Providers

RHAs/NLCHI   Other Agencies, Boards, Commissions   Government

## Engagement Framework

Engagement streams were established to provide varied opportunities for information to be shared and dialogue to take place. It was acknowledged that some information would be appropriate to be shared as an in-depth discussion with a particular committee or working group, while other information was more appropriate to be shared across all committees and working groups to ensure the integration of ideas.

Key informants from various organizations and associations were identified as those with whom engagement would be beneficial. In some cases, the Health Accord identified the key informants and reached out to arrange an engagement opportunity. In other cases, key informants approached the Health Accord with their willingness to share.

Using the engagement streams, we were able to ensure that meaningful discussion took place, and that learning across committees and working groups was maximized. These engagement streams included the following:

1. **One-on-One Meetings with Health Accord NL Co-Chairs**
   Meetings were held with stakeholders critical to decision-making including the three political parties. Among these were meetings with individual

members of the Task Force (leaders of unions, regional health authorities [RHAs]—leadership and boards, educational institutions, and provincial and Indigenous governments as well as community representatives and the individual members appointed by the three political parties).

2. **Meetings with Individual Strategy Committees or Working Groups**
   Each of the six strategy committees and four working groups invited key informants (individuals and groups) to share wisdom and insight from their lived experience or their research. These conversations ensured that the committees and working groups were aware of all the complexities of the issues which they were exploring, of the present realities concerning these issues, and of the potential ways forward.

3. **Public Town Halls**
   These meetings were held as public events by Zoom that anyone from the public at large could attend. The first and second rounds of town halls were designated for regional locations throughout the province to enable the public to focus on feedback critical to their area. The last three rounds were not regionally designated. These public town halls were carried out in a five-part series, each one within a two-week timeframe.

4. **American Sign Language (ASL) Interpretation**
   Through a dynamic relationship with the NL Association of the Deaf, public town halls hosted ASL interpreters and offered live transcripts.

5. **Special Interest Town Halls**
   These meetings were held as events with stakeholder groups to enable focus on the concerns of a particular group(s). Examples of groups that have used this stream include the Qalipu First Nation community, community sector organizations, high school students, and municipalities.

6. **Symposia**
   These meetings enabled the Task Force to invite stakeholders with knowledge and wisdom important for all committees to present to the Task Force. Representatives from all committees were present at each symposium. Symposia events have been held with groups such as health care professional associations, health advocacy groups, and private transportation operators.

7. **Focus Groups**
   This opportunity was offered to all stakeholders but more strongly encouraged for groups with diverse membership, such as the Newfoundland and Labrador Medical Association (NLMA), the Newfoundland and Labrador Association of

Public and Private Employees (NAPE), the Canadian Union of Public Employees (CUPE), the Association of Allied Health Professionals (AAHP), and the Registered Nurses' Union Newfoundland & Labrador (RNUNL). As a Health Accord NL supported option, focus groups were led by the stakeholder in a format that worked best for the organization. The purpose of using the focus group option was to ensure membership engagement in the Health Accord NL process, to ensure that the benefit of the wide reach of the groups across the province was realized, and to ensure the organization fully reflected the voice of its membership in providing feedback to Health Accord NL.

8. **Media**
   With the purpose of complete transparency and establishing trust among the public and other stakeholders, Health Accord NL Co-Chairs engaged the media at critical junctures of the Health Accord NL process. Using a transparent and open approach and providing flexible availability, the Health Accord was supported by various media outlets who assisted with the sharing of thoughts and ideas that challenged the Task Force, strategy committees, and working groups to be accountable every step of the way.

   The recognition that people wish to engage in different ways was critical when it came to reaching the public. Efforts to reach various targeted audiences via desired platforms were made through the creation and dissemination of a myriad of TV, radio, print, and social media content crossing various demographics in rural and urban settings in the province.

9. **Social Media**
   As an additional way to engage various target audiences, dedicated social media accounts for Health Accord NL were established—Facebook, Twitter, and Instagram. Such accounts enabled a social discussion dialogue that many have become accustomed to engaging with daily.

10. **Surveys and Polls**
    At each phase of the Health Accord NL process, surveys and polls have been promoted as mechanisms to provide feedback on key areas pertinent to Health Accord decision-making. This enabled an iterative learning process to take place organically as the Calls to Action evolved.

11. **Electronic and Written Submissions**
    Electronic (e-mail) submissions and written submissions were enabled through the Health Accord NL website. The website provided a submission form to be used by anyone wishing to submit thoughts, evidence, or otherwise to the Health Accord. A dedicated email for the Health Accord

([info@healthaccordnl.ca](mailto:info@healthaccordnl.ca)) also provided a way for email submissions to be received. Inclusive options, such as the submission of video messages, were also offered.

12. **Community Mail-Out**
    To ensure inclusivity, particularly as engagement was taking place during a time when COVID-19 guidelines were restricting travel and larger in-person events, a community mail-out was conducted with 25,000 households in the province, focusing on areas with low broadband connectivity. The feedback received from the mail-out was meaningful and enlightening as stories that would have otherwise been missed were able to help shape the final Calls to Action.

13. **The Health Accord NL Website (www.healthaccordnl.ca)**
    The purpose of establishing a dedicated Health Accord NL website was to ensure information could be readily shared. The website was designed to be user-friendly and reader-friendly and at a level that would be conducive for use by a wide range of stakeholders. The website also set the tone early for the Health Accord NL brand, including the logo, the Health Accord NL tagline, the imaging, and the slide set design, which have been helpful in establishing connection with stakeholder groups and setting the stage for culture change.

Four distinct factors enabled the engagement framework:

1. **Robust engagement resources**
   To bring the components of the engagement framework to life, staff were assigned specifically to operationalize engagement activities, including knowledge translation expertise. Perfect Day Ltd., a third-party marketing agency, was contracted to assist with creative thinking and design.

2. **Strong communication planning**
   A strong communications network of persons from Health Accord affiliated groups and organizations was empowered early to help spread the word of Health Accord NL and extend the reach.

3. **Dedicated budget**
   While the Health Accord was carried out with a very limited budget, dedicated resources were assigned to creative design, marketing, and promotions to ensure as many people in the province as possible had the opportunity to learn about Health Accord NL and contribute as they wished. The 126 members of the Task Force and its 10 committees/working groups were volunteers, with a secretariat of 10 members provided by Quality of Care NL,[6] funded by the

Canadian Institutes of Health Research and the Government of Newfoundland and Labrador.

4. **Steadfast commitment**
   Throughout the life of the Health Accord, the Co-Chairs and the members of the strategy committees and working groups remained committed to implementing an engagement process that is undoubtedly unparalleled by any engagement process that has previously taken place in Newfoundland and Labrador. It was driven by the belief that transformation in the health of the people of Newfoundland and Labrador can only happen with the leadership, engagement, and participation of the people themselves.

Feedback received from all engagement opportunities was analyzed and returned to committees and working groups for consideration. Quantitative and qualitative approaches to data collection were used to provide specific and open-ended opportunities to share ideas.

As of January 31, 2022, Health Accord NL had hosted 34 public town halls, 49 special interest town halls and 432 meetings with a wide range of stakeholders and groups, received 392 electronic/mail-in communications, and engaged with the media on 45 occasions.

| | |
|---|---|
| **34** public town halls | special interest town halls **49** |
| **432** meetings with a wide range of stakeholders and groups | media interactions **45** |
| **392** electronic/mail-in communications | |
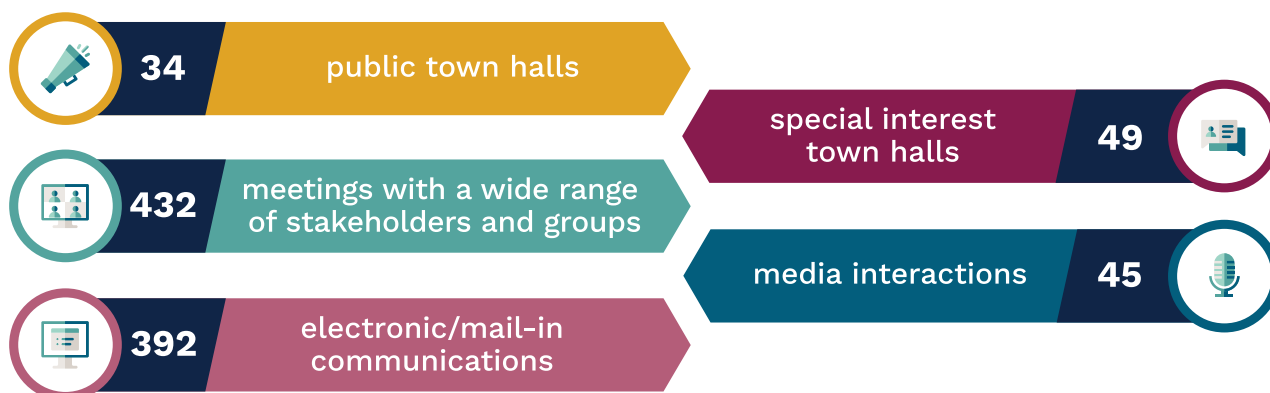
Samples of engagement materials may be found on the dedicated website for Health Accord NL, www.healthaccordnl.ca or on the Health Accord YouTube channel: https://www.youtube.com/channel/UC7js-Giu6_qCm1iYj1vbF6A. Health Accord NL also reviewed extensive engagement received via our social media network on Facebook, Twitter, Instagram, and YouTube.

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[6] *Quality of Care NL* is a collaborative effort between the leading health care entities in Newfoundland and Labrador. Its goal is to improve quality of care by facilitating change to ensure the right treatment gets to the right patient at the right time. Its partnership with *Choosing Wisely Canada* enables the promotion of established national guidelines and recommendations that cross all disciplines to support the reduction of low-value health care, including unnecessary tests and treatments, particularly where harms outweigh benefits. This work is carried out by *Quality of Care NL* on behalf of *Choosing Wisely NL*.
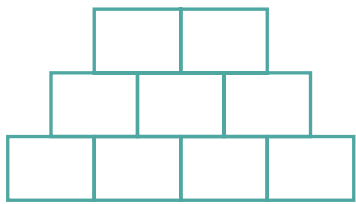
# 4

# Building the Foundation of the Health Accord
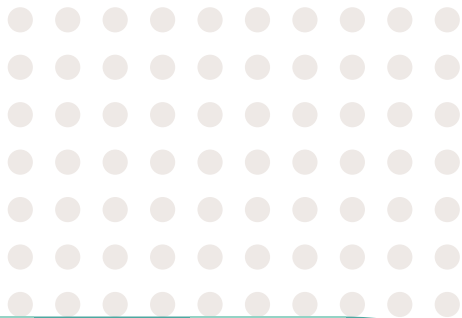
Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**
**THE REPORT**

From the beginning, the Task Force visualized agreement among persons and communities, stakeholders (including political parties, municipalities, and Indigenous governments), and the provincial government on how we should proceed to improve health and strengthen health equity in the province. In beginning our work on building Health Accord NL, we developed a statement of vision, five principles, and six core values to guide our work. We initially identified two lenses—inclusion and quality—as a further grounding of the work.

These initial guiding documents were strengthened and enhanced through the five rounds of public engagement and the numerous meetings with multiple stakeholders and government leaders and officials over the past year. In this chapter, we present these statements as revised by the wisdom gained in these engagement processes.

Our revised guiding principles highlight our shared values, intentions, and goals. These guiding statements have been fundamental to our efforts, especially to our work on the Direction Statements and Calls to Action that will lead to the transformation needed in the health system, our collective health outcomes, and health equity in our province. They are the foundation for Health Accord NL and provide a framework for accountability to the people of Newfoundland and Labrador.

## Our Vision

Our vision is improved health and health outcomes of Newfoundlanders and Labradorians through acceptance of and interventions in social determinants of health, and a higher quality health system that rebalances community, hospital, and long-term care services.

## Our Guiding Principles

Having listened to the people of the province, multiple stakeholders, and government officials and leaders, the Task Force affirms the following principles as the foundation for Health Accord NL.

### An Accord
Improving health outcomes will require committed and timely action at individual, community, stakeholder, and government levels. Bringing together those with lived experience (their values, their perspectives, and their preferences) and those who are responsible for policy and decision-making will create a common

purpose and lead to decisive action. Building on existing strengths and initiatives, public engagement and partnerships across all sectors are key to bringing about healthy culture change.

## Diversity and Inclusion

Diversity names the differences among us (e.g., age, gender, sexual orientation, ethnicity, religion, ability, education, economic status, and national origin). Inclusion describes the creation of an environment where everyone feels welcome, is treated with respect, and can fully participate and thrive. United by a deep sense of place and steadfast resilience, strengthened by the diversity among us, and growing in our sense of belonging, Newfoundlanders and Labradorians will find the energy that we need to transform health and health equity for generations to come.

## Healthy People, Healthy Environment

Social and economic factors, health behaviours and health systems, genetics and biology, and natural and built environments together determine the health of individuals and communities in our province.

## Well-Being

Closely linked with health, well-being is a way of expressing a sense of feeling happy, healthy, socially connected, and purposeful. It means that we have coping skills to deal with stress, that we have strong self-esteem, that we eat well and move our bodies, that we have meaningful relationships with others, that we add meaning to our lives through finding purpose, and that we are part of a community where we feel valued.

## Ripple Effect

Actions taken at one level affect change at other levels. As individuals take action to improve their health, they positively impact their community. Community-level actions have impacts on the entire province. Government action to improve health can affect both communities and individuals. Our combined impact will be strengthened by continual monitoring, evaluation, and adjustment.

## A Self-Reflective Health System

The rebalanced health system will critically examine itself and the reality in which it operates. It will deliver care in a way that prioritizes quality and breaks down silos by helping to promote different services working together rather than independently. It will act on inequities and barriers to services for people who are presently under-served within the health system.

### Building on Our Strengths

Professionals and other workers in our health and social systems are providing strong, focused, and compassionate service to the people of Newfoundland and Labrador. They do so despite the barriers and challenges that they face every day. Many aspects of the Health Accord will call for the types of changes that they have wanted and have advocated for over many years. The extent to which the health and social systems have functioned well to date is because of the energy and the commitment of people who work within these systems. Their renewed energy and commitment will be at the heart of the leadership required to implement the Health Accord and to hold it accountable for improving health and health outcomes for all of us.

### Sustainability

Sustainability focuses on responding to the needs of the present without compromising the ability of future generations to meet their needs. Within the domain of the Health Accord, sustainability includes the long-term ability to recruit and retain the professionals and other workers needed in our health and social systems, to fund programs beyond the initial steps of implementing the programs, and to adapt systems as health needs of the people change.

### Health in All Policies

Health is a resource for everyday living. We must take into consideration the health impact of major decisions on individuals, communities, regions, and the province—decisions made by provincial and Indigenous governments, municipalities, community organizations, stakeholder groups, and private sector companies. For this reason, we champion a "health in all policies" approach for the public sector, the community sector, and the private sector to support improved population health for the people of the province.

## Core Values Guiding the Work of the Task Force, Committees, and Working Groups

The way in which the Task Force, the six strategy committees, and the four working groups carried out their work to build the 10-year Health Accord for Newfoundland and Labrador was directed by core values: focusing on health outcomes, leading with integrity, insisting on equity and inclusion, listening respectfully, acting collaboratively, engaging holistically and integrating across sectors, and upholding accountability and transparency. These core values, named at the beginning of the Health Accord process in November 2020, have been an invaluable guide in the work and have led to new understanding and greater insights as the work progressed.

## Our Three Lenses

The Task Force initially chose two lenses to guide its work: inclusion and quality. After extensive public engagement which repeatedly identified the silos within and among systems as a detriment to improved health outcomes, a third lens was added—the lens of integration.

### Inclusion

The Task Force developed a simple illustration with three flowers of varying heights to communicate the elements which guided the use of the inclusion lens. The first frame shows equality—the three flowers have a place at the fence and are in the same size flowerpots. However, only one of the flowers is tall enough to catch the rays from the sun. The next frame shows equity—now the three flowers are placed on stands of varying heights allowing each one of them to reach above the fence to catch the rays from the sun. In the third frame, justice is shown. Now the fence is removed, and all three flowers capture the rays of the sun without the need for any additional supports.

True inclusion is not achieved, however, until the flowerpots are also removed, allowing the three plants to catch the rays of the sun, to receive nourishment from the soil, and to interact with one another to achieve health and well-being.
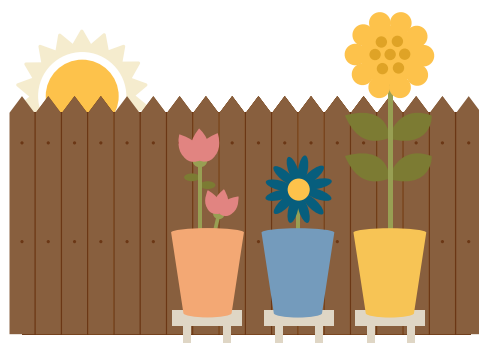
**Equality**

**Equity**

**Justice**

**Inclusion**

## Quality

The second lens is also illustrated with a diagram, this time a wheel with a central hub and six spokes. Each hub illustrates six domains of quality adapted from the Institute of Medicine framework. This framework allows us to understand measures of quality that are used by researchers or managers to show us when outcomes are being achieved or the degree to which they are being achieved. There may be conflicts between certain domains that will require setting priorities determined by the organization producing the information in consultation with those affected by the priorities being set.

## Integration

The third lens, which flows from the first and second lenses, is integration. The most consistent concern identified in all conversations with stakeholders, members of the public, and government officials was silos. The silos exist at multiple levels. They exist within systems and among systems. They relate to areas as diverse as sharing data for both secondary use and patient care, or communication among caregivers, or sharing information among government departments. The silos have an influence on situations as diverse as the care

of an individual, the links between caregiving and health education, the development of a cohesive program, the costs of a specific service, the links between the health system and health research, the richness of shared cultural activities, or the wisdom learned from lived experience.

A diagram which illustrates integration was used in a vignette which brought together the social determinants of health (the green circle) with health and social systems (the maroon circle) to improve the health of persons and families (the blue triangle) in their communities (the orange circle). Improved health through integration between health and social systems will also be strengthened by integration with health education and research as together we create a learning health and social system (see chapter 11, section four).

**Integration of the Person and Their Family With Their Community, The Health and Social Systems, and the Social Determinants of Health**

## Preparation of The Blueprint for Implementation of Health Accord NL

This Health Accord NL Report describes the major actions needed to transform health and lead us in the direction of a healthier Newfoundland and Labrador. A more detailed blueprint for implementation of Health Accord NL, The Blueprint, will be provided within two months of this Report to guide the health and social systems during the implementation process.

The Blueprint will outline in more detail the tactics needed to operationalize the Calls to Action named in this Report and will describe the process to ensure clear and consistent implementation. The Blueprint will be guided by the same vision and objective, the same guiding principles and core values, and the same three lenses as described above for this Health Accord NL Report. However, unlike The Accord Report, The Blueprint may include caveats or objections by Task Force members to specific implementation recommendations.

## Guidelines for The Blueprint for Implementation of Health Accord NL

Given the multiple options possible to develop The Blueprint and the various pathways to the best possible implementation, the following ground rules are given to help guide the creation of The Blueprint.

1. **Culture of Compassion:** The person and family/caregivers will be central to how the Health Accord will be implemented. All structures and processes are to flow from a culture of compassion permeating the health and social systems.

2. **Patient Focus:** While the Health Accord is attentive to the improved health outcomes for all Newfoundlanders and Labradorians, the health system itself must be centered on patients/clients/residents and their families. The rebalancing of the health system, the implementation of frail elderly programs, and the improved navigation through existing silos will lead to a better, more seamless experience for patients and residents who need the services of the health system.

3. **Health of Indigenous peoples:** We are aware of the health inequity experienced by the members of Indigenous communities in Canada and in Newfoundland and Labrador. Respecting the move of Indigenous communities to self-governance and listening to the voices of Indigenous people and communities, Health Accord NL will ensure that its Calls to Action are made in the awareness

of the health outcomes of all people who live in Newfoundland and Labrador and are shaped by the wisdom gained from listening to the voices of lived experience. An important resource in listening to the lived experience of Indigenous peoples comes from the Truth and Reconciliation Commission's Ten Principles for Reconciliation and 94 Calls to Action that speak to all sectors of Canadian society.[7]

4. **Clear lines of accountability:** The governing approach for successful implementation of Health Accord NL is introduced in this Report and will be more fully described in The Blueprint for implementation of Health Accord NL. Government will be encouraged to implement a transitional governance structure to ensure the immediate initiation of the implementation of the Accord.

5. **Recognition of the Health Accord as a holistic integrated approach:** The Health Accord needs to be considered in its entirety since it has been developed in a holistic manner, relying on connections among all the components. There will be more flexibility with The Blueprint which will give possible ways of and options for the best approach to implementation.

6. **Progressive implementation process:** From the beginning of the work to create Health Accord NL, it was recognized that certain steps needed to be taken before other steps could begin. For example, a more integrated ambulance system needs to be in place before services in some community hospitals are relocated. The short-, medium-, and long-term actions will be delineated in The Blueprint to ensure attention to a step-by-step implementation approach. Throughout the entire implementation process, ongoing recruitment and retention of necessary health care professionals will be required.

7. **Accountability for reasonableness:** Accountability for reasonableness is an ethical framework for priority setting to ensure that the process towards setting priorities is fair. To hold decision-makers accountable for the reasonableness of their decisions, the process must be public and fully transparent about the grounds for its decisions. The decisions must rest on reasons that stakeholders can agree are relevant. Decisions should be able to be revised in light of new evidence and arguments. There should be assurance through leadership that these conditions (publicity, relevance, and revisability) are met. All relevant stakeholders have the chance to participate in the process, there is respect for differing views, and space is given to consider divergent opinions and preferences.

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[7] National Centre for Truth and Reconciliation. (n.d.). *Reports*. https://nctr.ca/records/reports/.

8. **Ongoing performance monitoring, evaluation, and public reporting:** From the first days of the formal acceptance of Health Accord NL, there will be an ongoing evaluation process to ensure that the initial Calls to Action are being implemented as outlined, to assess the beneficial outcomes achieved during implementation, to determine the potential impact of any major social changes on specific Calls to Action, to assess unintended negative consequences, and to maintain accountability to the people of the province. This developmental evaluation process will include feedback loops to ensure that the process is iterative and engages with all those who have a vested interest in improved health outcomes for the people of the province.

9. **Consideration of impacts on workers in the health and social systems:** There must be transition agreements in place to mitigate any harmful effects on individual workers by decisions made to support the Health Accord's implementation.

10. **Involvement of members of the public and community-based organizations in implementation:** Given the regional diversity in the province, decision-making processes for a region will include representatives from the public in that region as well as the municipal or local councils in the planning for implementation. Adherence to the basic elements of the Health Accord will be balanced with sensitivity to local and regional differences. An evidence-informed approach will be essential.

11. **Financial accountability:** This Health Accord NL Report outlines broad approaches to acquire the financial support needed to respond to the Calls to Action. The Blueprint will give more specific detail on how the financial support will be managed, including negotiations with the federal government about possible new approaches to monies now being promised to all provinces in specific areas relating to the health system, to digital technology, and to social determinants of health.

12. **Collaboration:** Governments at provincial, federal and municipal levels and the governments of Indigenous communities will be encouraged to work together with groups already active in the community to find efficiencies and new ways to work together to reimagine how roles and responsibilities as well as financial resources can be realigned to fully achieve the vision of Health Accord NL.

Health Accord NL is an agreement among the people of the province, organizations with specific links to our health and social systems, political parties, municipalities, Indigenous governments, community organizations, and the Government of Newfoundland and Labrador. It is needed because of the compelling case outlined in chapter 2 of this Report, a case which highlights the inequity in health for this province when compared with the other provinces of Canada and the inequity among groups within this province. The statements in this chapter provide the foundation for the work which follows.

In the next chapters of the Health Accord NL Report, we will describe how the process for the building of the Accord unfolded. We then present the Calls to Action needed to bring the Health Accord to life and to ensure that it achieves the transformation in health which the people of Newfoundland and Labrador need and deserve.

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# Social Determinants of Health

## What Really Matters

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Social determinants of health (SDH) is the name given to the conditions in which people are born, live, learn, work, play, worship, and age. These conditions affect a wide range of health, functioning, risk, and quality-of-life outcomes. Among the most often named social determinants of health are in the following list with descriptions taken primarily from the work of Dennis Raphael and colleagues:[8] They fall broadly into two categories: (i) social exclusion based on factors of identity, and (ii) social safety net based on ways of responding.

## Social Exclusion

Social exclusion refers to specific groups being denied the opportunity to participate in social life with limited access to social, cultural, and economic resources. Indigenous peoples, people of colour, recent immigrants, women, and people with disabilities are especially likely to experience social exclusion. Socially excluded persons are more likely to be unemployed and earn lower wages. They have less access to health and social services and means of furthering their education. Excluded groups have little influence upon decisions made by governments and other institutions.

>    **Indigenous ancestry:** The health of Indigenous peoples in Canada is strongly influenced by their history of colonialization. This has taken the form of legislation such as the Indian Act of 1876, disregard for land claims of Métis peoples, relocation of Inuit communities, and the establishment of residential schools.

>    **Race:** Racism takes three forms, all of which will influence health outcomes. Institutionalized racism is concerned with the structures of society and may be reflected in practice, law, and governmental inaction. Personally mediated racism is defined as prejudice and discrimination and can manifest itself as lack of respect, suspicion, devaluation, scapegoating, and dehumanization. In the health care system, personally mediated racism impacts quality of care. Internalized racism is when those who are stigmatized accept these messages about their own abilities and intrinsic lack of worth. This can lead to resignation, helplessness, and lack of hope.

>    **Immigration:** Non-European immigrants, especially those of colour, report higher levels of mental health problems the longer they are in Canada. These immigrants also become more likely to suffer from chronic illnesses such as adult-onset diabetes, arthritis, and heart disease.

[8] Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). *Social Determinants of Health: The Canadian Facts*. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management.

Acculturation to a new environment and cultural norms impede access to health care. Immigrants' adverse health outcomes are due to a disproportionate exposure to health-threatening SDH that are a result of social exclusion and the racialization of poverty.

**Culture:** The influence of culture on health is vast. It affects perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness and pain are experienced and expressed, where patients/clients/residents seek help, and the types of treatment they prefer. Health professionals and patients are influenced by their respective cultures. Our health system has been shaped by the mainstream beliefs of historically dominant cultures.

**Gender:** Gender refers to the roles, attributes, behaviours, and opportunities associated with being male, female, or gender non-binary. It is a complex social structure that creates power relationships that shape access to and control over resources.[9]

**Disability:** Disability includes physical, mental, intellectual, cognitive, learning communication, or sensory impairment or a functional limitation that is permanent, temporary, or episodic in nature that, in interaction with a barrier, prevents a person from fully participating in society and having the rights afforded all citizens. Nearly one in four Newfoundlanders and Labradorians are affected by barriers whether they are physical, attitudinal, systemic, or technological. It is extremely important to remove barriers as it helps to make the province more inclusive and accessible, which benefits everyone.

**Geography:** Geography influences our health through the air we breathe, the food and water we consume, and the environmental pollution to which we are exposed. Rural, remote, isolated, northern, and urban geographies determine not only physical aspects of the environment, but also other SDH such as access to health care, food, education, employment, and housing. The climate crisis is a glaring illustration of the importance of geography as it changes landscapes through the erosion of coastal areas, severe floods, rising sea levels, declining sea ice, droughts, and massive wildfires.

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[9] *Gender and Determinants of Health*. (n.d.). The UCL Centre for Gender and Global Health. Retrieved January 19, 2022, from http://www.ighgc.org/gender-and-determinants-of-health.

# Social Safety Net

The social safety net refers to a range of benefits, programs, and supports that protect people during various life changes that can affect their health. These life changes include normal life transitions such as having and raising children, attaining education or employment training, seeking housing, entering the labour force, and reaching retirement. There are also unexpected life events such as having an accident, experiencing significant loss, becoming unemployed, and developing a physical or mental illness or disability.

**Early child development:** Early childhood experiences have strong immediate and longer lasting biological, psychological, and social effects upon health. Chapter 7 speaks more clearly to this reality.

**Education:** People with higher education tend to be healthier than those with lower educational attainment. The level of education is highly linked with other SDH such as the level of income, employment security, and working conditions.

**Housing Security:** Poor quality housing and homelessness are clear threats to the health of people. Quality housing is affordable and provides a stable and secure base, is a place where we feel safe and comfortable, provides for all the household's requirements, and is connected to community, work, and services.

**Food Security:** Food is one of the basic human needs and is an important determinant of health and human dignity. Food security is defined as physical and economic access to adequate amounts of nutritious, safe, and culturally appropriate food to maintain a healthy and active life. People in food insecure households have lower self-rated health, worse mental and physical health, worse oral health, and greater stress. They are more likely to suffer from chronic conditions such as diabetes, hypertension, and mood and anxiety disorders.[10]

**Income and income distribution:** Income is one of the most important social determinants of health. It shapes overall living conditions, affects psychological functioning, and influences health-related behaviours. It determines the quality of other SDH such as food security, housing, and other basic requirements for health.

[10] Food First NL, Nourish Leadership. (2021, September). *Transforming Food, Transforming Health, A Submission to the Health Care Task Force, Health Accord for Newfoundland and Labrador.*

**Employment and working conditions:** Employment provides income and a sense of identity and helps to structure day-to-day life. Working conditions which shape health outcomes include employment security, physical conditions at work, work pace and stress, working hours, and opportunities for self-expression and individual development at work as well as appropriate compensation and associated benefits (e.g., health and dental insurance, pensions). A living wage reflects what earners in a family need to bring home based on the actual costs of living in a specific community. Unemployment frequently leads to material and social deprivation, psychological stress, depression, anxiety, and increased suicide rates. Job insecurity causes exhaustion (burnout), general mental and psychological problems, and low self-rated health status.

Four additional points are noted with respect to SDH. First is the growing awareness of the concept of **intersectionality**. Age, gender, ethnicity, religion, ability, education, economic status, and national origin come together to make each one of us unique. This intersection of unique life experiences can also lead to increased bias and discrimination based in privilege and prejudice. For example, an Innu woman with a disability is facing three pressures of inequity: her gender, her race, and her disability. The impact is greater even than the sum of the individual impacts on her health. Only by being aware of and responding to these complex and overlapping layers of inequities together will we be able to make the culture change needed to ensure better health outcomes, while helping people become and stay healthy, find well-being, and thrive economically.

Secondly, the concept of **health equity** means ensuring that everyone has the chance to be as healthy as possible. The World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically." In other words, health inequity is socially determined, preventing people from making the most of their potential. Movement to health equity seeks to reduce inequalities and to increase access to opportunities and conditions conducive to health for all.[11] Bringing about health equity in Newfoundland and Labrador is socially just, leads to better health, decreases pressure on the health system, and has social and economic benefits. The move to strengthen health equity takes a combination of political, community, and personal efforts.

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[11] Public Health Agency of Canada, Pan-Canadian Public Health Network. (2018, August). *Key Health Inequalities in Canada: A National Portrait*. https://www.canada.ca/content/dam/phac-aspc/documents/ services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf.

The recognition of the long-term impact of trauma is challenging us to engage in new ways of responding to persons who have experienced such trauma—a **trauma-informed approach**. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. A trauma-informed approach assumes that an individual is more likely than not to have a history of trauma.

Trauma-informed care is an ecological approach to trauma intervention based on the understanding that environmental factors influence well-being, that health is to a great extent socially determined, and that interventions must target individual, interpersonal, and community systems.[12] It shifts the focus from "What's wrong with you?" to "What happened to you?", from "How can I fix you?" to "What do you need to support your development and recovery?"

**Intergenerational trauma** (also known as transgenerational trauma or historical trauma) is trauma passed down through generations. If an experience is overwhelming, unresolved, or significantly impacts one's life, it can be transmitted to one's children and then their children for generations. Because the human brain develops in direct response to the environment, the emotional responses of the parent will affect the developing brains of their offspring. Trauma can produce neurochemicals in the brain that will alter brain functioning. These neurochemical changes can also be passed on. Intergenerational trauma such as slavery, genocide, surviving terrorism, and warfare have been widely studied. Individual trauma such as rape, physical abuse, and extreme neglect can also have long-lasting effects over generations.[13]

This delineation of the SDH is not complete, but it gives us a good sense of what we mean by this inclusive term. Even more, it outlines for us the areas of our lives as individuals, as families, as communities, and as populations which influence our health, have an impact on our health outcomes, and determine if we can find health equity. In the following three chapters, we will identify Calls to Action related to many of these determinants of health which we believe will strengthen health for the people of Newfoundland and Labrador.

[12] Substance Abuse and Mental Health Services Administration. (2014, July). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

[13] Trauma and Beyond Center. (n.d.). *Understanding Intergenerational Trauma*. https://www.traumaandbeyondcenter.com/blog/understanding-intergenerational-trauma/.

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# Social Determinants of Health

## How We Decide, What We Know, How We Live, Where We Live, How We Relate

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**
THE REPORT

Responding to Health Accord NL's vision for improved health outcomes and increased health equity through attention to the social determinants of health (SDH), we outline an overall direction statement that leads to twelve major Calls to Action outlined in this chapter and in the two following chapters on early childhood and youth, and on aging.

## Direction Statement

**We will continue to seek a clearer understanding of the social, economic, and environmental factors which have led to continuing health inequity in Newfoundland and Labrador. We will engage people and communities in identifying and addressing specific areas of concern. We will challenge the health system to strengthen its leadership role in promoting health equity. We will champion a "health in all policies" approach by provincial and municipal governments, encourage its expansion to include education, public, community and private organizations, and work to reduce silos in and among these areas.[14] We will build on our strengths and existing initiatives to bring about a cross-sectoral approach, essential to improving the health of Newfoundlanders and Labradorians.**

To improve health outcomes and to achieve health equity, we focus in this chapter on:

▶ **What We Know** – Awareness and Understanding of Social Determinants of Health

▶ **How We Decide** – Embedding the Social Determinants of Health

▶ **How We Live** – Life with Economic Security

▶ **Where We Live** – Addressing our Climate Emergency

▶ **How We Relate** – One Inclusive Society

[14] "Health in All Policies" is a strategy to include health considerations in policy making across different sectors that influence health, such as transportation, agriculture, land use, housing, public safety, and education. It reaffirms public health's essential role in addressing policy and structural factors affecting health, and it has been promoted as an opportunity to engage a broader array of partners.

With a common purpose and through decisive action together, and only together, can government, organizations, and groups with a vested interest in health, and the people of Newfoundland and Labrador ensure that all of us live healthier lives. The following five Calls to Action outline areas of decisive action to bring about improved health outcomes and greater health equity.

# Calls To Action

## What We Know – Awareness and Understanding of Social Determinants of Health

**Action 6.1:**
Increase awareness and understanding of the social determinants of health to change attitudes and bring about action among decision-makers regarding the direct impact on population health as well as community and economic well-being.

## Background

Although we know that SDH affect the health of all of us in Newfoundland and Labrador, we need more focused research to explain which specific factors have the greatest impacts on the people in the province. We are starting to recognize the effects of intergenerational trauma related to our history, including the residential school system on Indigenous peoples, the near erasure of recognition of the Qalipu First Nation, the resettlement programs after Confederation, and the cod moratorium.

With a better understanding of the effect of SDH and using a "health in all policies" approach, we can make better decisions to improve health outcomes and health equity for the people in our province. The endorsement of this approach is already embedded in Sections 5 and 6 of the *Province's Public Health Protection and Promotion Act* (2019).

## Objectives

✓ Facilitate the development of evidence-based research and evaluation programs, including longitudinal studies, on the SDH, specific to the population of Newfoundland and Labrador.

✓ Link existing information systems across partners/silos for both patient/client/resident care and secondary uses (e.g., research, policy, system management).

✓ Improve access to the data for all partners in care (e.g., RHAs, Departments of Health and Community Services, Children, Seniors and Social Development, Finance, Education, and Justice and Public Safety).

✓ Integrate SDH data in public policy decision-making and program delivery models.

✓ Ensure effective dissemination models to support improved SDH literacy.

✓ Support measures which encourage and sustain healthy behaviours and practices.

✓ Encourage a "health in all policies" approach by provincial and municipal governments and encourage public, community, educational, and private organizations to adopt a similar approach.

# How We Decide – Embedding the Social Determinants of Health

**Action 6.2:**
Integrate the social determinants of health together with a rebalanced health system into all governance, policy, program, and infrastructure decisions that influence health.

## Background

Research shows social, economic, and environmental factors account for a greater impact on health outcomes than does the health system. Despite the predominance of these factors in determining a population's health, the province of Newfoundland and Labrador has increased funding for social programs (excluding education) by just 6% in the past 38 years, while the health system saw an increase of 232% during that same period—or almost 40 times more.

If current demographic trends continue, the median age of the province—already the highest in the country—will increase into the foreseeable future. As we age, we consume more health care with every decade of life. As a result, public expenditures related to the delivery of health care will increase. Health care already makes up the largest component of public expenditures and, unless radical changes are made, health care will take up even more of public spending, impacting other expenditures on education, infrastructure, and public welfare.

It has become clear that our focus needs to shift to more upstream measures,[15] including gradual but persistent reallocation of resources from health systems to social systems, signalling the need for a culture shift in the way we think about health and well-being. Decision-makers need to immediately begin to make a substantially greater investment in social spending and start us on the journey to better health.

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[15] An "upstream" approach in the context of health asks us to consider the social, economic, and environmental origins of health problems that manifest at the population level, not just the symptoms or the end effect. Upstream measures focus on improving fundamental social and economic structures to decrease barriers and improve supports that allow people to achieve their full health potential.

## Objectives

✓ Support individuals in incorporating their knowledge of SDH and a rebalanced health system into their daily decision-making processes.

✓ Support both the community sector and the private sector in working with their stakeholders to embed the SDH in broad planning areas and business decisions.

✓ Encourage municipalities to ensure a SDH lens is used in the context of a rebalanced health system in making community needs assessment and in planning activities.

✓ Ensure that decision-makers across all government sectors and the public sector embed social determinants of health and a rebalanced health system at the beginning of policy and program development processes to allow for appropriate integration of these factors in presented alternatives.

✓ Encourage a "health in all policies" approach by educational organizations.

✓ Embed SDH and a rebalanced health system in every interaction with the federal government.

> ❝
> Remove the aspects of privilege such as money, ability, and access so that everyone has the same opportunities for mental and physical well-being.
>
> *– High school student, town hall participant*

## How We Live – Life with Economic Security

**Action 6.3:**
Ensure that Newfoundlanders and Labradorians have a liveable and predictable basic income to support their health and well-being, integrated with provincial programming to improve food security and housing security (see Action 7.3 in the next chapter which adds further depth with a focus on the impact on children and youth).

## Background

The World Health Organization states that poverty is the largest determinant of health. Poverty has profound cumulative effects throughout a person's lifespan and has a direct impact on both the health system and the productive capacity of the province. Poverty levels vary significantly by social circumstances and geography. The effect of poverty is seen in different areas of an individual's life including health, education, food security, and housing.

Under-served populations are at high risk of poverty, including Indigenous people, individuals with disabilities, individuals with mental illness, single mothers, seniors, and Black, Indigenous and People of Colour (BIPOC). There are many people living just above the poverty line who are also at risk.

One policy approach which is being considered by many groups across Canada at the provincial and federal level is an approach to a basic livable income for all Canadians.[16][17][18] It has been described in two different ways. **Universal basic income (UBI)** means that everyone in a society—rich or poor—gets a monthly cheque for the same amount. At the end of the year, the government uses the tax system to balance out the scales and recoup that extra cash from the higher income earners who do not need it. **Guaranteed basic income (GBI)** is the system most people are referring to when they talk about basic income in Canada. It is an income-contingent system, meaning monthly payments only go to families and individuals with lower income. A variation of that approach has the basic income guaranteed for specific groups of families or individuals with lower income (e.g., persons with disabilities, single parent families, or older persons).

While a predictable, reliable, and adequate livable income for all households presently living in poverty is needed, the provision of such a basic income would need to be a federal program with sustainable core funding in which the province participates. Federal support is needed whatever approach is taken (UBI, GBI, or a focus on specific groups of families or individuals). It is possible that the province, given its population size, either by itself or as part of the Atlantic Provinces, could become a pilot project for a basic income undertaken by the federal government.

A second measure to address economic security and poverty relates to conditions of employment and is described in the concept of decent work. The International Labour Organization states, "Decent work for all women and men ensures social inclusion and dignity as the world of work plays a key role in economic and social progress and political stability everywhere." Decent work includes creating an inclusive and stable work environment, providing fair wages, respecting workers' rights, valuing workers' input and contribution, and investing in workers' growth and development.

Food security and housing security are among the many social determinants of health. They are also two markers of poverty. Food insecure households have poorer self-rated health, poorer mental and physical health, poorer oral health, greater stress, and are more likely to suffer from chronic conditions such as diabetes, hypertension, and mood and anxiety disorders. Our province has the

[16] Office of the Parliamentary Budget Officer. (2020, July 7). *Costing A Guaranteed Basic Income During The Covid Pandemic*. https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-014-M/RP-2021-014-M_en.pdf.

[17] Forbet, E.L. (2020). *Basic Income for Canadians: From the COVID-19 Emergency to Financial Security for All*. Toronto: Lorimer and Co.

[18] Swift, J., Power, E. (2021). *The Case for Basic Income: Freedom, Security, Justice*. May 2021. Between the Lines.

highest rates of diet-related chronic disease in Canada, and St. John's has been named as the city having the highest level of food insecurity in Canada.[19] [20] Children and youth who experience hunger are more likely to have poorer health, and children who face hunger repeatedly are more likely than others to develop several chronic health conditions, including asthma. Other issues related to food insecurity include the province's dependence on food sources outside Newfoundland and Labrador, the cost and quality of bringing food into the province, and the loss of importance of foods harvested or hunted that are integral to culture, health, and sustainability.

Stable, safe, adequate housing is critical to mental and physical health. A healthy person who ends up in poor housing or homeless will become unhealthy. Stable housing facilitates the provision of services that help address issues commonly experienced by individuals experiencing homelessness, including mental health and addictions.

The complexity and design of existing programs present barriers to access, misalignments, transition gaps, and disincentives to employment. There are unacceptable and avoidable silos which are making an already difficult situation even more challenging. Patient navigators have been identified as an additional resource in the midst of this complexity.

These navigators will be part of interprofessional community teams where they will work alongside other health care staff to identify patients/clients/residents with social issues affecting their health and connect them with needed resources. Patient navigators will be trained in several areas of competence including motivational interviewing, trauma-informed care, and mental health first aid. There are four possible points of contact between the patient/client and the navigator: during a health care visit but outside the clinical encounter, during a clinical encounter, as part of an initial assessment for care, or as part of an outreach program related to social support.

Another resource, **social prescribing**, is an emerging form of referral from primary care practitioners (e.g., family physician, nurse practitioner) which recognizes the importance and diversity of the social determinants of health. This is a means of enabling health professionals to refer people to a range of local, non-clinical services, including social events, fitness classes, and social services. It allows nonmedical treatment options for the myriad primary care illnesses influenced by

[19] Tarasuk, V., Mitchell, A. (2020). *Household food insecurity in Canada, 2017–18*. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/.

[20] Hussain, Z., & Tarasuk, V. (2021). *A comparison of household food insecurity rates in Newfoundland and Labrador in 2011–2012 and 2017–2018*. Canadian Journal of Public Health, 10.17269/s41997-021-00577-6. Advance online publication. https://doi.org/10.17269/s41997-021-00577-6.

social context.[21] Examples would be group learning (learn to knit, learn to garden, other clubs for hobbies), local visiting programs such as to a local seniors' home, cooking classes, community sports, getting outdoors for a hike or visiting local attractions such as provincial parks, or volunteering.

## Objectives

✓ Support provision of a basic income—a predictable, reliable, and adequate income either for all households presently living in poverty or for targeted persons living below the poverty line (e.g., persons with disabilities, single parent families, etc.).

✓ Simplify the income support process.

✓ Recognize and treat food security as a health equity issue.

✓ Recognize and treat housing security as a health equity issue.

✓ Improve access to public transit in large urban areas and enhance alternate transportation systems in rural and remote communities.

✓ Pilot social prescribing in one of the health regions to make further links between SDH and the health system.

✓ Create patient/client navigator positions in the health system and a data pathway to enable referrals and partnerships.

[21] Nowak, D.A., Mulligan, K. (2021) Social prescribing: A call to action. *Canadian Family Physician, 67*(2), 88–91. DOI: 10.46747/cfp.670288.

# Where We Live – Addressing the Climate Emergency

**Action 6.4:**
Take an aggressive and proactive approach to addressing the climate emergency through increased awareness, focused planning, aligned resources, and effective accountability mechanisms.

## Background

The effects of climate change are already being observed in Newfoundland and Labrador and are expected to increase. This is often not apparent to residents, and the desire to act has been limited. Observable provincial changes include increased permafrost melting, flooding, and damage to infrastructure, reduced sea ice, coastal erosion, threats to peat bogs as a carbon capture resource, and animal habitat changes. Climate change also has a very direct impact on food security because it impacts the availability and affordability of food.

Many of these changes are more pronounced in northern and coastal areas where the accessibility of traditional land-based activities (fishing, hunting, and gathering) have already been negatively impacted. These losses have an impact on the food security as well as the mental health of the populations affected. We are also seeing heightened risk of vector-borne diseases such as Lyme disease, respiratory illnesses such as asthma, and increased allergies.

For most in the province, the link between the climate emergency and health is tangential at best. From a program and policy perspective, it is apparent that climate action activities are occurring across different levels of government(s) and across departments in silos which undoubtedly impact the province's ability to optimize resources and achieve outcomes. The health care sector itself makes up 4.6% of greenhouse gas (GHG) emissions in Canada and represents an opportunity for dedicated action to support population health.

The Government of Newfoundland and Labrador has one Department and thus one Minister responsible for Environment and Climate Change. However, the government plan takes a whole-of-government approach to tackling climate

change, and, as such, actions within this plan will be led by departments and agencies across government, in collaboration with partners. Reporting on the outcomes of the plan, while coordinated by the Department, is completed with input from various departments, including the Departments of Fisheries, Forestry and Agriculture; Finance; Industry, Energy and Technology; and Transportation and Infrastructure.

There is an awareness that the oil industry in this province is an important employer. Any move to a green economy must take this into account. Natural Resources Canada states that a "Just Transition involves preparing the workforce to fully participate in the low-carbon economy while minimizing the impacts of labour market transitions, identifying and supporting inclusive economic opportunities to support workers in their communities, and including workers and their communities in discussions that affect their livelihoods."[22]

## Objectives

✓ Develop and implement an awareness campaign on the local climate emergency impacts on the health of residents of the province with a focus on proactive actions that need to be taken at the regional, community and individual levels to mitigate future negative health impacts.

✓ Implement action to reduce the environmental footprint of the health system.

✓ Aggressively implement and build on the actions set out in the government's plan for climate change.

*continued...*

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[22] Natural Resources Canada. (n.d.). *Helping workers and communities thrive in a net-zero carbon economy*. Just Transition. Retrieved January 19, 2022, from https://www.rncanengagenrcan.ca/en/collections/just-transition.

## Objectives (continued)

✓ Ensure implementation of a "Just Transition"—a framework to encompass a range of social interventions needed to secure workers' rights and livelihoods when economies are shifting from a fossil fuel-based economy to sustainable production.

✓ Support the integration of climate emergency actions across sectors.

✓ Ensure that there is ongoing education on climate change, evolving in response to knowledge gaps, new information, and demographic changes so that individuals, businesses, communities, and regions have impetus and support for engaging in positive climate action.

✓ Maximize opportunities to leverage federal funding to proactively support the achievement of provincial climate change outcomes.

✓ Prioritize the provincial and regional supports required to ensure safe drinking water for all residents of the province.

✓ Engage with agricultural and fishery sectors to build connections between human and planetary health to address, adapt, and mitigate against the health effects of climate change with greater environmental stewardship.

✓ Recognize environmental sustainability, including sustainable food systems, as a dimension of health care quality.

# How We Relate – One Inclusive Society

**Action 6.5:**
Take immediate action to create a provincial Pathway for Inclusion, shaping an inclusive health system within an inclusive society.

## Background

Inclusion itself is a SDH. People who are isolated within society often experience detrimental health impacts. Racism and all forms of exclusion limit access to social supports, including health care treatment, and negatively affect the health and wellness of Indigenous peoples and other excluded groups.

The World Health Organization describes barriers as "Factors in a person's environment that, through their absence or presence, limit functioning and create disability." These include aspects such as a physical environment that is not accessible, lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices), negative attitudes of people towards disability, or services, systems and policies that are either non-existent or that hinder the involvement of all people with a health condition in all areas of life. The barriers may be attitudinal, communication, physical, policy, programmatic, social or transportation.

"

## Diversity is a fact. Inclusion is a choice.

*– Participant in symposium on inclusion*

Health Accord NL Co-Chairs were told repeatedly that current education and training programs are inadequate in addressing racism, discrimination, and bias in health care (e.g., Indigenous persons, older adults, persons with disabilities, 2SLGBTQIA+, immigrants, persons living in poverty, BIPOC, incarcerated individuals, rural residents, women, youth, Francophones).

There are no procedures to report exclusion and no specific measures of inequity in the health system. Indigenous peoples and other groups experiencing exclusion in health care are typically not part of health leadership and decision-making processes and have not been engaged appropriately in care delivery models. Almost every group speaking about inclusion during our public engagement sessions and stakeholder meetings echoed the same message, "Nothing about us, without us."

## Objectives

✔ Formalize and integrate across the system responsive means of engagement, knowledge collection, knowledge transfer, and participation for groups experiencing health inequities in a "meeting people where they are" approach.

✔ Implement a province-wide, comprehensive, zero-tolerance policy on racism and exclusion.

✔ Implement an effective inclusion lens for new and existing policies, programs and environments that are developed and implemented with the full participation of excluded groups.

✔ Actively address racism and all forms of exclusion system-wide through the implementation of informed and comprehensive plans of action.

*continued...*

## Objectives (continued)

✓ Raise awareness of the multiple barriers faced by persons with disabilities and do what is needed to remove these barriers.

✓ Create a culture of equity and inclusion within health organizations demonstrated through the values, language and behaviours of people working in the system and the reports of patients/clients/residents.

In the following two chapters, we explore in more detail two further SDH: early childhood and youth, and older persons and health. While the number of children in our province is decreasing, they still have many health needs in order to live and age in as healthy a way as possible. We have increasing numbers of older adults who require supports to age in place; we must focus our energies on how we can best respond to this reality.

**7**

# Investing in Our Future

## Early Childhood and Youth

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**
**THE REPORT**

Children and youth who have access to healthy food, physical activity, quality education, health care and positive parenting tend to be healthier and better equipped for the challenges they face growing up.

## Engagement with Young People

Through written submissions and a town hall with high school students from across the province, Health Accord NL heard the voices of young people as they expressed their concerns related to health and health care. Their communications with us reflected thoughtful attention to the key issues which the Health Accord believes to be important.

### Key Issues Voiced During Youth Engagement

| | | | |
|---|---|---|---|
| mental health | drug use and addictions | physical well-being | referral and testing waitlists |
| local, healthy food | bio-psycho-social health care model | trauma-informed approaches | poverty and economic standing |
| shortages of physicians and health professionals | youth have a voice | | |
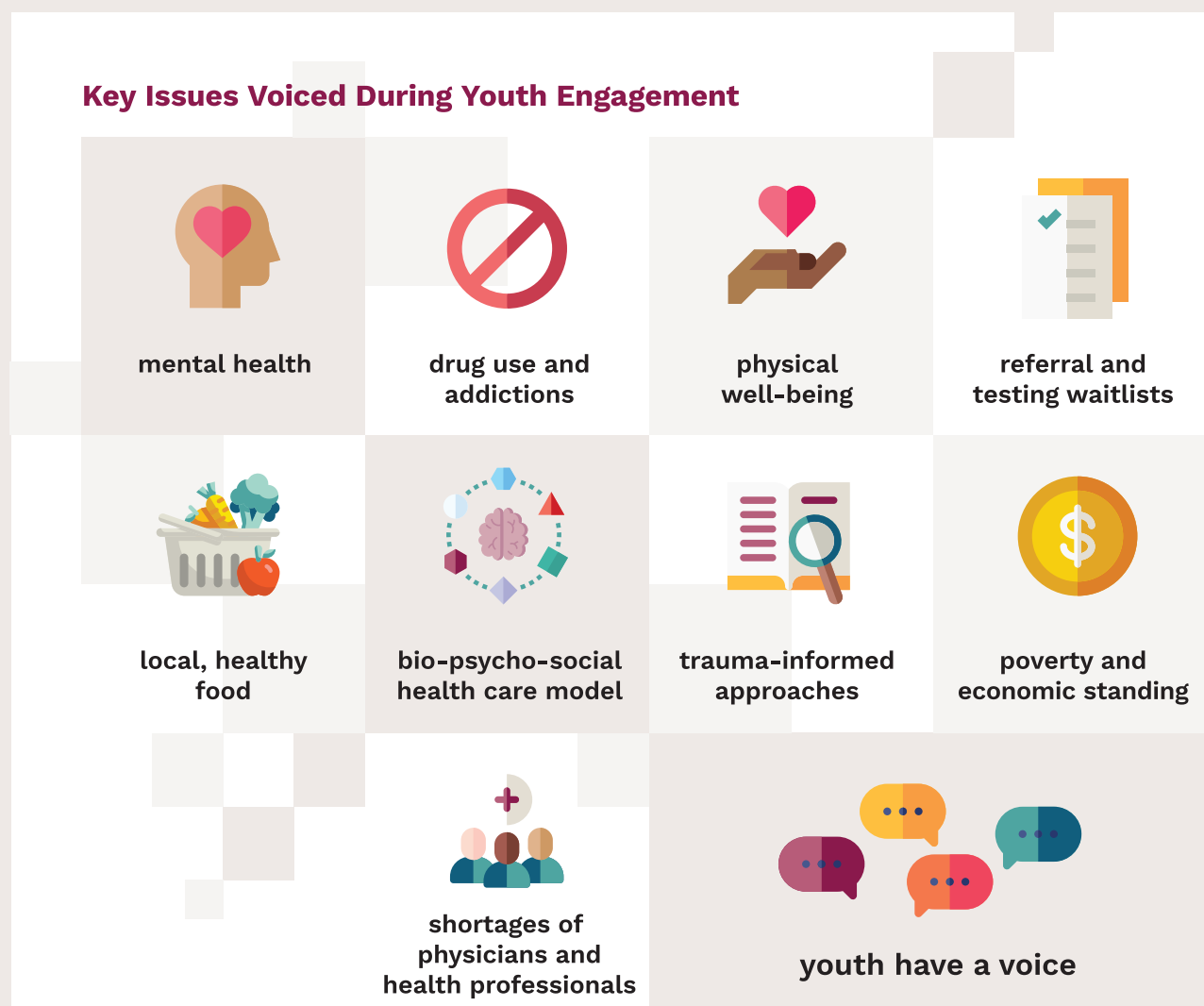
**Mental health was the most named issue**, linked to factors like stress, COVID-19, and family issues. The young people were concerned that help is hard to get with long waiting lists. They also noted that too many times the need for mental health support is hard to prove. They said that stigma around mental health is still very prevalent in both school and home settings with too many young people labeled as simply lazy or troubled. Adults are still not talking about mental illness enough to normalize it. They encouraged more training and education around mental health for teachers. They noted that the lack of socialization due to the pandemic has resulted in social isolation from family and friends and has increased mental illness as well as a lack of physical activity.

Closely linked to concerns around mental illness were **issues related to drug use and addictions**: cocaine, cigarettes, vaping, and alcohol. They fear that more substance abuse is moving into younger grades. They encouraged teaching and learning related to substance abuse, making it more relatable for kids and teens with the message coming from those of a similar age or those with lived experience.

Relating again to health care, they were concerned that students who may have attention deficit hyperactivity disorder (ADHD) face **waiting lists for referral and then for testing**. They were also concerned that families who cannot afford private testing have to wait even longer than those who have more resources. The impact on the person includes challenges in the classroom and disrupted family relationships. This example reflects a larger concern about access to services related to learning disabilities and mental health. It highlights disparities for people with different incomes influencing access to services, different levels of support, and different degrees of speed in addressing problems.

**Physical well-being was highlighted in several ways** including affordable access to physical activity programs, more physical activities in the community supporting all age groups (sports, fitness, hobby groups, spaces to encourage walking, marathons), incentives for children and adults to get involved and be more active and healthy, community gardens accessible to everyone, links between children and seniors to teach and learn knitting, arts or other activities, and diversity of school activities beyond just popular sports such as hockey.

Linked to physical well-being was a **focus on local healthy food**. They wanted schools to make it easier for children to eat healthier food with education for parents to encourage healthy eating and an active lifestyle for themselves and their children. They encouraged growing your own vegetables, having spaces to raise chickens, and community presentations or classes online for growing vegetables, raising livestock, and working with reusable seeds/roots.

> **Mental illness is a prevalent issue in high schools... many teenagers feel they have no one to turn to as parents may not always be a safe outlet. We need to address these issues within the school system, which means we need medical professionals to visit schools regularly to help students in need. Stigma is still very prevalent in school/home settings, and I've seen too many kids be labeled as simply lazy or troubled instead of being shown a way forward.**
>
> *– High school student, town hall participant*

One student spoke to the need for a **bio-psycho-social model of health care** where each person within the health system is treated as a whole individual and all aspects of health are addressed, including social and psychological problems and their effects on disease outcomes. Students were also aware of **the need to focus on trauma-informed approaches and care** with a concern that providers are not always aware of the need for these approaches.

**Poverty and economic security were named under a variety of factors**: inadequate insurance coverage for dental care, travel costs for people from rural areas to go to St. John's for specialized treatment, costs of post-secondary education and tuition fees, lack of access to affordable sporting, housing, costs of good food as well as other services such as electricity and rent. Their recommendations were along a spectrum from an increased minimum wage to food sharing and book sharing posts throughout the community (take what you need, leave what you can).

With respect to the health system itself, young people fear the **shortages of physicians and other health professionals**. They believe that resources such as virtual health care can extend the reach of existing professionals as well as benefit seniors who find difficulty in leaving their homes. They wondered if more

training opportunities from the Memorial University's Faculty of Medicine could be present in western Newfoundland. They also felt that free university education with a return in service agreement might encourage more young people to go into health professional education.

The final issue which was threaded throughout all the conversations was **youth having a voice**. They know that they have a unique perspective which needs to be heard. They feel that they need to get their friends involved in conversations about health (mental and physical) and about peer pressure and substance abuse. They want to encourage conversations with their parents and teachers but also with companies and government.

# Calls To Action

## Continuum of Education, Learning, Socializing and Care for Children and Youth

**Action 7.1:**
Strengthen efforts to create a continuum of education, learning and socializing, and care for children and youth (from prenatal to adulthood).

## Background

In a WHO-UNICEF-Lancet Commission report which was published in February 2020, the following statement summarizes well the situation with respect to children and youth in Newfoundland and Labrador:

> Despite dramatic improvements in survival, nutrition, and education over recent decades, today's children face an uncertain future. Climate change, ecological degradation, migrating populations, conflict, pervasive inequalities, and predatory commercial practices threaten the health and future of children in every country ... The evidence is

clear: early investments in children's health, education, and development have benefits that compound throughout the child's lifetime, for their future children, and society as a whole.

Successful societies invest in their children and protect their rights, as is evident from countries that have done well on health and economic measures over the past few decades. Just as good health and nutrition in the prenatal period and early years lay the foundation for a healthy life course, the learning and social skills we acquire at a young age provide the basis for later development and support a strong national polity and economy. High-quality services with universal health care coverage must be a top priority. The benefits of investing in children would be enormous, and the costs are not prohibitive.[23]

Comprehensive school health (CSH) is an internationally recognized approach to support the development and maintenance of healthy, safe, and positive school learning environments and foster healthy behaviours for life. The CSH Framework was adopted by the Government of Newfoundland and Labrador in 2004 and supported through the interdepartmental Healthy Students Healthy Schools (HSHS) committee. The aim of HSHS is to foster collaboration across the health and education sectors to promote and sustain the environments and conditions that support students to make healthier choices. There is a need to renew the governance structure of HSHS to ensure schools are supported in using the CSH Framework, share knowledge, coordinate priorities, enhance capacity, and align the work of health and education throughout the province.

Adolescence can be a period of vulnerability as young people transition from the dependence of childhood to the independence of adulthood. During this time, young people take control of their health and education, enter the job market, and become independent members of society. Young people's experiences can have lasting impacts on their future health, social and economic outcomes. When provided with appropriate supports, young people can reach their full potential, to the benefit of all Newfoundlanders and Labradorians.

To some degree, the Department of Health and Community Services (HCS), the Department of Education, and the Department of Children, Seniors and Social Development (CSSD) are operating in silos at government and regional levels. This prevents the best approach to the implementation and delivery of child and youth health services.

[23] Clark, H., Coll-Seck, A.M., Banerjee, A., Peterson, S., Dalglish, S.L., Ameratunga, S., et al. (2020 February 19). A future for the world's children? A WHO–UNICEF–Lancet Commission. *The Lancet Commissions*, *395* (10224), 605–658. https://doi.org/10.1016/S0140-6736(19)32540-1.

Several recent government initiatives have highlighted the need to strengthen the continuum of education, learning and socializing, and care for children and youth. Among these initiatives are the *Towards Recovery Action Plan*, the *Education Action Plan*, and the *Autism Action Plan*.

## Objectives

✓ Implement a Prevention and Early Intervention Plan focusing on fostering resilience in children and families.

✓ Invest in universal access to early childhood education, prioritising children in under-served families.

✓ Review and update all early childhood programs provided by public health in Newfoundland and Labrador based on best practice.

✓ Implement early childhood health and education programs accessible to all children in Newfoundland and Labrador.

✓ Implement health promoting initiatives in all schools, including the revised school health curriculum, food literacy, and physical activity programs using the CSH Framework.

✓ Implement a renewed governance structure for HSHS to facilitate the use of the CSH Framework in schools (this would be the joint work of the Departments of Education and HCS).

✓ Ensure collaboration with existing government initiatives and ongoing engagement with members of the public in these endeavours.

# Integrated Models of Care for Children and Youth at Risk

**Action 7.2:**
Develop one model of community health services for children and youth with complex health needs and a more integrated approach to respond to health needs of children and youth in care.

## Background

Health outcomes and educational achievement are related to each other by several causal pathways. Health problems (e.g., vision and oral health problems, asthma, teen pregnancy, malnutrition, obesity, chronic stress, and ADHD) and risk-taking behaviour (e.g., aggression and violence, unsafe sexual activity, unhealthy eating, physical inactivity, and substance use) are associated with low scholastic performance. Conversely, low academic achievement is strongly associated with risk-taking behaviour, compromised health status, and reduced longevity.

The first response is to build a society in which every child has a healthy start in life. When risks become evident in the home or in the life of the child, every effort must be made to provide parents with the supports and intervention services that they require to adequately care for the child in a place of safety and love. As noted above, the school also provides the healthy, safe, and positive learning environment which supports the child's health and well-being. However, programs and services must also be provided when the risks facing the child become too great.

Children from low-income and racial or ethnic minority populations are more likely to develop chronic health problems than more affluent and white children are and are less likely to have a usual source of medical care. Thus, if school-based health centres can increase receipt of needed health services and overcome educational obstacles in disadvantaged populations, they can advance health equity.

Another group of children at risk are immigrants. In a study completed in 2019, Michael Clair noted, "In the 2019/20 academic year, there were about 250 refugee

children in the English school system. Some of these children are fleeing a war zone and may have been traumatized … It is estimated that overall, taking account of all children in the school district (immigrant and native-born), a quarter of students have diagnosed exceptionalities that require the teacher's attention. Of these, 15% require a targeted approach (e.g., to treat ADHD) and 5% require intensive care (e.g., a severely autistic child or a traumatized refugee). Only a handful of teachers have taken professional development in trauma-informed learning."[24]

Newfoundland and Labrador has the highest rate among all the provinces of children and youth with medically complex needs. Despite increased health and community resources along with decreasing numbers of children and youth, this population continues to have worse outcomes.

The first approach to children at risk is to provide guidance and supervision in the home, ensuring that parents know and avail of the supports and intervention services that they require to adequately care for the child. These services may be provided by staff from the Department of CSSD, other departments or agencies of government, or through service providers within the community.

If support in the home is no longer effective, further intervention is needed. There are more than 1,500 children and youth in Newfoundland and Labrador at any one time who need protective intervention and require an out-of-home placement. As of June 30, 2021, there were 995 children and youth (0–18 years) in care—480 in Central Health (CH) and Western Health (WH), 285 in Eastern Health (EH), and 230 in Labrador-Grenfell Health (LGH). There were 580 children and youth in kinship care arrangements. A disproportionate number of Indigenous children are in care in our province. In her 2019 report, the Child and Youth Advocate found that 34% of children in care are Indigenous (15% were Inuit).[25]

Children in out-of-home placement have higher medical, emotional, developmental, and educational needs which are under-recognized and neglected. Risk factors leading to this include poverty, prenatal exposures to drugs, parental mental illness, and exposure to domestic violence in their families of origin. Barriers to ensuring appropriate medical supervision for these children include parental incapacitation, inadequate medical records, and lack of consistent care and follow up due to multiple placements and movements within the system, and lack of communication between caregivers.

[24] Clair, M. (2021). *Immigration in Newfoundland and Labrador: How it works, how it worked, and how it might work*. Memorial University of Newfoundland, Harris Centre. https://www.mun.ca/harriscentre/Clair_NL_Immigration.pdf.

[25] Office of the Child and Youth Advocate NL. (2019, September). *A Long Wait for Change: Independent Review of Child Protection Services to Inuit Children in Newfoundland and Labrador*. https://www.childandyouthadvocate.nl.ca/files/IndependentReview2019.pdf.

These children have experienced many gaps in their health care journey including missed appointments and lack of communication between care and health care providers resulting in further neglect of their medical and mental health.

The CAYAC (Children and Youth in Alternative Care) clinic at the Janeway Hospital, started in September 2019, is an interprofessional, multiagency clinic that provides a medical home for children and youth in care in Newfoundland and Labrador. It is staffed by a developmental pediatrician, a general pediatrician, speech language pathologist, occupational therapist, CSSD liaison social worker, Janeway school principal, and music therapist, each providing between 5–10% of their clinical time to the clinic. Most referrals are from the child/youth's CSSD social worker who is required to attend the clinic appointments. Also attending are any adults who are relevant to the child/youth's guardianship including foster parents, biologic parents, group home workers, or other relatives or caregivers.

## Objectives

✓ Ensure the implementation of one model of Child and Youth Community Health (CYCH) Services (including families) for Newfoundland and Labrador with central intake and access and a streamlined organizational structure.

✓ Implement an interprofessional province-wide program to provide health support to children and youth in care, modeled on the CAYAC.

✓ Endorse the immediate implementation of the recommendations set out in the December 2021 report by the Office of the Child and Youth Advocate entitled: "A Special Kind of Care" related to children in care with complex health needs or disabilities.

It is noted that these models of care connect with community teams and with Janeway outreach services, the nature of the connection being dependent on the care provided.

# Livable and Predictable Basic Income for Families

**Action 7.3:**
Ensure that the families of children in Newfoundland and Labrador have some form of a livable and predictable basic income to support their health and well-being, integrated with provincial programming to improve food security and housing security (this Action echoes Action 6.3 in the previous chapter, but adds more depth with respect to children and

## Background

In Newfoundland and Labrador, the number of young people has fallen dramatically from approximately 200,000 in 1971 to 70,000 today. It is important that all children and youth have a solid start in life as they are the future of the province. The impact of poverty on children and youth is well documented.

Extreme poverty can impact how the body and mind develop and can alter the fundamental architecture of the brain. Children who experience poverty have an increased likelihood of chronic illnesses and a shortened life expectancy. Poverty creates and widens achievement gaps. Starting in infancy, gaps are evident in key aspects of learning, knowledge, and socio-emotional development. Children living in poverty lag behind their peers at kindergarten entry and ultimately are more likely to drop out of school or fail to obtain post-secondary education.

Poverty leads to poor physical, emotional, and behavioural health. Children living in poverty are more likely to experience food insecurity and are less likely to receive preventative medical and dental care. Children living in poverty are more likely to live in neighbourhoods with concentrated poverty, which is associated with numerous social ills such as academic underachievement; more social and behavioural problems; worse health and physical outcomes; exposure to environmental toxins; and other physical hazards, including crime and violence.

We also note the reality of intergenerational poverty, that is, poverty transmitted from one generation to another, with children from families living in poverty more likely to become adults themselves living in poverty. The consequences of

intergenerational poverty include food insecurity, birth and developmental issues, unsafe living conditions, and increased risk of violence, incarceration, and victimization. Every consequence of growing up in poverty acts as another barrier for someone to rise above the poverty line.

Poverty can harm children through the negative effects it has on their families and the home environment such as higher stress on parents and higher housing insecurity.

According to data provided by the Newfoundland and Labrador Statistics Agency, in 2019, there were 230,000 families and unattached individuals in Newfoundland and Labrador. This province has a higher percentage of families and unattached individuals with after-tax income less than $40,000 compared to Canada as a whole (Canada 30%; Newfoundland and Labrador 34%). According to the 2019 Market Basket Measure,[26] 10.1% of the population (3.7 million individuals) in Canada were low income. The rate for Newfoundland and Labrador was slightly higher than the Canadian rate at 10.7% (55,000 individuals).

In 2020, children in the province living in families receiving income support represented 8.7% of all children in the province under age 18 years (7,473 of 86,055). The percentage of children under age 18 living in families in receipt of income support decreased from 11.8% (16,191 of 137,479) in 1996 to 8.7% in 2020, mainly due to the introduction of federal child benefits in the late 1990s. A slightly greater proportion of children under ten, 9.6% (4,202 of 43,700), are in families receiving income support. In 2020, 2,600 youth, age 18 to 24, received income support as adult recipients as well as dependents, and represented 6.5% of people in the province in that age group (39,731).[27]

The Canada Child Benefit (CCB) is a tax-free monthly payment made to eligible families with children under age 18 years to help with the cost of raising a child. When this benefit was introduced in 1998, the provincial income support program rate structure was changed so that families could retain their full CCB.

The Government of Canada has developed a plan to provide parents in Canada with, on average, $10 a day regulated childcare spaces for children under age six by 2025/26. This plan is intended to build a Canada-wide, community-based early learning and child care system that will make life more affordable for families and every child a real and fair chance at success. In July 2021, Prime Minister Trudeau and Premier Furey announced an agreement that will support

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[26] Used by Statistics Canada, Market Basket Measure (MBM) is a measure of low income based on the cost of a specified basket of goods and services representing a modest, basic standard of living.

[27] Compiled by the Department of Finance's Community Accounts Unit based on information provided by the Department of Immigration, Population Growth and Skills (Government of Newfoundland and Labrador).

an average parent fee of $10 a day for regulated childcare spaces in Newfoundland and Labrador in 2023, significantly reducing the price of child care for families, supporting new infant, toddler, and preschool spaces and a new full day, and year-round pre-kindergarten Early Learning and Child Care Program (ELCC) for four-year-old children in 2023.[28]

This plan is for regulated spaces only. Given that almost two-thirds of existing child care facilities in the province are unlicensed home-based businesses and that children in small communities will be less likely to have access to regulated child care spaces, it will be important to address the gaps if the plan is to provide the level of support needed for children in their early years. It is encouraging to see that the agreement includes a year-round pre-kindergarten program to be instituted by 2023.

## Objectives

✓ Ensure the development of actions and policies regarding basic income, housing security, and food security to reduce poverty in the general Newfoundland and Labrador population.

✓ Address gaps relating to subsidized rates for childcare for children attending unregulated daycare facilities and for children living in small communities. Implement pre-kindergarten program.

✓ Engage families with children and youth in the development of these policies and actions.

✓ Ensure that these policies and actions are targeted toward and effective for those families with greater poverty: single parent households, households with three plus children, new immigrants, Indigenous children, and children aged 0 to 2 years.

*continued...*

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[28] Prime Minister of Canada Justin Trudeau. (2021, July 28). *$10 a day child care for families in Newfoundland and Labrador*. https://pm.gc.ca/en/news/news-releases/2021/07/28/10-day-child-care-families-newfoundland-and-labrador.

## Objectives (continued)

✓ Ensure youth who have left the family home but are living in poverty are engaged in any policy and program development and ultimately new services targeted toward this population.

✓ Improve access to public transit for families with children and youth as well as youth who have left the family home and are living in poverty.

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**The strength of the model rests on the holistic understanding it presents—health is not simply treatment but is largely determined by social measures. Getting people out of poverty is such an important step.**

*— Engagement series 5 survey participant*
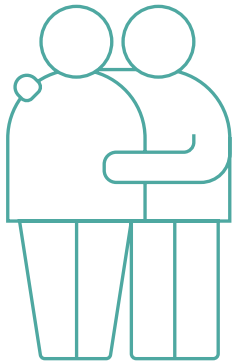
**8**

# Aging in Our Community

## Older People and Health

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**

> **Aging in place, keeping people in their homes as long as possible, is good both for them and for their families and reduces burden on health care system in care facilities.**
>
> *— Engagement series 3 survey participant*

The impact of ageism was a commonly discussed concern among individuals and groups speaking on behalf of the province's older population during the Health Accord process. There were far too many stories of older people having decisions made for them, being forced into care options that were not their choice, being indirectly forced to give up work before they were ready, and experiencing discrimination, social isolation, and belittling remarks. Whatever the discussion topic or meeting agenda, the need for "autonomy, choice, respect and dignity" for older people was top of mind. All believed that older people should have the ability to choose the care options they want, and, most importantly, that they should be treated with the respect and dignity they deserve.

The ability to "Age in Place" was perhaps the most common request heard throughout engagement sessions. Many seniors in our province own their homes and are concerned about whether they will be able to remain there as they age or as their health declines. Group after group pointed out that seniors often only need minimal supports (snow clearing, basic maintenance, transportation to appointments, etc.) to stay in their homes where they prefer to remain. Such supports are often much less expensive for the province than other residential options (personal care homes, long-term care) would be.

Home First is a philosophy to help frail patients get out of hospital and back into their homes as soon as possible. It is meant for patients who have completed acute care treatment and no longer need 24-hour attention in hospital, patients who can heal safely at home with the right kinds of support. Health Accord NL supports this Home First philosophy of government and believes that this approach should be advanced into formal policy for the health system in our province.

COVID-19 brought many challenges, especially for older residents of the province. A disproportionate number of cases and deaths came from the older population. The value of family care in the lives of seniors became much more apparent. Limitations on visitors in households and care facilities had a significant impact on social isolation and on meeting the basic day-to-day needs of older people. Family members unable to spend time with their loved ones found it very difficult to ensure their well-being and to function as advocates on their behalf when their care was not as it should be. The committee recognizes the role of family members in supporting the older population and emphasizes the need to acknowledge and support them in this role.

Much of our work aligned clearly with the five strategic objectives of the *World Health Organization (WHO) Global Strategy on Ageing and Health:*[29]

▶ commitment to action on healthy aging in every country

▶ developing age-friendly environments

▶ aligning health systems to the needs of older populations

▶ developing sustainable and equitable systems for providing long-term care (home, communities, institutions)

▶ improving measurement, monitoring and research on healthy aging

## Direction Statement

**The people of Newfoundland and Labrador will be enabled and empowered to transition seamlessly through age and health-related changes with dignity and autonomy. This will be rooted in family and community supports, strengthened by a commitment to aging-in-place in age-friendly communities, and supported by home support and long-term care and other health system supports in which quality of care and quality of life are fundamentally linked.**

[29] Global strategy and action plan on ageing and health. (2017). Geneva: World Health Organization. Licence: CC BY-NC-SA3.0 IGO. Retrieved from, https://www.who.int/publications/i/item/9789241513500.

# ⟩ Calls To Action

## A Comprehensive Provincial Frail Elderly Program

> **Action 8.1:**
> Develop and implement a formal Provincial Frail Elderly Program to address the critical need of our population.

## Background

Compared to the rest of Canada, the population of Newfoundland and Labrador has aged more rapidly over the last 50 years, and over a quarter of its population over 65 years is considered frail.[30] The province has the largest proportion of seniors with three or more chronic illnesses. The consequence of advanced age and more than two chronic illnesses is frailty. Data suggest that the prevalence of frailty in acute care in this province is higher than the national average, with approximately 80% of individuals over the age of 65 years who are admitted to hospitals being vulnerable or frail.

Frail older persons are the highest users of acute care. In 2016/17, seniors accounted for 19.4% of the population in St. John's. In that same year, 58% of acute care admissions consisted of individuals over the age of 65. From 2013–2018, the population over 65 grew by 2.8%, yet emergency department visits in this age group increased by 22.3%. This is a marker of increasing frailty within our local population. Although seniors comprise 21% of the provincial population, 47.2% of government health spending is provided for services for older people.

Assessment of and detection of frailty are limited at the community level. Without a comprehensive geriatric assessment completed by the appropriate care provider, older persons are not able to be identified as frail with multiple,

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[30] Frailty is a medical condition of reduced function and health in older individuals. Existing on a spectrum, it is broadly understood as a state of increased vulnerability and functional impairment caused by cumulative declines across multiple systems. It may be physical, psychological, social, or a combination of these. Frailty may include loss of muscle mass and strength, reduced energy and exercise tolerance, cognitive impairment, and decreased physiological reserve, leading to poor health outcomes and a reduced ability to recover from acute stress.

and often complex, care needs. This often causes unnecessary visits to the emergency department and ultimately admission to hospital when many of the presenting issues could have been identified earlier and even prevented.

Emergency departments in our province have not been certified as "Senior Friendly." Without this standard, older persons are frequently treated for a single issue instead of the other likely causes that led to that visit. This pathway frequently leads to misdiagnoses and thus inappropriate care.

Twenty percent of all acute care beds are occupied by patients who do not require the level of intensity of services provided in an acute care setting. This category of bed usage is known as "Alternate Level of Care" (ALC). Every day 300 older persons on average occupy these beds.

Of the 300 persons in this ALC, 43% are waiting for long-term care placement, 11% are waiting for end-of-life care, 14% are waiting for rehab services, 11% are waiting for home support services, and 8% are waiting for personal care home placement. Without attention to this issue, the demand will continue to increase as the population ages. Many of these individuals, if treated in a timely, comprehensive manner by an interprofessional team with a geriatric focus and with appropriate discharge planning, can return home or to a lower level of care. Recent research at St. Clare's Mercy Hospital in St. John's has shown that proper assessments can result in 50% lower risk of readmission to acute care and 28% lower risk of visiting the emergency department. In other jurisdictions, with similar caseloads, the program resulted in a 30% decrease in persons in an ALC.

> **I personally seen and experienced the lack of care and follow through in emergency when it comes to an older adult who has been there several times for the same reason only to be "pushed" out the door because they don't have anyone advocating for them—it shouldn't be this way.**
>
> *– Engagement series 5 survey participant*

A comprehensive plan for the next ten years to help improve the health status of frail seniors in Newfoundland and Labrador is essential. This can be built through consultation with Canadian and international counterparts in a manner that is both evidence-based and comparable with other interprofessional models of care.

The Health Accord has adopted a population health approach, taking into account the determinants of health and wellness. An early assessment of frailty with a comprehensive plan where all care providers receive timely information and the right care provider delivers the right care at the right time can provide a respectful pathway of care for older persons and promote a more appropriate allocation of human and financial resources.

## Objectives

✓ Implement a Comprehensive Provincial Frail Elderly program that is incorporated across the continuum of care and is designed as a provincial geriatric care service model.

✓ Develop an education and training plan for all health care workers engaged in care for older persons (in community teams and in health facilities) which supports an interprofessional approach to care based on "Care of the Elderly" models.

**Note:** there are references to the Provincial Frail Elderly Program in the Calls to Action for both Community Teams and Hospital Services in chapter 9.

# An Integrated Continuum of Care

**Action 8.2:**
Implement and support an integrated continuum of care to improve the effectiveness and efficiency of care delivery, improve health and social outcomes for older adults and older adults with disabilities, and support older adults to age in place with dignity and autonomy.

## Background

The continuum of care for older adults is an approach that considers the main social and health supports needed as people age. The continuum starts with self-care and considers the impacts of the social determinants of health (SDH) of the person in the home and the community. It goes on to include acute medical treatments, rehabilitative and supportive care, supported living arrangements for those whose capacities decline as they age, and end-of-life care.

Benefits of a continuum of care include the provision of a defined pathway around which services and supports can be organized and delivered and the identification of transition areas between care levels or settings. Built into the concept of a continuum is also an assumption that there is integration of the care provided and the providers who deliver it.

Older adults in Newfoundland and Labrador want to be able to age as safely and as independently as possible in the place of their choosing.[31] Yet, in our province, our current system is centered around a disease-based model of aging focused on episodic care in acute care centres. There is very little integration, and transitions between care types and settings are not well supported.

There is an urgent need to shift direction from acute, episodic care to integrated models and create system changes to enable and support older adults to live in their homes and communities.[32] A comprehensive, coordinated, person-centered

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[31] Office of the Seniors' Advocate Newfoundland and Labrador. (2019, September). *Long May Your Big Jib Draw: Setting Sail*. https://www.seniorsadvocatenl.ca/pdfs/LongMayYourBigJibDrawSettingSail2019.pdf.

[32] Ibid.

system of care rooted in respect and choice is required to meet the diverse needs of older persons when cared for in the community, hospital, in personal care homes and long-term care homes, or during end-of-life care.

These changes will lead to better health outcomes, more appropriate utilization of health resources, and reduced presentation and admissions to acute care centres and placement in long-term care facilities.

## Objectives

✓ Enhance the availability of home support which includes support for those who need help in the activities of daily living by addressing the barriers to access.

✓ Integrate allied health professionals trained in caring for the elderly into community teams.

✓ Make available appropriate rehabilitation, restorative, respite, and end-of-life care options.

✓ Implement a person and family-centered care philosophy and an approach that is based on wellness and on building and maintaining people's physical and mental function and capacity.

✓ Establish certified senior friendly emergency departments.

✓ Establish a defined Home First policy approach to care of the seniors that can be implemented throughout the province.

✓ Ensure early acute care discharge planning that includes the person and their family, and the supports necessary for the transition back to community.

*continued...*

## Objectives (continued)

✔ Ensure that care providers are supported by an inclusive and integrated health information system (HIS) from the moment individuals are admitted to health care facilities.

✔ Ensure the availability of longer-term residential options when care at home or individualized community care is no longer an option. Such options must be designed in accordance with the principle of the fundamental link between quality of care and quality of life and with the support of interprofessional teams.

✔ Support transitions through levels of care and care settings with trained patient navigators.

# Addressing Ageism and Building Age-Friendly Communities

**Action 8.3:**
Take immediate steps to identify and respond to the ageism in our province, including support for the development of age-friendly communities that enable Newfoundlanders and Labradorians to age positively.

## Background

In a 2019 report, the Seniors' Advocate for Newfoundland and Labrador noted that "Seniors—all people in fact—want due respect and recognition. While most negative 'isms' like sexism and racism are globally denounced, ageism is too often regarded as less serious." The Advocate goes on to say that "Seniors are

concerned about being marginalized and feel that too often negative stereotypes about aging taint perceptions, especially amongst youth."[33]

Ageism is defined as prejudice or discrimination on the grounds of a person's age. It is often systemic. Ageism can appear in multiple areas of everyday life and includes discriminatory practices in retail, marketing, the workplace, health care, social programming, etc. This discrimination can have serious negative impacts on an individual's well-being and can directly impact their health.[34]

The first steps in addressing ageism are (i) acknowledgement that it exists, and (ii) provision of education about the stereotype, including education at the early school age level. The next step is to ensure that the knowledge is then translated into action at an individual, community, and provincial level.

The *Age-Friendly Newfoundland and Labrador Communities Program* assists communities in Newfoundland and Labrador to support changing demographics by developing and implementing policies and plans, undertaking projects that enable residents to age in place, and facilitating the creation of age-friendly communities. It has been adopted in some areas of the province and is working well in these areas. It is acknowledged, however that many communities in the province have limited resources and are challenged even to provide basic services. Additional supports and resources are necessary for the expansion of this program. Education is required for community leaders and planners on how to integrate age-friendly and universal design principles into existing planning mechanisms and tools.

The World Health Organization (WHO) has identified eight domains to truly define an age-friendly community: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services. This framework can assist communities in beginning this important work.[35]

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[33] Ibid.

[34] What is Ageism. (n.d.). Ageism. https://www.ageism.org/what-is-ageism/.

[35] World Health Organization. (2007). *Global age-friendly cities: a guide*. https://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf.

**The 8 Domains of Age-Friendly Communities (Adapted from the WHO).**

transportation

respect and
social inclusion

communication
and information

outdoor spaces
and buildings

**8 Age-Friendly Community Dimensions**

community support
and health services

social
participation

civic participation
and employment

housing

## Objectives

✓ Ensure a non-ageist culture of caring approach in health care.

✓ Mandate a sustained age-friendly lens in municipal/community planning activities.

✓ Apply universal design principles for developing Age-Friendly Communities.

✓ Identify teams/champions across communities to complete age-friendly needs assessments and support implementation activities.

✓ Increase the number of age-friendly assessments for the completion of community action plans.

*continued...*

## Objectives (continued)

✓ Increase alignment of government funding and policy for municipalities and community organizations to support age-friendly practices.

✓ Establish targeted development programs for volunteers who support older people in their communities.

✓ Establish an award/incentive program for communities who are actively becoming more age-friendly.

✓ Incorporate local businesses into age-friendly planning at the community level.

✓ Optimize the use of electronic portals to support community teams and others to share best practices and lessons learned in becoming age-friendly.

## Progressive Aged Care Legislation, Regulation, and Policy

**Action 8.4:**
Develop and implement provincial legislation, regulation, and policy required to provide appropriate, quality, and accessible care and protection for older persons in Newfoundland and Labrador.

## Background

It is acknowledged that there has been much success in some areas of care for older persons in our province. But, as the number of older persons continues to rise, particularly the frail elderly, the system is becoming increasingly stressed, and inconsistencies in care, access issues, silos, issues with the quality of care provided, and costs are growing.

Improving the health status of older persons in our province requires the commitment of many people across and throughout the health and social system, and successful partnerships with communities, community organizations and Indigenous governments. It also requires the right legislative, regulatory, and policy structure to ensure consistent and standardized action and accountability mechanisms necessary to keep moving forward.

Newfoundland and Labrador is one of the few provinces without legislation specific to long-term care or care of the elderly. Services throughout the province have been managed through regulation and policy, some of which are now outdated (e.g., Personal Care Home Regulations), or have not been implemented consistently across the system (e.g., the Home First philosophy). In other areas (e.g., home support), new regulations and accountability agreements with agencies are required to effectively manage the service and support the individuals providing the care. Many of these updated policy and regulatory areas are under development by the Department of Health and Community Services (HCS) and must be advanced in a timely manner.

With respect to health-related financial supports for older persons, it is important to note the Canada Health Act clearly provides supportive funding for care related to physicians and hospitals. However, it does not provide comparable supports for many allied health practitioners, other private providers (e.g., dentists), important vaccinations for seniors, services in the community in general, and assistive equipment that can help individuals age in a setting that is most appropriate for them.

> **"**
>
> **Enable people to be and do what they have reason to value.**
> *– World Health Organization*

## Objectives

- ✓ Develop and implement new legislation to enshrine the rights of older adults and establish an accountability structure for an integrated, transparent, and coordinated approach to quality care.

- ✓ Develop a modern legislative framework (Act and regulations) for home care, supportive housing for seniors, personal care homes and long-term care facilities.

- ✓ Update home care, personal care home and long-term care facilities policies to support the new legislative framework.

- ✓ Explore options with current residential providers to address unmet residential needs of seniors.

- ✓ Broaden vaccination, pharmaceutical, dental, vision, and foot care coverage for older adults.

- ✓ Develop and implement policies to address limitations imposed by the Canada Health Act on long-term care.

- ✓ Fully implement the Provincial Home First Policy in a coordinated manner with community teams.

- ✓ Fully implement a policy for the completion of Advance Health Care Directives (defined by the province's Advance Health Care Directives Act, 1995).

- ✓ Work with the federal government to better support services currently outside the Canada Health Act for seniors.

- ✓ Include a lifespan approach in legislation, program, and policy development.
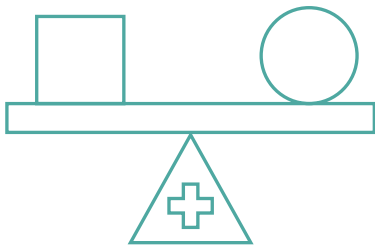
**9**

# Rebalancing the Health System

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**
THE REPORT

Our existing health system was designed for a younger population with more episodic acute illness. The population of Newfoundland and Labrador has an older population, living longer and with more chronic illness. While the population of the province has always been distributed across a large and diverse geography, the technologies we have today enable new ways of linking patients/clients/residents and health care providers. We have grown in our understanding of the connections between social, economic, and environmental factors in influencing our health. All these reasons combined challenge us to rebalance our health system in ways that strengthen its role in improving health outcomes and health equity.

In this chapter, we explore the rebalancing of the health system through the establishment of province-wide community teams, the strengthening of hospital services, and the creation of a provincial integrated air and road ambulance system. Key to all domains of care is the central role of interprofessional team-based care.

**community teams**          **hospitals**          **air and road ambulance**

> **The collaborative team model is an excellent model. It will support both the community and the health care workers that are part of the team. Recruitment for positions should stress the importance of working in a team and looking for people with that skill.**
>
> *— Engagement series 5 survey participant*

## Section One: Community Teams

### Direction Statement

**Every person in Newfoundland and Labrador will have timely access to social and health services, and to continuous care centered in the community as part of a well-connected network. This structure will be enabled and strengthened by interprofessional teams working collaboratively with individuals and their families and focusing on all aspects of health and wellness.**

# Calls To Action

## Community Teams

**Action 9.1:**
Connect every resident of Newfoundland and Labrador to a community team providing a central touchpoint of access and a continuum of care.[36 37 38]

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[36] The importance of team-based care cannot be overstated. The following references are examples of how this approach to care is now the standard in all domains of care. Additional references may be found in the Health Accord report entitled *Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Evidence.*

[37] The College of Family Physicians of Canada. (2011, September). *A Vision for Canada, Family Practice, The Patient's Medical Home.* https://patientsmedicalhome.ca/files/uploads/2014/07/PMH_A_Vision_for_Canada.pdf.

[38] Newfoundland and Labrador Medical Association, Memorial University Faculty of Medicine, Newfoundland and Labrador College of Family Physicians. (2018). F*amily Medicine in Newfoundland & Labrador - A Ten Year Vision.* https://nl.cfpc.ca/wp-content/uploads/2018/06/Family_Medicine_in_NL_-_A_Ten_Year_Vision.pdf.

## Background

Currently, up to 20% of residents of NL have no access to a family physician (FP), and many more lack timely access. The health system is fragmented, uncoordinated, and difficult to navigate. Providers are working in silos and expressing burn out. High turnover rates of providers lead to lack of continuity of care and high costs to the system to support locum coverage. More primary health care providers and an integrated approach that includes social supports and services are urgently needed to support the population and the vision of community teams across the province.

Such an approach will go a long way towards building the Provincial Frail Elderly Program outlined in chapter 8 with its focus on helping frail elderly persons remain healthy and living in the community—true integrated care for older people.

Team-based care has been shown to improve continuity of care, improve timely access, improve chronic disease management and health outcomes, improve provider satisfaction and work-life balance, and reduce emergency department visits, hospitalizations, and entry to long-term care. Building and strengthening community teams is an essential starting point for transformation of our rebalanced health system.

Introducing a blended capitation model for FP payment would be foundational in developing this new approach to community teams.

## Objectives

✔ Create approximately 35 community teams in Newfoundland and Labrador within the next five years to provide patient-centered, comprehensive community care with providers working to the full scope of their practice.

✔ Provide care by a community team to a population base of 7,000–8,000 and upwards, with special arrangements for more isolated communities.

*continued...*

## Objectives (continued)

✓ Ensure that team size and composition are based on the health and social needs of the local population.

✓ Ensure the integration of FPs, nurse practitioners (NPs), nurses, and allied health professionals from various regional health authority (RHA) community programs including Community Support, Community Mental Health and Addictions, Community Care, and Public Health. Included will be mental health providers, occupational therapists, physiotherapists, chiropractors, dietitians, social workers, and other providers (both public and private), elder care workers, pharmacists, and patient navigators joining together to form community teams, while removing the silos of our current system.

✓ Build on the existing structure of community primary care in the province, recognizing the excellent work and deep longitudinal relationships in primary care between FPs, NPs, and their patients/clients.

✓ Include in the integration process new arrangements to connect existing providers and practices in the community (both publicly funded and privately funded) with providers in the RHAs so that the current barriers to team-based care are removed.

✓ Roster patients/clients to a core primary care provider within the community team to coordinate care. Rostering of patients/clients must always allow for personal choice with respect to a person's health care provider.

*continued...*

## Objectives (continued)

✓ Establish a Provincial Health and Social Workforce Planning Strategy including coordinated recruitment and retention of community care providers within the community teams with the goal of ensuring that every person can be attached to a comprehensive primary care provider and has timely access to primary care.

✓ Connect community teams with patients/clients, families, schools, and community organizations.

✓ Support advanced access and after-hours access for community care (this may be a shared responsibility between multiple teams and family practice clinics).

✓ Ensure that community teams are included in the overall evaluation framework for the Health Accord.

# Coordination of Care

**Action 9.2:**
Improve coordination of care across the health and social systems by enhancing communication and system navigation.

## Background

Our health and social systems are disconnected, siloed, and often program-based. Navigation of this complex system is challenging for both providers and patients/clients/residents, creating inefficiencies and duplications in care, yet significant gaps remain. Inefficiencies mean that we are not getting all the possible

benefits from the resources that are being used in their current manner or that we could achieve our current services in a way that uses fewer resources or less money.

Navigation is especially difficult for the aging population, those with disabilities and complex needs, and under-served groups. Under-served populations include, but are not limited to, those with physical and intellectual disabilities, housing challenges, and mental health and addictions challenges, as well as the 2SLGBTQIA+ population, children in care, and the aging population. Coordination of care must be seamless and integrated, especially at transitions of admission and discharge when patients are extremely vulnerable.

We heard countless examples of the challenges facing people in the province in their attempts to access care:

▶ Patients/clients having to travel long distances for multiple appointments due to lack of coordination

▶ Reports not being available to providers at the time they are needed

▶ Patients with multiple emergency department visits without the FP ever being contacted

▶ Community assessments for home care or long-term care placement with records inaccessible to other team members

▶ Patients/clients and providers with no idea how to find or access the supports that they need

▶ Longer hospital stays due to lack of coordinated discharge planning and community supports to prevent readmission

Coordination of care is impeded by ineffective communication and lack of information sharing. Our information systems (hospital-based information system, primary care electronic medical records, and community-based record management system) do not connect with each other. This creates gaps and lack of coordination between hospital and community, among health professionals, and with the patients/clients and families themselves. Teams must have access to all pertinent patient/client information and community/population-level data through digital technology solutions to plan teams and enable shared care.

**Objectives**

✓ Establish the position of a care coordinator/patient navigator in every community team.

✓ Establish touchpoint access (any moment where a patient/client interacts in some way with the service) for patients/clients and families to direct them to the right care at the right time with the right provider.

✓ Establish a communication platform to enable collaboration where team members and their roles are easily identified and accessible.

✓ Develop a web-based platform that includes learning pathways for education around team-based care, quality improvement, and change management.

✓ Ensure that teams are digitally connected (see chapter 10 for more detail).

✓ Enable community groups, non-profit organizations, and community advisory groups to connect to community teams.

✓ Develop an integrated approach to patient engagement within the new community team structure.

✓ Support the change management process, education, and digital infrastructure needed to enable effective communication and sharing of patient/client information as necessary.

✓ Establish communication pathways between hospital and community at intersections of care, especially hospital admission and discharge.

*continued...*

## Objectives (continued)

✔ Establish a centralized and accessible source of information for individuals and family caregivers that clearly specifies available supports and resources.

✔ Connect home care and home support services for residents of all ages and abilities to community teams to enable collaboration.

✔ Prevent gaps and delays in assessment and care for persons with intellectual and learning disabilities.

✔ Enable early evaluation and assessment of children with intellectual and learning disabilities in a more coordinated way between schools and the health system providing year-round connection.

# Health Promotion and Well-Being, Social Determinants of Health, and Chronic Disease Management

**Action 9.3:**
Place greater emphasis on health promotion and well-being, the social determinants of health, and chronic disease management.

## Background

Newfoundland and Labrador has the lowest life expectancy and highest rate of chronic disease compared with other provinces in Canada. The majority of health system funding is focused on treating illness and on hospitals with little attention to prevention, early intervention, social determinants of health (SDH), community care, and social programming. See further detail in chapters 5 to 8.

## Objectives

✓ Enable communities to become healthier through increased support for health promotion and wellness strategies, collaboration, use of existing infrastructure, and social prescribing.

✓ Eliminate gaps in services and supports for students when the school year ends by ensuring schools are connected to community teams so that services and supports are year-round, coordinated, and integrated.

✓ Enable all team members to work to their full scope of practice to address the needs of their catchment population, including preventative care and chronic disease management.

✓ Integrate public health nurses into community teams.

✓ Support models of care which promote self-management and prevention.

✓ Optimize community level partnerships with wellness coalitions, municipal partners, and patient-led self-help groups.

✓ Expand and strengthen disease prevention programs.

✓ Expand preventative dental care with special attention to schools and long-term care settings.

# Improving Appropriateness of Medication Use

**Action 9.4:**
Establish a pharmacist-supported model to improve appropriateness of medication use and continuity of care in the community, long-term care and in hospitals. Support the creation of a National Pharmacare Program.

## Background

Newfoundland and Labrador has among the highest rates of potentially inappropriate medication use and adverse health outcomes. Older adults among community-dwelling and residents of long-term care facilities have very high rates of polypharmacy (the use of multiple drugs at the same time by a single patient, for one or more conditions). Polypharmacy is associated with poor outcomes including falls and impaired cognition (which impede one's ability to age in good health at home), medication-related hospitalizations and increased mortality.

A multipronged approach is necessary to improve medication use at the point of prescribing and dispensing, closer patient monitoring to ensure achievement of optimal outcomes from medication use, proactive interventions to reduce potentially inappropriate or unnecessary medications, and patient support and education to ensure they receive optimal benefit from medications especially as they move through transitions of care.

Community pharmacies are in virtually every community, which presents an opportunity to leverage existing resources and infrastructure to address this issue.

Canada has a fractured approach to pharmacare associated with considerable inequity in access and out-of-pocket payments for drugs. Our country has one of the highest costs for drugs in the world which could be mitigated by a National Pharmacare Program.

## Objectives

✓ Prioritize the addition of pharmacists to community teams who focus on underutilization and overutilization of medications with levels to be determined by roles and responsibilities, sustainability of the model, and the fiscal envelope of the province.

✓ Support the creation of a National Pharmacare Program.

# Health Centres

**Action 9.5:**
Reorganize the services provided at the 23 health centres in the province to reflect population needs by utilizing a principles-based and criteria-based approach.

## Background

The province currently has 23 health centres that provide a mix of primary, emergency, acute hospital, and long-term care. Many sites provide low volumes of services, making it difficult to ensure high quality, sustainable care. It is the intention that the health centres will become integrated into community teams.

Emergency services will be provided by the 13 hospitals in the province, an integrated ambulance service and virtual emergency care. Health centres within 60–90 minutes of a hospital serving catchment populations less than 5,000 people do not need to provide 24-hour emergency care but should provide 12-hour urgent/same-day care. In other health centres, sustainability of 24-hour

FP-based emergency care is a concern particularly on islands, in remote areas, and in regions with small catchment populations. Consequently, collaborative care models linked to virtual care will be necessary.

Improved virtual care, an enhanced and integrated ambulance system, and connections with community teams are essential in rebalancing the role of health centres. See references to health centres in the sections of this chapter on Hospital Services and Ambulance System.

## Objectives

✅ Provide equitable access within an urgent care model in health centres based on distance from a hospital emergency department, geography, size of the catchment population, and availability of providers.

✅ Ensure that health centres distant from a hospital develop collaborative care models linked with virtual care and hospital emergency departments.

✅ Create appropriate linkages in health centres to higher levels of care.

# Occupational Health Clinic

**Action 9.6:**
Create an Occupational Health Clinic with linkages to the community teams.

## Background

It is well recognized that regular employment and one's working conditions affect one's physical, mental, and social well-being. There have been many times in Newfoundland and Labrador's working history when occupational disease has impacted the lives of people and their families in many communities: St. Lawrence, Baie Verte, Marystown, and Labrador City. In 1977, the Baie Verte asbestos miner strike was the first in Canada where the miners took job action not for higher wages but for health and safety issues.

Annually on April 28, the Day of Mourning, WorkplaceNL publicizes the annual numbers of workers who officially died as a result of a workplace incident or illness. Occupational disease is not a problem of the past. A new study by the Occupational Cancer Research Centre in Ontario reports the workplace is responsible for 10,000 cancers each year across Canada. Silica exposure leading to lung cancer was identified as an issue for our province as was diesel engine exhaust.

Many workers develop health problems that may temporarily or permanently prevent them from re-entering the workplace. A minority of these "disabled" workers incur substantial work absences and/or life disruptions that can lead to prolonged and possibly permanent withdrawal from the workforce. For many of these workers, their conditions began as a common problem (e.g., strain, sprain, depression, or anxiety) but escalated to long-term or permanent disability. The American College of Occupational and Environmental Medicine in 2006 recommended: (i) adopt a disability prevention model, (ii) address behavioural and circumstantial realities that create and prolong work disability, (iii) acknowledge the contribution of motivation on outcomes and make changes to improve incentive alignments, and (iv) invest in system and infrastructure improvements.

Workplace NL recognizes that there is a strong need to build more enhanced services to achieve better physical, mental, and social outcomes for injured workers and that the injured worker needs to receive the right help at the right time. This enhanced program would include early identification of injured workers requiring more support, referral to occupational therapy as early as possible, and ongoing communications with FPs and employers.

This process would be enabled by the interprofessional approach in community teams and by an independent Occupational Health Clinic.

This independent Occupational Health Clinic would have a fivefold mandate: an inquiry service to answer work-related health and safety questions, medical

diagnostic services for workers who may have work-related health problems, group service for workplace health and safety committees and groups of workers, outreach and education to increase awareness of health and safety issues and promote prevention strategies, and research services to investigate and report on illnesses and injuries.

Workers, Occupational Health and Safety committees, employers, and unions would use such a resource for advice on addressing chemical, biological, physical, ergonomic, and psychosocial hazards. Such a clinic with its capacity to help identify work-related safety hazards and specific prevention strategies would lead to a reduction in work-related injuries and illness, safer and healthier workplaces, lower employer assessment rates, and an overall reduced health burden. The proposed clinic would be a site for training health professionals in occupational health and serve as a resource for community teams.

## Objectives

✓ Establish an Occupational Health Clinic, funded through Workplace NL.

✓ Create a close link between the Clinic and the SafetyNet Centre for Occupational Health and Safety Research at Memorial University.

The Direction Statement and Calls to Action which follow assume that there is a governance structure for the health system that recognizes and is responsive to local care needs. This will be required to facilitate sustainable systemic change and incorporate an inclusion lens. We must move to an interconnected health system that relies on the sharing of resources and responsibilities to provide high quality, equitable services. Training and continuing education will be needed for physicians, nurses, and allied health professionals who provide the appropriate skill mix to meet the needs of the future health system. System redesign must incorporate an inclusion lens.

## Direction Statement

**Quality hospital services will be delivered through better integrated hub-and-spoke team-based care where all practitioners will be able to fully utilize their skills. The care model will be delivered in collaboration with community services to provide sustainable, appropriate, equitable, and person-focused care that supports the needs of the patients/clients in their communities. Patient/client travel will be minimized by the utilization of virtual technology. When travel is necessary, patients/clients will access an improved and more accessible transportation system.**

# Calls To Action

## A Planned Hospital System

**Action 9.7:**
Establish better integrated, team-based care by arranging hospital service delivery into a network consisting of community, regional, and tertiary hospitals that offer timely access to a full array of services.

## Background

There are presently 13 hospitals in Newfoundland and Labrador, well-distributed geographically across the province. At the present time, the services provided across the range of hospitals do not match the needs of the population in the varied catchment areas and are not sustainable from a human resource perspective. All thirteen are needed to provide the level of care required by the people of the province, including emergency care. They must be positioned to be well connected to each other, and to the community teams within their catchment areas.

The hospitals closest to the communities, referred to as community hospitals, need to be responsive to the needs of the people in these communities to the extent possible given the limitations of geography and sustainability of health professionals. The community hospitals should be well connected to community teams. Emergency services, medicine, basic laboratory testing, diagnostic imaging services, mental health services, elder care including restorative care, and pharmacy support are needed in these hospitals. Specialized services in surgery and obstetrics, where numbers are low, are better provided at the regional level. Exceptions may need to be made for geographically isolated areas of the province.

At the regional level, more specialized services can be provided where the higher volumes of cases encourage highly trained health professionals in specialized

disciplines to remain. These hospitals are referred to as regional hospitals. Given the increasing number of older people in the province, there is a need to add specialized geriatrics care to regional hospitals. The regional hospitals will provide stroke care and restorative care as well as consultation support for community hospitals and community teams to ensure appropriate follow-up care and to address prevention of frailty among older members of the communities. These services will be offered by establishing regionally based centres of excellence for geriatrics.

Tertiary care[39] is centered in St. John's in what is referred to as the tertiary hospital. Given the small population and rural nature of the province, tertiary care must be extended throughout the province, using virtual care and outreach specialty clinics.

Hospitals closest to the communities, regionally-based hospitals, and the tertiary hospital must be better connected, supporting each other.

In the realignment of health services, it will be important to consider the impact on people who will have challenges related to transportation, including poverty and accessibility. Transportation in this context is understood broadly to include ambulance services, public transportation systems, and the Medical Transportation Assistance Program (MTAP).



Home    Community Team    Health Centre

Community Hospital    Regional Hospital    Tertiary Hospital
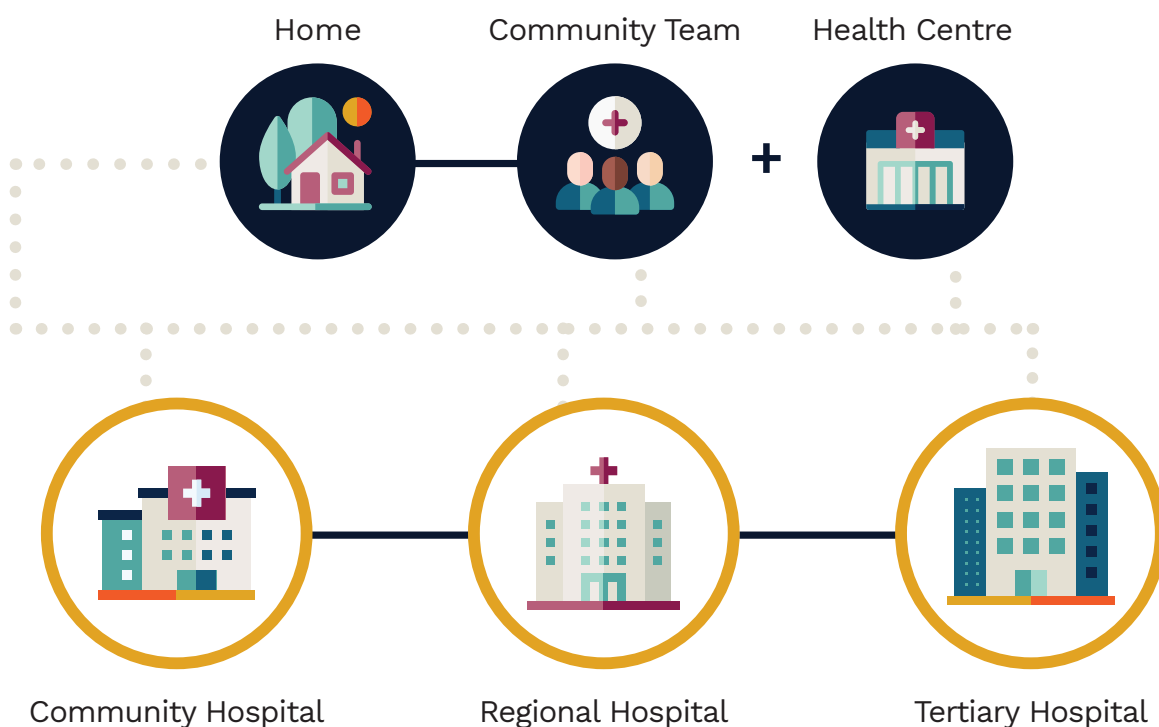
[39] Tertiary care is the level of care in the health system that consists of complex procedures given in a health care centre that has highly placed specialists and advanced technology. Examples include cardiac surgery, neurosurgery, cancer care, plastic surgery, and burn treatment.

## Objectives

✓ Organize the hospital system into three levels of care delivery:

**1. Community Hospitals**
These hospitals provide a full spectrum of services up to and including lower complexity acute care and ambulatory/outpatient care provided by FPs, nurses, allied health professionals, and some visiting specialists. These services include medicine, basic laboratory testing, diagnostic imaging services, mental health services, elder care including restorative care, and pharmacy support. The community hospitals provide emergency care 24/7 for the local population. Some community hospitals provide select specialty services in surgery and obstetrics as appropriate and sustainable.

There are seven community hospitals in the province—in Burin, Carbonear, Clarenville, Stephenville, St. Anthony, Happy Valley-Goose Bay, and Labrador City.

**2. Regional Hospitals**
These hospitals provide a full spectrum of services up to and including secondary acute and ambulatory/outpatient specialty services primarily by generalist specialists (e.g., general surgeons, general internal medicine specialists, obstetricians, psychiatrists) with family physicians and some visiting subspecialists, as well as appropriate nursing and allied health professionals. They also provide centres of excellence for elder care provision as well as consultation support in geriatric care for community hospitals and community teams. And they provide care for emergencies 24/7 for the local population, with escalation of care when required.

There are three regional hospitals in the province—in St. John's, one hospital on two sites (without unnecessary duplication of services) in central Newfoundland, and in Corner Brook.

## Objectives (continued)

### 3. Tertiary Hospital

The tertiary hospital provides a full spectrum of services up to and including tertiary acute and ambulatory/outpatient subspecialty services primarily by subspecialists with specialists and FPs, as well as appropriate nursing and allied health professionals. It has capacity to manage complex trauma and provide a full range of time-critical emergency medical services 24/7.

The tertiary hospital is in St. John's with programs reaching out across the province through travelling clinics and virtual care technology.

✔ Ensure standardization of hospital services.

✔ Implement best practices for care provision (e.g., senior friendly emergency departments, stroke care). See the section on a Comprehensive Provincial Frail Elderly Program in chapter 8.

✔ Ensure baby friendly obstetrics units.

✔ Ensure the skill mix of health professionals appropriate for the level of services provided.

✔ Establish procedures for transfer and return of patients/clients/residents to the referring hospital.

✔ Develop a Centre of Excellence on Aging[40] in the regional hospitals in Central Health (CH) and Western Health (WH) with a geriatrics team, a stroke care unit, restorative care, a focus on reducing alternate level of care use, and partnerships with other health facilities and community teams in the region.

✔ Ensure appropriate wait time objectives are established, monitored, and pursued as a key part of the reorganization of hospital services.

[40] In the Eastern Health region, the programs at the Miller Centre and the Acute Care of the Elderly (ACE) Strategy at St. Clare's Mercy Hospital provide these functions. It is the expectation that all the Centres of Excellence on Aging will be linked with the Aging Research Centre-Newfoundland and Labrador. ARC-NL is located at Memorial University's Grenfell campus with a mandate to create a provincial network of researchers studying late life issues in Newfoundland and Labrador, prioritizing knowledge mobilization and engagement with older adults.

# Location of Services

**Action 9.8:**
Realign core specialty health services in facilities to match the current and future needs of the population in the province to enhance continuity of care based on the changing needs in the community and on the changing demographics.

## Background

With the declining and aging population in rural Newfoundland and Labrador, utilization of specialty services is decreasing in rural facilities. Maintaining specialty services in locations with low volumes of patients/clients/residents and one to two specialists on the call schedule is difficult to sustain from a recruitment and retention perspective and requires the use of locums. These situations create provider burnout, high levels of turnover, and instability at the site. Provider teams must have adequate numbers to allow for reasonable on-call frequency even when vacancies may occur.

### Objectives

✔ Realign services in health facilities to match the current demography of the population and health needs, utilizing criteria of population, numbers of people in the catchment area with specific health needs, distance and travel time, and sustainability of health professional teams.

✔ Deliver medical services in a timely manner, using innovative methods and models.

*continued...*

## Objectives (continued)

✔ Deliver care at the right place, at the right time, with professionals working to their full scope of practice and supported by an interprofessional team in a new model that reflects the needs of each catchment area.

✔ Develop a hub of medical specialists, working to their full scope of practice, in strategic locations that provide service to facilities through regular and travelling clinics and virtual care. The outreach specialty services will be provided to facilities to serve the needs of the communities in that region.

✔ Align the number of acute care beds over time in facilities across the province with a target occupancy of 85%, length of stay near the comparable Canadian average, and decreased use of alternate level of care (ALC) (see Action 8.1).

✔ Before services are realigned, make needed investments in the establishment of community teams, improved emergency transportation, and enhanced information systems, including virtual care.

✔ Ensure those members of the public are engaged in the process to finalize decisions about realignment.

"

I am generally satisfied with the health care that I have received, but for me and most people, the lack of integration and coordination, and particularly wait times leave a good deal to be desired.

*— Engagement series 4 survey participant*

# Janeway Hospital Services

**Action 9.9:**
Optimize the utilization of the Janeway Hospital, by improving access to pediatric services, by creating linkages with community teams for vulnerable children and youth province-wide, and by incorporating Women's Health.

## Background

In 2001, at the time the current Janeway Hospital was opened, Newfoundland and Labrador's population comprised almost 130,000 people under the age of 20. Since then, the population of children and youth in the province has decreased by over 26% to under 95,000. As of 2019/20, the Janeway has reduced the number of beds to 72 but still maintains an occupancy rate of only 55.6%.

Despite the decreasing size of the child and youth population, there are often long wait times to receive services, most notably in speech language pathology, autism, and occupational therapy.

### Objectives

✓ Optimize the utilization of the Janeway services to ensure children receive timely access to appropriate care.

✓ Provide a provincial program that provides integrated, interprofessional care for children and youth with complex health needs and those who are in out-of-home care.

*continued...*

## Objectives (continued)

✓ Design a seamless transition from youth to adult care.

✓ Incorporate Women's Health into the Janeway Hospital acute care beds.

# Pathology and Laboratory Medicine

**Action 9.10:**
Establish pathology and laboratory medicine as a provincial networked service based on hub-and-spoke modelling.

## Background

Sustainable, high quality and efficient pathology and laboratory medicine services provide accurate and timely test results and contribute to safe and cost-effective health care.

Pathology and laboratory medicine consumes less than 5% of health care expenditures but influences most clinical decisions and impacts downstream health care costs.[41] The present system is challenged by excessive and costly testing equipment; regional differences in practices, processes, and quality; excessive per capita spending compared with Canadian norms; inadequate access to testing at rural and remote settings; inadequate specimen transport infrastructure; and both overuse and underuse of available tests.

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[41] Naugler, C., Wyonch, R. (2019). *What the Doctor Ordered: Improving the Use and Value of Laboratory Testing*. C.D. Howe Institute Commentary 533; ISBN: 978-1-987983-92-0. http://dx.doi.org/10.2139/ssrn.3338061.

Sustainability is challenged by difficulties in recruiting front-line workers in this area, including medical laboratory technologists, and is impacted by shortages across Canada. Sustainability depends on a robust system that evolves with changing service needs.

Given the nature of pathology and laboratory medicine services today, it is possible to use a hub-and-spoke model in our province with centralization of core routine services to three regional hubs, core routine inpatient services to the seven community hospitals and the second hospital in CH, and dissemination of point-of-care technologies to rural and remote sites.

## Objectives

✓ Improve pathology and laboratory medicine service to achieve greater sustainability, efficiency, quality, and safety by establishing:

  ◇ A provincial management structure.
  ◇ A laboratory test formulary which provides an up-to-date and searchable registry of orderable laboratory tests and laboratory test information.
  ◇ Modernized specimen transport system.
  ◇ Centralization of core routine services to three hub sites for the regions.
  ◇ Continuation of core routine inpatient services to the other eight hospitals.
  ◇ Dissemination of point-of-care technologies to rural and remote sites.

✓ Assign oversight and accountability for service quality to pathology and laboratory medicine specialists.

# Keeping Care Close to Home

**Action 9.11:**
Enhance care across the continuum to ensure that access to appropriate and high quality care and service is available to patients/clients/residents in the most appropriate setting and to minimize the need to travel to obtain appropriate services, or receive timely or affordable care.

## Background

Much care that is provided in hospitals and health centres in Newfoundland and Labrador, including in acute, ambulatory, and emergency settings, could be provided appropriately if delivered in the community or in other settings closer to home.

Across the province, there is high occupancy with high ALC in acute care hospitals in Gander, Grand Falls-Windsor, Corner Brook, and Happy Valley-Goose Bay. The reasons for ALC include awaiting long-term care placement, awaiting home supports, needing end-of-life care, awaiting rehabilitation services, and awaiting personal care home placement. Since most patients/clients in an ALC are seniors, this issue will likely persist as the population of seniors in the province increases.

There is a high volume of emergency department visits and ambulatory care clinic visits in the province. Most of these visits do not require emergency care or ambulatory care in a hospital setting and could be more appropriately addressed in the community.

## Objectives

- ✓ Create a new model of care for vulnerable older adults across the continuum.

- ✓ Develop robust, standardized admission, discharge, and transfer planning processes in hospitals.

- ✓ Support care planning and case management of older adults in acute care.

- ✓ Develop the appropriate linkages to community teams and community hospitals to provide accessible and enhanced community/primary care (e.g., chronic disease management, mental health supports).

- ✓ Mobilize visiting specialists and well-coordinated virtual care with specialists in the regional and tertiary hospitals.

- ✓ Enhance emergency departments with appropriate skill mix and best practices.

> " I think re-evaluating and spreading out the services offered at the primary, secondary and tertiary levels is a good thing. Everyone naturally wants everything close at hand but based on actual NEED rather than aspiration is a good way to go. The collaborative concept of community teams is the backbone of this new system and I think that is a good way to go.
>
> *– Engagement series 5 participant*

## Setting the Standards for Provincial Acute Care Services

**Action 9.12:**
Develop explicit statements of system processes and expected standards of care to ensure integrated and accessible clinical program services delivered in a comprehensive, province-wide system.

### Background

Currently, there is limited provincial acute care policy. There are many clinical services that cross geographic service lines, without a provincial utilization approach to maximize access, efficiency, and sustainability.

An overarching set of provincial standards must be developed to provide guidance for quality service delivery and reduce unnecessary variation in service provision across the province. These standards will facilitate system cohesion, reduce system gaps in transfer of care, and support high-quality service.

Standards would include foundational concepts such as admission, transfer, and discharge processes which are relevant to all acute care health services. Additional Provincial Clinical Program Standards should be developed to define the key service components to be achieved through clinical care pathways.

Such standards should ensure that care delivery is people-centered, with respect to and consideration of culture, unique needs, and rights.

## Objectives

✔ Develop and implement acute care standards (linked to standards for other services) that include:

◇ A people and family-centered philosophy.
◇ Care provision by interprofessional teams across the continuum.
◇ A framework and classification system to define acute care services, including:
  • Definitions of a standardized measurement of an acute care bed;
  • Levels of service and care model delivery standardization.

✔ Develop provincial standards and programming based on the best available information regarding effectiveness and/or best practice, and system stakeholder engagement. Include process and outcome measures to monitor performance and impact on relevant health outcomes, to be utilized for continuous quality improvement.

✔ Develop bed management processes across health authorities to ensure interregional clinical efficiencies and to ensure equitable access.

✔ Link provincial and program standards to a province-wide accountability structure.

# Digital Technology Requirements for Hospital Services

**Action 9.13:**
Renew hospital services by improving coordination and flow of health and social system information between hospitals and the community and by maximizing the use of integrated digital technology and information systems.

## Background

Modern digital tools and techniques such as virtual care, interoperability and integration, and clinical decision support will be key enablers to strengthening hospital services. Currently, however, many of our core health information systems (HIS) (e.g., Meditech, the Client and Referral Management System) are antiquated, incomplete, and disconnected. This has meant a continued reliance on paper-based records and manual processes (e.g., mail, fax) for conveying information across care settings and services. In many instances, important patient/client/resident information is simply unavailable at the point-of-care, resulting in information gaps, poor coordination, and delays in care.

Enhanced digital technology will support the renewal of hospital services in terms of coordination with other parts of the health system, extending access to services geographically, and providing standardized, high-quality care.

## Objectives

✓ Eliminate information silos and allow the seamless flow of care information.

✓ Improve access to critical and emergency care and specialty services.

✓ Empower citizens with online access to their own health information and self-serve functions.

✓ Leverage software and data to support and enforce standards for clinical practice and documentation, and to drive continuous quality improvement.

See <u>chapter 10</u> for more detail on digital technology.

## Improvements in Provincial Programs for Cancer, Cardiac Care, and Stroke

**Action 9.14:**
Develop and implement a five-year plan for improvement in mortality rates for cancer, cardiac disease, and stroke over the next 10 years, led by the provincial programs for these disease entities.

## Background

Age-sex standardized cancer mortality rates for men and women in Newfoundland and Labrador are the highest among the ten Canadian provinces, cardiac mortality is the second highest, and stroke mortality the third highest. These adverse health outcomes are the result of social, economic, environmental, and behavioural factors. Outcomes of care in the three clinical areas are not optimal. Eastern Health's (EH) tertiary cardiac service was not designed to optimize flow and outcomes and is dominantly a hospital-based delivery model. Endovascular therapy (EVT) for ischemic stroke is not yet available in the province.

Communication with the three programs confirms that areas in need of change include transportation, integration from community to each level of hospital, connections through virtual care and outreach, quality, and accountability.
In the Cancer Care Program, successes have been obtained in smoking cessation programs, collaboration with Indigenous peoples, use of data, patient navigators, and early integration of palliative care.

Clinical data are essential for quality improvement. The Cancer Care Program has good data acquisition, but information across the stroke care continuum is needed. The Cardiac Care Program uses the APPROACH database.

Newfoundland and Labrador has the highest rate of end-stage renal disease in the country and the lowest use of home dialysis, relative to hospital-based dialysis. Consistent efforts to increase the use of home dialysis are necessary.

### Objectives

✓ Create a Cardiac Centre of Excellence to provide an organized hub of tertiary services within a spoke network enabling equitable access to cardiac care.

✓ Organize infrastructure and processes for expanded ambulatory access to cardiac care.

*continued...*

## Objectives (continued)

✔ Start a Provincial Stroke Care Program that follows quality standards for value-based care as part of a learning health and social system.

✔ Provide better stroke care across the continuum: early recognition by the public of symptoms indicating stroke, improved thrombolysis rates, initiation of EVT in ischemic stroke, regional stroke units, rehabilitation, and reintegration with community teams.

✔ Enhance a culture of quality through use of program specific data with a focus on improving health outcomes. Develop an information management system to measure performance and outcomes across the stroke care continuum.

✔ Engage in an aggressive prevention program in oncology, cardiology, and vascular disease, including secondary stroke prevention.

✔ Optimize and develop cancer screening programs, particularly focused on groups at high risk.

✔ Improve access to cancer and cardiovascular care across the province, including interventions at the regional level, better and more coordinated virtual care, more visiting specialists, and better coordinated patient tertiary care visits (including transportation and clinical care).

✔ Support existing efforts to increase the use of home dialysis with a focus on patient recruitment, consistent processes involving physicians and nurses, and a well-designed and consistent education approach.

✔ Engage with air carriers to determine the feasibility of scheduled flights from Labrador and the west coast of the Island to bring patients to St. John's for tertiary services.

# ⏩ Call To Action

## Provincial Integrated Air and Road Ambulance System

**⏩ Action 9.15:**
Design one provincial, modern, integrated air and road ambulance system with a central medical dispatch. The system must have triage capacity and must utilize dynamic deployment to function as a mobile health system. The system must be linked with virtual emergency care and advanced care paramedicine to enable patients to begin receiving emergency care in their homes or wherever they initially experience the emergency while facilitating rapid access to a hospital emergency service, provide community paramedicine, and access appropriate non-emergency transportation.

## Background

The current air and road ambulance system in Newfoundland and Labrador is neither modern nor integrated, nor does it provide value or quality for the resources that are utilized in its delivery. There are many independent players and, for the resources provided, the resulting outcome is not of the highest quality.

The following quote from the August 2013 Fitch and Associates, LLC report, entitled *Newfoundland and Labrador Ambulance Review*, remains true today as the system has not been dramatically transformed in the way this report recommended: "Despite the increased investment, the Newfoundland and Labrador Ambulance Program has not reached its full potential as a high-performance emergency ambulance service that consistently and predictably delivers clinical excellence, response time, reliability, economic efficiency, and patient/customer satisfaction."

"

**Road and air Ambulance are in a mess and it's not all to do with money and training. Paramedics with very poor working conditions, pay, etc are not staying in the system. Road and air ambulance systems need a major overhall immediately**

*– Engagement series 3 survey participant*

The Department of Health and Community Services (HCS) has primary legislative, regulatory, and funding responsibility through the Emergency and Paramedicine Services Division. This Division is responsible for provincial standards and policy, funding administration, paramedic registration, and the Office of the Provincial Medical Director.

*Road Ambulance*: There are 60 road ambulance operators (13 RHA-based, 25 private, and 22 community) completing approximately 80,000 patient transports per year. RHAs provide service for 13 areas of the province while 25 private sector operators provide ambulance services from 45 bases throughout the province. RHA services complete 55% of transports with other providers completing 45%. EH has a modern Central Medical Dispatch Centre that dispatches calls for Metro St. John's and Carbonear (one-third of all provincial calls).

*Air Ambulance*: Government policy is to provide two air ambulance bases 365 days per year, 24/7, one in St. John's (staffed 24 hours per day) and one in Happy Valley-Goose Bay (staffed 14 hours per day). Government provides the funding and manages aviation assets for the air ambulance program. EH manages the day-to-day operations and provides the medical personnel for air ambulance missions. The medical flight staff who are employed by EH are stationed in two locations: St. John's and Happy Valley-Goose Bay. The program currently uses four fixed wing aircraft. Government Air Services, under the Department of Transportation and Infrastructure, provides two King Air 350 aircraft. The other two aircraft are supplied via contracts established with aviation partners, Exploits Valley Air Services and Provincial Airlines.

Labrador-Grenfell Health (LGH) separately manages a contract with Air Borealis for two twin otter aircraft for coastal Labrador patient transportation medevacs and scheduled transport (*schedevacs*). This contract is for medical flight availability with a back-up also available. Response times for first response and second aircraft differ. HCS contracts professional air ambulance services for one-off out-of-province flights to locations such as Toronto, Montreal, and Halifax. Government departments share in a Canadian Helicopter contract for rotary wing aircraft.

While paramedics working in acute care are invaluable in emergency response, paramedics working in community paramedicine programs indicate a relatively new and evolving health care model. This model would allow paramedics to operate in expanded roles by assisting with public health and primary health care and preventive services to underserved populations in the community. Paramedics working in community medicine programs would be members of the community teams. The goals are to improve access to care and to avoid duplicating existing services.

## Objectives

- ✔ Design and implement a modern, integrated air and road ambulance system for Newfoundland and Labrador.

- ✔ Support training, recruitment, and retention within the road ambulance system that would have a solid skill mix of advanced care paramedics and primary care paramedics.

- ✔ Create one Central Medical Dispatch System for the whole province.

- ✔ Establish one Provincial Air Ambulance System that would include bases in St. John's and Happy Valley-Goose Bay, *medevac* services for Labrador, helicopter services which fly 24/7, and one-off out-of-province flights.

    *continued...*

## Objectives (continued)

✔ Establish services centered around a strong provincial non-emergency transportation system, enabling emergency ambulances to be freed up for emergency calls. In consultation with Indigenous partners, consider if *schedevac* services in Labrador should become part of the non-emergency provincial transportation system.

✔ Solidify management expertise and electronic systems which support the integrated air and road ambulance system.

✔ Develop a virtual emergency system with physicians and nurse practitioners (NPs) to improve access to emergency care in more rural settings.

✔ Provide public oversight of the integrated ambulance system.

✔ Provide community paramedic services in areas such as seniors' wellness assessments and palliative care, resulting in fewer emergency department visits and more efficient use of road ambulance resources.

✔ Link community paramedicine with community teams.

# Call To Action

**Action 9.16:**
Begin action immediately on initiatives needed to rebalance the community, long-term care, and hospital system.

## Background

There is agreement among stakeholders that integrated interprofessional teams are necessary in the community, in the long-term care sector, and in hospitals to assure sustainability. However, some interventions need to be in place before other interventions can be implemented.

Consequently, short-term, medium-term, and long-term plans are necessary. Current problems with access to primary care, interprofessional care for children in care or for children who have complex health needs, the integrated ambulance system, management of the frail elderly, health information systems (HIS), and inefficiency in the use of health care resources demand action in the short term. Some efficiencies will offset the cost of new programs both in the short term and in the long term.
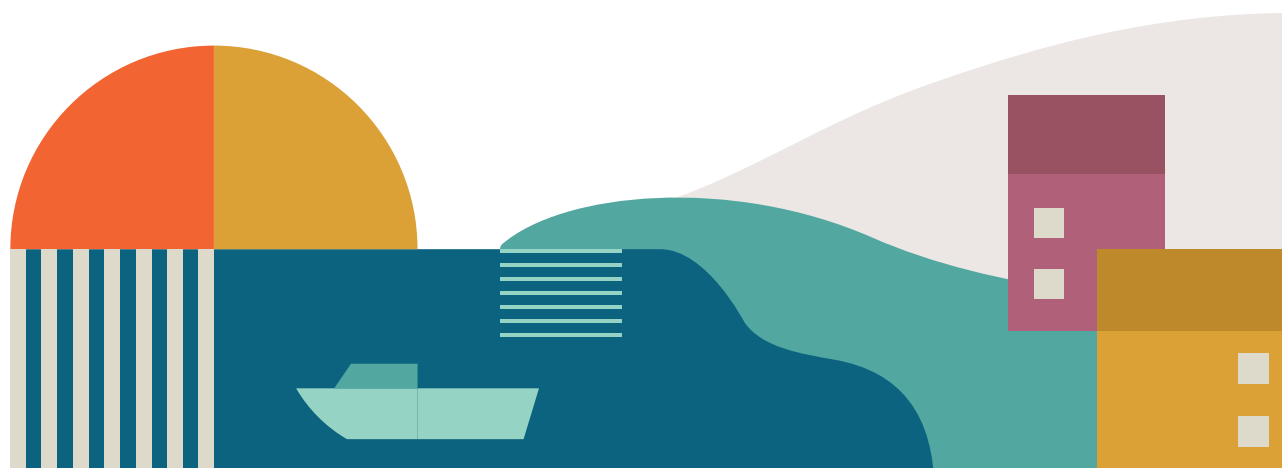
## Objectives

✓ Implement new community teams beginning with high priority areas, including rural areas and regions without good access to primary care. Use start-up funding from the federal government to support this stage of implementation.

✓ Initiate programs to improve the health of children at risk. Ensure that the first set of community teams to be implemented include attention to better interprofessional care for children in care and children with complex health needs.

✓ Engage with communities on how integration of community teams, health centres, community hospitals, regional hospitals and tertiary care outreach would occur in their regions.

✓ Develop and implement acute care standards that include a people and family-centered philosophy, care provision by interprofessional teams across the continuum, and a framework and classification system to define acute care services.

✓ Align the number of acute care beds over time with the objective of having 85% occupancy, length of stay similar to acute care programs in other provinces in Canada, and reduction in the alternate level of care rate.

✓ Reduce the ALC by appropriate management, proactive restorative care, and better access to long-term care beds.

✓ Initiate a formal Frail Elderly Program with interprofessional geriatric teams in regional hospitals with outreach to community hospitals and community teams.

*continued...*

## Objectives (continued)

✓ Initiate the implementation of a 24-hour, integrated, province-wide air and road ambulance system with public oversight. This system would be staffed by primary care paramedics and advanced care paramedics, with a single provincial dispatch system and a virtual emergency system staffed by physicians, NPs and nurses trained in emergency medicine.

✓ Create models of collaborative urgent care in individual health centres based on the distance from a hospital emergency department, the size of the catchment population, geography, and sustainability of health team members.

✓ Initiate immediate planning and investment in a modern, integrated, Provincial HIS and give priority to improvements in virtual care.

✓ Through consultation with stakeholders, create a Provincial Health and Social System Human Resource Plan. See chapter 10, section 2.

## The Rebalanced Health System

**Integration of Community Teams, Hospitals, Long-Term Care, and the Ambulance System**



social, economic, and environmental conditions

health system
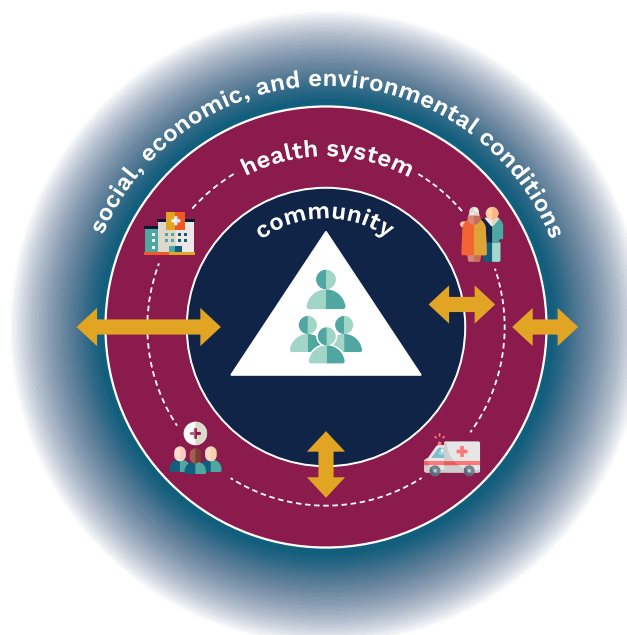
community

**Facilitated by:**
patient navigators
community contacts
virtual care
information systems
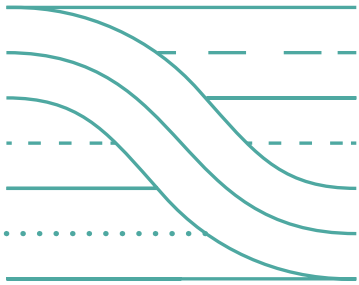
# 10

# Pathways to Improving Health

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**

**THE REPORT**

## Direction Statement

**Digital technology will improve health and health outcomes in the province by empowering people with information, access, and choice. By embracing digital technologies, we will connect people and integrate systems, and we will link health and social factors. Using an agile, iterative, and evidence-based approach, we will spur leading innovation and a culture of exploration, which will become a driving force for inclusion.**

Several foundational elements are required if the digital technology recommendations are to be successful. It will be necessary to establish methods to leverage existing and capture new data related to social systems at both the individual and population level, supporting decision-making. A provincial governance model will ensure a holistic approach with cohesive policies having clear definitions for data sharing and custodianship. Legislation and policy will retain the right of patients/clients/residents to access and correct their own personal health information, establish the rules for collection, use and disclosure of personal health information, and direct ways to leverage data held in community care and private clinics. Strategy regarding procurement, management, and integration will be aligned across the province. Key will be the adoption of a learning health and social system, marked by transparency. This learning health and social system will capture and leverage data, measure and provide evidence, initiate change based on evidence, and ensure an ethics-based response to all health system development.

According to the federal government, by 2026, 98% of Canada should have broadband access, but some limitations will remain. Supports in communities with limited access must be considered, such as community care centres with access or other supports to ensure that patients/clients in the home can access virtual care. Support initiatives will be designed to increase digital literacy and provide supports with community teams.

Change management will be led by quick response teams (both technical and digital support teams) to roll-out new technology and virtual care technology. Inclusion and choice are most important: the patient/client has the choice of virtual care or in-person care. As well, the person is connected to the system to access their personal health record.

# Calls To Action

## Modernization of Foundational Information Technology Systems

**Action 10.1:**
Modernize foundational information technology systems.

## Background

Modernization of the health system's foundational information technology infrastructure encompasses two elements:

1. Modernize the current health information system (HIS) used by the regional health authorities (RHAs) as well as seamlessly integrate existing systems in health and social sectors.

2. Upgrade management systems used by the RHAs (e.g., finance, human resources, administration, and procurement that may or may not come as part of the upgraded HIS).

The main element of this Call to Action is the need to upgrade the current HIS—the other Calls to Action stemming from the other Health Accord committees and working groups can only be achieved through this upgrade. The current HIS (software name: Meditech) used by the RHAs in the province is a version based on 1984 technology. It is essentially a patient registration system, not an integrated, functional health system.

To further complicate matters, there are different customized versions and installations of the system across the RHAs, instead of one shared, integrated version. The current system does not communicate with the modern Electronic Medical Record (EMR) used in primary care, nor does it allow for integration of other community care and social systems. There are an estimated 1,500 fax machines in use in the RHAs today due to the antiquated HIS. There are many more fax machines used in community care settings since fax machines are the only way that community practitioners can communicate with RHAs and other HIS users.

This Call to Action must take a holistic, broad approach to public health, community, private health care, and social systems, ensuring seamless integration and ease of use.

## Objectives

✓ Modernize the HIS to meet modern cyber security requirements and to enable modern health functions such as e-ordering, e-scheduling, e-prescribing, e-referrals, secure messaging, and electronic notes.

✓ Improve quality and outcomes, resulting in less paper, fewer inefficiencies, and help to retain health practitioners through a system that supports their workflow.

✓ Ensure that information systems are inclusive to everyone in Newfoundland and Labrador, particularly minority and at-risk groups, to support timely and appropriate patient/client/resident care and to enable appropriate data collection for measurement and evaluation.

✓ Integrate technology across health and social systems to better act on social determinants of health (SDH) data, supporting both macro level policies and individual level interventions.

*continued...*

## Objectives (continued)

✓ Create a personal health record that will empower patients/clients/resident and practitioners to better manage health.

✓ Upgrade management systems to allow for effective management of RHAs, including access to data for benchmarking, performance management, transparency of performance, and better support for decision-making and accountability.

✓ Support innovation and local industry expertise as well as support innovation and continuous improvement of the health system.

Cost estimates will be made based on a five-year implementation period. These cost estimates will include training and education as well as health process changes. Cost savings realized by elimination of unneeded software and other savings will be factored in. There are significant other cost savings which will be identified to ensure appropriate overall costing for the modernization process.

# Virtual Care Technologies

**Action 10.2:**
Adopt and leverage virtual care technologies.

## Background

There are three prerequisites to the adoption of virtual care technologies. First, virtual services are critically dependent on broadband access across the province. While this is a federal responsibility and commitment (to be realized by 2026),

it is important that the provincial government maintain a focus on the importance of this foundational step. Secondly, the HIS upgrade must be addressed. Only then can information collected at the point of care be seamlessly integrated along the care pathway, across community and acute care teams, and connect the social system with the health system.

The third prerequisite is that any adoption of virtual care pathways must be inclusive, meaning choice is paramount. For example, patients/clients wishing to have appointments in person need to have that choice available. Patients/clients who prefer virtual care to avoid the costs and safety issues associated with travel, or to lessen the burden of being away from work or parenting responsibilities, should be able to access their providers virtually when this modality is appropriate. Further, when digital literacy is a challenge, patients/clients need community support offered as part of the community team (or in partnership with community organizations) or have the choice of in-person care.

Virtual care includes interactions between patients/clients and the health system mediated by technology. It encompasses a variety of technologies and uses. Virtual care appointments and supporting functions with health practitioners span a continuum from telehealth and telemedicine care to more robust and interactive audio-visual conferencing technologies (e.g., Webex, Zoom, Skype).

To ensure appropriate virtual care, functions in HIS and the EMR must be integrated (e.g., appointment scheduling, reminders, e-consult, e-referral). Remote patient monitoring (RPM) and other forms of virtual care delivery include technologies such as RPM for diabetes care. Virtual care allows patients to remain in the comfort of their own homes while receiving access to needed resources. The virtual emergency system, envisioned as an essential element in the reimagined integrated provincial ambulance service, provides access to emergency department expertise in remote settings through rich audio-visual technologies.

> **"**
>
> **I believe the digital technology will be key to all of this working. Given our large geographic area and our aging population, what other option is there?**
>
> *– Engagement series 5 survey participant*

## Objectives

✔ Develop a framework and guiding document for appropriate use of virtual care.

✔ Ensure that virtual care complements rather than replaces in-person services.

✔ Empower and connect people through digital access to personal health information, enabling patient/client self-reporting and monitoring, and supporting more preventative and proactive care, screening, and remote monitoring.

✔ Enhance the community by making every home a part of the health system.

✔ Develop a strategy to ensure that all physicians are using EMRs and have the capacity to participate in virtual care.

✔ Support key technologies, such as telephone, for simple appointments with family physicians (FPs), a richer visual conferencing software for more involved appointments, and extension of existing RPM and other programs into new areas as our virtual care health system matures.

✔ Provide guidance for the appropriate use of virtual care, given variations related to the patient's/client's capacity in using the technology, the term of the relationship between the patient/client and the provider, and the quality of the electronic connections.

*continued...*

## Objectives (continued)

✓ Collect SDH data through the capacity of virtual care to allow for information collected when care is being given (including social factors) that can be analyzed to support effective policies and interventions, always with the same protections as are present for all data collection.

✓ Support the change management process, education, and infrastructure needed to enable virtual care.

✓ Enable team-based care and provider communication when there is not co-location.

To support the adoption of virtual care, key recommendations are being made. First, technology support resources will be placed with community teams to help with adoption and use of virtual care technologies, and to support clinics with adoption of new tools. This requires support for both health care practitioners and patients/clients. Second, digital literacy supports are present in health centres, along with staff to support virtual care. Third, where broadband is limited, health centres may act as a hub for virtual care appointments. Finally, choice remains paramount—patients/clients retain the ability to have in-person appointments with practitioners. Supports in community teams can seamlessly integrate virtual with in-person care pathways.

## Use of E-Technology for Improved Outcomes

**Action 10.3:**
Develop a Provincial Digital Technology Strategy and policy to guide e-technology development and implementation.

## Background

Digital technologies and clinical decision support tools are valuable tools that help improve health outcomes as they help augment clinical decision-making, contribute to improvements in clinical workflow, reduce patient safety risks, reduce unnecessary test ordering, and enable better documentation.

These solutions can also enable the monitoring of quality indicators (i.e., benchmarks, wait times, and dashboards for quality assurance measures).

Switching from paper requisitions to e-technology solutions has been shown to eliminate handwriting legibility errors, reduce lost orders and double order entry, and give trace-ability within the system.

Digital technology will require a digitally literate population who are well-equipped with digital devices and access to connectivity. Connectivity is more than good broadband access. It is also about affordability of internet/Wi-Fi and personal online ability. This is an issue for families living in poverty as well as for families with moderate income and for older people. The technology and learning to use the technology come at a cost. While some funding has been made available for community organizations to provide support for digital literacy, such funding is limited and not sustained.

## Objectives

✓ Implement e-ordering tools in medical imaging and laboratory, implement e-prescribing, and expand e-consult services.

✓ Develop further the use of e-consults which allow FPs and nurse practitioners (NPs) to electronically consult with other medical specialists about the appropriateness of a consult or an alternative approach to the management of care of the patient/client.

*continued...*

## Objectives (continued)

✓ Implement a modernized and integrated HIS that encompass the full continuum of care.

✓ Adopt "integrated by design" as a principle for future health technology investments, meaning that integration is considered from the very beginning of the design of any process or investment.

✓ Develop strategies, including funding support, to address broadband and digital literacy issues in the province.

## Section Two: Health Human Resource Planning

For any sector to thrive, it requires human resources who offer the appropriate mix of skills to meet demands. The health sector is no different. However, the diversity of the health sector poses challenges that are unique and must be carefully considered.

There were 43,700 health care and social assistance jobs in Newfoundland and Labrador in 2021, 19.9% of all jobs in the province.[42] This is the largest sector of employment in the province. About 19,000 individuals work in the RHAs, 45% of whom are registered nurses (RNs), licensed practical nurses (LPNs), or personal care attendants (PCAs). It is estimated that 8,500 persons are employed in home care, 1,600 in personal care homes, and several hundred in assisted living facilities. There were 630 FPs and 651 specialists, 200 dentists, many private allied health professionals, and several hundred staff in more than 300 non-profit organizations that provide health care.

In April 2021, the overall vacancy rate in the RHAs was 8.8%. There were 1,675 vacancies with 1,050 nursing vacancies (NPs, nurses, LPNs, and PCAs) and 625

[42] Statistics Canada, Labour Force Participation for Newfoundland and Labrador. (2021). Labour force characteristics by industry, annual (statcan.gc.ca).

other vacancies. Among FPs, the vacancy rate was 6.5%, but in rural areas this was higher for both FPs and other hospital-based specialists. Several health professions have high vacancy rates (e.g., clinical psychology 44%, audiology 26%). Outside the RHAs, similar data are not available, but the home care sector has indicated similar difficulty in recruiting and retaining workers.

There are problems in recruiting and retaining FPs in the community. Indicators include the growing number of unattached patients/clients, the large number of health centre sites where resignations have necessitated virtual care emergency systems and diversion of patients/clients, the decline in recruitment of international medical graduates since the change in College licensure requirements, and the general sense of concern in the population about not being able to access stable primary care. While the immediate response has focused on establishing interim collaborative team clinics, the Health Accord is focused on addressing the longer-term need to rebalance and stabilize the health system.

The vacancy rate within the Newfoundland and Labrador health workforce is influenced by the aging of the population, lower numbers of young people entering the workforce, a greater emphasis on work-life balance, national and global health provider shortages, and challenging working conditions. These factors together create a situation in which the workforce is becoming increasingly difficult to sustain, particularly in rural and remote communities.

Discussions related to human resources are inextricably linked with discussions related to education. In developing the recommendations outlined, the workforce readiness working group worked closely with the education working group to align and delineate issues and strategies.

Pressures regarding human resources are well recognized by leadership groups, associations, unions, and the provincial government. As the work of Health Accord NL was ongoing, the Department of Health and Community Services (HCS) responded to the increasing pressures of the health workforce. On October 18, 2021, HCS announced immediate and interim steps to improve access to primary health care in Newfoundland and Labrador and help stabilize the workforce.[43] It is the stated intention of HCS to do this planning in a way which will easily integrate with the Health Accord. The Health Accord will provide action plans focused on the appropriate number, distribution and mix of health providers to meet the needs of the patient/client/resident and their families in an integrated and rebalanced health and social system.

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[43] Government of Newfoundland and Labrador Department of Health and Community Services. (2021, October 18). *Initiatives Aim to Improve Primary Care Access in Newfoundland and Labrador.* https://www.gov.nl.ca/releases/2021/health/1018n02/.

When we examine the data pertaining to health human resources and when we listen to providers, patients/clients/residents and others that interact with the system in various ways, we are given a clear signal to design a health and social system for the future that is different from the system which we have in place today.

Given the focus of Health Accord NL on improving health and health equity for Newfoundlanders and Labradorians, the following workforce Calls to Action are focused on ensuring that there are an appropriate number, distribution, and mix of health providers focused on the needs of the patient/client/resident and their families in an integrated and rebalanced health and social system. Health care providers will require systems to support the sharing of patient/client/resident information in real time as well as systems that will enhance collaboration in planning and delivering care for patients/clients/residents and their families.

The Calls to Action are broad in scope and not dependent upon the governance structure or employer (public or private) for health care workers.

# Calls To Action

## A Provincial Health and Social System Human Resource Plan

Below we outline one umbrella Call to Action and six component Calls to Action. These Calls to Action along with those from the following section on Education would form the basis of a "Provincial Health and Social System Human Resource Plan." This plan is to be created jointly by engaging with system stakeholders, including members of the community, over the initial one to two years of the Health Accord implementation.

**Action 10.4:**
Through consultation with stakeholders, create a Provincial Health and Social System Human Resource Plan.

## Components of the Plan

### Human Resources

✓ Create Workforce Transition Guiding Principles for all health and social sector employees to provide workforce security and protection.

✓ Create a health and social system environment that enables all providers to work to the highest scope of practice within their education and/or training.

✓ Create a Strategic Recruitment Plan that will ensure health care providers are in place.

✓ Create strategies to engage, stabilize, and retain the current and future health and social system workforce and encompass actions required as a result of the ten-year Health Accord. Ensure strategies support inclusion of under-represented groups and quality of care in the provision of services.

✓ Create an environment that values leadership and management and inspires those with potential to lead. This includes creating value in management positions and succession planning for those with leadership and management potential to receive training and mentorship.

✓ Leverage existing evidence and data in the health and social systems and expand this knowledge base where evidence and data do not already exist. Use this evidence and data in strategy development.

*continued...*

## Components of the Plan (continued)

### Education

✓ Develop and apply clear guiding principles in all education development and delivery initiatives.

✓ Develop and deliver education and continuing education programs that use an integrated, inclusive, and collaborative care model where practitioners learn and practice together. This requires integration across curricula and across programs throughout the learning experience.

✓ Update and renew curriculum for health and social system practitioners to better prepare them to deliver equitable, interprofessional care to the full scope of their practice.

✓ Provide education and resource support to the people of the province to facilitate their full participation in a modernized learning health and social care system.

# Workforce Transition Guiding Principles

**Action 10.5:**
Create Workforce Transition Guiding Principles for all health and social system employees and physicians to provide workforce security and protection. Where employees or physicians are represented by unions/associations, a high-level principle-based document inclusive of guiding principles would be created jointly with employee or physician representation, including NAPE, CUPE, RNUNL, AAHP, NLMA, and others. Further, union-specific transition agreements may in turn need to be negotiated with each employee or physician representative group.

Where those persons negatively impacted by the system changes are not represented by unions or associations (e.g., managers), these staff members would also have input into the development of the principles guiding their transition.

## Background

Implementation of the Health Accord will lead to transformation that will encompass all health sector and social sector organizations in the province and all care continuums including hospitals, health centres, community teams, and long-term care services.

To create an environment with the greatest opportunity for success, employees and physicians must be treated as the most valuable resources with the provision of security and protection as they are impacted by this important change process. Given the current vacancies that exist in the health and social sector, it is imperative to retain staff and physicians and their skills in the rebalanced system.

## Objectives

✔ Provide an environment that is fertile for health and social system change while at the same time ensuring that employees and physicians have protection and security as they are impacted by this immense change process.

✔ Develop the needed Workforce Transition Agreements following the key principles outlined below.

✔ Follow key principles jointly developed by the employee or physician representative bodies, employers, and government including the following taken from the National Health Service England Framework for Integrated Care Boards:[44]

◇ People-centred: Taking into account the needs of patients/ clients/residents and families and the impact on employees or physicians; a supportive approach with those impacted by change; stability of employment where possible; a standard approach to change for all employee and physician groups where possible; a skills-based approach that maximizes existing skills and retraining where necessary.

◇ Compassionate and inclusive: Openness and transparency of process and actions, actions to increase the diversity of the new workforce and particularly the leadership, and supportive change management.

◇ Minimized disruption: Keep policy as simple as possible and work together to avoid unnecessary duplication of effort, provide employment stability throughout the transition period while minimizing uncertainty as much as reasonably possible.

*continued...*

[44] National Health Service England. (2021, August 1). *HR framework for developing integrated care boards; Supporting the successful transition of people into integrated care boards*. https://www.england.nhs. uk/wp-content/uploads/2021/06/B0790_ICS_HR-Framework-Technical-Guidance_FINAL18Aug.pdf.

## Objectives (continued)

✓ Facilitate the transfer of staff and physicians with the program or service being relocated, balancing the need to keep skills within the service and the place of residence of the affected person.

# Scope of Practice

**Action 10.6:**
Create a health and social system environment that enables all providers to work to the highest scope of practice within their education and/or training.

## Background

Health and social system providers are a scarce and valuable resource. To obtain the greatest value from this workforce while at the same time accomplishing the goals of the Health Accord, it will be necessary to create an environment that enables and supports these providers to work to their highest level of education. There will be enhanced job satisfaction and personal fulfillment if employees can work using their full scope of practice.

Health regulatory colleges are responsible for ensuring that regulated health professionals provide health services in a safe, professional, and ethical manner. In the increasingly complex environment of health care delivery and the need for greater integration with social determinants of health for improved health outcomes, the regulatory colleges will need to work together to ensure a safe and ethical approach to transformation. In specific cases, legislation for health

professionals and corresponding regulation will need to be modernized to support these changing scopes while in other cases policies and practice within workplaces will need to promote the highest scope of practice.

In the case of unregulated providers, clarity of practice and competency development are necessary. For all providers, strong interprofessional practice will be encouraged and supported.

## Objectives

✓ Ensure that all health and social system providers in Newfoundland and Labrador work to their highest level of education and/or training. This will create an environment with the greatest chance of success for the achievement of Health Accord goals while simultaneously creating a milieu with the highest chance of provider engagement and quality of care for the patient, client, or resident.

✓ Given the potential for significant change resulting from the reimagined health system and integration with social systems, work with the appropriate professional colleges to review legislation and regulation of regulated professions to determine if change is required.

✓ Review provincial workforce policy and practice to clarify scope and, for provider teams, to understand the potential contribution of every member of the team.

✓ Implement a Provincial Education Strategy for team members to understand one another's role and scope.

✓ Increase scope of practice for pharmacists in Newfoundland and Labrador consistent with other Canadian jurisdictions.

*continued...*

## Objectives (continued)

✓ Review scope of practice of pharmacy technicians in Newfoundland and Labrador compared to other Canadian jurisdictions.

✓ Define the provincial scopes of practice for unregulated providers such as Personal Care Attendants, home care workers, and therapy assistants.

✓ Complete a systematic review to determine when a generalist approach to the provision of care could be implemented.

✓ Create strong interprofessional collaborative practice.

# Recruitment of Health and Social System Providers

**Action 10.7:**
Create a strategic recruitment plan that will ensure health care providers are in place to offer stable direct care and services to patients/clients/residents and families in a rebalanced health and social system, while at the same time providing work-life balance for employees.

## Background

The supply and demand for health care professionals is increasing worldwide. Currently, there is a high demand for health professionals resulting in high vacancy rates. This situation has been further exacerbated by the COVID-19 pandemic with retirements and resignations expected to be higher than anticipated.

Recruitment and retention in Newfoundland and Labrador are impacted by many factors including but not limited to:

1. **The rural and remote nature of the province resulting in:**

   a. higher turnover and longer time to fill positions;
   b. low critical mass of positions and availability of relief staff;
   c. declining candidate pools for "grow your own"—in 1971 there were approximately 200,000 young people in the province; today there are 70,000;
   d. limited access to amenities;
   e. a single location in the province for training for many groups;
   f. persistent high attrition in some programs;
   g. unique challenges in more remote areas, especially in Labrador, connected with living in the north, living in Indigenous communities, and responding to the Truth and Reconciliation Calls to Action.

   Many of the above elements apply in urban as well as in rural and remote areas of the province.

2. **Compensation issues:**

   a. national or international marketplaces for some occupations;
   b. competition from private industry and/or other jurisdictions;
   c. the current job evaluation system not accounting for market factors or for equal pay for work of equal value among health professionals;
   d. financial supports for families and limited employment opportunities for spouses;
   e. non-pensionable market adjustments.

3. **Training capacity issues:**

   a. high and competing demands for limited training spaces;
   b. proximity, availability, and length of training programs; some programs are only available outside the province and some in one location provincially and/or nationally;
   c. inadequate numbers of clinicians who can train students;
   d. funding for accommodation and travel for those learning in rural and remote areas (an incentive for later recruitment to these areas).

4. **Work-life balance issues:**

   a. high workloads and increasing job demands.

## Objectives

✓ Identify the current and future demand for each category of health care provider, the current and future supply of these same provider groups based on existing patterns of entry and exit from the workforce, and the calculation of the gap between supply and demand for each provider group now and for at least ten years into the future. Update the data annually.

✓ Develop a Recruitment And Retention Plan for addressing each provider gap, using strategies of marketing, incentives, compensation, expanded education and training, and immigration.

✓ Deploy strategies to stabilize the current workforce inclusive of:

◇ developing an immigration strategy;
◇ working in partnership with local communities and stakeholders;
◇ creating a "Grow Your Own" recruitment and retention strategy in partnership with Memorial University of Newfoundland and the College of the North Atlantic;
◇ encouraging urban and rural high school students to pursue health careers.

✓ Evaluate the strategies to make sure they are sufficient to address any deficits between demand and supply.

✓ Address specific Health Accord goals such as the addition of patient navigators and an increase in geriatricians, advanced care paramedics, nurse practitioners, rural generalist FPs, and home care workers.

## Strategies to Engage, Stabilize, and Retain the Current and Future Workforce

**Action 10.8:**
Create strategies to engage, stabilize, and retain the current and future health and social system workforce and encompass actions required by the 10-year Health Accord. Ensure strategies support inclusion of under-represented groups and quality of care in the provision of services.

## Background

The creation of the 10-year Health Accord will require a stable health and social system workforce. To implement the Health Accord, it will be necessary to address current issues of workforce instability but also new issues arising because of the directions created by the Health Accord. Such issues include creation of strong interprofessional community teams; transition from institutional sector to the community; strengthened care, resources and supports for older persons; and less siloed care provision for children.

## Objectives

Develop a Change Management Plan for Health Accord implementation including proven principles of change management, particularly in relation to the development of community teams including integration of pharmacists, changing roles of health facilities, integration with the broader social and extended health system, stronger team development, and changes within institutions related to restructuring.

*continued...*

## Objectives (continued)

✓ Implement change management strategies for Health Accord implementation inclusive of greater use of innovative methodologies for quality care and virtual care.

✓ Support extension of tertiary care services beyond St. John's, including support to travel and to deploy virtual care options.

✓ Support collaboration across sectors including RHAs, multiple government departments, private health care, the education sector, regulatory colleges, municipalities, and the non-profit health and social sector.

✓ Use current engagement survey feedback; and, where necessary, complete further research to understand low engagement within the current workforce and use this information to action specific initiatives with the goal of enhancing employee and physician engagement.

✓ Use workplace data to create strategies to enhance physical and psychological safety of employees and physicians.

✓ Focus on needs of the public in workforce design and allocation.

✓ Implement strategies that aim to increase workforce retention.

✓ Create an engaged workforce that is committed to remaining with the organization and within Newfoundland and Labrador.

# An Environment that Values Leadership and Management

**Action 10.9:**
Create an environment that values leadership and management and inspires those with potential to lead. This includes creating value in management positions and succession planning for those with leadership and management potential to receive training and mentorship.

## Background

Regional health authorities have 7.1% of their 986 leadership and management positions vacant at the present time. As a percentage of overall payroll or administrative cost, RHAs in this province spend below the Canadian average on management. Ninety-three percent of the RHA workforce is unionized. Therefore, skilled leaders with potential for full time management and leadership positions are often reluctant to accept management positions for little extra remuneration and loss of the job security offered by union membership.

It is a challenge to manage the health sector in Newfoundland and Labrador with the vast geography of the province, resulting in many managers responsible for multiple sites, multiple functions, and/or multiple disciplines. There has been increasing concern from staff and their unions that the health system is undermanaged. Staff express concern that managers are not available, do not give routine feedback, and are not accessible for the discussion of issues that occur in the workplace.

The changes that are envisioned by the Health Accord will require leaders (managers as well as staff champions) to make this transformation. Managers are responsible for overseeing the provision of service and care for all RHA patients, residents, and clients as well as for managing budgets in the order of $2.2 billion with 19,000 employees. Strong leadership and management will be crucial for the system to be operated efficiently, maximizing value. While the forgoing information is about RHAs, these issues are just as important for the provincial health and social sector outside RHAs.

## Objectives

✓ Cultivate a climate where individuals with leadership potential aspire to manage and lead.

✓ Create organizations where best in class management and leadership techniques are how these organizations function, including succession planning and mentorship programs.

✓ Support management to achieve full potential with a review of the span of control including number of employees and number of services/disciplines as well as geographical location of services to identify if changes are required.

✓ Deploy succession planning programs to identify and develop future leaders.

✓ Provide best in class leadership development in all areas of management competency for current leaders and those with potential to move to management and leadership positions.

" Health care delivery for the 21st century requires major departures from the status quo. The Health Accord provides a formal mechanism to develop a concrete strategy to begin the transformation that should have occurred yesterday.

*– Symposium participant*

# Strategies and Evidence to Support Human Resource Planning

**Action 10.10:**
Leverage existing evidence and data in the health and social systems and expand this knowledge base where evidence and data do not already exist. Use this evidence and data in strategy development.

## Background

Reasonably good information can be obtained on the RHA workforce from the health human resource information system implemented within the RHAs and on the health workforce within all Canadian jurisdictions through the Canadian Institute for Health Information (CIHI). However, there is less information available on the social sector and private sector health workforce.

Health Accord NL implementation will require evidence and data on all aspects of the health and social sector workforce for planning purposes.

## Objectives

✅ Create strong health and social system human resource planning led by the HCS, and Children, Seniors, and Social Development (CCSD).

✅ Create systems/processes to capture robust, comprehensive, and timely data and evidence regarding the social system and private sector health workforce to create strategic workforce plans.

✅ Collaborate with key partners such as employers, regulatory bodies, professional associations, unions, and others in workforce planning activities.

✅ Solicit input from stakeholders and under-represented groups in the health and social system workforce.

✅ Ensure workforce planning considerations are part of all future health and social system strategic planning.

✅ Partner with stakeholders and researchers to document areas for improvement, evidence collection, and key policy questions requiring investigation.

✅ Identify key research areas and support research completed by academics, consultants or within organizations to inform this work.

✅ Work nationally, building on what is currently available from CIHI, to develop a health and social system comprehensive human resource database that can be used for comparison and strategy.

The education working group was formed in response to a round of stakeholder engagement where it was clearly identified that a better-balanced health system that includes the social determinants of health would require changes to the educational content delivered to providers in their formal education programs and through continuing education.

A robust and responsive health human resource plan is essential for educators to develop the educational structure and resources that underpin content and program implementation.

Memorial University educates physicians, nurses, NPs, social workers, pharmacists, kinesiologists, and clinical psychologists. The College of the North Atlantic educates respiratory therapists, medical laboratory technologists, medical laboratory assistants, medical imaging technologists, ultrasound technologists, primary care and advanced care paramedics, rehabilitation assistants, PCAs, and practical nurses (PNs) at sites outside St. John's.

Memorial University's Faculty of Nursing (MUNFON) and the Centre for Nursing Studies (CNS) both in St. John's, as well as the Western Regional School of Nursing (WRSON) in Corner Brook, offer the Bachelor of Science in Nursing (BScN) (Collaborative) Program across the province. Both the CNS and WRSON are governed by RHAs, specifically Eastern Health (EH) and Western Health (WH) respectively. Students from all three sites receive their degree from Memorial University. The Centre for Nursing Studies offers the PN Program in St. John's and is the lead organization for the PN Program in the province (the College of Licensed Practical Nurses of Newfoundland and Labrador determines curriculum and required teaching credentials and gives approval for all learning sites). Private colleges also educate primary care paramedics, laboratory assistants, pharmacy technicians, etc.

There are several professional groups whose initial education programs are not within the province, e.g., speech language pathology, audiology, occupational therapy, physiotherapy, chiropractic, genetic counselling. Newfoundland and Labrador purchases occupational therapy and physiotherapy training seats for Newfoundland and Labrador students at Dalhousie University. Clinical placements are provided in the province for this University and others. This brings added complexity to the ability to influence curricula for these groups as well as for the development of the health human resource plan.

> ❝
>
> For too long, health care provider education has occurred in silos. While this creates professional identity, learners must also learn together so they can practice in teams effectively.
>
> *– Participant in symposium on education*

## Gaps/New Requirements Identified

Some needed enhancements/extensions to existing curriculum and some new requirements for education have been identified throughout the Health Accord process. For the most part these fell into seven broad categories:

▶ Competencies related to health equity, inclusion, cultural safety, and anti-racism

▶ Competencies related to the SDH

▶ Competencies related to the changing demographic of the province, especially care of the elderly

▶ Competencies related to the changing delivery models, e.g., digital technology and virtual care, interprofessional or team-based care, a learning health and social system

▶ Public education on a reimagined health system

▶ New education programs for care providers without training

▶ Targeted diversity in student recruitment to ensure that the future workforce is reflective of the population it serves

These enhancements and new requirements vary from profession to profession.

## Challenges in Updating Content and Context

Challenges were also identified in how the gaps and new requirements may be addressed in current curricula. For many health disciplines, concerns were raised during engagement with Health Accord NL regarding the length of existing education programs. Programs were identified as being very full and not having space to include new content. The rapid development of new knowledge and changes in skill requires all educators to be creative to integrate this content into the continuum of learning. This will increasingly occur outside the didactic components of the formal curriculum. Interprofessional learning and self-learning from a menu of virtual courses or modules were identified as ways to help providers stay current. Where necessary, licensing requirements have been and can be used as an enabler to ensure critical content areas are not only part of the formal pre-certification curriculum but also part of continuing professional development in practice.

Life-long learning is a critical component of any professional's continuing practice. As evidenced by the COVID-19 pandemic, the world is constantly changing and the education of providers who respond to these changes is ongoing. Continuing professional health care provider education presents both a challenge in how to best bring new knowledge to busy practitioners located throughout the province and, when successful, an opportunity as it allows the nimbleness and respon-siveness necessary to always keep the competencies of providers up to date.

There are also challenges related to how the education provided is applied and implemented in practice environments. As new curriculum content areas are identified and developed, direct expectations for implementation should be included.

Opportunities must be developed to enable health care providers to meet current and changing needs of the communities they serve. Some opportunities may be provided through redesigning clinical placements prior to completion of a provider's education. Other opportunities must be made available while in practice. An example of this is the need during the COVID-19 pandemic to increase the mobility of health care providers across provincial/territorial boundaries and the increased adoption of virtual care by health care professionals and the public. In-practice, on the job educational modules and support for health care providers to adapt to the changing needs are critical.

# ⊙ Calls To Action

## Principles for Health Provider Education

> **Action 10.11:**
> Develop and apply clear guiding principles in all education development and delivery initiatives.

## Background

As educational priorities were identified throughout the Health Accord process, it became apparent that many of the priorities were principles that should be applied across all education activities.

For example, throughout the Diversity and Inclusion Symposium Series conducted by the Health Accord in September and October 2021, group after group highlighted the lack of cultural and ethnic knowledge in the health system and the lack of training on intersectionality. There was universal recognition of the need for a fundamental shift to team-based and patient-centered care with the patient/client as part of the team. While the groups varied in their mandates, all noted that the changes need to start as students enter their respective programs and in the methods used to both develop and deliver education to health providers.

These groups were clear that the concepts had to be embedded as principles in the learning process and not added on after other educational activities are concluded. These high-profile community-based groups noted that they were seldom or only intermittently involved in health care provider education.

Most health professions have accreditation standards that they need to meet in all their education programs. Accreditation standards require that the educational institution has a clear mission and goals that reflect the societal needs of their community.

## Objectives

✓ Develop and apply principles aligned with the following as educators renew, refine, and implement educational programming:

◇ Collaborate to enable health professionals to work in interprofessional teams that promote and advocate for the health of the individual and the community.

◇ Recognize the role of the patient/client/resident, acknowledge patient/client/resident autonomy, and ensure that the patient/client/resident is an active member of the care team. Should the patient/client/resident not be competent, the family member, caregiver, or designated substitute decision-maker must be included to bring the patient's/client's/resident's perspective.

◇ Recognize the patient/client/resident as a critical focus of public engagement, and the patient/client/resident as a participant in the educational program.

◇ Ensure that curriculum and clinical experiences are developed through inclusive and equitable lenses.

◇ Include change management principles and provide contextual approaches to all health care providers.

◇ Integrate quality assessment and improvement practices in every aspect of care.

◇ Provide clear, comprehensive programming on care for Indigenous peoples which includes the concepts of cultural safety/humility, anti-racism, equity, and inclusion.

*continued...*

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## Objectives (continued)

◇ Actively include community perspectives into curriculum planning.

◇ Create a focus on continuous improvement in a learning health and social system.

◇ Recognize that health provider care requires a life-long learning process including adaptation to change both in what is delivered and how it is delivered.

◇ Prepare learners with the requirements associated with a learning health and social system, e.g., onboarding,[45] transitioning through stages of practice.

◇ Find creative ways to engage with health care education institutions outside the province whose graduates come to work in the province so that learners can experience some of their education and have clinical mentors in Newfoundland and Labrador.

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[45] Onboarding is a human resources term referring to the process of introducing a newly hired employee into an organization. Also known as organizational socialization, onboarding is an important part of helping employees understand their new position and job requirements and integrate seamlessly with the rest of the organization.

# Learners Learning Together – A Collaborative Education Development and Delivery Model

**Action 10.12:**
Develop and deliver education and continuing education programs that use an integrated, inclusive, and collaborative care model where practitioners learn and practice together. This requires integration across curricula and across programs throughout the learning experience.

## Background

The pervasive presence of silos in the provincial health system has been identified through the Health Accord NL engagement process. These silos have been identified within and across professional and staff groups, and across program and geographical areas. A working group member noted in a presentation to the Task Force that it is important that our providers learn to act as a team, think like a team, and learn about each other's respective roles to optimize the care provided.

While there are some programs supporting interprofessional education, these programs are not mandatory for all disciplines. Learners who do get experience in team-based practice during their formal programs often find that this approach is not supported once they enter the workforce.

Groups like the Centre for Collaborative Health Professional Education have highlighted priorities for the future which include coordination with other programs to adopt interprofessional education, organization of interprofessional practice placements, enhanced collaboration in interprofessional health/social care teams, and policy frameworks to support interprofessional collaborative practices.

While much curriculum content is discipline specific, there are several common areas of study such as ethics, leadership, change management, health system structure, work in unionized environments, work in rural areas, health equity, mental health in the workplace, work-life balance, patient-centered care, communication and listening skills, advocacy for patients/clients/residents, appreciative inquiry, technology and virtual care, and artificial intelligence that

cross disciplines and can be offered in a collaborative manner. There are also clearly overlapping roles that require acknowledgment and management in the team environment.

Concerns have been identified related to the limited number of interprofessional education clinical placements available for learners, often resulting in various disciplines competing for the same mentors or preceptors. It was noted that coordination of this function may serve to support interprofessional learning and optimize the placements that are available.

An integrated and collaborative learning and care model is required to maximize the value of the programs currently offered, to effectively recruit and retain practitioners, and to improve health outcomes for the people of the province.

## Objectives

✓ Provide health care education to teams in their practice environments through a province-wide distributed model incorporating digital technology, where appropriate.

✓ Create collaborative governance[46] [47] among faculties and schools to oversee interprofessional team learning.

✓ Co-create curriculum and employ integrated clinical placements.

✓ Facilitate the integration of interprofessional clinical placements across the province for all faculties and schools through a central coordination and management system.

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[46] According to Emerson, Nabatchi, and Balogh (2012), "collaborative governance" refers to the processes and structures of public policy decision-making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished.

[47] Emerson, K., Nabatchi, T., Balogh, S. (2012). *An Integrative Framework for Collaborative Governance. Journal of Public Administration Research and Theory, 22*(1), 2. https://doi.org/10.1093/jopart/mur011.

## Objectives (continued)

✓ Engage all relevant partners, including Black, Indigenous and People of Colour (BIPOC) and other marginalized voices, in curriculum development and delivery activities.

✓ Clearly define the expected competencies of the formal education process for each professional group recognizing overlapping roles, e.g., the entry level practitioner, the generalist, and the specialist.

✓ Provide collaborative continuing professional education responsive to specific and changing community health care needs.

✓ Review and revise the current governance structure and funding arrangements for interprofessional education within Memorial University's health-related faculties and schools.

✓ Promote a more focused approach to collaborative governance of the health sciences faculties and schools at Memorial University of Newfoundland to include nursing, pharmacy, medicine, social work, and kinesiology.

✓ Where not provided in-province, establish needed specialty and subspecialty education through inter-provincial agreements with local input, and clinical placements with supported educational programs and mentorship in the province.

# Updated Curriculum Content

**Action 10.13:**
Update and renew curriculum for health practitioners to help them better understand the importance of the social determinants of health, quality assessment and improvement, care of older adults, digital technology, and patient-centered care and to better prepare them to deliver equitable, interprofessional care to the full scope of their practice.

## Background

Based on a preliminary review of health programming in the province, it was observed that many health programs include brief content on subjects such as the SDH, quality assessment and improvement, care of older adults, digital technology, and patient-centered care early in the educational curriculum. However, for many, this content is not common across health care practitioners, is often not included in the clinical learning experience, and does not fully prepare the learner to integrate these learnings into practice. It can be difficult for learners to integrate this knowledge into their practices when their experience of the topic may be limited.

Several areas for content updating have been identified. Modern andragogy (method and practice of teaching adult learners: self-direction, transformation, experience, mentorship, mental orientation, motivation, and readiness to learn) will need to drive the changes. However, it is acknowledged there are limitations on the amount of additional learning time that can be added during formal training programs. Licensure requirements have been identified as a means of getting broad application of mandated competency areas across professional groups outside the structured four-year or five-year entry to practice program. Accreditation requirements may also be factored into all proposed changes.

Changes to program length or to content should be viewed as opportunities to update curriculum and clinical placement/training using a collaborative approach. Other possibilities include mentored or sponsored transition into practice and the provision of specific educational modules determined by community need.

## Objectives

Ensure that the health care provider curricula prepare the graduate to become an entry level practitioner with competencies, skills, and confidence to provide a defined scope of practice focused on the patient/client/resident:

◇ Demonstrate knowledge of the SDH, the health impacts on different populations, and ways to influence these impacts.

◇ Demonstrate knowledge of public health, its function in communities, and collaboration as health care providers.

◇ Demonstrate knowledge and competences in age-related health factors including multi-dimensional care, frailty, mental health, aging, and dementia.

◇ Actively participate in quality programming including quality assessment and the practice of continuous quality improvement at the individual, team, and community levels.

◇ Actively strengthen the approach to inclusion and equity.

## Preparing the People of the Province

**Action 10.14:**
Provide education and resource support to the people of the province to facilitate their full participation in a modernized learning health and social system.

## Background

As patients/clients/residents, families, and communities become active partners in health care, it is important that they have the knowledge and skills to support active participation in this role. For example, the increased use of technology and virtual care will be dependent on the capacity of people outside the direct health system to use the technology. Similarly, knowledge of the SDH and the role that individuals, communities, and environments play in health outcomes will be critical if we are to improve the health status of our residents.

Patients/clients/residents, and their families will contribute to defining the needs of the community. The role of individuals, community organizations, and families in educating the public to change their perception on what quality health care means is also important. As a rebalanced health system is implemented, there should be focus on providing individuals with the information they need to demonstrate the benefits of the new model.

### Objectives

✓ Provide resources and education for patients/clients/residents, families, and other caregivers to effectively undertake electronic communication and to access practitioners and necessary records.

✓ Develop patient/client/resident participation networks to enable participation at the system level.

✓ Enhance knowledge among community leaders to recognize, demonstrate and encourage:

◇ The benefits of interprofessional teams and their role in a sustainable health care model;

◇ The benefits of community-based care and community teams;

*continued...*

## Objectives (continued)

◇ The measures of quality care and their role in continuous improvement activities;

◇ The preparation for current and future technologies and their role in care;

◇ The preparation for changing environments and their impact on health;

◇ The individual and community level actions that can improve health status;

◇ The continuing role of public health;

◇ The role of social determinants of health, especially inclusion, on health outcomes;

◇ The role of a holistic approach to health and health care (e.g., social prescribing);

◇ The benefits of inclusive and age-friendly communities.

## Section Four: Change Management

Change management is an intentional approach to ensuring that change, once identified as needed, is carefully implemented and sustained over time. It responds both to the broader implications of change and to the ways in which individuals, teams, and organizations help both shape the change and adapt to it.

Social network theory offers new insights into change management which links with the underlying premises of Health Accord NL in its focus on public

engagement, integration and ending silos, a learning health and social system, and wiser use of digital technology. The elemental building blocks of networks are nodes and links. The nodes represent the persons, the links indicate the relations among them. The often-invisible webs of relationships within health and social systems can be invaluable resources in managing change.

The transformation imagined by Health Accord NL will need change management at several levels. Three examples are described below to illustrate the scope and the diversity of need for change management: (i) attention to the connection between interventions in the SDH and the rebalancing of the health system in bringing about improved health outcomes and strengthened health equity, (ii) creation of community teams across the entire province, and (iii) the use of digital technology to enhance health care delivery and to strengthen the connections between the SDH and the health system.

Understanding the magnitude of the change and providing leadership to manage that change will be essential if the implementation of the Accord is to be successful.

# Calls To Action

## Example One: Change Management and Connections Between Social Determinants of Health and the Health System

**Action 10.15:**
Within the leadership structures of government departments, the health system, social systems, and the regional social and health networks, develop an integrated change management approach to improve health outcomes and health equity. This approach should focus on shifting from health system responsibility for health outcomes to shared responsibility of the health and social systems together with health educational institutions, municipalities, community organizations, and the private sector.

## Background

Interventions in social, economic, and environmental factors influencing our health outcomes and health equity will be the responsibility of persons and organizations different from those who will be rebalancing the health system. However, leadership will be required to find the intersection of both and to ensure that integration replaces existing silos and gaps and creates a new vision for health and well-being embedded in a culture of inclusion.

## Objectives

✓ Ensure a common understanding across the leadership structures of government departments, the health system, social systems, and the Regional Health Councils about the scope of factors which influence health, health outcomes, and health equity (see chapter 11, section one).

✓ Develop expectations of leaders in taking responsibility and ensuring accountability for integration across all their organizations for their roles in health.

✓ Provide resources to support these roles and responsibilities.

✓ Develop ongoing evaluation processes to ensure that integration is happening and to adapt when new learning leads to new directions.

# Example Two: Change Management and Community Teams

**Action 10.16:**
Invest in change management to initiate and maintain community teams so that they provide care across the spectrum of health care including children in need, patients/clients with disabilities, and the frail elderly. The community teams integrate provider groups, hospitals, and the various systems that influence health. They engage with the public and communities.

## Background

Health Accord NL envisages community teams as the glue that binds the health and social systems, fills current gaps in care, and replaces silos of health providers with integrated processes. The vision of intervening to improve the SDH and to rebalance the health system requires a process of public and stakeholder engagement not only to facilitate change but also to maintain effective structures over time. This change management process will require both provincial and regional accountability.

The membership of the community teams will include existing health care professionals who will be working in a different manner than they do today and new members coming into the health system. Change management will be important in enabling all members to work as a team during this time of significant change in existing systems. Failure to invest in the initiation and maintenance of effective change management will likely prevent community teams from achieving their vision and meeting their objectives.

**Objectives**

✔ Develop and invest in a change management plan at both provincial and regional levels, in the short-term and the long-term, to assure the development and maintenance of effective and responsive interprofessional teams.

✔ Develop and execute a public engagement plan to initiate and maintain community teams and their integration with communities and other services that influence health.

✔ Develop and execute a plan to integrate the community teams with health centres, long-term care facilities, and hospitals.

✔ Develop and maintain a process to assure that current unmet needs are met (e.g., children in need, persons with disabilities, persons with mental illness and addictions, and the frail elderly).

✔ Develop and use metrics in relation to inclusion, quality of care, and integration that facilitate improvement.

## Example Three: Change Management and Digital Technology

**Action 10.17:**
Invest in change management and training in digital technology across the spectrum of health providers and institutions, all regions of the province, and communities.

## Background

Provision of a modern HIS and applications/technologies to facilitate virtual care will require change within RHAs, across institutions within the province, across systems that influence health, across provider groups, and with the public, particularly patients/clients/residents and their families. Use of new applications, created to effectively meet an important need, requires training for optimal use.

Given the large geographic size and small dispersed population of the province, the opportunities provided by virtual care will fail to be taken without a substantial investment in change management. It is envisaged that the implementation of a complete digital technology solution will take five to six years with each phase of implementation requiring a specific training strategy. Solutions to improving digital literacy for members of the public will require involvement of communities and community teams.

## Objectives

✓ Invest adequately in change management and training at each phase of implementation to ensure effective virtual care and integrated provision of information to providers and institutions.

✓ Develop and execute change management plans that integrate a wide range of providers, systems, and institutions.

✓ Develop and implement a plan to enhance digital literacy among the public, meeting the needs of those who do not have these skills.

# ⊙ Calls To Action

## Financial Implications

> **Action 10.18:**
> Provide a five-year plan of short, medium, and longer term priorities that influence financial decisions taken by government within the fiscal envelope of the province to ensure the long-term improvement in health outcomes and strengthening of health equity needed for a thriving and prosperous province.

## Background

The fiscal impact of actions recommended by Health Accord NL must be considered in the context of several factors: (i) the response to existing crises, (ii) the costs that come with increasing numbers of older people leading to an increasing proportion of the population who are elderly, (iii) the rural nature and diverse geography of the province, (iv) cost savings to be achieved over time, (v) areas which coincide with the present priorities of the federal government, (vi) changes that require transformative thinking and action but come with little cost, (vii) the capacity of the province to pay for new interventions, (viii) the capacity of a transformed health and social system to improve health outcomes, and (ix) the cost of doing nothing new as the health system becomes less sustainable and the health outcomes of the people of the province remain well below the Canadian average.

Three issues which exist today because of crisis situations demand an immediate financial investment no matter what the Health Accord recommends: community care with a focus on primary care and inadequate FP coverage, the ambulance system, and the HIS.

The future fiscal challenges of the province are directly linked to the aging of the population. The model proposed for the frail elderly is critical in providing more optimal care for people over the age of 65 years. The realities and consequences have been noted throughout this document.

The major opportunities for cost reduction are found in using hospitals and health centres more efficiently and reducing the use of unnecessary interventions. These opportunities require collaboration between management and providers. They also are dependent on people having a better understanding about optimal care provision. Consequently, improvement in these areas will take time, but they will come if the actions of the Health Accord are implemented. Changes in location of services are driven by sustainability concerns, a source of increased costs, and require planning for the most effective and most efficient ways to deliver care.

Recruitment and retention of health care providers are major challenges for sustainability of the health system in the province today. Recruitment and retention difficulties impose restrictions and limitation on programs and increase stress and anxiety for health care providers and other workers. The negative effects on the health care workplace not only increase costs related to sick leave or locum coverage but also further deter new graduates from remaining in the province. Present efforts in this area have not been coordinated in a strategic, persistent manner. The Health Accord actions invite transformation of the health system in ways that will encourage more health providers to work in the province and focus on more strategic activities to strengthen recruitment efforts.

The federal government often provides funding related to specific areas of social policy. In particular, the federal government has expressed interest in approaches to and funding for basic income, housing, climate change actions, childhood development, learning from the COVID-19 pandemic to improve long-term care, and meeting the current national challenges in the provision of primary care. The federal government has a plan to target broadband 50/10 provision to 98% of Canadian households. All these areas are priorities for Health Accord NL.

It is recognized that the changes called for in Health Accord NL will come at a cost. However, there are also changes called for which do not require financial investment. Cultural change in the health system which is characterized by inclusion, achievement of quality outcomes, and integration across and within systems requires time, perseverance, and leadership, without the need for large spending. Such a cultural change is essential, however, if the desired health outcomes and improved health equity can be achieved.

While there will be a cost of implementing the Health Accord Calls to Action, a failure to act will come at an even greater cost. Without a more integrated ambulance system or modernized HIS, there will be increased costs as we have witnessed recently in the province. Without a more efficient and sustainable health system, we will face delays for patient/client/resident diagnosis and treatment, patient/client/resident dissatisfaction, and related increased costs. The failure to create a healthy workplace within the health system will lead to further vacancies and locum costs as well as increased costs for sick leave and workplace injuries.

Without a strategic plan to present to the federal government which avoids the silos often accompanying federal government grants, the monies now being made available will not be accessed in a way which will most effectively bring about the transformation needed in health and health care in the province. Without a recognition of the impact of the social, economic, and environmental factors on the health of the people of the province, the worse health outcomes and health inequity of Newfoundlanders and Labradorians will continue. If the people of a place are not healthy, there is no hope of creating a healthy economy. Our unacceptable health outcomes and health inequity mean that we will not be able to achieve economic prosperity or thrive socially in our province unless we bring about better health for individuals and for the population.

The greatest opportunity for long-term cost reduction is to be found by improving population health, which will be done by increasing investments in the SDH. This will have the effect of reducing the incidence of chronic illnesses and increasing wellness, thereby decreasing the demands on the health care system.

> **I truly believe that people who have access to good food, shelter, family and community support, and care will thrive— children who are warm, comfortable and not hungry, and have caregivers who are present and supportive, are better able to focus on activities, friendships and studies. They will also build stronger physical and mental health.**
>
> *– Engagement series 4 participant*

We ask the political system, government, and political parties to place the Health Accord plan at the center of decision-making so that spending decisions necessitated by the fiscal state of the province are consistent with the plan. A failure to do so will lead to a failure to achieve the economic, social, and environmental balance needed to have a thriving and prosperous Newfoundland and Labrador.

## Objectives

✓ Place the Health Accord plan at the center of decision-making so that spending decisions necessitated by the fiscal state of the province are consistent with the plan.

✓ Use the funding estimates over time and the potential for new sources of funding for community teams, an integrated air and road ambulance system, and a modern HIS to determine the speed at which change can occur.

✓ Identify efficiencies that can be achieved in the short and medium term in the health system, to support changes that can occur within the fiscal envelop of the province.

✓ Use the new governance system, NL Council for Health Quality and Performance (see chapter 11, section three), and a learning health and social system to support an effective approach to improved use of health resources, which includes reduction in overutilization of unnecessary interventions and increased utilization of necessary interventions.

✓ Use the new structure and initiatives on recruitment and retention to decrease vacancies and the use of locums, increase workplace satisfaction, and decrease sick leave and workplace injuries.

# Engagement with Federal Government

**Action 10.19:**
Develop a provincial strategic plan to immediately engage with the federal government for funding of a basic income approach, climate change actions, childhood development programs, meeting the needs of the aging population, community teams for primary care, and increased broadband penetration to communities.

## Background

The federal government is a key partner in enabling many of the priorities of Health Accord NL, in both the SDH and the health systems.

In the recent mandate letter from the Prime Minister to the newly appointed Minister of Health,[48] specific correlations with the work of the Health Accord are noted: ensure health care workers are supported and recruited; advance an integrated and patient-centric strategy; harness the full potential of data and digital systems; support hiring of new FPs, nurses and NPs; expand virtual care; help to cover digital infrastructure and other system improvements; expand the number of FPs and primary health teams in rural communities; create a world-class health data system; establish a permanent and ongoing Canada Mental Health Transfer; support efforts to improve the quality and availability of long-term care homes and beds; develop national standards and a Safe Long-Term Care Act to ensure seniors get the care they deserve; train and raise wages for personal support workers; modernize the federal research funding ecosystem for research excellence and downstream innovation; work in partnership with Indigenous peoples to advance their rights; ensure that public policies are informed and developed through an intersectional lens; engage with willing provinces and territories towards national universal pharmacare; recognize that a healthy population is key to reducing vulnerability to health events; promote healthy eating; promote seniors' physical and mental health to enable them to live longer at home; reduce emissions, create clean jobs and address the

[48] Office of the Prime Minister of Canada. (2021, December 16). *Minister of Health Mandate Letter*. Retrieved January 20, 2022, from, https://pm.gc.ca/en/mandate-letters/2021/12/16/minister-health-mandate-letter.

climate-related challenges communities are already facing; and address the profound systemic inequities and disparities that remain present in the core fabric of our society, including our core institutions.

An example of the potential of the federal government to provide up-front funding to start an important initiative is the projected money for primary care which on a per-capita basis would provide Newfoundland and Labrador with $12 million or more per year for four years. Provincial governments are regularly in receipt of targeted funds from many federal initiatives, with the concern being continued funding in the long-term for new programs facilitated by federal funding. There is also merit in considering partnering with other provinces in areas of like interest (e.g., basic income).

## Objectives

✓ Use the research and strategic initiatives provided by Health Accord NL, together with intergovernment experience and knowledge of funding provided by various departments of the provincial government, to apply to the federal government for consolidated targeted funding over several years for the priorities identified by Health Accord NL.

# 11

# Governance Approach

Health Accord
for Newfoundland & Labrador

**Our province. Our health. Our future.**
THE REPORT

**Section One: Formal Structures at the Provincial and Regional Levels**

Governance means the process of decision-making and the process by which decisions are implemented or not implemented. Good governance draws on four key dimensions: (i) who has power, (ii) who makes decisions, (iii) how stakeholders make their voices heard, and (iv) how accountability is rendered. Key governance principles, based on the United Nations Development Program's (UNDP) principles of good governance, include legitimacy and voice (participation and consensus-building), inclusion, direction and purpose, effective performance and responsiveness, accountability and transparency, and fairness and ethical behaviour.[49]

Governance is essential when we want to change outcomes at a population level, to address the underlying conditions that hold complex problems in place, to work differently together to change outcomes, or to find more inclusive ways to understand and solve problems identified.

Good governance also assures alignment and provision of services in ways that enhance the experiences of individuals, ensure they receive the right care by the right providers in the right place, and enable easier navigation of multiple services.

Is the current governance approach for health within Newfoundland and Labrador best designed to support the changes needed to improve health outcomes? How can governance in the province be reimagined to encourage, facilitate, and hold accountable existing and new systems to ensure improved health outcomes?

If real and measurable change is to occur, a fundamental shift to the overall structure(s) must be made.

## Challenges with the Current Governance Model

The current governance model has challenges which must be addressed in the reimagining of any new approach. Among the challenges are the following:

1. **Reporting structures and silos**:

    a. Many partners and individual practitioners who are important to health and health outcomes are not part of a well-developed or well-designed structure (fee-for-service physicians outside hospitals, dentists,

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[49] Institute on Governance. (n.d.). *What is Governance?*. Retrieved January 20, 2022, from, https://iog.ca/what-is-governance/.

optometrists, chiropractors, pharmacists, community sector organizations, recreation providers, etc.).

b. In some instances where there are reporting structures, it is unclear whether or how the information is received or effectively used or integrated into action.

c. While there are some accountability mechanisms in place within the health system, there are gaps. Existing accountability mechanisms are not connected in a way that ensures all partners are aligned toward the achievement of health outcomes.

d. There is no provincial reporting or transparency on quality in the health system in our province.

e. There continue to be silos which directly impact the ability to maximize limited resources in the province.

f. The current governance structure is not set up to incorporate community teams or integration with the community sector (housing, food security, social integration, etc.).

g. Many community organizations, especially small local non-profits with few resources which play such an important role in well-being and support for individuals, could benefit with support and training to ensure effective board governance and service delivery.

2. **Funding arrangements:**

a. There are many types of partnership arrangements in place such as Memorandums of Understanding, shared service contracts or other types of contracts, formal and informal agreements. There are also areas without any formal arrangements in place.

b. There are multiple funding sources—the provincial government, the federal government, health foundations, other fundraising bodies, corporations, etc.

c. Most agencies do not have multi-year funding agreements with the provincial government. This perpetuates the inability for long-term effective and efficient planning and further challenges staff recruitment and retention for these agencies.

d. Fund diversification is challenging especially for small not-for-profit organizations. The need to use so much energy preparing and competing for funding is a major deterrent for volunteers and is a source of inefficiency since time and energy would be better used directly in service provision or in core activities.

e. Without a coordinated approach to funding, further silos are created and opportunities for funding cannot be realized and exploited for maximum health gains.

3. **Structures to support collaboration:**

   a. There are no formal structures that require collaboration or integration among partners within current geographic areas or across different areas or sectors (e.g., education, community, and police).
   b. There are structures and processes that put partners in competition with one another rather than encourage them to work together to maximize results.
   c. Without system alignment, it is difficult to identify gaps in the system or areas where there is duplication of service or misalignment.

4. **Engagement mechanisms to genuinely include the voice of lived experience:**

   a. The importance of true partnerships with people with lived experience is not consistently recognized or formalized throughout the entire system.
   b. While there have been successful initiatives in some regions to engage citizens in existing governance structures, such success is not widespread.
   c. There is need to ensure that the governance structure provides a voice to those people who have not traditionally been heard during discussions about health and health care. Regional health authorities have reached out for public involvement, but it is challenging for some people with a variety of lived experience to participate in formal structures. A different and supportive model is needed.

5. **Data governance:**

   a. There is no clarity with respect to data governance.
   b. There are concerns over what is perceived as conflict between data privacy and care delivery.

The health of the people of Newfoundland and Labrador is influenced by the SDH, by the health system, and by biology and genetics. Governance for improved health lies with all government departments and all entities within the province which influence the social, economic, and environmental factors in the lives of the people. There is a need for a governance structure which ensures accountability for the health system, is inclusive of the publicly funded system, and is linked with the privately funded providers.

Therefore, a response to the challenges noted above must include four elements: (i) a reimagined governance structure for the health system, (ii) a mechanism to link the health system with other systems and organizations which influence health (e.g., education, justice, social programs, community organizations,

municipalities), (iii) an entity that reports to the health and social systems, providers, and the public on quality and performance, and (iv) a modernized approach to data governance.

## A Reimagined Governance Structure for the Health System

In a reimagined health system, the governance structure must operate at the provincial and regional levels, and these two levels of governance must be connected.

There is need for a provincial level structure that will have responsibility, authority, and accountability for the overall health system and for those programs and services that can be best standardized, integrated, and delivered provincially.

Stakeholders have clearly emphasized the need for regional structures if we are to best serve our residents and avoid the less-efficient, one-size-fits-all approach that typically occurs in a centralized model. The critical importance of this has been demonstrated in this province by Community Advisory Councils of the RHAs that provide a local voice to ensure that our limited resources are best utilized to meet the unique needs of our regions. This voice will become increasingly more important as community teams are integrated to support service sustainability at local levels. This is a strength that we need to empower, something we cannot afford to lose.

# ⊙ Calls To Action

## Provincial Health Authority

**Action 11.1:**
Create a Provincial Health Authority to provide province-wide planning, integration, and oversight of the health system and to deliver province-wide programs such as the ambulance system and information systems.

## Background

Many elements of the health system are most effective when centralized at the provincial level, given the small population of the province and the need for consistent standards and integration within the health system.

For this Provincial Health Authority (PHA), there will be a government-appointed board of trustees and a Chief Executive Officer (CEO) with a senior executive team. The competency-based board of the PHA will have membership from all regions of the province.

### Objectives

✔ Develop and maintain standards of care for provincial programs of care delivery.

✔ Create and have oversight of the integrated air and road ambulance system.

✔ Modernize and manage the province's health information system (HIS) including its management systems and virtual care technology.

✔ Oversee accountability for health outcomes through monitoring and reporting on quality, safety, and performance.

✔ Increase province-wide efficiencies within the health system by ensuring the sharing of resources through a clear division of responsibilities, improved communications, and enhanced collaborations.

✔ Ensure a provincial, progressive, and persistent strategy for recruitment and retention, finance, and other support areas.

*continued...*

## Objectives (continued)

✓ Find the most effective and efficient approach to procurement for the province's health system, building on the work that Central Health (CH) has done in its role as the lead for the provincial supply chain.

✓ Engage with post-secondary educational institutions to ensure a common vision and direction regarding the formation of highly qualified personnel, applied research, and shared resources as well as the development of an Academic Health Sciences Network.

✓ Partner with Indigenous communities to ensure appropriate response for all areas of health system delivery which are provided for the members of Indigenous communities.

✓ Be directly linked to the regional entities responsible for care delivery in their regions.

# Regional Health Councils

**Action 11.2:**
Create Regional Health Councils that (i) have the level of authority needed to address the organization and quality of health care delivery at the regional level, (ii) are sensitive to local and regional variations, and (iii) facilitate engagement with patients/clients/residents and with members of the public (including youth) to ensure that the health system is responsive to the identified health needs of the people of the region.

## Background

The geography of Newfoundland and Labrador with many small communities in rural and remote areas leads to variations in health outcomes and challenges the goal of health equity. A high level of sensitivity is needed to ensure an appropriate response to the diversity of health issues which result from these variations. Decentralization of service delivery within the parameters of provincial standardization seems to be an appropriate way to structure the health system to ensure that response to geographical diversity.

At the regional level, there will be government-appointed Regional Health Councils (RHCs) with Regional Administrators. The Regional Administrators will be members of the provincial senior executive team.

The PHA will delegate authority to the RHCs for the organization and quality of health care delivery at the regional level. The RHCs will be sensitive to local and regional variations and facilitate engagement with patients/clients/residents and with members of the public.

### Objectives

✓ Assume responsibility for the direct provision of health services at the regional level.

✓ Facilitate the effective and coordinated delivery of programs through community teams, health centres, mental health programs, community and regional hospitals, and publicly funded long-term care facilities.

✓ Include formal and informal structures for working with Indigenous partners.

*continued...*

## Objectives (continued)

✅ Focus on inclusion and public engagement to ensure continued high quality of care to all residents of the province, regardless of race, income, age, gender, ethnic identity, place of residence, ability, etc.

✅ Include formal and informal structures for partnering with patients/clients/residents and with members of the public.

✅ Partner with community organizations to reach vulnerable populations and other groups that have proven challenging to reach through traditional health care pathways.

✅ Be accountable for health outcomes through monitoring and reporting on quality, safety, and performance.

✅ Reduce the silos among the publicly funded and privately funded health care providers while maintaining the autonomy of organizations involved.

✅ Be directly linked with the Provincial Health Authority (PHA).

The two Calls to Action identified above are not new. Elements of these structures have been in place here in our province and in other provinces across Canada. However, there have been challenges with how these structures have been operating as noted above. Three elements are essential if this balance of centralization and decentralization is to provide the response needed by the people of the province: (i) effective and coordinated delivery of health care, (ii) participation of citizens in decision-making, and (iii) decreased silos among all the organizations which provide health care (publicly funded, privately funded, or delivered by community entities).

It will be essential that the respective mandates of the province-wide body and the regional structure be clearly defined to avoid conflicts and to maximize

the opportunities for collaboration. Among the areas which require clarity are the following:

1. The determination of the number of regions—this will need to take account of several factors: what seems to be most appropriate from the employees' perspective, what ensures the most effective functioning of the programs and services, and ultimately what best serves the people of the province being served by the health system.

2. The delivery of programs within the rural areas of what is today Eastern Health (EH)—will this be a separate region?

3. The delivery of programs within the St. John's area (given that tertiary and secondary services are provided within the same facilities in St. John's and that community teams, health centres, mental health programs, and publicly funded long-term care facilities serve many people in this area)—will there be a separate region for the St. John's area or would it be the responsibility of the provincial authority?

4. The appointment process for the provincial CEO and Regional Administrators.

5. The delineation of roles and responsibilities between the PHA and the RHCs.

6. The delineation of roles and responsibilities between the Department of Health and Community Services (HCS) and the provincial and regional structures.

> **"**
>
> **Continue to practice frequent and effective communications with the public. We must have public buy-in if we expect our political leaders to act expeditiously on the implementation plan.**
>
> *– Engagement series 5 survey participant*

# Call To Action

**Action 11.3:**
Establish a Regional Social and Health Network in each region of the province which is responsible for the integration of the services of various organizations that influence health and health outcomes (e.g., health systems, social programs, municipalities, schools, police, recreational programs, arts and cultural programs, community sector non-profit and voluntary groups, and private sector businesses).

## Background

The previous chapters of the Health Accord Report outline the Calls to Action needed to improve health outcomes and move to health equity for the people of Newfoundland and Labrador. At both the national and international levels, jurisdictions are realizing that we have set expectations for our health systems that are not possible to meet unless we expand our focus to address all factors that truly affect health. A founding principle of this Report is the impact of social, economic, and environmental factors on health outcomes and health equity.

People's health can be positively influenced by providing employment, better housing, nutrition, recreational opportunities, and social inclusion, by shaping the physical environment, and by reducing incidences of racism, sexism, and childhood trauma. These are the factors that have the largest impact on our health outcomes, and our governance structure must include this expanded focus. The province will be better served by a system that is able to benefit from the combined and added value that occurs when the right groups are talking to each other and aligning available resources to proactively address challenges that cannot be dealt with alone.

Movement towards this vision requires better integration between the health system and those partners whose work has an impact on health. Among these

partners are municipalities, community sector organizations delivering health or social services, personal care homes, family physicians (FPs), private providers (e.g., dentists, pharmacists, physiotherapists, occupational therapists, chiropractors, massage therapists, naturopaths), the K–12 education system, the post-secondary education system, social services programs, and the justice system. Space must also be found for persons whose voices must be heard but who do not have connections with formal organizations.

Today, collaboration among these partners is often based on the personal decisions of those involved and their dedication to improving the health of the people of the province. More formal ways to ensure collaboration and integration among these partners are needed.

## Objectives

✓ Establish a Regional Social and Health Network (RSHN) in each designated health region.

✓ Encourage and facilitate the culture shift to acknowledge the link between social, economic, and environmental factors and population health.

✓ Provide a forum for dialogue and collaboration among the various partners in the communities in the regions.

✓ Ensure accountability for integration among and across these partners.

✓ Encourage the participation of partners who are unique to an individual region in addition to those who are common among regions.

✓ Provide resources to support these new RSHNs.

*continued...*

## Objectives (continued)

✓ Ensure that the leaders of the various groups in the regions are the members of the RSHNs.

✓ Even though the groups function as equals within the RSHNs, give responsibility to the health system to convene the RSHN.

This RSHN is a second structure positioned at the regional level. **However, its role is different from the RHC identified in 11.2. The structure set out in 11.2 is the regional health service delivery body responsible for health care delivery. In contrast, this RSHN is a collaborative structure where different stakeholders at the regional level can come together to identify opportunities for common focus.** They can then bring that information back to their own organizations to determine where they can better align services with the other stakeholders to improve client outcomes.

This RSHN is a way to focus attention to address health issues proactively and effectively (an upstream approach) rather than to focus solely on a health care response (a downstream approach). These RSHNs are new to our thinking in Canada and in our province. There will be a time period during which the role and responsibilities of the RSHNs will evolve before the structure can be finalized.

**Section Three: NL Council for Health Quality and Performance**

**Direction Statement**

We must build a culture of compassion, quality, learning, and innovation across the social and health systems. We will improve individual and population health, as well as the performance of our social and health systems. All people of the province will receive high value, timely services in a way which matches actual practice with best practice. Accountability, oversight, research, and beneficial innovation will ensure optimal quality of care.

# ⊙ Calls To Action

## NL Council for Health Quality and Performance

**Action 11.4:**
Establish the NL Council for Health Quality and Performance to improve health and social systems, which fully incorporates principles of diversity, inclusion, and integration.

## Background

In previous chapters, we have noted the unacceptable rates of adverse health outcomes in Newfoundland and Labrador in comparison with the other provinces in Canada, including life expectancy, disease-specific mortality rates, and rates of chronic illness. We have also noted the imbalance between increases in health system funding compared with social spending within the province over the past four decades.

Approximately 20–30% of the health budget for interventions such as drugs, laboratory tests, and diagnostic imaging is being spent on interventions that are unnecessary and potentially unsafe. It is estimated that up to 30% of all medical measures may be unnecessary and offer no clinical value to patients.[50] Long after research contradicts common medical practices, patients continue to demand them, and physicians continue to deliver. The result is an epidemic of unnecessary and unhelpful treatments, which is a global problem.

It is estimated that Canadians have more than 1 million potentially unnecessary medical tests and treatments every year, and these tests have both adverse cost and clinical implications.

For example, one of the top ten health issues noted by the World Health Organization (WHO) is the overuse of antibiotics and the harm associated with bacterial resistance. Physicians in Newfoundland and Labrador prescribed 19% more antibiotics than those in the second highest province in Canada in 2016. Another example is overuse of CT scanning in which the dangers of radiation with attendant risks of cancer outweigh the benefit arising from a CT ordered without an appropriate indication. Newfoundland and Labrador has one of the highest rates of CT scanning in Canada.

Furthermore, this province also spends the most per capita on health care, driven at least in part by substantial overuse of certain medical tests (e.g., laboratory testing, diagnostic imaging), treatments (e.g., antibiotics) and both acute hospitalization and use of long-term care. Many jurisdictions both nationally and internationally have introduced organizations mandated to address these quality issues with substantial evidence of benefit. In Canada, the provinces of British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and New Brunswick implemented quality councils between the years of 2002 and 2008.

Quality of Care NL and NL Centre for Health Information (NLCHI) have worked together to transform data into actionable information and to translate this knowledge for action by institutions and providers. In our current system, accountability structures exist in the RHAs but not elsewhere in the health and social system. Given the diversity of organizations/individuals in these two sectors who are expected to contribute to change, a defined accountability framework is necessary in the new governance structures.

[50] Born, K. B., & Levinson, W. (2018). Choosing Wisely campaigns globally: A shared approach to tackling the problem of overuse in healthcare. *Journal of general and family medicine, 20*(1), 9–12. https://doi.org/10.1002/jgf2.225.

There are currently several Officers of the House of Assembly (Auditor General, Seniors' Advocate, Child and Youth Advocate, Citizens' Representative) who report directly to the Legislature. By reporting directly to the Legislature, they are independent entities with legislative protection. The CEO of the NL Council for Health Quality and Performance (The Council) could become an Officer of the House of Assembly, thus having the independence, resources, influence, and transparency needed for the wide scope of subject matter envisioned in this Report.

Accountability for improved outcomes is the responsibility of the health and social systems that deliver care. In support of this accountability, The Council would have three major roles: (i) reporting on quality and performance of the health and social systems to the public, providers, institutions, and governance structures; (ii) developing and executing the evaluation plan for the Health Accord; and (iii) providing leadership for the learning health and social system. The Council is envisaged as directly connected to Quality of Care NL whose focus is evaluation, research, and knowledge translation.

## Objectives

✓ Create an organization, protected by legislation and arms-length from government, which provides information and advice, in an iterative process, to improve quality and performance of institutions and providers in the health and social systems. This should evolve from structures already created to provide clinical interpretation and knowledge translation of data and to improve quality in the province.

✓ Develop an approach to quality of care and performance in partnership with hospitals, long-term care facilities, community teams, individual providers, and the social system.

✓ Develop an approach to quality of care and performance in partnership with the private sector, such as ambulance operations, home care, and personal care homes.

*continued...*

**Objectives (continued)**

✓ Provide advice to the delivery systems on possible interventions that ensure actual practice is best practice, using evidence-based guidelines in health care, including recommendations from Choosing Wisely Canada.[51]

## Accountability for Improved Health Outcomes

**Action 11.5:**
Improve accountability structures within the health and social systems to focus on achievement of better health outcomes.

### Background

According to the Commonwealth Fund analysis, Newfoundland and Labrador has the worst health system performance among the ten provinces in Canada based on the integration of multiple metrics. Targeted action is required by health and social sectors to change these health outcomes. Given the diversity of organizations and individuals in both the health and social sectors required to contribute to the change, a defined accountability framework which is the responsibility of the governing structures at the provincial and regional levels is needed.

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[51] *Choosing Wisely Canada* is a Canadian-based health education campaign launched on April 2, 2014, under the leadership of Dr. Wendy Levinson in partnership with the Canadian Medical Association and based in Unity Health Toronto and the University of Toronto. The campaign aims to help clinicians and patients/clients/residents engage in conversations about unnecessary tests, treatments, and procedures and to assist physicians and patients/clients/residents in making informed and effective choices to ensure high quality care. See https://choosingwiselycanada.org.

In a time of fiscal restraint, there is a critical need to develop responsive and accountable health and social service systems where expectations are clear, and all components work collaboratively.

## Objectives

✔ Implement a comprehensive accountability framework to improve health outcomes for the province inclusive of both health and social sectors and the structural changes recommended by Health Accord NL.

✔ Amend the Regional Health Authorities Act, the Public Health Act, the Patient Safety Act, the Health and Community Services Act, the Emergency Health and Paramedicine Services Act, and any related regulations to include specific requirements for accountability that cross all levels of health organizations—board, CEO, executive, management, and front line.

✔ Review existing accountability mechanisms to determine whether and how they should be improved.

✔ Develop an evaluation agenda to measure system performance including metrics for appropriate medication use across the health system to inform interventions on overutilization and underutilization by providers and institutions, access to comprehensive primary care, adverse events, wait times for critical procedures and services, and backlogs of surgeries.

✔ Engage with community organizations and municipalities to adopt and evaluate a "health in all policies" approach.

✔ Establish a program for monitoring wait times and report publicly on how our system is achieving appropriate standards.

As work proceeds in the development of an accountability framework, it will be important to focus on setting expectations, monitoring performance, and reporting on outcomes: three main components of any accountability cycle. In the following section, there are Calls to Action which set up the oversight structure to ensure that these components are in place and identify initial accountability-related priorities that will support the province in working toward better health outcomes.

## Long-Term Evaluation Plan

**Action 11.6:**
Design a long-term evaluation plan related to the implementation of Health Accord NL (based on its Calls to Action) to determine whether the actions undertaken are achieving the objectives of each strategy.

" The public must be kept aware of how the plan is proceeding not only for issues of transparency but to EDUCATE the public about WHY this is being done. As a population, we must take responsibility for our own health in the long term and understand that we, too, must make changes in our expectations for the good of the whole system.

*– Engagement series 5 survey participant*

## Background

Evaluation of change requires baseline information before change has occurred and identification of metrics, data sources, and teams with expertise on evaluation and implementation science.

It is recognized that much evaluation happens within the current health and social systems. The intention of this Call to Action is to focus on the implementation of the Health Accord. From time to time, it will use the outcomes of other evaluation activities or partner with other groups to do joint evaluation projects.

A long-term plan requires information on an on-going basis so that actions can be changed if they are not having the anticipated impact.

## Objectives

✔ Identify the leads and groups needed to evaluate each component of the 5-year Health Accord NL plan that evolves over the 10-year horizon for the plan.

✔ Determine in 2022 the metrics and data sources necessary so that baseline data are available prior to implementation of the plan.

✔ Ensure the evaluation plan focuses on inclusion and integration.

✔ Assign responsibility for the implementation of the evaluation plan to the NL Council for Health Quality and Performance.

# Measuring and Tracking Indicators of the Social Determinants of Health

**Action 11.7:**
Identify, document, address, and track indicators of social determinants of health in Newfoundland and Labrador, in an ethically transparent and publicly accessible manner, at the point of care in the health system and at community, regional and provincial levels.

Measuring indicators of the social determinants of health (SDH) in Newfoundland and Labrador is essential to assess the extent of the challenges to health, plan implementation of interventions, determine trends over time, and measure outcomes.

Several jurisdictions measure indicators of the SDH but may not identify them as such. In Newfoundland and Labrador, these measurements are not systematic, comprehensive, or consistent and are dispersed across multiple different information sites. Some countries have developed national well-being indicators (e.g., Wales collects, documents, and tracks 46 such indicators). These indicators and others can serve as a starting point to begin the process of measuring and evaluating SDH indicators at regional and provincial levels in Newfoundland and Labrador.

Health systems often lack the necessary tools to identify, document and track SDH. An example of an organization which is doing innovative work in this area is Kaiser Permanente Northwest, an integrated health system providing care to more than 600,000 clients in 34 medical clinics and two hospitals in the northwestern United States. They use specifically trained patient navigators to identify and address the SDH of patients/clients, identified at three points: initial contact, referral from a clinician, and proactive assessment. All the information is captured in the Electronic Health Record (EHR), comparable in Canada to the Electronic Medical Record (EMR).

## Objectives

- Implement new and coordinate existing measures of SDH in Newfoundland and Labrador at community, regional, and provincial levels.

- Integrate trained patient navigators into interprofessional teams to assess, document, and address SDH at the point of care in the community.

- Ensure that all indicators of SDH are accessible for both patient/client/resident care and secondary uses.

- Develop a data governance structure framework to ensure the collection, quality, coordination, transparency, and analysis of SDH indicators (see Action 11.10).

- Ensure that all indicators of SDH are accessible for care delivery, tracking, and evaluation in a linked and safe manner.

- Commit to making indicators of SDH accessible and publicly available.

- Expand the Provincial Climate Data Information Portal to include a climate emergency "Report Card" to annually report publicly on the success of preventative actions taken throughout the province with respect to impacts on public health and progress toward defined provincial outcomes.

**Direction Statement**

**A learning health and social system is one in which science, education, informatics, incentives, and culture are aligned for continuous improvement, innovation, and equity. Best practices are seamlessly embedded in the delivery process, individuals and families are active participants in all elements, and new knowledge is generated as an integral by-product.**

# Call To Action

## Culture of Quality – Learning Health and Social System

**Action 11.8:**
Foster a culture of quality and establish a comprehensive, effective, and sustainable learning health and social system.

## Background

Newfoundland and Labrador has had the fastest uptake of EMRs among outpatient clinicians in the country. One of the Health Accord's major Calls to Action include a modern health information infrastructure which integrates data across regions and across the various sectors of the health and social systems. This will provide robust data for NLCHI which has the analytic capacity to provide information that can influence the performance of the delivery systems. Quality of Care NL has applied implementation science to data

provided by NLCHI to match actual practice and performance with best practice and performance. Thus, the basic components of a learning health and social system are present or planned.

Currently, some aggregate data exist on social system performance, but few data are collected on social factors that influence health in individuals and populations. There is a need to use current and emerging SDH metrics to measure and intervene in social system performance.

## Objectives

✓ Foster a culture of quality improvement among administrators, providers, all stakeholders, and patients/clients/residents.

✓ Expand on existing work in the RHAs, Quality of Care NL, NLCHI, and the educational institutions to form an integrated, coordinated, and effective learning health and social system that will facilitate improvement in the health of the population, and more effective and efficient systems.

✓ Assign primary responsibility for the learning health and social system to the NL Council for Health Quality and Performance to support learning health and social system activities across the province and integration with stakeholders, frontline staff, and the public.

✓ Develop standard tools for socio-demographic data collection which focuses on measurement of social system performance, social factors related to health of individuals, and SDH related to communities and population groups (see Action 11.7).

# ⊙ **Call To Action**

## Provincial Data Governance Model

**Action 11.9:**
Develop a holistic and integrated provincial data governance model which includes a strategy that defines a vision for how data will be used to improve the health and social systems of Newfoundland and Labrador in a transparent and accountable manner.

## Background

Data is an important, valuable public asset that is required to deliver patient care, make informed policy decisions, monitor health and social system performance, enable research and innovation, inform decision-making at the regional level, and empower citizens with access to their own health information.

Digital technologies and information systems are often implemented in an uncoordinated way, often with limited considerations of interoperability, the data collected, and the subsequent uses. Without a strong digital foundation and proper interoperability and data standards, data silos emerge and result in significant inefficiencies, patient safety risks and data gaps.

Currently, digital technology and information systems are provider-centric, and our legislation is designed based on custodians who determine access to patient information. There is an urgent need to shift from a provider-centric model to a person-centric model and modernize our legislation to enable appropriate data access and sharing for the purpose of improving health outcomes. Provider teams must have timely access to all pertinent patient/client/resident information and community/population-level data through digital technology solutions to enable

shared information for patient/client/resident care. Equally important, data must be accessible to patients/clients/residents, and for uses beyond care, such as research, innovation, and health and social system performance measuring and monitoring.

Data governance requires a holistic approach where all those who have a vested interest in the data participate in the practice and focus on learning and improving data over time. It is well-understood that unconscious bias and social cultural norms can cause people to reinforce exclusion and biases in collecting, analyzing, using, and sharing data. The voices of vulnerable and marginalized groups must be present and heard when data governance structures and processes are being developed and implemented.

Data governance is everything we do to ensure that data—for both internal and external uses—is secure, private, accurate, complete, available, trustworthy, and usable. It includes the actions people must take, the processes they must follow, and the technology that supports the entire data life cycle. **Data governance means setting internal standards or policies that apply to how data is gathered, stored, manipulated, accessed, and deleted.** Elements include privacy, data ethics, security, information management, data architecture, data modeling and design, data storage and operations, data integration and interoperability, documents and content, reference and master data management, data warehousing, meta-data, and data quality.

Data governance provides data management practices with the necessary foundation, strategy, and structure needed to ensure that data is managed as an asset and an invaluable resource.

## Objectives

✓ Create a Provincial Data Strategy, organizational structure, and processes that align with health and social system priorities, including linkages with the SDH.
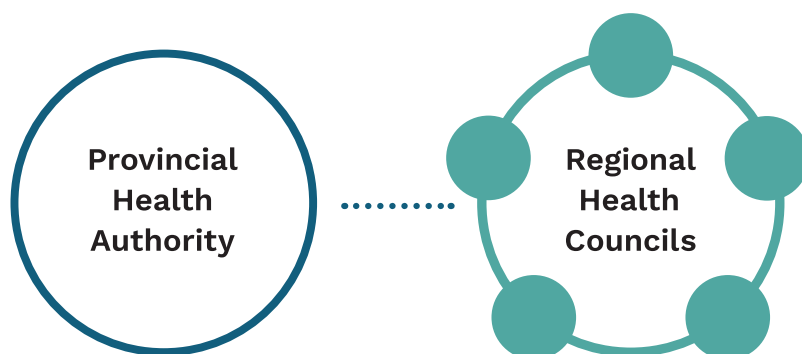
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## Objectives (continued)

✓ Engage all those who are representatives of the stakeholders (producers, users, or beneficiaries of the data) in shaping the data governance process. Be especially attentive to the inclusion of persons who are from vulnerable and marginalized groups in the province.

✓ Promote the goals and accomplishments of data governance and nurture a data-driven culture.

✓ Ensure that data governance clearly supports the priorities and strategies of those who need the data, serves the needs of users throughout the data life cycle, and balances apparent conflicts.

✓ Ensure that data governance includes the use of data for research to better inform strategy and priorities.

✓ Establish the infrastructure and technology with a "privacy by design" lens.

✓ Set up and maintain the processes and policies.

✓ Identify the persons or positions that have both the authority and the responsibility for handling and safeguarding specific types of data.

✓ Understand data governance as an ongoing and iterative process, responsive to changing circumstances and enabling leaders to rebalance priorities.

✓ Promote data governance as an asset for improving health outcomes and health equity.

The following graphic illustrates the two major components of the new governance approach: the governance structure for the rebalanced health system (the PHA and RHCs), and the new approach to support health governance (the RSHNs, The Council, and Provincial Data Governance).

## Components of the New Governance Approach

**Health System Governance**

**Provincial Health Authority**

**Regional Health Councils**

**New Approach to Support Health Governance**

**Regional Social and Health Networks**

+

**NL Council for Health Quality and Performance**

+

**Provincial Data Governance**

# ⏩ Call To Action

**Action 11.10:**
Establish a transitional governance structure to begin preparations for the implementation of Health Accord NL.

## Background

It is urgent that the transformation envisioned by Health Accord NL begin as soon as possible. Since creating legislation and establishing governing structures need appropriate time and careful attention, it is recommended that a transitional structure be put in place to prepare for the more permanent structure which is outlined above. The transitional structure must ensure that the transition focuses on the importance of attention to SDH so that we can begin to improve health and health outcomes in the province.

The transitional structure would have three components: an appointed senior executive (Health Accord), a transitional PHA and CEO, and a transitional NL Council for Health Quality and Performance. It is also recommended that an Advisory Council be established to ensure continuity with the Health Accord process and ongoing engagement with the people of the province. All would work closely together to begin the implementation process and to ensure the ongoing engagement with the public in these first steps.

Transition agreements and other supports will need to be put in place throughout the health system to support staff members and physicians and reduce disruption through the rebalancing of the system.

The development of the RSHNs will also be initiated in this transitional period, led by the senior executive (Health Accord) and the Advisory Council. As described in Action 11.3, there would be a RSHN established in each region of the province with responsibility for the integration of the services of various organizations that influence health and health outcomes. These RSHNs are key

to helping transform our approach to health in our province by recognizing and acting on the social, economic, and environmental factors that have the greatest influence on our health and health outcomes. Given that these RSHNs are new in Canada, the process related to their development will allow for a period of learning about the best ways to structure the RSHNs and to hold them accountable for their mandate of integration at the regional level.

## Objectives

✅ Appoint a senior executive (Health Accord) in Cabinet Secretariat. This position would be in place for two to three years with a mandate to oversee the beginning of the implementation of the Health Accord's Calls to Action with the authority to lay out the framework to support the full transition imagined in the Health Accord.

◇ The senior executive (Health Accord) would be supported by a council of deputy ministers from the many departments directly connected to this Accord implementation process.

◇ The senior executive (Health Accord) would provide advice on the shift in focus to SDH and initiate the development of the RSHNs.

◇ The senior executive (Health Accord) would provide policy advice on key initial implementation steps (e.g., integrated air and road ambulance system, new health information systems, development of community teams, the NL Council for Health Quality and Performance, sustainability of health services), and would participate in engagement with the federal government.

*continued...*

## Objectives (continued)

✓ Establish an Advisory Council which reports to the Premier and is supported by the senior executive (Health Accord). The Council should consist of members from the Health Accord's Task Force, strategy committees or working groups to ensure continuity with the strategic visioning process undertaken by the Health Accord and to include representation from all regions of the province as well as Indigenous communities.

✓ Appoint a transitional PHA and a transitional CEO. This transitional structure would be in place for one year with a mandate to set the groundwork for the implementation of the rebalanced health system. Acknowledging the instability this may cause already stressed staff, managers, and physicians, it is essential that the transitional CEO have strong and demonstrated change management skills.

◇ In accordance with current governance best practice, the Board of the transitional PHA would be competency-based with predetermined competencies, inclusive of geographic and Indigenous representation.

◇ The transitional Board and CEO would work closely with the existing RHAs and their CEOs who would continue their existing responsibilities during the transitional year. The RHAs would begin preparatory steps for the establishment of community teams and improvement of sustainability in health services.

◇ The transitional Board and CEO would work closely with the senior executive (Health Accord) in the preparation for actions needing immediate attention including the integration of the air and ground ambulance system and the new approach to health information systems.

*continued...*

◇  The transitional Board and CEO would be expected to use modern change management approaches to address the complexity inherent in rebalancing the health system.

✓  Put in place a transitional Council in anticipation of the legislated NL Council for Health Quality and Performance. This transitional Council would connect with Quality of Care NL; report on baseline indicators to the public, providers, institutions and governance structures; initiate the evaluation plan; and facilitate the culture shift to a learning health and social system.

✓  Determine how best to incorporate SDH with the health care structure by working closely with community sector organizations at the provincial and regional levels.
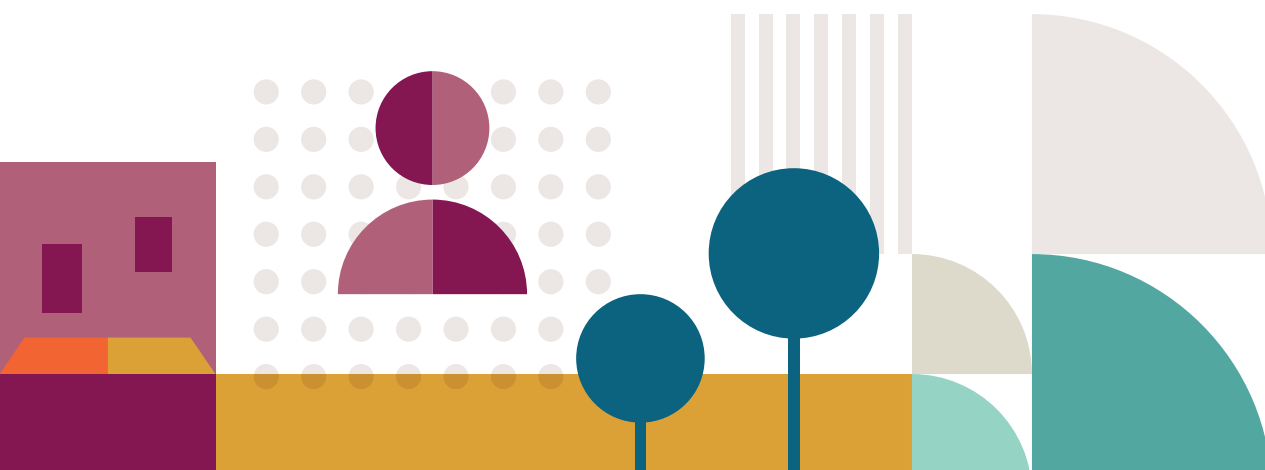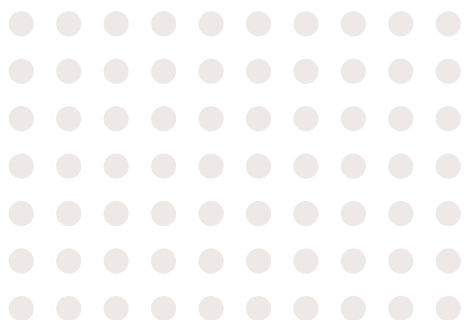
**12**

# Conclusion

## Our Vision, Our Future

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> " As someone who has worked in the healthcare system for the last 20 years it is the first time in a long time that I have had hope for a better future. I hope all the pieces come together so this plan can work.
>
> *– Engagement series 5 survey participant*

What will Newfoundland and Labrador look like when Health Accord NL is fully implemented? The person and the family are at the center—you and your family. Your community, which will change over time, is that space in which you are born, in which you live and grow, in which you eat and exercise, in which you learn and work and play, in which you are respected and feel safe no matter what group or race you belong to, and in which you age with dignity and autonomy.

## Impact of Social Determinants of Health

Social, economic, and environmental conditions influence your health and the health of your family, your community, and our province. We will know that influence is positive when there are social supports available to you, when you have a voice in what matters to you, when you enjoy good quality food and water, when your home is safe and warm, when there are strong efforts to reduce poverty in your area, when every child has a good start in life, when the school system serves your children well, when there is access to a full array of services for youth, when the justice system protects you, when there are strong supports and services for your mental health, when any signs of systemic racism in your community are recognized and addressed, when no one feels excluded or stigmatized.

# Impact of the Rebalanced Health System

The province's formal health system keeps all its key elements, but now they work better together to ensure that each person, no matter what age or geographic location or personal circumstances, has the best possible access to high quality health care. The health system has well-equipped, appropriately educated providers who work in an environment that values and supports them. The health system is embedded in a community where family members, care providers and volunteers, community groups and advocacy groups continue to provide support and connection.

## Aging in Place
Aging in place in age-friendly communities becomes the foundation for care for older persons in their homes, in personal care homes, and in long-term care facilities. Community teams permeate all components of the elder care system.

## Community Teams
Community teams cover the whole province, including every community, with access to every person of any age in defined catchment areas. Health centres provide urgent care, transition points for hospitals where they are needed and, in some instances, holding beds and long-term care beds.

## Hospitals
Community hospitals provide emergency services as well as a broad spectrum of general medicine, elder care including restorative care, mental health care, and core services that can be provided in a sustainable way. Regional hospitals provide specialized care including geriatric services, stroke care, and rehabilitation. The tertiary hub in St. John's provides the most specialized care for adults and children, for acute care, mental health care, chronic care, and rehabilitation.

## Integration
This health system, rebalanced now between community and hospitals, is integrated into the broader systems which influence health, health outcomes and health equity. Our health and social systems are balanced, collaborative, and connected, linked in real ways including by information systems, and are aligned in ways that support each other. Each one knows the services and programs which are being provided for you and for your family.

## Pathways
Pathways among the components are made by community points of contact who collaborate with each other, by virtual care or by information systems, by the land and air ambulance system, and by navigators whose only purpose is to help

cross the lines that, in the past, have not been easily crossed. Groups, centres, networks, and coalitions link social support and health care in their unique ways, connected more carefully and intentionally to other parts of the system.

## Impact on Workplace

People who work in our health and social systems enjoy their work, feel a sense of satisfaction in being able to work to the full scope of their practice, and know that they are making a difference. They delight in working in teams and are constantly learning from each other. They have found good work-life balance.

## How Will We Know that Health Accord NL has achieved its vision?

We are aware that specific social, economic, and environmental conditions are affecting your health and we are doing something about them. Health and social systems are balanced and are collaborating to ensure that you have better health outcomes. Before they ever make a major decision, every organization asks, "How will this affect health in the community?" We have lower rates of chronic illness and fewer deaths from stroke, heart disease and cancer. Every person feels safe and protected no matter what their age or what group they belong to. The health of the people of our province is as good as the health of those in other provinces. Each one of us is taking responsibility for ensuring that we are all healthy.

## Whole of Society Approach

Changing a culture with one of the worst health outcomes in the country will require a "whole of society" approach. It will not be sufficient to simply seek efficiencies within health institutions (hospitals, health centres, and long-term care homes) or the larger health system (that includes private practice physicians and other clinicians). We need to reimagine what makes a healthy population: a decent job, better housing, better nutrition, better social inclusion, etc. We need to ensure that the governance structure provides a voice to those people who have not traditionally been heard during discussions about health and health care. It will be essential to:

1. Support people's health by providing employment, better housing, nutrition, recreational opportunities, social inclusion, and physical environment, and by reducing incidences of racism, sexism, and childhood trauma.

2. Optimize utilization of the health system by ensuring the sharing of resources through a clear division of responsibilities, improved communications, and enhanced collaborations.

3. Ensure continued high quality of care to all residents of the province, regardless of income, age, gender, ethnic identity, or place of residence.

## Leadership

Making Health Accord NL come to life will demand the commitment and the energy of all Newfoundlanders and Labradorians. We will need intelligent and committed leadership at the highest political and executive levels of government and of our health and social systems. We will need wise and energetic leadership from the community sector, the private sector, the health education sector, municipalities, and Indigenous governments. We will need continued engagement and persistent demands from every one of us in this province that the Calls to Action be answered and Health Accord NL be implemented.

Only with this level of engagement, commitment, and leadership will the health outcomes of the people of this province reach a level comparable to all Canadians. Only then will health equity become real among us. Nothing less than this is acceptable. Only when we achieve this vision will Newfoundland and Labrador be a thriving, welcoming, and healthy place for us and for the generations to come.
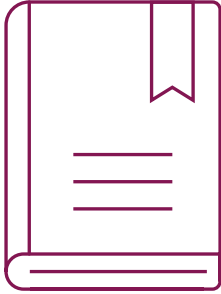
# Appendix A

# Health Accord NL
# Terms of Reference
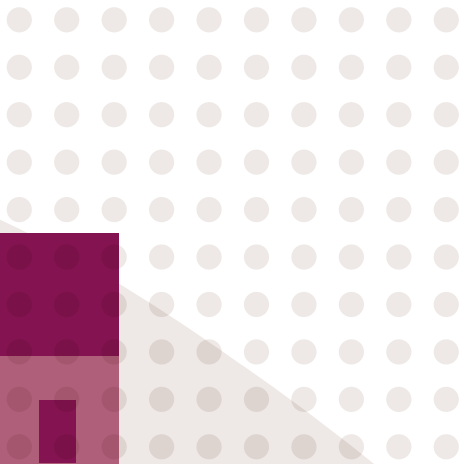
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# Appendix A:
# Health Accord NL Terms of Reference

## Purpose:

Health Accord NL, the provincial Task Force on health (the Task Force), is responsible for developing a 10-Year Health Accord for Newfoundland and Labrador that comprises actions and recommendations in strategic areas of health and health care to be implemented throughout the life of the Health Accord.

## Mandate:

The Task Force has the mandate to:

▶ Work with the Minister of the Department of Health and Community Services to assist in the delivery of the Task Force mandate.

▶ Work with the Task Force strategic committees and working groups to review work plans, provide strategic direction, ensure connection and continuity, and build consensus amongst stakeholders for actions and recommendations.

▶ Work to implement strategies to ensure opportunities for two-way engagement and communication with all stakeholders, particularly the public, including opportunities to provide feedback to and connect with representatives on the Task Force, committees, and working groups.

▶ Work with key informants, Indigenous communities, and the community sector to garner advice and counsel as needed, as well as to build consensus for actions and recommendations.

## Membership:

**Task Force Members:**

▶ Co-Chairs, Task Force (2 positions)
▶ Chair, Social Determinants of Health Committee
▶ Chair, Community Care Committee
▶ Chair, Hospital Services Committee
▶ Chair, Aging Population Committee
▶ Chair, Quality of Care Committee
▶ Chair, Digital Technology Committee
▶ Chief Executive Officers, Regional Health Authority (4 positions)
▶ Chief Executive Officer, NL Centre for Health Information
▶ Deputy Minister, Health and Community Services
▶ Executive Director, NL Medical Association
▶ President, Registered Nurses Union of Newfoundland and Labrador
▶ Executive Director, Association of Allied Health Professionals
▶ President, Newfoundland and Labrador Association of Public and Private Employees
▶ President, Canadian Union of Public Employees
▶ Dean, Faculty of Medicine, Memorial University
▶ Community Members (3 positions)
▶ Member from Indigenous Communities
▶ Member Appointed by Liberal Party
▶ Member Appointed by Progressive Conservative Party
▶ Member Appointed by New Democratic Party
▶ Engagement Advisor (1 position)
▶ Chair, Workforce Readiness Working Group
▶ Chair, Education Working Group
▶ Other representatives as invited or required by the Task Force

**Secretariat:**

▶ Operations Manager
▶ Senior Policy Advisor – Health
▶ Senior Policy Advisor – Interdepartmental
▶ Clinical Epidemiology Advisor
▶ Implementation Advisor
▶ Communications Advisor
▶ Other representatives as invited or required by the Task Force

# Rules Of Procedure:

**Meetings:**

▶ The Task Force will meet monthly.
▶ The Secretariat will support the Task Force and will distribute a draft agenda with relevant documents for the meeting no later than five days before an agreed meeting date.
▶ The Task Force will strive to work by consensus in drafting its advice and recommendations.
▶ A record of each meeting will be kept and will be circulated to The Task Force after each meeting.

**Accountability:**

▶ The Task Force is accountable to the Premier and the Minister of Health and Community Services.

**Members:**

▶ Attend meetings on a regular basis.
▶ Review all necessary meeting material and be prepared to speak to the items on the agenda.

**Review:**

These terms of reference will be reviewed as needed.
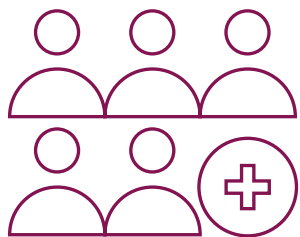
# Appendix B

# Membership: Task Force, Strategy Committees, Working Groups

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# Appendix B:
# Membership: Task Force, Strategy Committees, Working Groups

## Health Accord NL Task Force Members

| Task Force | |
|---|---|
| **Task Force Co-Chair**<br>**Committee Chair: Quality Health Care**<br>**Working Group Chair: Finance** | **Patrick Parfrey**<br>*(Clinical Lead, Quality of Care NL; John Lewis Paton Distinguished University Professor)* |
| **Task Force Co-Chair**<br>**Committee Chair: Social Determinants of Health**<br>**Working Group Chair: Governance** | **Elizabeth M. Davis** |
| **Committee Chair: Community Care** | **Shanda Slipp**<br>*(Family Physician, Western Health)* |
| **Committee Chair: Aging Population** | **Joan Marie Aylward**<br>*(Community Champion; Former Provincial Politician; Former NLNU President; Former Executive Director of St. Patrick's Mercy Home)* |
| **Committee Chair: Digital Technology** | **Paul Preston**<br>*(Former CEO, techNL)* |
| **Committee Chair: Hospital Services** | **Sean Connors**<br>*(Associate Professor of Medicine – Cardiology; Clinical Chief of Cardiac Care Program, Eastern Health)* |
| **Working Group Chair: Workforce Readiness** | **Louise Jones**<br>*(Former CEO, NL Council of Health Professionals; Former Regional Health Authority CEO)* |
| **Working Group Chair: Education** | **Ian Bowmer**<br>*(Past President, Royal College of Physicians and Surgeons of Canada; Professor Emeritus and former Dean, Faculty of Medicine, Memorial University)* |

| | |
|---|---|
| **Eastern Health** | **David Diamond**<br>*(CEO)* |
| **Central Health** | **Andrée Robichaud**<br>*(CEO)* |
| **Western Health** | **Michelle House**<br>*(Interim CEO)* |
| **Labrador-Grenfell Health** | **Heather Brown**<br>*(CEO)* |
| **NL Centre for Health Information** | **Steve Clark**<br>*(CEO)* |
| **Department of Health & Community Services, Government of NL** | **Karen Stone**<br>*(Former Deputy Minister as of Dec. 2021)* |
| **Department of Health & Community Services, Government of NL** | **Andrea McKenna**<br>*(Deputy Minister as of Dec. 2021)* |
| **Newfoundland & Labrador Medical Association** | **Robert Thompson**<br>*(Executive Director)* |
| **Registered Nurses' Union NL** | **Yvette Coffey**<br>*(President)* |
| **Association of Allied Health Professionals** | **Pamela Toope**<br>*(Executive Director)* |
| **NL Association of Public and Private Employees** | **Jerry Earle**<br>*(President), Member until September, 2021* |
| **Canadian Union of Public Employees NL** | **Sherry Hillier**<br>*(President), Member until December, 2021* |
| **Faculty of Medicine, Memorial University** | **Margaret Steele**<br>*(Dean of Medicine, Memorial University; Chair Elect, Association of Faculties of Medicine of Canada)* |
| **Community Member** | **Bud Davidge** |
| **Community Member** | **Linda Oldford** |
| **Community Member** | **Michael O'Keefe** |
| **Indigenous Community Member** | **Anthony Andersen**<br>*(Nunatsiavut Government, Minister of Finance)* |

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| | |
|---|---|
| **Task Force Member appointed by Liberal Party of NL** | **Jeff Marshall** *(Chiropractor)* |
| **Task Force Member appointed by NL New Democratic Party** | **Joshua Smee** *(CEO, Food First NL)* |
| **Task Force Member appointed by Progressive Conservative Party of NL** | **Ross Wiseman** *(Former Provincial Cabinet Minister & Health System Manager; appointed October 2021)* |
| **Engagement Advisor** | **Stephen Tomblin** *(Retired Professor of Political Science, Memorial University)* |
| **Support** | |
| **Operations Manager** | **Lynn Taylor** *(Manager, Quality of Care NL)* |
| **Senior Policy Advisor – Health** | **Heather Hanrahan** *(Assistant Deputy Minister, Government of NL)* |
| **Senior Policy Advisory – Interdepartmental** | **Tanya Noseworthy** *(Assistant Deputy Minister, Government of NL)* |
| **Clinical Epidemiologist** | **John Harnett** *(Retired Professor of Medicine, Memorial University)* |
| **Implementation Advisor** | **Cassie Chisholm** *(Director, Cardiac & Critical Care, Eastern Health)* |
| **Communications Advisor** | **Melissa Ennis** *(Communications Lead, Quality of Care NL)* |

## Health Accord NL Task Force Committee Members

| Social Determinants of Health | |
|---|---|
| **Chair** | **Elizabeth M. Davis** |
| **Community Leader** | **Penelope Rowe** *(CEO, Community Sector Council NL)* |
| **Health Professional** | **Steve Darcy** *(Family Physician, Eastern Health)* |

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| Regional Health Authority Leader | **Michelle House**<br>*(Interim CEO, Western Health)* |
|---|---|
| Content Experts | **Thomas Piggott**<br>*(Former Medical Officer of Health, Labrador-Grenfell Health)* |
| | **Brenda Wilson**<br>*(Professor & Associate Dean, Community Health & Humanities, Faculty of Medicine, Memorial University)* |
| | **Pablo Navarro**<br>*(Senior Research Officer, NL Centre for Applied Health Research)* |
| | **Bob Williams**<br>*(Retired Physician; Former RHA Executive; Former Deputy Minister, Health & Community Services)* |
| | **John Harnett**<br>*(Clinical Epidemiologist; Retired Professor of Medicine, Memorial University)* |
| | **Michelle Kinney**<br>*(Deputy Minister, Health and Social Development, Nunatsiavut Government)* |
| | **Tanya Noseworthy**<br>*(Assistant Deputy Minister, Government of NL)* |

## Support – Social Determinants of Health

| Secretariat<br>*(Quality of Care NL)* | **Kathleen Mather**<br>*(Knowledge Translation Lead)* |
|---|---|
| Senior Policy Advisor<br>*(Government of NL)* | **Maggie O'Toole**<br>*(Director of Policy, Planning, and Evaluation (A), Health & Community Services)* |
| Digital Technology Support<br>*(NL Centre for Health Information)* | **Don MacDonald**<br>*(Vice President, Data & Information Services)* |

*Also joining the Social Determinants of Health Committee on various sub-groups: Mark Griffin, Director of Quality Management and Training, Children, Seniors and Social Development; Cynthia King, Director, Income Support, Immigration, Population Growth and Skills; Renee Ryan, Director, Policy, Planning and Information Management, Children, Seniors and Social Development; Lisa Baker-Worthman, Program Consultant, Health and Community Services; Joanne Cotter, Provincial Director, Children & Youth, Children, Seniors and Social Development; Terri Jean Murray, Director, Disability Policy Office, Children, Seniors and Social Development; Aisling Gogan, Assistant Deputy Minister, Children, Seniors and Social Development

| Community Care | |
|---|---|
| **Chair** | **Shanda Slipp** <br> *(Family Physician, Western Health)* |
| **Community Leader** | **John Norman** <br> *(Mayor, Bonavista)* |
| **Health Professional** | **Lynn Power** <br> *(Executive Director, College of Registered Nurses NL)* |
| **Regional Health Authority Leader** | **Judy O'Keefe** <br> *(Vice President, Clinical Services, Eastern Health)* |
| **Content Experts** | **Nicole Stockley** <br> *(Family Physician, Eastern Health; Director of External Engagement, NL College of Family Physicians)* |
| | **Ada John** <br> *(Director, Conne River Health and Social Services)* |
| | **Michael Jong** <br> *(Retired Family Physician; Former RHA Executive, Labrador-Grenfell Health)* |
| | **Carmel Casey** <br> *(Family Physician, Central Health)* |
| | **Heather Hanrahan** <br> *(Assistant Deputy Minister, Government of NL)* |
| Support – Community Care | |
| **Secretariat** <br> *(Quality of Care NL)* | **Cheryl Etchegary** <br> *(Health Policy Analyst)* |
| **Senior Policy Advisor** <br> *(Government of NL)* | **Monica Bull** <br> *(Senior Manager, Primary Health Care, Health & Community Services)* |
| **Digital Technology Support** <br> *(NL Centre for Health Information)* | **Cynthia Clarke** <br> *(Director, eHealth)* |

## Hospital Services

| | |
|---|---|
| **Chair** | **Sean Connors** *(Associate Professor of Medicine – Cardiology; Clinical Chief of Cardiac Care Program, Eastern Health)* |
| **Community Leader** | **Dorothy Senior** *(Patient Partner)* |
| **Health Professional** | **Greg Browne** *(Clinical Chief of Surgery, Eastern Health; Chief of Staff, Eastern Health)* |
| **Regional Health Authority Leader** | **Gabe Woollam** *(Vice President, Medical Services, Diagnostics & Pharmacy, Labrador-Grenfell Health)* |
| **Content Experts** | **Tina Edmonds** *(VP People, Quality and Safety (Acting), Western Health)* |
| | **David Carroll** *(Interim VP Medical Services, Central Health)* |
| | **Larry Alteen** *(Retired Family Physician; Former RHA Executive, Eastern Health & Central Health; Former Medical Consultant, Health & Community Services)* |
| | **Jeannine Herritt** *(Director, Regional Medicine Program, Eastern Health)* |
| | **Heather Hanrahan** *(Assistant Deputy Minister, Government of NL)* |

## Support – Hospital Services

| | |
|---|---|
| **Secretariat** *(Quality of Care NL)* | **Karen Dickson** *(Health Policy Analyst)* |
| **Senior Policy Advisor** *(Government of NL)* | **Annette Bridgeman** *(Director, Regional Services, Health & Community Services)* |
| **Digital Technology Support** *(NL Centre for Health Information)* | **Pat Hepditch** *(Chief Information Officer)* |

## Aging Population

| | |
|---|---|
| **Chair** | **Joan Marie Aylward** *(Community Champion; Former Provincial Politician; Former NLNU President; Former ED, St. Patrick's Mercy Home)* |
| **Community Leader** | **Rick Singleton** *(Ethicist & Theologian)* |
| **Health Professional** | **Kim Babb** *(Geriatrician, Eastern Health)* |
| **Regional Health Authority Leader** | **Kelli O'Brien** *(President & CEO, St. Joseph's Care Group, Thunder Bay, ON; Former VP People, Quality and Safety, Western Health)* |
| **Content Experts** | **Roger Butler** *(Family Physician, Geriatric Researcher, Eastern Health)* |
| | **Suzanne Brake** *(Former Provincial Seniors' Advocate)* |
| | **Sharron Callahan** *(Chair, NL Seniors & Pensioners Coalition; President, CARP NL; Chair, Seniors Advisory Committee, St. John's)* |
| | **Nancy Healey-Dove** *(Nurse Practitioner, Central Health)* |
| | **Tanya Noseworthy** *(Assistant Deputy Minister, Government of NL)* |

## Support – Aging Population

| | |
|---|---|
| **Secretariat** *(Quality of Care NL)* | **Robert Wilson** *(Research Associate)* |
| **Senior Policy Advisor** *(Government of NL)* | **Henry Kielley** *(Director, Seniors & Aging and Adult Protection, Children, Seniors & Social Development)* |
| **Digital Technology Support** *(NL Centre for Health Information)* | **Nicole Gill** *(Director, Evaluation & Performance Improvement)* |

## Quality Health Care

| | |
|---|---|
| **Chair** | **Patrick Parfrey**<br>*(Clinical Lead, Quality of Care NL; John Lewis Paton Distinguished University Professor)* |
| **Community Leader** | **John Jeddore**<br>*(Medical Resident)* |
| **Health Professional** | **Melissa Skanes**<br>*(Chief of Interventional Radiology, Eastern Health; Clinical Assistant Professor of Radiology, Memorial University)* |
| **Regional Health Authority Leader** | **Antionette Cabot**<br>*(Vice President, Clinical Services, Labrador-Grenfell Health)* |
| **Content Experts** | **Ed Randell**<br>*(Clinical Chief Laboratory Medicine, Eastern Health; Professor, Division of Laboratory Medicine, Faculty of Medicine, Memorial University)* |
| | **Debbie Kelly**<br>*(Professor & Special Advisor of Practice Innovation, School of Pharmacy, Memorial University)* |
| | **Jared Butler**<br>*(Family & Sports Medicine Physician; Shalloway FPN; Medical Director Primary Care, Central Health)* |
| | **Kris Aubrey-Bassler**<br>*(Family Physician; Director, Primary Healthcare Research Unit, Memorial University)* |
| | **Tanya Noseworthy**<br>*(Assistant Deputy Minister, Government of NL)* |

## Support – Quality Health Care

| | |
|---|---|
| **Secretariat**<br>*(Quality of Care NL)* | **Susan Stuckless**<br>*(Research Associate)* |
| **Senior Policy Advisor**<br>*(Government of NL)* | **John McGrath**<br>*(Assistant Deputy Minister, Corporate Services, Health & Community Services)* |
| **Digital Technology Support**<br>*(NL Centre for Health Information)* | **Donna Roche**<br>*(Director, Analytics & Data Access)* |

| Digital Technology | |
|---|---|
| **Chair** | **Paul Preston**<br>*(Former CEO, techNL)* |
| **Community Leader** | **Josh Quinton**<br>*(Investment Advisor, CIBC Wood Gundy<br>& Board Director)* |
| **Health Professional** | **Brendan Barrett**<br>*(Nephrologist, Eastern Health; Professor<br>of Medicine, Memorial University)* |
| **Regional Health Authority Leader** | **Ron Johnson**<br>*(Vice President, Innovation and Rural Health,<br>Eastern Health)* |
| **Content Experts** | **Randy Giffen**<br>*(National Innovation Team, IBM Canada;<br>Retired Family Physician)* |
| | **Blair White**<br>*(Former Vice President, Corporate Services,<br>NL Centre for Health Information)* |
| | **Chandra Kavanagh**<br>*(Director, Bounce Health Innovation)* |
| | **Niki Legge**<br>*(Director, Mental Health & Addictions,<br>Health & Community Services)* |
| | **Heather Hanrahan**<br>*(Assistant Deputy Minister, Government of NL)* |

| Support – Digital Technology | |
|---|---|
| **Secretariat**<br>*(Quality of Care NL)* | **Owen Parfrey**<br>*(Project Coordinator)* |
| **Senior Policy Advisor**<br>*(Government of NL)* | **Andrea McKenna**<br>*(Deputy Minister, Health & Community Services)* |
| **Digital Technology Support**<br>*(NL Centre for Health Information)* | **Gillian Sweeney**<br>*(Former Vice President, Clinical Information<br>Programs & Change Leadership)* |

# Health Accord NL Task Force Working Group Members

| Workforce Readiness |
|---|
| **Louise Jones (Chair)**<br>*(Former CEO, NL Council of Health Professionals; Former Regional Health Authority CEO)* |
| **Antoinette Cabot**<br>*(Vice President, Clinical Services, Labrador-Grenfell Health)* |
| **Vanessa Mercer-Oldford**<br>*(Assistant Deputy Minister, Regional Services (A), Health and Community Services)* |
| **Dennis Rashleigh**<br>*(Vice President Clinical-Medical Services, Rural and Primary Health Care, Western Health)* |
| **Vernon Curran**<br>*(Associate Dean of Educational Development, Office of Professional & Educational Development, Faculty of Medicine, Memorial University)* |
| **Heidi Staeben–Simmons**<br>*(Associate Vice President, Public Affairs, College of the North Atlantic)* |
| **Debbie Forward**<br>*(Former President, Registered Nurses' Union NL)* |
| **Gordon Piercey**<br>*(President, Association of Allied Health Professionals NL)* |
| **Adam Churchill**<br>*(Senior Manager, Health Workforce Planning, Health and Community Services)* |
| **Heather Hanrahan (Secretariat)**<br>*(Assistant Deputy Minister, Government of NL)* |

| Finance & Intergovernmental Affairs |
|---|
| **Patrick Parfrey (Chair)**<br>*(Health Accord NL Co-Chair)* |
| **Patricia A. Hearn**<br>*(Deputy Minister, Intergovernmental Affairs)* |
| **John Kattenbusch**<br>*(Vice President, Corporate Services and Provincial Shared Services Supply Chain, Central Health)* |
| **John McGrath**<br>*(Assistant Deputy Minister, Corporate Services, Health & Community Services)* |
| **Ken Hicks**<br>*(Director, Economics, Department of Finance)* |

**Lynn Gambin**
*(Associate Professor, Department of Economics, Memorial University)*

**Josh Quinton**
*(Investment Advisor, CIBC Wood Gundy & Board Director)*

**James Rourke**
*(Professor emeritus & former Dean of Medicine, Memorial University)*

**Cathy Duke**
*(CEO, Destination St. John's)*

**Heather Hanrahan (Secretariat)**
*(Assistant Deputy Minister, Government of NL)*

## Education

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*(Past President, Royal College of Physicians and Surgeons of Canada; Professor Emeritus & former Dean of Medicine, Memorial University)*

**Collette Smith**
*(Vice President, Clinical Services and Human Resources, Chief Nursing Officer, Eastern Health)*

**Laura Chu**
*(Adult Neurology PGY5, Memorial University; Past President, Professional Association of Residents of Newfoundland and Labrador)*

**Andrew Hunt**
*(Assistant Dean, Distributed Medical Education, Faculty of Medicine, Memorial University)*

**Irene O'Brien**
*(Dean of Health Sciences, College of the North Atlantic)*

**Linda Inkpen**
*(Former Registrar, College of Physicians & Surgeons of NL)*

**Leah Healey**
*(Research and Education Specialist, Registered Nurses' Union NL)*

**Peggy Colbourne**
*(Director, Western Regional School of Nursing)*

**Paul Banahene Adjei**
*(Interim Dean, School of Social Work, Memorial University)*

**Amy Hudson**
*(Governance and Strategic Planning Lead & Co-lead Negotiator, Recognition of Indigenous Rights and Self Determination, NunatuKavut)*

**Tanya Noseworthy (Secretariat)**
*(Assistant Deputy Minister, Government of NL)*

## Governance

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*(Health Accord NL Co-Chair)*

**Victor Young**
*(Former Chair & CEO, NL Hydro and Fishery Products International; Former Chair, Royal Commission of NL's Place in Canada)*

**Michael Clair**
*(Consultant, Retired Public Servant and University Administrator)*

**Louise Bradley**
*(Former President & CEO, Mental Health Commission of Canada; Board Member, The Gathering Place)*

**Brad Graham**
*(Vice President, Institute on Governance; Senior Fellow at Munk School of Global Affairs and Public Policy)*

**Penelope Rowe**
*(CEO, Community Sector Council NL)*

**Kris Aubrey-Bassler**
*(Family Physician; Director, Primary Healthcare Research Unit, Memorial University)*

**Aisling Gogan**
*(Assistant Deputy Minister, Children, Seniors and Social Development)*

**Don MacDonald**
*(Vice President, Data & Information Services, NLCHI)*
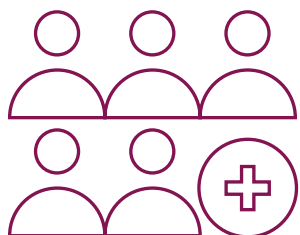
**Maggie O'Toole**
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**Kathleen Mather**
*(Secretariat, Social Determinants of Health Committee; Knowledge Translation Lead, Quality of Care NL)*

**Tanya Noseworthy (Secretariat)**
*(Assistant Deputy Minister, Government of NL)*

# Appendix C

# List of Calls to Action

**Health Accord**
for Newfoundland & Labrador

**Our province. Our health. Our future.**

THE REPORT

# Appendix C:
# List of Calls to Action

## Health Accord NL: Fifty-Seven Calls to Action

**What We Know – Awareness and Understanding of Social Determinants**

**Action 6.1:** Increase awareness and understanding of the social determinants of health to change attitudes and bring about action among decision-makers regarding the direct impact on population health as well as community and economic well-being.

**How We Decide – Embedding the Social Determinants of Health**

**Action 6.2:** Integrate the social determinants of health together with a rebalanced health system into all governance, policy, program, and infrastructure decisions that influence health.

**How We Live – Life with Economic Security**

**Action 6.3:** Ensure that Newfoundlanders and Labradorians have a liveable and predictable basic income to support their health and well-being, integrated with provincial programming to improve food security and housing security (see Action 7.3, which adds further depth with a focus on the impact on children and youth).

**Where We Live – Addressing the Climate Emergency**

**Action 6.4:** Take an aggressive and proactive approach to addressing the climate emergency through increased awareness, focused planning, aligned resources, and effective accountability mechanisms.

**How We Relate – One Inclusive Society**

**Action 6.5:** Take immediate action to create a provincial Pathway for Inclusion, shaping an inclusive health system within an inclusive society.

**Continuum of Education, Learning, Socializing and Care for Children and Youth**

**Action 7.1:** Strengthen efforts to create a continuum of education, learning and socializing, and care for children and youth (from prenatal to adulthood).

**Integrated Models of Care for Children and Youth at Risk**

**Action 7.2:** Develop one model of community health services for children and youth with complex health needs and a more integrated approach to respond to health needs of children and youth in care.

**Livable and Predictable Basic Income for Families**

**Action 7.3:** Ensure that the families of children in Newfoundland and Labrador have some form of a livable and predictable basic income to support their health and well-being, integrated with provincial programming to improve food security and housing security (this Action echoes Action 6.3, but adds more depth with respect to children and youth).

**A Comprehensive Provincial Frail Elderly Program**

**Action 8.1:** Develop and implement a formal Provincial Frail Elderly Program to address the critical need of our population.

**An Integrated Continuum of Care**

**Action 8.2:** Implement and support an integrated continuum of care to improve the effectiveness and efficiency of care delivery, improve health and social outcomes for older adults and older adults with disabilities, and support older adults to age in place with dignity and autonomy.

**Addressing Ageism and Building Age-Friendly Communities**

**Action 8.3:** Take immediate steps to identify and respond to the ageism in our province, including support for the development of age-friendly communities that enable Newfoundlanders and Labradorians to age positively.

**Progressive Aged Care Legislation, Regulation, and Policy**

**Action 8.4:** Develop and implement provincial legislation, regulation, and policy required to provide appropriate, quality, and accessible care and protection for older persons in Newfoundland and Labrador.

**Community Teams**

**Action 9.1:** Connect every resident of Newfoundland and Labrador to a community team providing a central touchpoint of access and a continuum of care.

**Coordination of Care**

**Action 9.2:** Improve coordination of care across the health and social systems by enhancing communication and system navigation.

**Health Promotion and Well-Being, Social Determinants of Health, and Chronic Disease Management**

**Action 9.3:** Place greater emphasis on health promotion and well-being, the social determinants of health, and chronic disease management.

**Improving Appropriateness of Medication Use**

**Action 9.4:** Establish a pharmacist-supported model to improve appropriateness of medication use and continuity of care in the community, long-term care and in hospitals. Support the creation of a National Pharmacare Program.

**Health Centres**

**Action 9.5:** Reorganize the services provided at the 23 health centres in the province to reflect population needs by utilizing a principles-based and criteria-based approach.

**Occupational Health Clinic**

**Action 9.6:** Create an Occupational Health Clinic with linkages to the community teams.

**A Planned Hospital System**

**Action 9.7:** Establish better integrated, team-based care by arranging hospital service delivery into a network consisting of community, regional, and tertiary hospitals that offer timely access to a full array of services.

**Location of Services**

**Action 9.8:** Realign core specialty health services in facilities to match the current and future needs of the population in the province to enhance continuity of care based on the changing needs in the community and on the changing demographics.

**Janeway Hospital Services**

**Action 9.9:** Optimize the utilization of the Janeway Hospital, by improving access to pediatric services, by creating linkages with community teams for vulnerable children and youth province-wide, and by incorporating Women's Health.

**Pathology and Laboratory Medicine**

**Action 9.10:** Establish pathology and laboratory medicine as a provincial networked service based on hub-and-spoke modelling.

**Keeping Care Close to Home**

**Action 9.11:** Enhance care across the continuum to ensure that access to appropriate and high quality care and service is available to patients/clients/ residents in the most appropriate setting and to minimize the need to travel to obtain appropriate services, or receive timely or affordable care.

**Setting the Standards for Provincial Acute Care Services**

**Action 9.12:** Develop explicit statements of system processes and expected standards of care to ensure integrated and accessible clinical program services delivered in a comprehensive, province-wide system.

**Digital Technology Requirements for Hospital Services**

**Action 9.13:** Renew hospital services by improving coordination and flow of health and social system information between hospitals and the community and by maximizing the use of integrated digital technology and information systems.

**Improvements in Provincial Programs for Cancer, Cardiac Care, and Stroke**

**Action 9.14:** Develop and implement a five-year plan for improvement in mortality rates for cancer, cardiac disease, and stroke over the next 10 years, led by the provincial programs for these disease entities.

**Provincial Integrated Air and Road Ambulance System**

**Action 9.15:** Design one provincial, modern, integrated air and road ambulance system with a central medical dispatch. The system must have triage capacity and must utilize dynamic deployment to function as a mobile health system. The system must be linked with virtual emergency care and advanced care paramedicine to enable patients to begin receiving emergency care in their homes or wherever they initially experience the emergency while facilitating rapid access to a hospital emergency service, provide community paramedicine, and access appropriate non-emergency transportation.

**Actions That Can Start in the Short Term**

**Action 9.16:** Begin action immediately on initiatives needed to rebalance the community, long-term care, and hospital system.

**Modernization of Foundational Information Technology Systems**

**Action 10.1:** Modernize foundational information technology systems.

**Virtual Care Technologies**

**Action 10.2:** Adopt and leverage virtual care technologies.

**Use of E-technology for Improved Outcomes**

**Action 10.3:** Develop a Provincial Digital Technology Strategy and policy to guide e-technology development and implementation.

**A Provincial Health and Social System Human Resource Plan**

**Action 10.4:** Through consultation with stakeholders, create a Provincial Health and Social System Human Resource Plan.

**Workforce Transition Guiding Principles**

**Action 10.5:** Create Workforce Transition Guiding Principles for all health and social system employees and physicians to provide workforce security and protection. Where employees or physicians are represented by unions/associations, a high-level principle-based document inclusive of guiding principles would be created jointly with employee or physician representation, including NAPE, CUPE, RNUNL, AAHP, NLMA, and others. Further, union-specific transition agreements may in turn need to be negotiated with each employee or physician representative group.

Where those persons negatively impacted by the system changes are not represented by unions or associations (e.g., managers), these staff members would also have input into the development of the principles guiding their transition.

**Scope of Practice**

**Action 10.6:** Create a health and social system environment that enables all providers to work to the highest scope of practice within their education and/or training.

**Recruitment of Health and Social System Providers**

**Action 10.7:** Create a strategic recruitment plan that will ensure health care providers are in place to offer stable direct care and services to patients/clients/residents and families in a rebalanced health and social system, while at the same time providing work-life balance for employees.

**Strategies to Engage, Stabilize, and Retain the Current and Future Workforce**

**Action 10.8:** Create strategies to engage, stabilize, and retain the current and future health and social system workforce and encompass actions required by the 10-year Health Accord. Ensure strategies support inclusion of under-represented groups and quality of care in the provision of services.

**An Environment that Values Leadership and Management**

**Action 10.9:** Create an environment that values leadership and management and inspires those with potential to lead. This includes creating value in management positions and succession planning for those with leadership and management potential to receive training and mentorship.

**Strategies and Evidence to Support Human Resource Planning**

**Action 10.10:** Leverage existing evidence and data in the health and social systems and expand this knowledge base where evidence and data do not already exist. Use this evidence and data in strategy development.

**Principles for Health Provider Education**

**Action 10.11:** Develop and apply clear guiding principles in all education development and delivery initiatives.

**Learners Learning Together – A Collaborative Education Development and Delivery Model**

**Action 10.12:** Develop and deliver education and continuing education programs that use an integrated, inclusive, and collaborative care model where practitioners learn and practice together. This requires integration across curricula and across programs throughout the learning experience.

**Updated Curriculum Content**

**Action 10.13:** Update and renew curriculum for health practitioners to help them better understand the importance of the social determinants of health, quality assessment and improvement, care of older adults, digital technology, and patient-centered care and to better prepare them to deliver equitable, interprofessional care to the full scope of their practice.

**Preparing the People of the Province**

**Action 10.14:** Provide education and resource support to the people of the province to facilitate their full participation in a modernized learning health and social system.

**Change Management and Connections Between Social Determinants of Health and the Health System**

**Action 10.15:** Within the leadership structures of government departments, the health system, social systems, and the regional social and health networks, develop an integrated change management approach to improve health outcomes and health equity. This approach should focus on shifting from health system responsibility for health outcomes to shared responsibility of the health and social systems together with health educational institutions, municipalities, community organizations, and the private sector.

**Change Management and Community Teams**

**Action 10.16:** Invest in change management to initiate and maintain community teams so that they provide care across the spectrum of health care including children in need, patients/clients with disabilities, and the frail elderly. The

community teams integrate provider groups, hospitals, and the various systems that influence health. They engage with the public and communities.

## Change Management and Digital Technology

**Action 10.17:** Invest in change management and training in digital technology across the spectrum of health providers and institutions, all regions of the province, and communities.

## Financial Implications

**Action 10.18:** Provide a five-year plan of short-term, medium-term and longer-term priorities that influence financial decisions taken by government within the fiscal envelope of the province to ensure the long-term improvement in health outcomes and strengthening of health equity needed for a thriving and prosperous province.

## Engagement with Federal Government

**Action 10.19:** Develop a provincial strategic plan to immediately engage with the federal government for funding of a basic income approach, climate change actions, childhood development programs, meeting the needs of the aging population, community teams for primary care, and increased broadband penetration to communities.

## Provincial Health Authority

**Action 11.1:** Create a Provincial Health Authority to provide province-wide planning, integration, and oversight of the health system and to deliver province-wide programs such as the ambulance system and information systems.

## Regional Health Councils

**Action 11.2:** Create Regional Health Councils that (i) have the level of authority needed to address the organization and quality of health care delivery at the regional level, (ii) are sensitive to local and regional variations, and (iii) facilitate

engagement with patients/clients/residents and with members of the public (including youth) to ensure that the health system is responsive to the identified health needs of the people of the region.

**Regional Social and Health Networks**

**Action 11.3:** Establish a Regional Social and Health Network in each region of the province which is responsible for the integration of the services of various organizations that influence health and health outcomes (e.g., health systems, social programs, municipalities, schools, police, recreational programs, arts and cultural programs, community sector non-profit and voluntary groups, and private sector businesses).

**NL Council for Health Quality and Performance**

**Action 11.4:** Establish the NL Council for Health Quality and Performance to improve health and social systems, which fully incorporates principles of diversity, inclusion, and integration.

**Accountability for Improved Health Outcomes**

**Action 11.5:** Improve accountability structures within the health and social systems to focus on achievement of better health outcomes.

**Long-Term Evaluation Plan**

**Action 11.6:** Design a long-term evaluation plan related to the implementation of Health Accord NL (based on its Calls to Action) to determine whether the actions undertaken are achieving the objectives of each strategy.

**Measuring and Tracking Indicators of the Social Determinants of Health**

**Action 11.7:** Identify, document, address, and track indicators of social determinants of health in Newfoundland and Labrador, in an ethically transparent and publicly accessible manner, at the point of care in the health system and at community, regional and provincial levels.

**Culture of Quality – Learning Health and Social System**

**Action 11.8:** Foster a culture of quality and establish a comprehensive, effective, and sustainable learning health and social system.

**Provincial Data Governance Model**

**Action 11.9:** Develop a holistic and integrated Provincial Data Governance Model which includes a strategy that defines a vision for how data will be used to improve the health and social systems of Newfoundland and Labrador in a transparent and accountable manner.

**Transitional Governance Structure**

**Action 11.10:** Establish a transitional governance structure to begin preparations for the implementation of Health Accord NL.

# Contact

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# Health Accord
for Newfoundland & Labrador

## Our province. Our health. Our future.
### A 10-Year Health Transformation

**THE REPORT**