

Central Regional Integrated Health Authority External Review



11 May 2018

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1. EXECUTIVE SUMMARY

Central Health region has a rich and storied past. It is a region made famous for its hospitality on Broadway. Its people have a long history of resourcefulness during times of adversity in fishery, in forestry, in peace time and in war—rising to the challenges, helping new friends and old.

While making the Forbes 2018 Best Employers in Canada list is a laudable marketing achievement, an inexplicable aura has hung over Central Health Regional Health Authority (CNRHA) for many years, some say impacting an ability to deliver healthcare services in some areas because of challenges recruiting and retaining staff. In February 2018 the Minister of Health and Community Services called for an external review of the organization.

At the commencement of the review the CNRHA CEO precipitously resigned as did the Chief of Staff at James Paton Memorial Regional Health Centre (JPMRHC). This left the organization without leadership at a time when it needed it most and helped reinforce what has been called a “victimized environment.”

Managing any health authority is a challenging complex endeavour at the best of times. Managing the health services of the second-largest population in Newfoundland and Labrador and the second largest geographic region is certainly a challenge. It has a responsibility to provide primary, secondary, long-term care, community health and other enhanced secondary services in two regional referral centres, nine health centres, 11 long-term care facilities including five co-located in health centres, 23 community health centres, 2 residential treatment centres and a regional office located in Grand Falls-Windsor.

The Strategic Plan (2017-2020) notes that as of April 2016 health and community services are provided at 41 facilities with 262 acute and 524 long-term care beds.

With a budget in 2015-16 of approximately \$380 million, direct patient care consumes 74%, support services 17%, and administration costs 9%. Central Health has approximately 3100 employees and 106 primarily fee-for-service physicians in the region supported by around 700 volunteers and 2 foundations. Central Health also works with its First Nation partners and collaborates with the Department of Health and Community Services on a variety of initiatives.

In its Strategic Plan Central Health “acknowledges that organizational culture plays a significant role in the quality of care, client experiences and staff engagement.” Moreover, to fully embed “LEADS throughout the organization, a cultural shift is required.”

This review’s mandate is detailed in the Terms of Reference (Appendix A). The review examined the effectiveness of the current governance model, senior management and clinical management; working relationships between and among these groups; succession planning; capacity to achieve stated goals and objectives, and the status of community engagement. The real question is, taken together, have these elements been able to achieve a cohesive regional health authority since its inception in 2004?

Central Health Review 2018

At least three reports have been undertaken in the past three years—Thistle (2015), Bhatia (2015) and Marsh (2016)— with recommendations to solve specific, mostly human resource issues. This review takes an overarching view to delineate recurring themes in line with the Terms of Reference and to provide recommendations for improvement.

The reviewer heard from individuals and groups with divergent views. On the one side views expressed believed there were *no* challenges facing Central Health beyond the challenges facing every RHA in Newfoundland and Labrador, while on the other hand there were individuals and groups who were adamant that the challenges facing Central Health were of such a long-standing, chronic nature that only major organizational change would address the issues.

There is no perfect health system and there are no perfect health regions. What the reviewer has learned from our many interviews and review of submissions is that specific areas of Central Health have a lot of hardworking people trying to deliver healthcare to the best of their abilities under trying circumstances.

The external review focuses on recurring themes to make constructive recommendations for practical improvement.

2. METHODOLOGY

The review took a qualitative analytic approach. In March and April 2018, the reviewer met with 115 individuals and groups for half hour face-to-face interviews covering a range of open-ended and structured questions (Appendix B). In addition, a confidential email address was established (centralhealth2018@gov.nl.ca) to allow the public, staff and physicians to submit their thoughts to the reviewer directly and confidentially. 178 emails were received and reviewed. The reviewer met people well into the evening, at hospital facilities, at private off-site locations to accommodate individuals expressed concerns for being seen speaking to the reviewer. The reviewer also received letters and submissions from both employees and citizens, as well as written submissions and meetings with representatives of the Town of Grand Falls-Windsor and the Town of Gander.

The Central Health website was reviewed as were documents including the Strategic Plan, the organizational chart, Environmental Scan, Canadian Institutes for Health Information (CIHI) on-line data, Accreditation Canada reports, Community Profiles, Patient Safety Culture Survey, Guarding Minds@Work (2016) survey, Client Relations Report (2017-2018), Central Health Annual Report (2017-2018), Budget Update 2017-2018, Board Bylaws, Board Minutes, Medical Staff Bylaws, Medical Advisory Committee Minutes, and the Human Resource strategic plan.

3. GOVERNANCE

The governance model established by the Health Authorities Act (2004) (<http://www.assembly.nl.ca/Legislation/sr/statutes/r07-1.htm>) outlines the accountabilities of the Board. Central Health Board was created as the result of the integration of the previous Central East, Central West and Community (Rural) Regional Health Authorities. The governance model of Central Health is therefore consistent with the Regional Health Authority structure defined in 2004.

Organizational competencies such as leadership, human resources, reliable information systems including security, confidentiality, privacy and group dynamics (culture) are recognized as essential components of a quality healthcare organization. This is what effective healthcare governance seeks to create and sustain.

The reviewer heard the integration of the previous health authority boards to Central Health was in name only. Silos and rivalries between the two referral facilities have perpetuated an “us against them” mentality the Board and senior management have been unable to resolve. In some ways the current governance structure only serves to perpetuate and exacerbate an unhealthy long-standing rivalry. This is articulated most acutely in the *feeling* that because the corporate offices are located in Grand Falls-Windsor, and the majority of senior staff reside in that area that Gander area “suffers” disproportionately.

The reviewer learned there is “nobody with a vision,” that there is “absent leadership at all levels.” One Board member flatly stated, “I’m ignorant of what governance is. Do I represent local or global perspectives?” Another said, there was “no common purpose,” and since the addition of new Board members in 2017 there has been little or no focus on Board education.

Although the previous CEO lived in Gander, the *belief* that the corporate office location determines priority of resource allocation is a firmly held view for many staff at JPMRHC. The perception that decisions are made primarily by “an old boys club,” for short-term financial benefit, or by central government micromanagement rather than best evidence (data) were repeated many times throughout the review.

The governance model contributes to a perpetuation of longstanding community rivalry at Central Health. The extent to which this is common throughout Newfoundland and Labrador is beyond the scope of this review. However, other than further consolidation of governing entities and the enhancement of local on-site clinical management it is highly probable that the longstanding rivalries between the two referral centres will continue to haunt Central Health until government sees the utility of further consolidation.

As long as management offices are physically disconnected from the hospital operations management will need to spend concerted effort to be present equally at both hospital sites. Even if senior management was located at both hospital sites equally there will need to be a major effort on the part of senior management to be present among staff for an extended period of time

to begin to rebuild the trust that has long eroded as a result of the historical absent senior management style that has developed over the past 14 years.

The responsibility to deliver high-quality healthcare is recognized as a corporate responsibility. Hospital and health region boards are largely responsible for overseeing the organization's financial budget and strategic agenda. Quality and patient safety should also be a top board priority. Culture exerts an enormous influence over an organization's ability to deliver results. Culture has a key role to play in the overall design of an organization's strategy for quality and patient safety. The culture of an organization has sometimes been described as the fundamental values or beliefs shared among members of the organization. It has been called the *glue* that holds an organization together and allows it to adapt to an ever-changing healthcare environment. Research shows that corporate culture influences leadership style more than anything else, and vice versa. So-called 'tone from the top' defines the attitude for the culture that drives an organization's ability to achieve its desired results.

Organizations in most sectors of the economy today are undergoing significant change. Healthcare is no different. Organizational design and governance of organizations need to evolve too. Hospital-based care became the dominant delivery model of the 20th century and is still the predominant focus of service delivery for Central Health region notwithstanding its stated commitment to primary health care. Many services are delivered in the community and primary care settings and in rural settings separate from the long-standing rivalries of the hospital-based communities. Collaborative practice is ad hoc. Most communities rely primarily on primary care physicians or nurse practitioners. In Grand Falls-Windsor there are leading practices in both collaborative care and primary care obstetrics led by local physicians while in Gander both of these services struggle. Where is the governance leadership for the scale-up and spread of these primary health care innovations throughout the Region?

The key issue of conflict between central control and local autonomy has been unresolved since the integration of health authorities 14 years ago. Conflict is part of life, but escalation of issues can be mitigated if these are discussed openly around the boardroom table. However, if the Board defers to the CEO as many board members related, conflict festers below the surface until it boils over, usually into multiple resignations or even into litigation. If the issues are with management itself, discussion should be taken offline, using a sub-committee reporting back to the full Board. Regularly asking "why?" is an important Board tactic to get to the root of conflicting interests. At Central Health, conflict at the points of care seems to have come to the Board only as part of an appeal process. Most of the time, the Board and CEO seemed to live, the reviewer was told, in a mutual "Garden of the Finzi Contini," referring to the film (1970) where the participants seemed oblivious to the threats around them.

The Board needs to safeguard accountability, transparency, fairness and consistency in the RHA's relationship with all its various stakeholders. The Board must ensure procedures to reconcile conflicting interests in accordance with its fiduciary responsibilities and oversight of the CEO.

As governance models evolve innovative high-quality healthcare systems have reduced the number of senior managers while enhancing on the ground competent clinical management.

Counterintuitively perhaps modification of governance structure to larger geographic areas can allow local service lines more autonomy, better accountability, and earlier conflict resolution providing there are enough competent on-site managers to help the organization achieve better results.

Central Health like other health regions arises within the historical context where physicians serve primarily as consultants and customers of the hospital paid on a fee-for-service basis where hospital resources (beds, technology and facilities) are managed by administrators and shared by departments. More recently high performing organizations have moved to physicians playing more active co-leadership roles alongside clinical managers.

In today's world of cyber technology boards have a significant role to play in the oversight of information technology, privacy and security, and risk. Risk therefore is one of the major areas of focus for any board. Risk for Central Health Board is focused primarily on finance, quality and patient safety.

At Central Health only the annual meeting is open to the public. In order to increase transparency and accountability Board meetings would need to be open to the public.

Rivalry among communities are a fact of life in Canada. Such rivalry however can impair the success of regional boards to achieve their policy objectives and better health outcomes for their populations. If the current model is maintained incentives to encourage municipal collaboration could facilitate a more regional approach.

Healthcare is not divorced from the rapid digitization occurring in other sectors of the economy. How this impacts the organization and governance of health services is an area that warrants further consideration in design and delivery of services. Modernization of health services and the ability to communicate reliably across large areas is changing the way many services are being delivered in parts the country and around the world (e.g., mental health services).

In our digitally connected age governments with small, diffuse populations can no longer afford parochial regional variation, one that divides communities into competing silos. While historically regionalization emerged as a way to contain cost and address regional disparity, the silos of the past are not the open digital horizon of tomorrow competing for scarce global human resources. Innovation in governance and management in health service delivery is needed to address many of the ongoing challenges.

RECOMMENDATIONS

3.0 Recommendation: Government should incentivize collaboration between the Municipalities of Grand Falls-Windsor and Gander.

3.1 Recommendation: The Board should focus its role on oversight of management—healthy tension is desirable.

- 3.2 Recommendation:** The Board develop a communication strategy a) internally for staff and physicians, and b) externally with communities to increase transparency of the Board decision-making process.
- 3.3 Recommendation:** Medical Bylaw changes are required to remove CEO as final authority for approval of Credentialing and Privileging of physicians. The responsibility for Credentialing and Privileging of physicians should be a Board responsibility based on the recommendations of the RHA Credentials Committee.
- 3.4 Recommendation:** Amend Board Bylaws to open meetings to the public beyond the annual meeting. In camera meetings should be confined to matters pertaining to finance, legal and human resource issues only.
- 3.5 Recommendation:** The Board should devote at least one meeting annually to risk assessment and risk mitigation.
- 3.6 Recommendation:** The Board invest in governance training such as the Institute of Corporate Directors program.
- 3.7 Recommendation:** The Board hold management accountable for measurable improvement in organizational culture civility and respect.

4. LEADERSHIP

“The core issue is leadership.” More than any other issue leadership dominated the review. Staff feel “left to their own devices.” Communication with management is “sporadic” according to many staff interviewed. There is “absent leadership at all levels.”

Yet Central Health management has been exceptional producing many excellent reports. However, as management consultant Peter Drucker remarked many years ago, “Culture eats strategy for breakfast.” The best indicator of leadership effectiveness is culture.

The reviewer met with senior management team both collectively and with many individuals. The reviewer also considered a number of reports, minutes, presentations and plans submitted by the senior team, as well as data available from CIHI, including views expressed by staff, physicians and citizens.

In addition, meetings with the Board chair and Board members, and input from confidential email gave the reviewer an overview of the leadership style, operation management and organization.

Like most RHA's a great deal of effort is taken to contain cost including within the past year elimination of management positions (including but not limited to facility managers) and regionalization of administrative processes, and increasingly working with the provincial government to introduce shared services. While the reviewer was not primarily considering the cost-saving efforts it is clear that there is a constant focus on cost-reduction across management portfolios.

One of the most generally accepted measures of administrative effectiveness are the CIHI administrative ratio reports on administrative spending as a percentage of operating costs.

CIHI average administrative ratio for Newfoundland (2015-2016) was 3.9% while Central Health's administrative ratio for the same time period was slightly higher at 4.5%. This ratio includes general administration, finance, human resources and communications cost centres. In the recent Budget Update (2017-2018) the administrative ratio was reported at 10% which is consistent with the Independent Auditor's Consolidated Financial Statement (2017) and somewhat higher than Central Health's previously reported CIHI administrative ratio, and higher than the provincial average reported 2-3 years ago. However, this ratio includes four cost centres in the CIHI ratio plus a number of other cost centres including information management and technology, switchboard, mail services, utilization management, clinical efficiencies, planning and development, privacy, infection control, quality assurance, telecommunications, emergency preparedness, materials management, etc..

The use of administrative ratios as a measure of management effectiveness is controversial because it depends on how the information is coded, or more specifically what to include in administrative cost. Items such as administration offices, the Board, the executive, finance, communications, infection control, quality and risk, labour relations, recruitment and retention,

human resources and other areas may be included. In other words, many factors can be included in the administrative cost area.

The unintended consequence of an ongoing effort to focus on cost-containment has resulted in the reduction of on-site facility management, the elimination of which places an increased burden on remaining managers who expressed feelings of helplessness, burnout and stress.

A reduction of “boots on the ground” leads to an expansion of span of control with some managers reportedly overseeing 50 to 60 staff or more, responsible for performance appraisals, scheduling, mentoring and support. As a result, effective management and oversight, and therefore, accountability is increasingly at risk.

While Accreditation Canada requires that all employees receive annual performance appraisals and while this is an important activity, it becomes increasingly dysfunctional and impractical when the span of control is so large, and management is stretched across a large geography.

The practical reality is what the reviewer heard many times: individuals feel unsupported and disconnected from management which further leads to an erosion of respect, and a “Wild West” feeling that anything goes when there is “absent management.” The reviewer heard numerous anecdotal reports from staff at all levels regarding the perception that accountability was impossible at present.

The result is a serious gap in leadership at the points of care. This does not mean managers should merely “work harder.” Managers are already stretched thin which means the management *modus operandi* is to focus on crisis management, or as the reviewer heard many times “we are one resignation away from closing something.”

Effective leadership includes listening, coaching, goal-setting, performance assessment, and talent management. None of which can be achieved in an environment of constant crisis. “The next leadership needs to focus on the ‘heart’ of the place,” one tearful point of care staff member said.

While focus on cost-containment is clearly an appropriate ongoing management competency and an important part of the RHA accountability, a so-called “death by a thousand cuts” approach fails to see the forest for the trees and the resulting impact on point of care staff who lack the necessary management support, seriously jeopardizing the ability of the organization to achieve its strategic goals.

Leadership or more specifically a lack of on-site leadership is the very heart of many longstanding issues at Central Health. Effective leaders including physicians need to lead by example—yelling, bullying, disrespecting or humiliating staff or colleagues cannot be tolerated.

When surveys such as the GuardingMinds@Work (2016) indicate “significant concerns” with the “organizational culture” and “significant concerns” with “Civility and Respect” (Appendix C) leaders should not remain cloistered in their offices. These issues and others the

reviewer heard about did not arise over night or under any one leader's tenure. And while there is no one right way to lead, different situations call for different types of leadership.

Increasingly leaders need to acquire "soft" skills (self-regulation, empathy, motivation, self-awareness and social skills). What can sometimes sound "optional" is increasingly understood to be an essential competency of successful leadership. A leader who understands one's own and other people's emotional makeup well enough to move people collectively in the direction of accomplishing the organization's goals are the skills most needed today. Central Health needs leadership that has organizational awareness and an ability to read the currents of organizational life, build decision networks and trust, and navigate the internecine local politics.

The reviewer heard from numerous staff and managers that they lack the appropriate training. For example, physician leaders need training in communication, negotiation and conflict resolution. Positions such as Vice President Medicine should seek out professional certification in management (e.g., Canadian Society of Physician Executives). Central Health needs physician leaders with exceptional skills in communication, resilience, empathy, and relationship building; skills that will help the organization change for the better.

Some managers lack the basic skills to do their jobs including awareness of gender and racial bias. The reviewer heard many examples of hurtful language over many years. Is it any wonder therefore that when a few individuals disrupt parts of the workplace and wreak havoc and get away with it that a sense of helplessness dominates these micro-cultures in parts of the organization?

RECOMMENDATIONS

- 4.1 Recommendation:** All physician leaders should complete the Physician Manager Institute (PMI) leadership programs. While physicians gain tremendous knowledge in medical school to become skilled physicians, management leadership skills are often learned on the job which is not the best way to address issues of increasing complexity especially HR issues and conflict resolution.
- 4.2 Recommendation:** All hiring should be posted and competed through Human Resources. Hiring should be based on defined competencies (knowledge, skills, management experience). There is nothing more destructive to morale than the perception that a position has been awarded on anything other than merit.
- 4.3 Recommendation:** There should be a full-time Vice President of Medicine for the RHA. The recruitment process should be open, transparent, and free of perception of bias.
- 4.4 Recommendation:** Human Resource leadership should make a concerted effort to be visible, get out of their offices and talk to and listen to staff where staff work *on a daily basis*.

4.5 Recommendation: Develop a Central Health medical co-leadership model with the assistance of Memorial University Medical School and the Newfoundland and Labrador Medical Association (NLMA).

5. CLINICAL MANAGEMENT

Prior to the consolidation of Eastern Central and Western Central RHAs each geographic area in conjunction with the Community RHA each had its own Medical Advisory Committee (MAC). Essentially these structures still exist. There is no operational Regional Medical Advisory Committee (RMAC). Representatives from referral sites participate via teleconference at each other's MACs, yet there is no consolidated regional MAC. The differences are highlighted by the very different structures of agendas and meeting Minutes. In addition, the Rural MAC seems to function independently of the challenges the reviewer heard about at the two hospital sites other than a frustration occasionally with referrals to what were described as “difficult” on-call specialists.

The reviewer heard on numerous occasions primarily from Gander-based physicians regarding the allegation of bias related to the number of leaders residing in Grand Falls-Windsor. Central Health leadership interviewed took great pains to outline their efforts to ensure they sought to achieve a balance in representation and decision-making. The reviewer heard many examples where resources were actually tilted in favour of JPMRHC. However, the ongoing perception of bias is an indication of the inability to achieve one of the benefits of regionalization.

After reviewing MAC meetings Minutes the reviewer was struck by the wide variance in design and structure betraying a startling lack of uniformity between the two MACs, symptomatic of a deeper underlying inability to consolidate the strongly institutional-centric clinical realms of the two hospital-based cultures. In some ways it is the tip of the iceberg. While there are many cases of collegial referral between sites and among the many communities referring to those sites the reviewer heard, on many occasions, challenges of peripheral clinicians making referrals, in particular but not limited to, JPMRHC in Gander.

The many examples of challenging behaviour the reviewer heard about primarily emanate from the JPMRHC site, and notwithstanding the many valiant attempts by clinical leadership there can be no better example of the failure of clinical regionalization within the challenges depicted in the attempts to regionalize clinical chiefs of services. Attempts to reconcile historical and structural anomalies by appointment of clinical leaders perhaps sympathetic to the goals of senior management have spectacularly backfired and have been the subject of several consultants' reports. It is not our intention here to delve into the details of individual cases since this is outside the scope and mandate of this review. However, these cases do highlight structural challenges of a long-standing nature. From a clinical management perspective there has not been the attention to integration of clinical management seen in other areas of the organization. As a result, medical leadership functions in a parallel universe.

Nursing leadership the reviewer heard has been stripped of effective on-site management at both facilities. From a management and leadership perspective, and more than any other specific area of concern the reviewer heard about was the implementation of the Ottawa Model of Care.

The Ottawa Model of Care seeks to provide safe, competent care from the most appropriate nursing provider. The Ottawa Model has been successfully implemented across Newfoundland and Labrador, and many other parts of Canada with ongoing evaluation and modification as required.

At Central Health, however, concerns regarding the Model have been voiced by both nursing and medical staff. The Model of Care issue is important because it illustrates a leadership tone deaf to the concerns of point of care nursing and medical staff for many years. The Model was introduced some years ago in an effort to approve point of care accountability and to maximize scope of practice.

However, both nursing and medical staff complained to the reviewer about repeated attempts to raise concerns over many years to senior management to no avail. Without any quantitative data to substantiate claims there are numerous anecdotal examples of potential patient consequences due to a lack of communication between and among clinicians as a result of how the Model of Care has been implemented at Central Health. Recent attempts to internally evaluate the Model have met with apathy perhaps the result of long-standing inertia on the part of management to seriously consider the concerns of nursing and medical staff. Over a year later management are still working on soliciting feedback on a Model of Care review.

The process to divert obstetrical services from JPMRHC to CNRHC due to a lack of physician obstetrical resources at JPMRHC is another area the reviewer heard many complaints from nursing staff at both sites that highlights the management by crisis at Central Health. Nursing staff from JPMRHC must be available to either transfer patients or work at CNRHC with little advance planning or notice. Numerous staff have written or met with the reviewer to outline their concerns not only with the design of the solution for obstetrical services but also how staff were not included in either the implementation or the planning. The reliance on locums and specialty care for obstetrics creates a sustainability issue for the service while at CNRHC a robust primary care obstetrics service thrives in conjunction with speciality obstetrical support. The JPMRHC obstetrical “crisis” is an example of reliance on an unsustainable model and an inability to scale and spread what works in one part of the region to the other, one of the major benefits of regionalization. Midwifery is being added to the mix at JPMRHC in the near future.

RECOMMENDATIONS

- 5.0 Recommendation:** Implement a primary health collaborative care (family physician, midwifery and obstetrical support) model of obstetrical care regionally building on the successful primary care model at CNRHC.
- 5.1 Recommendation:** Engage Memorial University expertise to undertake a qualitative and quantitative evaluation of the Ottawa Model of Care focused on communication, patient safety and outcomes.
- 5.2 Recommendation:** Seek Memorial University Medical School assistance to develop a Peer Support Network for Central Health physicians.

- 5.3 Recommendation:** Work with Memorial University Medical School and the Newfoundland and Labrador Medical Association to offer courses in Professionalism and Ethics for medical staff as part of a Continuing Medical Education curriculum.
- 5.4 Recommendation:** Review the clinical management reporting structure to clarify accountability and reduce span of control.
- 5.5 Recommendation:** Combine Medical Advisory Committees into one Regional Medical Advisory Committee (RMAC). Minutes should have Consent Agendas (matters related to pre-reading and approval) and business focused on Action Items not verbatim discussions.
- 5.6 Recommendation:** Central Health work with the Department of Health and Community Services to evolve a programmatic approach to clinical services across the RHA.
- 5.7 Recommendation:** Central Health in consultation with the Department of Health and Community Services should develop an evidence-based decision-making protocol for implementing changes to clinical services.

6. RELATIONSHIPS

Relationships between and among the Board, senior management, clinical management, and clinicians at Central Health can best be described as “complex.” The reviewer heard repeatedly from those interviewed and in written statements: “we do not communicate” and “we do not collaborate” between and among parts of the RHA. Yet Medical Staff at CNRHC wrote they have “no concerns about the governance and management of Central Regional Health Authority.” In their view the issues leading to the review were the result of “a few disgruntled physicians” in Gander.

The CEO and the senior leadership team which is responsible for the operation of the RHA manage the day-to-day operation of the delivery of health services in the region.

The relationship between the Board and senior management appears to be very cordial. The Board directs the business of the Corporation in accordance with the RHA's Act, Bylaws, strategic planning, vision, mission and values, along with board policies and other applicable laws and regulations governing healthcare in the province.

The strength of the Board are its members from a variety of communities, experience and backgrounds throughout the region. The Board chair seeks to maintain a culture of honesty and integrity, striving to achieve consensus in his decision-making process. The Board chair and vice chair and nine trustees focus their attention on their financial obligations and a commitment to quality and patient safety. Communication is left to the CEO and the senior leadership team. The committees of the Board including governance, planning and finance, performance improvement and community advisory committees try to fulfil their roles to the best of their abilities with the information they are given by management.

While the Board strives to leave the day-to-day management of operations to the CEO and the senior leadership team, the reviewer noted from many conversations with senior staff and Board members that the *modus operandi* of the Board has been to defer to the CEO. For example, if staff gave a presentation to the Board, the CEO answered the questions. This tendency to defer to the CEO arises from a sense that the CEO knows more about the healthcare business than the individual volunteer members of the Board. Healthcare is a highly technical and specialized enterprise that can sometimes be daunting to the average citizen entrusted with the responsibility of overseeing the operation of a \$380 million health system with over 3100 employees.

The clinical management including the structure of local and regional chiefs in many cases has struggled to achieve cohesion between and among referral facilities. There are many examples when collegiality between physician leaders works very well based in large part on mutual respect and trust. At other times there is significant acrimony at the point of care often witnessed by staff and the public. Such behaviour creates the opposite: disrespect and mistrust. Among some physicians there is a lingering impression that somebody else is getting a better deal. This sense of learned helplessness was a recurring theme throughout the review.

It is evident that senior management and the Board have been well aware of the challenges related to civility and a respectful workplace. The CEO and the senior leadership team have invested significant resources including engagement of several external consultants with numerous recommendations and workshops in an effort to improve the culture. By far the most common phrase used to describe the culture at the JPMRHC site was “toxic.” When asked to further describe what people meant by that term, issues regarding civility and respect in the workplace were the most common recurring themes. It is important, however, to note that healthcare institutions are not homogeneous and that many institutions have their own micro-cultures in various parts of the institution (e.g., emergency departments, clinics, wards, and operating rooms). It was however a recurring theme at the JPMRHC site.

The GuardingMinds@Work survey (Appendix C) notes that *11.4% of employees report being bullied or harassed verbally, physically or sexually in the workplace*. For the purpose of illustration only that would be over 350 people in this small rural area who have been bullied or harassed verbally, physical or sexually in the workplace. This is significantly higher compared to the national average of 6.7% noted in the Ipsos Reid Canadian surveys. Organizational culture is one of the recurring areas of concern noted in that survey (2016).

Working relationships between and among groups appear to function on a day-to-day level yet below the surface there are troubling chronic issues of civility and disrespect over many years that can be described as pockets of micro-culture normalized incivility and disrespect.

These observations have been noted many times in surveys and notwithstanding senior leadership team’s engagement of external consultants there is still a fundamental lack of visible leadership on the ground. Some of this is structural as has been noted elsewhere in this report because of the span of control of management and the resulting lack of visible clinical management particularly in the after-hours and on weekends.

One consultant engaged by the RHA the reviewer heard about numerous times was Sharone Bar-David author of *Trust Your Canary* who delivered eight workshops in 2017. The idea was to give leaders a foundation from which they could return to their workplace and bring a message to point of care staff regarding the need for civility and respect as a fundamental component of building a safety culture.

The reviewer heard many times how staff actually felt more insulted being told to simply, what many of them felt to be the advice: “smarten up.”

Paying attention to the canary in the mine means listening to point of care staff and their concerns whether it be regarding the Model of Care, lack of clinical management on-site, or input to decisions to change a clinical service. Leadership relationship equity suffers when leaders are not visible and available to staff and clinicians. The practice of “leadership walkabouts” when a large entourage of senior leadership parade at prearranged times throughout facilities are actually seen by staff as “show time.” These walkabouts are further evidence of a fundamental lack of understanding of the issues of concern to staff, and relationship equity plummets.

The reviewer heard that for many point of care staff they didn't know who the senior leadership team were, and over many years had never seen the senior leadership come out of its offices. The location of the majority of the senior management team at 21 Carmelite Road in Grand Falls-Windsor, a facility remote from *both* hospitals appears to have exacerbated management isolation which in turn has further alienated point of care staff.

As part of the strategic planning process employees, physicians, management and volunteers identify the demand for services exceeds capacity to provide services (21.4%) as the most serious issue for the organization to do something about. The second-highest of the top five challenges identified was “lack of communication, collaboration and teamwork between departments, facilities and management and front-line employees and lack of accountability and engagement and leadership...” (17.2%).

Where the relationship between the Board, senior management, clinical management and clinicians are functional it is because of personal relationships based on mutual respect. The opposite is also true. In parts of the organization where there is no contact and no personal relationships there is disrespect and contempt, and a tendency to undermine strategic intent.

RECOMMENDATIONS

6.0 Recommendation: A clinical management on-call system is needed to support point of care staff after-hours and on weekends.

6.1 Recommendation: Locate senior management offices equally between CNRHC and JPMRHC facilities.

6.2 Recommendation: The senior leadership team including CEO, individually and regularly as a routine part of their daily activities walk through facilities engaging staff, listening to staff, and clinicians and develop action items to incorporate into senior leadership agendas for discussion, action and follow-up.

7. SUCCESSION PLANNING

Succession planning and human resource planning was another constant theme heard by the reviewer. As in other rural parts of Canada issues of physician shortages dominated the discussion. Along with wait times physician shortages particularly of family physicians and specialists in Gander tend to overshadow staffing concerns at virtually all levels. Interestingly, the physician shortages are not equally distributed between the eastern and western parts of the region. The Gander area seems to have more challenge recruiting family physicians and retaining specialists than the Grand Falls-Windsor area.

Rural and northern RHA's have greater difficulty recruiting and retaining qualified staff in all healthcare areas. Historically there has been a high dependence on international medical graduates (IMGs) and a tendency to fill acute shortages with temporary transient physicians known as locums. Many of the IMGs have historically completed a minimum period of time required to gain experience and meet requirements before moving on. Clearly communities are grateful for the services of the IMGs, yet a perpetual revolving door of physician services is less than ideal for communities. This is often exacerbated because of isolation both culturally and professionally and the stress and burnout associated with being constantly available in rural areas. In addition, the constant turnover and shortages increases the stress and burnout of remaining physicians and staff.

An aging workforce and retirements can make it challenging to recruit clinicians into management positions. Often there is a sense of “it's your turn” when it comes to recruitment of physician leaders into positions of clinical management such as department heads or chief positions.

Issues of recruitment and retention are one of the areas of acute rivalry between the Gander and Grand Falls-Windsor areas. This is where the perception of bias is either proclaimed as patently evident or passionately denied. In the past there were ad hoc incentives that have contributed to a lingering sense of unfairness. This is not evident at present with greater provincial standardization of incentive programs. Although the reviewer was told management might direct interested potential recruits to one place over another it is highly likely that physician micro-cultures play a more significant role in where new recruits feel welcomed, supported and mentored. In the end physicians will go where they and their families feel at home professionally and personally. As the literature attests: money gets them, but it won't keep them.

Before regionalization human resource planning was fragmented into competing boards and facilities. While today there is one RHA Board, an unhealthy rivalry persists between the two largest communities that once were the headquarters of the old Central Eastern and Central Western RHAs. The reviewer heard many examples of individual concerns expressed regarding bias, on many levels, including gender and racial. Because bias by its definition is inclination to prejudice the *perception of bias* becomes a hallmark no community brooks lightly. It hampers the very thing a community values most: its integrity.

The discrepancy between payment for in-hospital services to physicians at CNRHC (fee for service) and JPMRHC (stipend) betrays a fundamental failure of regionalization to achieve consistency. Regionalization should allow RHAs to bring more resources and skills to focus on the regions unique challenges and requirements. Regionalization should allow for the maximization of human resources. Regionalization affords the opportunity to direct resources to areas of greater need. However, a palisades mentality of “us vs. them” is inimical to the intentions of regionalization as contemplated in 2004.

Community involvement and ownership of recruitment and retention is a critical factor in increasing the effectiveness of regionalization. Community involvement in recruitment and retention at the grassroots is an elegant example of how communities can be involved in creating a vibrant sustainable health region. Many communities have learned that it is not just the healthcare provider one is recruiting but the partner and family as well. Regions can make or break recruitment in their engagement of not only healthcare providers but their families by making them feel welcome, supported and at home.

In addition, “grow your own” activities to train and recruit Newfoundland and Labrador students has been very successful in parts of the region and are increasingly seen as a way to reduce the need for reliance on IMGs beyond reasonable historical levels. The Grand Falls-Windsor area has been particularly successful in family medicine with its strategy to train medical students who then put down roots and stay in the area. This is a tried and true approach supported by the literature and used across the country. The difference in approach to recruitment and retention between the communities highlights the differences in both management approach and medical community success between rival parts of the region.

The reviewer heard startlingly different approaches to how family medicine is organized in the Grand Falls-Windsor and the Gander areas. The Grand Falls-Windsor area has a vibrant forward-thinking family medicine cohort keen on being involved in education, recruitment and retention. While in the Gander area family medicine tends to be isolated and “independent,” with marginal relations to anyone, seemingly content with minimal engagement with the health region. In this regard there has been an historical focus on medical/surgical specialties at both hospitals. It was also startling to learn that in 2018 there are still primary care physicians who do not have electronic medical records.

Notwithstanding the above the RHA staff work with wide variability of physician engagement and support to recruit for key clinical positions. In parts of the region physicians do an excellent job replacing themselves, while in other areas communities are actively discouraged from assisting, only serving to underscore the ad hoc inconsistent approach across the region. In the long-term, application of a more data driven approach for recruitment might better ensure the allocation of scarce health human resources.

Public expectation of access to healthcare is only increased in the digital age. How digitization of healthcare delivery factors into succession planning could be a part of the RHA strategic planning process.

RECOMMENDATIONS

- 7.0 Recommendation:** Central Health should develop and implement an evidence-based, data-driven long-term health human resources strategy for all health professions.
- 7.1 Recommendation:** Central Health should promote and support the success of “grow your own” recruiting and retention as one of its primary recruiting and retention strategies.
- 7.2 Recommendation:** Human Resource leadership should develop and implement a plan to be more visible to staff.

8. CAPACITY FOR SUCCESS

On paper Central Health is an impressive organization and the credit for that goes to the senior leadership teams responsible for Quality Assurance and Performance. In particular the work of the quality department is impressive for a small organization. It is clear that the Board, the CEO and the senior leadership team highly valued a focus on quality and patient safety. The Board's education efforts have focused on that area in the past.

The mission of Central Health states that "Central Health will provide quality health and community services and programs that are responsive to the needs of the people of central Newfoundland." The Strategic Plan 2017 - 2020 states that the goals set out in the plan will be achieved "by centering care on the person and their family, we will achieve: better care for individuals, better health for the population and better value through improvement." It will be a challenge for Central Health to achieve many of the areas of improvement depicted in the Strategic Plan.

The Strategic Plan outlines in great detail the tactics and progress made to achieve the many stated goals. While the Strategic Plan has many activities the most important issues for citizens the reviewer heard about consistently were wait times and recruitment and retention of family physicians. Focus on these two areas in addition to a focus on public health including diet, exercise and healthy lifestyle would go a long way to address many of the challenges facing the aging population with an increasing chronic disease burden. Many of the activities in the strategic plan focused on these areas could benefit from specific, measurable, achievable, realistic, and time-limited goals.

Financial accountability is a priority. Great effort goes into working on provincially directed financial targets. However, without leadership to address the issues of culture, absent management and a relationship equity deficit it is unlikely that some of the underlying challenges that have been ruminating for years will see the improvement required to increase recruitment, retention, and address wait times in some areas such as Diagnostic Imaging. A happy workforce delivers better outcomes.

The primary indicator of success for Central Health in achieving its Strategic Plan will be focusing on leadership, engagement of staff, physicians and the community around a new attitude of working together. Infighting between the two major referral centres over many years has inhibited the region from achieving its full potential.

9. COMMUNITY ENGAGEMENT

To develop its Strategic Plan Central Health engaged 230 community members and 22 hosted communities. Each community identified its main issues, challenges and strengths as well as weaknesses of the healthcare system. Many of the challenges related to wait times particularly for mental health services and other specialty services, better chronic disease management, and issues around transportation in rural areas. There were many positive comments around access to services such as dialysis (although dialysis is clinically managed differently at CNRHC and JPMRHC sites). However, how to access some services and who to contact for information was an issue the reviewer heard about in citizen responses.

While many of the community responses as part of the strategic planning process recognize that unhealthy lifestyle and behaviours such as diet, exercise, substances abuse, gambling, and smoking are priorities, targeted strategies to change behaviour are limited.

In the top five challenges to Central Health 31.4% of community members surveyed said recruitment and retention is the top issue. How the community is engaged in recruitment and retention is a key opportunity.

The Board has 8 Community Advisory (CACs) committees who in many ways are the eyes and ears of the Board in the community. The CACs offer an excellent opportunity to connect with citizens across the region, to hear their concerns and celebrate their achievements beyond traditional reporting mechanisms. Their involvement in recruitment and retention for example could be a powerful grassroots addition to professional recruitment efforts.

RECOMMENDATIONS

- 9.0 Recommendation:** Develop an RHA Patient Navigator position to assist patients and families chart their way through the healthcare system.
- 9.1 Recommendation:** Engage Towns of Grand Falls-Windsor and Town of Gander in joint planning session for health services including the articulation of plans for access to collaborative community-based care.
- 9.2 Recommendation:** Strengthen Community Advisory Committee relationship with the Board by having the Chair of each CAC attend the Board meeting to report on current issues.
- 9.3 Recommendation:** Engage the Community Advisory Committees in the development of a recruitment and retention strategy for healthcare professionals.
- 9.4 Recommendation:** Update Central Health web site to a more user-friendly resource for accessing services.

10. OTHER ISSUES

There were many Operational and Human Resource issues brought to the attention of the reviewer during the interviews and by email beyond the scope of the external review.

1. Paramedics responsible for security in Emergency Departments and hospitals. Paramedics are not trained in security measures. The reviewer raised this with Board members and Staff during the review.
2. Paramedics required to be stationed at “The Junction” have no bathroom facilities.
3. Infection Prevention and Control reports to management without senior authority to require clinical attention.
4. The reviewer heard many longstanding individual Human Resources complaints symptomatic of the culture deficit noted in the review.

11. SUMMARY OF RECOMMENDATIONS

GOVERNANCE

- 3.0 **Recommendation:** Government should incentivize collaboration between the Municipalities of Grand Falls-Windsor and Gander.
- 3.1 **Recommendation:** The Board should focus its role on oversight of management—healthy tension is desirable.
- 3.2 **Recommendation:** The board develop a communication strategy a) internally for staff and physicians, and b) externally with communities to increase transparency of the Board decision-making process.
- 3.3 **Recommendation:** Medical Bylaws changes are required to remove CEO as final authority for approval of Credentialing and Privileging of physicians. The responsibility for Credentialing and Privileging of physicians should be a Board responsibility based on the recommendations of the RHA Credentials Committee.
- 3.4 **Recommendation:** Amend Board Bylaws to open meetings to the public beyond the annual meeting. In camera meetings should be confined to matters pertaining to finance, legal and human resource issues only.
- 3.5 **Recommendation:** The Board should devote at least one meeting annually to risk assessment and risk mitigation.
- 3.6 **Recommendation:** The Board invest in governance training such as the Institute of Corporate Directors program.
- 3.7 **Recommendation:** The Board hold management accountable for measurable improvement in organizational culture civility and respect.

LEADERSHIP

- 4.2 **Recommendation:** All physician leaders should complete the Physician Manager Institute (PMI) leadership programs. While physicians gain tremendous knowledge in medical school to become skilled physicians, management leadership skills are often learned on the job which is not the best way to address issues of increasing complexity especially HR issues and conflict resolution.
- 4.3 **Recommendation:** All hiring should be posted and competed through Human Resources. Hiring should be based on defined competencies (knowledge, skills, management experience). There is nothing more destructive to morale than the perception that a position has been awarded on anything other than merit.

- 4.4 Recommendation:** There should be a full-time Vice President of Medicine for the RHA. The recruitment process should be open, transparent, and free of perception of bias.
- 4.5 Recommendation:** Human Resource leadership should make a concerted effort to be visible, get out of their offices and talk to and listen to staff where staff work *on a daily basis*.
- 4.6 Recommendation:** Develop a Central Health medical co-leadership model with the assistance of Memorial University Medical School and the Newfoundland and Labrador Medical Association (NLMA).

CLINICAL MANAGEMENT

- 5.0 Recommendation:** implement a primary health collaborative care (family physician, midwifery and obstetrical support) model of obstetrical care regionally building on the successful primary care model at CNRHC.
- 5.1 Recommendation:** Engage Memorial University expertise to undertake a qualitative and quantitative evaluation of the Ottawa Model of Care focused on communication, patient safety and outcomes.
- 5.2 Recommendation:** Seek Memorial University Medical School assistance to develop a Peer Support Network for Central Health physicians.
- 5.3 Recommendation:** Work with Memorial University Medical School and the Newfoundland and Labrador Medical Association to offer courses in Professionalism and Ethics for medical staff as part of a Continuing Medical Education curriculum.
- 5.4 Recommendation:** Review the clinical management reporting structure to clarify accountability and reduce span of control.
- 5.5 Recommendation:** Combine Medical Advisory Committees into one Regional Medical Advisory Committee (RMAC). Minutes should have Consent Agendas (matters related to pre-reading and approval) and business focused on Action Items not verbatim discussions.
- 5.6 Recommendation:** Central Health work with the Department of Health and Community Services to evolve a programmatic approach to clinical services across the RHA.
- 5.7 Recommendation:** Central Health in consultation with the Department of Health and Community Services should develop an evidence-based decision-making protocol for implementing changes to clinical services.

RELATIONSHIPS

- 6.0 **Recommendation:** A clinical management on-call system is needed to support point of care staff after-hours and on weekends.
- 6.1 **Recommendation:** Locate senior management offices equally between CNRHC and JPMRHC facilities.
- 6.2 **Recommendation:** The senior leadership team including CEO, individually and regularly as a routine part of their daily activities walk through facilities engaging staff, listening to staff, and clinicians and develop action items to incorporate into senior leadership agendas for discussion, action and follow-up.

SUCCESSION PLANNING

- 7.0 **Recommendation:** Central Health should develop and implement an evidence-based, data-driven long-term health human resources strategy for all health professions.
- 7.1 **Recommendation:** The success of “grow your own” recruiting and retention in one area of the region, Central Health should promote and support this as one of its primary recruiting and retention strategies.
- 7.2 **Recommendation:** Human Resource leadership should develop and implement a plan to be more visible to point of care and medical staff.

COMMUNITY ENGAGEMENT

- 9.0 **Recommendation:** Develop an RHA Patient Navigator position to assist patients and families chart their way through the healthcare system.
- 9.1 **Recommendation:** Engage Towns of Grand Falls-Windsor and Town of Gander in joint planning session for health services including the articulation of plans for access to collaborative community-based care.
- 9.2 **Recommendation:** Strengthen Community Advisory Committee relationship with the Board by having the Chair of each CAC attend the Board meeting to report on current issues.
- 9.3 **Recommendation:** Engage the Community Advisory Committees in the development of a recruitment and retention strategy for healthcare professionals.
- 9.4 **Recommendation:** Update Central Health web site to a more user-friendly resource for accessing services.

12. ABOUT THE REVIEWER

Peter W. Vaughan, CD, MA, MD, MPH is the former Deputy Minister of Health and Wellness, Province of Nova Scotia, and former President and Chief Executive Officer, and former Vice President Medicine, South Shore District Health Authority, Bridgewater, Nova Scotia.

Dr. Vaughan has been CEO/Secretary General of the Canadian Medical Association and Board Chair, Accreditation Canada. He has been an emergency physician, GP/entrepreneur, RCAF Flight Surgeon and healthcare executive for over 35 years.

Dr. Vaughan is currently Board Chair, Canada Health Infoway, member of the World Health Innovation Network Advisory Council, Board member of the Supply Chain Advancement Network for Health (SCAN Health), and member of the Government of Canada's Innovation, Science and Economic Development Ministry's Health/Bioscience Economic Strategy Table.

Competing Interests: None

APPENDIX A

TERMS OF REFERENCE

February 5, 2018

Central Health Review 2018

The review will focus on the effectiveness of the current governance, senior management and clinical management systems in Central Health to achieve a cohesive regional health authority. As part of the review, the consultant will examine and provide recommendations on:

- a. the governance model of the board of trustees,
- b. the design of and effectiveness of decision-making processes of the senior management team,
- c. the design of and effectiveness of decision-making processes of the clinical management team,
- d. the working relationships between the board, senior management, clinical management, and clinicians,
- e. the status of succession planning for senior managers, clinical managers and clinicians
- f. the capacity of Central Health to achieve the goals and objectives of its strategic plan,
- g. the state of community engagement and measures of public acceptance of the effectiveness of Central Health to meet the health needs of the region, and
- h. any other related matters deemed appropriate by the consultant after conferring with the Minister of Health and Community Services.

The consultant will meet with the Board Chair and CEO of Central Health to seek input on the design of the review after which a work-plan and timetable will be submitted to the Minister for his approval. A final report will be submitted to the Minister on or before May 3, 2018.

APPENDIX B

INTERVIEW QUESTIONS

Relationship with physicians

What are the issues?

Describe the history?

How should physicians be engaged?

What are the strengths and weakness of regionalization of services?

What should it look like?

How would you describe the culture?

Is there bias related to governance and management?

Are there physician incentives? How are these determined?

Governance

In decision making how much autonomy does CH have versus provincial government accountability?

Describe the governance model?

How does the board make decisions? Policy development? Example?

How does management make decisions? Example?

What is the strategic planning process?

What areas would you like to see improved? Why?

How do you do succession planning?

How would you describe the relationship between and among the following groups?

1. The Board

2. Senior management

3. Middle management

4. Clinical management

5. Clinicians

How is conflict resolved?

How can Central Health achieve its goals and objectives described in the strategic plan?

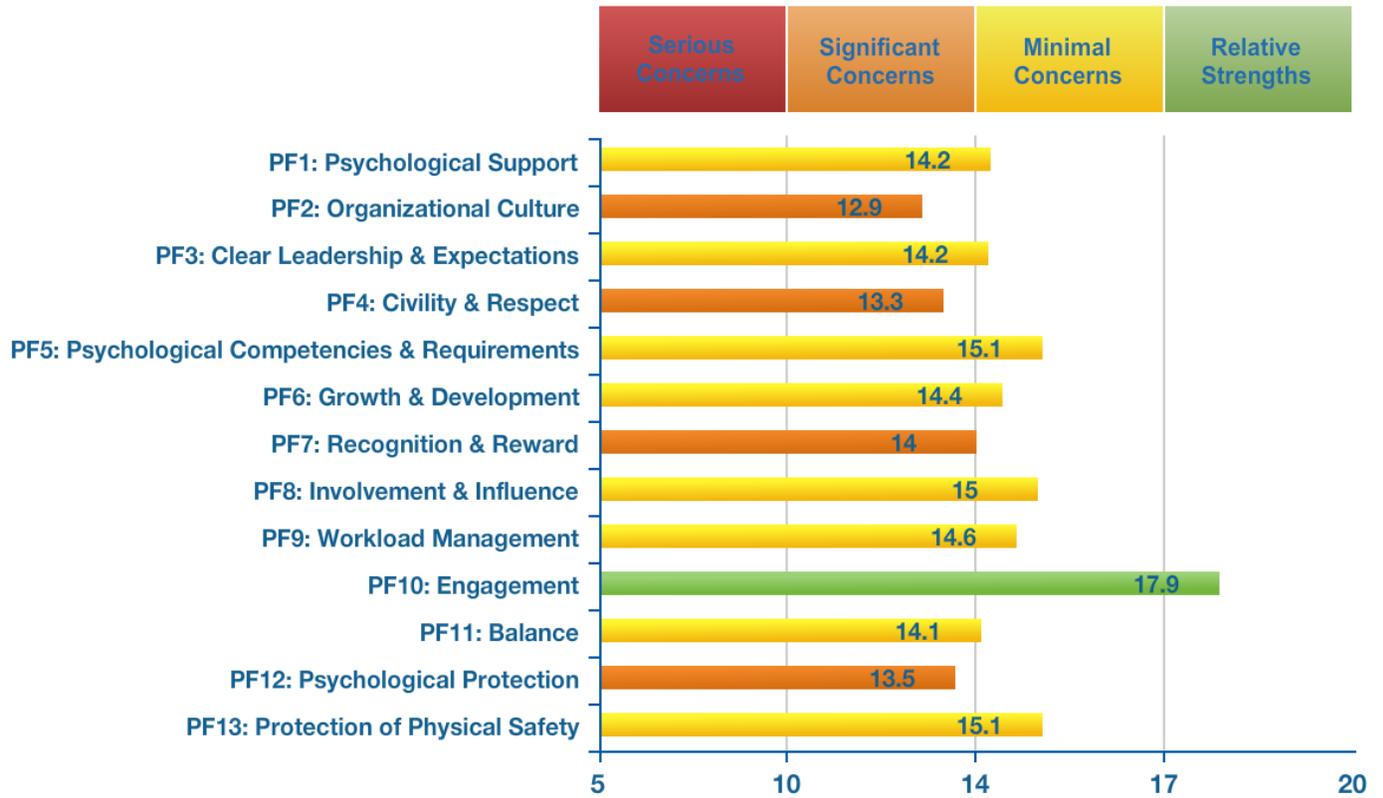
How do you understand your community's burden of illness?

How is the public engaged in planning health services?

Is there anything else you would like to add?

APPENDIX C

GUIDING MINDS@WORK Survey 2016



Serious Concerns = 5 to 9 Significant Concerns = 10 to 13 Minimal Concerns* = 14 to 16 Relative Strengths** = 17 to 20