

# **NOR-MAN RHA (NRHA) REVIEW**

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## TABLE OF CONTENTS

Purpose of the Review .....	1
Environment in the Region .....	4
Physician issues.....	6
Community relationships .....	12
First Nations concerns .....	15
Patient related issues .....	19
Flin Flon issues .....	25
Finances .....	32
Board functioning and governance .....	33
CEO performance .....	41
Summary of Recommendations .....	46

## **NOR-MAN RHA (NRHA) REVIEW**

### **PURPOSE OF THE REVIEW**

In the fall of 2010, government became concerned about an accumulation of ongoing issues and correspondence received by the Minister of Health in relation to the Nor-Man Regional Health Authority (referred to in this report as NRHA). Areas of concern were its aboriginal populations and services, the planned movement of the Flin Flon Clinic into the Flin Flon General Hospital, the suspension of privileges of a local physician, and general concerns that were being raised about the quality of patient care in the Region.

In late November, 2010, the issues were highlighted by the Deputy Minister to the Chief Executive Officer of the Region, Drew Lockhart. These included

- o discharge planning,
- o communications,
- o physician services, critical incidents protocols, and access to care
- o relationships with First Nations and governance.

In Dec, 2010, a community meeting was called by a private citizen in Flin Flon where about 350 people attended and raised concerns about the NRHA, particularly in the areas of the Flin Flon Clinic, access to physician services, and quality of care. Representatives of the Minister of Health attended and briefed the Minister following the meeting.

In recognition of all the concerns, the Minister announced on December 17, 2010 the establishment of an external Review Team to examine the NRHA operations and make recommendations in an effort to help NRHA improve relationships with its communities on these issues.

The members of the Review Team include:

**Reg Toews**, former Chief Executive Officer, South Eastman Health- Sante Sud-Est

**Donna Forbes**, former Associate Deputy Minister, Manitoba Health

**Jan Currie**, former Vice President and Chief Nursing Officer, Winnipeg Regional Health Authority, and

**Dr. Brian Postl**, Dean, Faculty of Medicine, University of Manitoba, and former CEO, Winnipeg Regional Health Authority.

The Review Team was instructed to focus on eight areas:

Physician issues

Community relationships

First Nations concerns

Patient related issues.

Flin Flon issues

Finances

Board functioning and governance

CEO performance

The public was asked to submit material to the Review Team by means of a designated confidential email, mailing address, a toll free phone line established for the purpose, or by interview with the Review Team. In the first few days the team requested assistance from the NRHA for some travel arrangements and appointments were made by the NRHA as a means of locating some individuals. All subsequent interview arrangements and responses to the correspondence received were made by staff of Manitoba Health in Winnipeg and were not known to the NRHA, in order to protect confidentiality of those involved.

The Review Team made visits to the Region (a total of 31 reviewer days) in December 2010 and in January and February 2011, with various members involved as necessary for the topics to be reviewed. The communities of Flin Flon, The Pas, Grand Rapids, Easterville and Moose

Lake were visited, in some cases more than once, and some interviews were held in Winnipeg for the convenience of those being interviewed. Over 150 individuals were involved in the interview process. These included a broad range of relevant groups such as community representatives, local civic officials, care providers, First Nation Chiefs and representatives, NRHA senior staff, physicians and provincial nursing station staff, Board members (current and former) and persons who have received care in NRHA. In late January, it was announced that submissions would be received until Feb 11, 2011, and a final visit to the Region occurred on Feb 17, 18, 19 and 20, 2011. Those individuals who could not be accommodated on that visit were offered telephone interviews the following week.

In addition, a wide range of emails, phone calls, and letters were received and provided to the Review Team directly and in a confidential manner. These represented dozens of staff, physicians and citizens in total. The Region provided written information and followup information as requested by the Reviewers.

The Report that follows is compiled by the Review Team from the information we were given and is organized according to the headings that formed its mandate. Followup of specific patient care encounters was outside the mandate of this Review.

## **THE ENVIRONMENT IN THE REGION**

The NorMan Region comprises 12 communities spread across 72,000 square kilometers in the northwest corner of the province. During the course of our interviews, and in our review, several distinguishing characteristics are evident.

The Region is economically diverse with some employment centres with a natural resource base. Two major communities exist, and a “competition” is seen to exist between them for share of resources. This competition was frequently described as a rivalry.

Flin Flon has seen a reduction in the mining sector activities, with a corresponding decrease in population and services. The Pas has enjoyed a more robust economic environment, and is also a sister community of Opaskayak Cree Nation where there is a large population, progressive leadership and an aggressive developmental approach. Flin Flon appears to be highly sensitive to the view that The Pas has assumed some kind of precedence in the Region. The Region has a high disease burden and excess morbidity and mortality relative to other Regions of Manitoba.

It has historically been very difficult to recruit health personnel in the Region, and there has been a long time dependence on physicians trained in other countries (International Medical Graduates- IMGs). It was evident in our interviews that there is a long history of divisiveness within the medical staff, perhaps with ebbs and flows over time, but frequently experienced. The First Nations communities are important constituents of the Region. Some have been covered by the 1964 agreement transferring authority from the federal to the provincial government. When regionalization occurred, the provincial government did not transfer responsibility or authority for care within the First Nations communities to the Region. Although the responsibility for care for First Nations and Metis people within hospitals was clearly regional, responsibility for Primary care and continuity of care was not.

Certain events in Flin Flon triggered this Review. They included concerns regarding physician disputes, the movement of a clinic to the hospital, and access to physician care for the community. This was highlighted by a community meeting that was frequently described during our contacts.

The Review Team received a great deal of input, frequently case specific, during the Review. The Review reflects a synthesis of what was told to us. We did not review individual clinical records or clinical files. We did review some administrative records as seemed appropriate to our mandate.

Often highly polarized views were expressed. Within that context, there were a broad range of views that came to us, ranging from this being a “tempest in a teapot” to the more prevalent view that this was an ultimately unsustainable environment. Many people reflected that some of the “triggers” were rife with individual self- interest and a manipulated environment that intersected with broader community views.

Many of the difficulties we were told of clearly preceded regionalization of the health care system and the formation of the NorMan regional structure as it exists today. The many positive things that have been accomplished seem to have been overwhelmed by issues of physician access and concerns about acute care services.

The Health Authority clearly had a huge set of expectations and needs and functioned in a very complex environment.

## **PHYSICIAN ISSUES**

There were a number of physician issues identified within the Review. Information was made available by interviews of many physicians, health staff, and members of the community. In addition, the Medical staff Bylaw, physician contract, ER contract, physician schedules and other relevant documents were reviewed.

The Review was triggered specifically by physician issues in Flin Flon, but physician issues there and in The Pas were examined.

The entire Region has been staffed predominantly for many years by international medical graduates (IMGs). Despite widespread concern expressed to us about their preparation, in recent years, these physicians gain access to practice after a very competitive process allowing entry to University of Manitoba programs. Programs may be 3 months (by assessment) or 1 year in length. All physicians have passed national level exams (LMCC 1) and relevant entry exams. Some practice under a special permit from the Minister. Others are completely licensed as family doctors. All have a return of service expectation of 2 years, and many have stayed beyond this requirement. All have a practice advisor assigned by the College of Physicians and Surgeons (Mb) and all are qualified in advanced cardiac life support programs.

These IMGs have integrated well into many communities in Manitoba. They practice within a contractual arrangement with the Regional Health Authority, Manitoba Health, and Doctors Manitoba. The terms of their practice are defined within the contract.

Other established physicians function on a fee for service (FFS) basis. The intent has been to slowly evolve IMGs from salary to FFS practice as experience in the health care system is gained.

Physicians are well paid and are roughly consistent with after-cost incomes in rural Manitoba.

There was a broad range of opinion in the Region, from praise for individual physician activities to concern with “competence” and attitude. Our undertaking was not a clinical review. There are many mechanisms for practice review that should be in place; these will be discussed later.

Dr Sethi is a senior physician in the Flin Flon community. His privileges to practice were suspended by the RHA in 2010. After a legal process, his suspension was later quashed. His suspension was one of several issues that attracted a great deal of community attention. We will not comment on the suspension or its overturning by the courts, other than to note that the Medical Staff Bylaw was not fully complied with during that process.

Flin Flon specific issues will be addressed first. New doctors there, over several years, have not felt supported by senior physicians in the community. They spoke frequently of being undermined and having no sense of nurturing or teaching from senior colleagues. There was a lot of concern expressed to us during the Review, particularly about Dr Sethi’s attitude, behaviors, and activities.

Indeed, IMGs felt frequently at risk of being reported to high authorities with both explicit and implicit threats to their futures. For many physicians, trained in non democratic countries, this is a particularly frightening concept. They speak of frequent innuendo, undermining with other staff, and individual targeting within the medical staff. Although largely supportive of the RHA, they report frequent undermining of the Region by their senior physician colleagues, even those working within defined regional roles.

At least in part because of the innuendo associated with this non-collegial environment, many community members came to question the competence of physicians in their community. Despite their concerns, when physicians undertook continuing medical education (CME) activities or evaluations in southern centers, they were evaluated by senior physicians there as more than competent.

The Region was not perceived as a collegial environment by most physicians we interviewed, in both Flin Flon and The Pas.

Physician services to patients in the Emergency Departments of the hospitals in Flin Flon and The Pas are delivered through a contract between Manitoba Health and individual physician signatories. These services are funded for 24 hour service 365 days of the year.

The contract is seen as financially lucrative for physicians and is designed to ensure a comprehensive service. The allocation of the funds within the contract is within the purview of the co-signatories.

In Flin Flon, not all interested and qualified physicians were included within the rotation for ER coverage, which caused significant resentment. Those who were included in the rotation were paid at rates below that defined in the contract, allegedly on the basis of their lesser experience. Although legally acceptable, this practice is not seen as collegial. Several of those excluded had particular interest and equivalent competence to provide the service.

Another key issue identified in Flin Flon by the community related to access to physician services in their clinic practice. This was intertwined with the decision to move Regional physicians from the Flin Flon Clinic to one located in the hospital. Recruitment issues and understaffing of family doctors and the loss of a senior physician in an accident in 2010 exacerbated the situation.

The contract defines the expected number of patient contacts per day. In addition, each physician had a specific responsibility in such areas as obstetrics, primary care support, dialysis, long term care, and oncology.

In Flin Flon the definitions of “patient contact” appeared to be quite broad, even including telephone contacts. Many physicians were reported as limiting access to their “panel” for new patients, and regularly canceling appointments for other responsibilities and meetings. There was a physician added within the Region with primary responsibility for “walk ins” who worked on a FFS basis. The perception of the community was that patients were referred to the walk in clinic, sometimes with lengthy waits, rather than being added to a primary care panel. The number of patient appointments per physician in Flin Flon were below those seen in The Pas, and both would be below average in comparison with most practices. Many physicians acknowledged they would see more patients in a FFS environment.

These reduced appointments in our view exacerbated concerns re access and the number of patients per physician needs to be increased to more closely approximate that defined by the contract. There is a view that the new hospital clinic will facilitate this.

Physicians across the Region all take care of their own patients who are hospitalized. CME is available through several programs, but there is little initiated from within the group or in combination with other health care professionals.

Concerns among physicians in The Pas, while somewhat less intense, were also evident, and seemed to increase during the course of our Review, perhaps as there was opportunity given to examine practice. Similar concerns regarding a sense of not being welcomed into a “group practice” were evident.

There were particular concerns with the operations of the Whitewater Clinic in The Pas, where most “regional” physicians worked. The RHA entered into a comprehensive contract with the Whitewater Clinic to house and support these physicians. Despite the comprehensive nature of the contract, (which was reviewed), physicians noted a lack of access to Internet and library services and access to computers, and “unreasonable” expectations of filing and incomplete

administrative supports. There were perceived conflicts of interest within the management of the clinic that undermined the collegial atmosphere of their joint practice.

In The Pas, similar concerns to those in Flin Flon regarding access to shifts in the Emergency department were identified, and distribution of third party payments received were raised as another concern.

There is a fully trained Internist available in the Region. It is unclear that his expertise is fully utilized by physicians in the Region for consultation and the potential benefit to patient care.

In summary, Nor-Man appeared to lack a collegial environment in which physicians, especially those new to the region, could practice and integrate into northern communities. This is further compounded by a lack of positive relationships in the workplace with other health professionals, and little interprofessional activity in support of patient care.

One respondent perhaps was most succinct:

"The problems with the doctors.... are other doctors."

In our view there needs to be an extensive overhaul of the physician environment in the Region that would improve collegiality, improve patient centeredness, improve CME and quality of care, and enable the voices of all physicians within the Region.

## **RECOMMENDATIONS**

1. A medical staff bylaw exists and should be completely implemented.
2. A Vice President Medicine should be hired at the regional level and Chief Medical Officers should be in place at each hospital site who report to that Vice President. In the short term

it may be necessary to provide external senior medical supports while the structures below are rebuilt or reinvigorated.

3. A Regional Medical Advisory Committee has to be more vigorously implemented to provide oversight to the Regional medical standards of practice.
4. Regional Standards Committees must be re-established to provide support to the Region and enable interdisciplinary discussion of patient care issues. Issues of clinical care that have not been resolved at the practice level, such as those raised to the Reviewers, should be relayed to this structure for review.
5. The College of Physicians and Surgeons should review the process of practice supervisors within small or remote regions to help ensure a nurturing environment and a focus on the quality of care.
6. Finally, the method of payment for physicians in the IMG program should be reviewed to ensure an appropriate balance between quality of care, accountability and productivity.

## COMMUNITY RELATIONSHIPS

Communication issues abound across the NRHA- many said “if they would only tell us.” Plans for communication at the time of the opening of the Flin Flon Clinic sound appropriate, but are not as timely as they needed to be. We also heard from the NRHA that proper approvals were not available to proceed with communication on the prospective movement of the Clinic to the hospital until after the proposal and funding identified was approved and that this prevented the communication that was needed. Memos to staff about the Review were very late, and memos in the middle of the Review in response to media reports are seen by many as insincere and inappropriate.

A few residents viewed the discord in Flin Flon as “a vocal minority”, not representative of the town - but most indicate the concerns are very widespread.

Anticipated sudden growth of 400 residents in Snow lake area is a concern to many, without any obvious planning visible to the community by the RHA to adapt health services there.

In the First Nations communities we visited, many First Nations people expressed a desire to receive care in Winnipeg rather than The Pas. The sense that there was limited communication with the Region was widespread.

Many are unclear whether NRHA population numbers include the estimated 10,000 on reserve communities, and believe that the Region uses their population numbers to obtain funding for which they do not receive services.

Most of the local leaders, other than the current Board of Directors of the Region, described little or no relationship with the CEO of the Region; many had never met him, although some had met him once when they were first elected at their invitation. We also frequently heard that

the community meeting in December, 2010 was triggered and supported by individuals with profound self interest and was an incomplete representation of the views of the community.

“Optics” issues, such as inappropriate use of fleet vehicles, perceived nepotism in hiring, Board functions, RHA offices perceived as ivory towers, trips to Winnipeg by senior staff, and lack of transparency and fairness of Northern Patient Transportation policies are seen very negatively, and have not been recognized by the Region as critical to public confidence.

Generally, those interviewed, newspaper reports, and concerns previously relayed to government are consistent in their comments about the NRHAs lack of communication with the citizens of the Region.

There is a widespread belief that the current RHA organization and structure cannot be trusted and that lack of transparency and communication over time has destroyed relationships with senior administration. While there is recognition that, on paper, the “right” processes might be in place, the lack of application of those processes are not evident to patients, staff and communities. Belief that there is favoritism, an ivory tower approach, and lack of consultation with communities exists, despite apparent and promised mechanisms such as public consultation over the Flin Flon Clinic (that did not occur), the existence of mandated District Health Councils, an ongoing community health assessment process, and a large amount of reporting of quality measurement processes and written reports from the Region.

Timely consultation with citizens is essential. Matters that connect to physician and hospital services are of particular concern to the citizens, and are often not readily identified through the traditional community health assessment processes.

## RECOMMENDATIONS

1. Community Health assessment findings and learnings from quality assurance processes, particularly in acute care, should be utilized effectively and translated into appropriate strategic directions that are clear to the community.
2. Formal relationships with local administrations: Mayors, Reeves, First Nations Chiefs and others, should be established on an ongoing basis by the CEO and used to develop positive initiatives for patient care and to provide the CEO with direct knowledge of the needs and requirements of the people.
3. District Health Councils, while seen by the Board as valuable, are mainly currently used to hear reports and conduct "events"- opportunity exists to use them as a source of community input. There are annual meetings of the Councils with the Board, which have the potential to be used more effectively. This may also increase interest in membership in the Councils, to which there has been difficulty recruiting members.
4. Mechanisms such as town hall meetings, comment cards, newspaper input invitations, and on line opportunities for ideas and feedback should be explored. There is no substitute for senior staff "going out to" the community to ensure visibility , to build credibility for the Region and to ensure that the communities' wishes are considered wherever possible.

## **FIRST NATIONS ISSUES**

Visits by the team to three First Nations communities; Moose Lake, GrandRapids, and Easterville were made, meeting with chiefs and staff, as well as meetings with several representatives of Opaskwayak Cree nation. Continuing partnerships with First Nations communities will be essential to the future functioning of the region.

The burden of illness in First Nations communities is widely recognized to be much greater than in the general population. Despite the greater need for health services, Federal on reserve health care services, Provincial Nursing Stations, NRHA services generally do not integrate on Reserve communities. Indeed, on reserve health services are considered as outside the mandate of the NRHA, but residents in First Nations communities receive care in the acute care hospitals and seek care from physicians who are part of the NRHA. In addition, many First Nations people live off reserve within the NRHA communities.

In the Nor-Man Region, diabetes services has made some progress in preventing duplication as federal, provincial and regional services all serve the same populations, and several people pointed to these efforts to sort out “who does what” as a potential model for other services.

NRHA provides DER (Diabetes Education Resource) and some Mental Health services to patients at the Nursing Stations. These are well received, but insufficient, and there are no other ongoing links to the RHA at the leadership level.

Standardization of Emergency transport services is not yet complete. NRHA provides ambulance service to Grand Rapids, which is well received. In Easterville, the service is still run by the First Nations community, which is seen by some as inadequate, but by the Band as an important source of employment. In Moose Lake, The Pas ambulances serve the community, and the distance is a concern.

EMT regulation and licensing requirements have seriously affected the number of EMTs qualifying to provide emergency services in the First Nations communities. Land ambulance medical transportation costs for senior citizens and low income citizens prohibits them from paying for these services.

Access to communications varies - for example, Moose Lake has no cell phone service, and is concerned about their ability to access transport services for accidents.

Most of the Chiefs of First Nations communities have not met the CEO of NRHA. They would welcome opportunities to work together in planning in parallel for their respective communities.

The Chief of the Easterville community raised concerns regarding access to PCH beds for their people and is requesting consideration be given to a new PCH for First Nation people in Easterville and surrounding communities.

A Health Centre is due to open on Opaskwayak Cree Nation (OCN) adjacent to The Pas in March 2011, with little discussion with NRHA to date about how the Region could assist or coordinate services between them.

Racism allegations by several First Nations people were felt by The Pas hospital staff to be misrepresentations. There is currently little meaningful cultural awareness training or representative workforce strategy, although there have been some attempts in the past.

There is one Aboriginal Liaison position in The Pas hospital which is highly valued by all staff and MDs, but cannot meet the need in a facility where 60% of patients have First Nations backgrounds. She provides translation, support, cultural services, and ensures communication with the Nursing Stations, particularly regarding obstetrical patients. There is no vacation replacement for her, and one position cannot meet the need. Apparently a similar single position exists in Flin Flon.

Communication of concerns regarding patient care among the Manitoba Health affiliated nursing stations tends to be to and from Winnipeg, and not directly to The Pas or Flin Flon where the concern may have arisen.

Physician coverage models differ in the First Nations communities; some are Northern Medical Unit, some are provided from The Pas, some are private arrangements. The model being researched for the OCN Wellness Centre in The Pas will add another complexity. This promotes wide variation in the services available.

There is no apparent single accountability at the Senior Management level of the RHA for First Nations issues, although over almost 50 percent of the population of the Region is defined as Aboriginal.

Health problems such as diabetes are widely known to be higher in Aboriginal people, and a discussion of that is beyond the scope of this Review. However, in a Region where almost 50 percent of the population is Aboriginal, one might expect an organized approach to joint planning among service providers, regardless of their jurisdiction, and ongoing mechanisms for problem solving. Although there are health service providers on reserve, and Manitoba Health Nursing stations on some, Federal or NRHA Nursing stations on others, there is not a structure for all to jointly plan or deliver services. Acute care services are provided in The Pas, Flin Flon and Snow Lake facilities operated by the Region, but many First Nations people indicated to us a preference to seek care in Winnipeg because of lack of trust and fair treatment in the Region's hospitals. (Note that Snow Lake Health Centre was not visited, so there is no direct observation there.)

## RECOMMENDATIONS

1. Training in all health care disciplines in Manitoba should include ongoing awareness of aboriginal health issues and history.
2. Training programs located in northern communities should be supported wherever possible to enable qualified staff who represent the community and understand northern issues.
3. Recent Roundtable meetings among all 3 Northern RHAs with first Nations representatives were seen as a good start and should be supported. 6 Working groups have been established and are seen to have potential to improve relationships.
4. The NRHA should define its role in relation to the First Nations communities, and prioritize joint planning and service delivery to avoid duplication. Positive relationships must be developed with First Nations leadership and are essential to the Region fulfilling its mandate.
5. Designation of accountability for First Nations issues in a Senior Leadership role must occur. Both workforce representation and advocacy for culturally appropriate care must occur. This should include a standing committee that includes elders, chiefs, and the Region.
6. The Board may want to establish an Aboriginal Advisory Committee, which would provide a forum for addressing aboriginal issues.
7. Manitoba Health should encourage provincial Nursing Stations to strengthen relationships and problem solve jointly with The Pas and Flin Flon Acute Care facility staff.
8. Manitoba Health should make a concerted effort to work closely with First Nations people on planning for the transfer of the Provincial Nursing Stations from the province to the NRHA.

## **PATIENT RELATED ISSUES**

Specific case reviews are beyond the mandate of this Review: the large number of concerns raised by individuals about the care received by themselves or their family members cannot be investigated within the Review. Mechanisms for ongoing review of care in the Region, particularly concerns about physician performance and interprofessional review of patient care situations are recommended.

The major and overriding concern expressed about patient care surrounds physician practice and access to physician care; this is addressed elsewhere in the Report. Patient care must be the priority for everyone concerned.

Within the services being provided, bullying comments were frequent, from staff to staff, MD to MD, MD to staff, and staff to patient. Comments about an atmosphere of fear and intimidation were frequent. There seems to be little faith that the current administration can address this.

Discharge planning and communication to the receiving area appears satisfactory in Obstetrics, but an audit recently done by the Manager shows it to be very poor on the Acute Care unit in The Pas. This concern, also raised by the Nursing Stations, results in gaps in care and an assumption, especially for First Nations individuals returning to on reserve communities, that care can be managed without adequate communication and resources to do so.

Patient complaint data published by the Region is thought by staff to be inconsistent with their experience. Reliance on "the form" rather than problem solving and discussion among the parties to improve patient care seems to be the norm. The originator of the complaint often lacks information on the resolution. The complaint form is received by the communications department and an acknowledgement letter is sent, but no one with whom we met indicated any personal contact or further feedback being received even several months or years after the complaint was acknowledged.

Regional approach to clinical services is lacking. Some acute care services (diagnostics, specialized intravenous access services, for example) are available in The Pas and not Flin Flon, or vice versa, but mechanisms to ensure they are shared are unclear or nonexistent. A specialist in Internal Medicine is available in the Region, but mechanisms to ensure appropriate and timely consultation are unclear.

Staff perceive a significant lack of support and many described a lack of valuing of patient care as a priority. Many describe a “corrupt” system, where performance appraisal of staff is lacking; clinical supervision, especially in the initial stages of employment, is minimal; ongoing education is not a priority; and accountability for problem solving is unclear. Concerns about patient care by physicians raised by nursing staff, particularly in Flin Flon, did not appear to be discussed beyond the level of the Executive Director, and were apparently unknown to the Chief of Staff.

In The Pas, the model exists where some Units are supervised by an in scope Head Nurse and others by a Unit Manager, apparently with the intent that this model is to be addressed by attrition. This mixture causes confusion, missed communications, unequal supervision of care, and unclear accountability. The management structure requires review in order to ensure that accountabilities are clear and the number and nature of supervisory roles, both in and out of scope, is appropriate.

Significant issues remain regarding the recent termination of a Mental Health worker who had criminally misrepresented his qualifications. There does not appear to have been appropriate debriefing or follow-up in the region to ensure that staff concerns are addressed, and that the affected patients’ care is ensured.

Although the NRHA has introduced significant new services in the Primary care area, these services are almost completely separate from the majority of the physician service providers in the community, and are not recognized by the community as having an impact on their access

to physicians. This could be a very significant resource for the community, but is poorly integrated, particularly in Flin Flon.

Several interviewees commented on their Home Care experience as very satisfactory, once they were able to establish what service they would be approved for. They did not however, always credit the NRHA with this success, since their concerns about physician services outweighed their satisfaction with other aspects of the Region's services, and overwhelm the positive features the Region has achieved.

Emergency transportation services and the EMT (Emergency Medical Technician) services managed by the NRHA were also seen as satisfactory, other than in the communities referenced in the First Nations section.

Supports for patient care such as equipment and functioning facilities appear to be missing. This ranged from elevator breakdowns to broken or outdated equipment for patient/ resident care. While these may have been funding issues, they have resulted in a sense for staff of the non importance of the core business of patient care while more visible improvements such as the clinic and offices have been possible.

There is no clear Regional structure for professional nursing issues, since the Executive Director of Professional services position was not filled. This position also served as Chief Nursing Officer and could be held responsible for ensuring consistent patient care practices across the Region and the introduction of new procedures or practices. This lack of clinical oversight is particularly apparent in the acute care sector.

There is widespread concern about hiring practices for senior positions, lack of formal posting of vacancies, transparency of process, and qualification verification. This affects both staff confidence in the NRHA and credibility and trust for patient care. Examples of family members

or others known to those hiring obtaining positions without due process are widely believed to be evidence of unfair hiring practices.

Significant concerns about the quality of care, particularly in the area of physician services exists, although data to support such concerns is conflicting. Many staff and patients described a feeling of vulnerability and lack of trust in the current physician model.

There is little interprofessional activity in support of patient care. Case reviews in ER, case conferences on the inpatient Units, joint patient care quality meetings, links between acute care, long term care, public health and nursing stations, and other regular mechanisms for learning from patient care situations and measuring care provided against established standards appear to be absent.

## **RECOMMENDATIONS**

1. Hiring practices in NRHA should be reviewed to ensure transparency and fairness.
2. Mechanisms should be found to enable out of scope Unit Manager accountability for all patient care Units. This could include use of Clinical Resource Nurse positions, red circling of incumbents, or other means, and should be jointly planned with the Manitoba Nurses Union and should not rely on attrition alone.
3. In the case of the Provincial Nursing Stations, the route of communication of concerns to Winnipeg should be reviewed, as it does not promote local problem solving or relationships and is not included in the data published by the Region, thus understating the number of concerns.
4. Consistency of acute care services across the Region should be the goal. Where volumes or finances do not permit, there must be mechanisms to share the services or personnel in

order that patient care is not compromised. A Senior Clinical position at the Regional level in each of Nursing and Medicine is needed to ensure accountability for patient care. The current model of an Executive Director at each acute care site does not promote regional integration of these services, and there is little evidence of regional consistency or care practices. These positions should be visible and available to the clinical staff, and accountable for standards and quality of care across the Region.

5. An interprofessional Patient Advocacy approach to complaints management and critical incident review with support at the most senior levels is needed.
6. Continuing to increase the use of telehealth services for specialist consultations should be sought, as a means both to obtain consultation and to reduce travel cost and inconvenience to the public. Winnipeg providers need to enable this and mechanisms at senior levels to “grow” the services between NRHA and WRHA should be established.
7. Mechanisms for regular interprofessional reviews of care need to be established, particularly in acute care. This should include interprofessional review of each resuscitation event, and should include specialist physicians who are present in the Region permanently or on a locum basis where possible. Significant support and role modeling from senior nursing, physician and allied health staff will be necessary for this to be effective in improving care. Initial efforts by designated quality improvement staff have been made, but there is little or no physician involvement.

8. Models that include other roles such as Nurse practitioners and midwives should be considered to enable the scarce physician resources to be directed to those duties that only a physician can perform. Physician readiness for these supports is always essential. Introduction of these roles requires considerable support and education of all those involved, but could if carefully introduced, will make a significant improvement in the care available in the community.
  
9. The criteria for approval for Home Care should be reviewed to ensure they are fair and transparent. Client managed care should be available in the Region, and disputes over eligibility or changes in service should be referred to the Provincial Home Care Appeal Board if they cannot be resolved in the Region.

## **FLIN FLON CLINIC ISSUES**

The new medical clinic in Flin Flon opened its doors on February 1. Manitoba Health had been clear that the clinic move would proceed on schedule and that the work of the Review Team would not effect this decision. Consequently the Review Team has only completed a brief assessment of this move and of the process followed in making this decision and preparing and approving the Business Plan itself.

Nevertheless, the Review Team heard many comments from the community on this move. These comments typically followed a few themes. Many comments were heard regarding access issues. The design of main entrance to the hospital continues to represent difficulties in easily entering the hospital. There are numerous reasons for this but most frequently cited was the difficulty with the ramp, parking availability, clinic location which in the minds of some community members would be inadequate. The location of the clinic in the hospital itself was seen as problematic in these comments. There was concern that the people attending the clinic would have to go through an indirect route in the main hospital area to get to the clinic and the entrance to the clinic was not visible and therefore unsafe if someone was ill. The feeling was expressed that bringing outside people into the hospital who were coming with a variety of illnesses was not a good decision. There was also the need to navigate a short, steep ramp when entering the clinic area. This might be difficult to navigate for individuals having difficulty walking or in wheel chairs. Positive comments about this move were also heard. The doctors who will be practicing in this clinic were very pleased with the move. They felt that this should definitely help their practice and make them more efficient. Hopefully this move will contribute very positively to the doctors seeing more patients. Comments were also made that give the new location a bit of time and people will begin to feel more positively about the new location.

The RHA has taken steps to address many of the concerns expressed plus others that came to their attention. According to the RHA not all of the issues can be addressed due to the structural and design limitations of an old building. A detailed Flin Flon Medical Clinic FMEA

Action Plan was developed and according to the information made available to the Review Team many, if not most, of the recommendations have been implemented. Steps that have been taken include improved signage both in the hospital and the parking area. Initially, at least the intent is to have greeters at the front entrance. The parking lot has been reconfigured to provide more parking spots. Stairwell lighting has been improved. In regard to infection control issues masks will be available at the front desk as well as other measures. While there is public concern about the spread of infection from hospital to clinic patients, it is common practice for clinics to be situated within hospitals, and infection control can be managed effectively. There will be a private area for breastfeeding moms. The RHA informed the Review Team that the matter of an onsite pharmacy will be reviewed once the clinic is up and operational. A number of other areas will be monitored on an ongoing basis. Some further enhancements are also included in the RHA capital plans.

The Review Team members toured the new clinic space before it was opened. It was our feeling that the space was very attractive and well designed with ample waiting areas, large doctors' offices and ample light.

Many of the comments heard centered on the region's lack of transparency and not sharing information in the process of making a decision to move the clinic. The first time the community became aware of this decision to open the new medical clinic was the Manitoba Health announcement on March 30, 2010. At that time a final decision had been made and consulting with community on the basic decision was no longer an option. In May a stakeholders meeting was held with significant representation from different organizations in the community. However, a public meeting was never held. We also heard from the NRHA that proper approvals were not available to proceed with communication on the prospective movement of the Clinic to the hospital until after the proposal and funding identified was approved and that this prevented the communication that was needed. In all likelihood greater transparency and better communication would have mitigated the public reaction, reduced suspicion and possibly affected the decision, though that is all speculative. There was also a delay in the public release

of the Business Plan. This meant that until very late in the process there was a lack of public information.

What appeared to be of particular concern to some of the community members that we interviewed was that this decision had the effect of putting a long term community businessman out of business. They considered that to be grossly unfair and they did not feel that the RHA should have acted in that manner. Obviously community members were not necessarily aware of any discussion that might have taken place between the business owner and the RHA. Nevertheless, this perception of the owner not being treated properly was detrimental to the RHA. Other individuals interviewed, however, expressed the opinion that the public meeting that highlighted concerns was triggered by individuals with significant self interest, and that at least in part, the owner had precipitated the situation by putting the building up for sale. If it had been sold the RHA would have been forced to find space for a new medical clinic.

#### The Business Case

The April 17, 2009 letter from the owner of the Medical Clinic, Scott Davidson motivated the RHA to consider clinic alternatives. In his letter Mr. Davidson states "It has become apparent that the Flin Flon Clinic cannot continue to operate as it is currently funded. Unless some other arrangements can be made which will see our costs fully met and a reasonable return on capital, we will be bringing to an end our relationships with all physicians and the region, and closing the facility." Briefly the owner proposes two considerations for the RHA. The RHA could lease the building and Flin Flon Clinic was prepared to continue to provide management services. The base rent would need to be negotiated and Davidson indicated what his fee would be for management services. The fees were a very substantial increase over the fees being currently paid. Secondly, the RHA could purchase the building based on agreed upon terms and again Davidson was prepared to provide management services at a proposed rate. Davidson indicated he was looking forward to working with the RHA to find an appropriate future for the

clinic but if they were unable to reach an agreement he intended to close the clinic on August 1, 2009.

In order to delay closure while solutions were being sought a substantial increase in the lease/management fees was negotiated between Davidson and the RHA. Ultimately the arrangement was extended until Jan 31, 2011.

After the receipt of the letter the RHA began to work on alternatives developing six options. The preferred option to move the clinic to the hospital and for the RHA to take over management of the clinic was recommended to Manitoba Health and was subsequently approved and announced.

There appears to have been a breakdown in communication between the RHA and the owner of the medical clinic. It appears that no substantive discussion or negotiation ever occurred between the two parties. The owner may have miscalculated what the reaction of the RHA would be (it is possible that Davidson may have considered his letter merely as an opening move leading to the negotiation of suitable terms) and the RHA miscalculated/underestimated what the reaction of the community would be. It would appear that the RHA saw this development as a way of dealing with issues related to the management of the clinic e.g. physician accessibility issues, including the low number of patients being seen by the doctors. Early on in the process the RHA became committed to moving the clinic and for reasons identified earlier this intent was apparently not clearly communicated to Davidson until the announcement on March 30, 2010. Then it was too late and strong negative reaction followed (community members came forward on their own initiative but according to comments we received they were also encouraged to do so).

The Review Team reviewed the Business Case and all documents provided. Of the six alternatives only the preferred option was referred to Manitoba Health who did their own due diligence and ultimately approved. The RHA has publicly indicated that the new medical clinic

should save \$250,000 annually. While the Review Team does not have the auditing capacity on its team to do a thorough review of the various alternatives it is difficult to determine where that saving will come from. All of the alternatives have a number of assumptions built into them which we do not have the capacity to verify. An auditor would need to review this.

It was the assessment of the RHA that it must take over the management of the medical clinic in order to successfully address the current problems of wait times for patients to get a doctor's appointment and in obtaining a family doctor. Given the complexity of the issues and the urgency to address them this assessment by the RHA was quite likely correct. The previous medical clinic did not have the necessary contractual relationship with the doctors, or quite likely the motivation, to achieve the required changes.

In order to achieve a reduction in wait times the RHA planned to implement the Advanced Access model. The six elements of this model are: balancing supply and demand; reducing backlog; reducing the variety of appointment types; developing contingency plans or unusual circumstances; working to adjust demand profiles and increasing the availability of resources to reduce bottlenecks. This model has been effective in other jurisdictions and is recommended by Manitoba Health. The RHA has also received support from Manitoba Health for two Nurse Practitioner positions. So far, despite aggressive efforts, the RHA has been unsuccessful in recruiting.

The other physician related issues that must be addressed in order to improve medical services include the ability of residents to get a family physician and an increase in the number of patient occurrences or patient visits completed by each family physician. Currently the contract family physicians are seeing fewer patients than listed under their contract. Access to physicians is perceived as difficult and the concept of "closing" practices to new admissions and frequent cancellation of appointments by the Clinic has been a major community concern. If this area can be improved then it should lead to improvement in obtaining a medical appointment or a family doctor.

If the RHA is successful in making major headway in addressing the above doctor related issues than its decision to take over the ownership and management of the medical clinic will be seen as a wise decision. If it is not successful, however, the current situation will continue to deteriorate and the community frustration and anger will continue to grow. The RHA has taken on a large challenge.

The new medical clinic opened at the beginning of February. At this point it is impossible for the Review Team to predict what its success will be.

## **RECOMMENDATIONS**

1. The new medical clinic is in operation and only down the road will its success be determined. The movement to the hospital holds potential to enable patient centered care processes, more consistency of physician practices, and improved facilities. Efforts by the Region such as the use of volunteers, signage, introduction of pharmacy access, and public education will need to be very successful in order to obtain public support of the new location.
2. Efforts should continue to recruit Nurse Practitioners and to incorporate them into the operation of the Medical Clinic. Steps must be taken to work with the clinic doctors to effectively incorporate the Nurse Practitioners.
3. Systematic plans must be implemented to ensure that issues of physician accessibility are addressed and are effective. Specifically, this includes ensuring that individuals can obtain timely medical appointments, that people can obtain a family doctor, that the number of patients seen by the clinic doctors achieves the requirements of the contract.

4. Any improvements regarding the location of the clinic in the hospital and parking lot that are still outstanding should be reviewed and implemented in a timely manner. Movement of records from the existing Davidson Building clinic to the hospital must be accomplished in a way that does not inconvenience or cost patients, and must comply with both legislation and regulation.
5. Use of a system such as Advance Access is being implemented in the new Clinic and must be carefully monitored to ensure it meets its goals of improved access and quality of care.
6. Efficient management of the new clinic, and a resulting increase in access to physician services is essential for community confidence to be restored and the clinic to be successful.

## **FINANCE ISSUES**

As the Review Team began its work it became apparent very quickly that the matter of finances was not one of the burning issues. The other issues identified in the report were the priority ones rather than finances. Additionally the Review Team members did not have the necessary skill set to complete a financial review. As a consequence this area has received little attention.

Review Team members did, however, meet with the Nor-Man RHA CFO, with the Manitoba Health CFO as well as with members of the internal Audit team. It was agreed that the Review Team would not include in its work any of the areas to be covered by the internal audit.

The meetings with the regional and Manitoba Health Chief Financial Officers identified that the RHA cumulative deficit is projected to reach approximately \$14m by the end of 10/11. We were informed by the region that the major drivers of cost increases are compensation increases (salaries and benefits account for over 60% of total costs), medical remuneration, additional community-based programming, and the Northern Patient Transportation Program. The Manitoba Health analysis would add to that increasing demands for Land Ambulance and Long Term Care.

## **RECOMMENDATIONS**

1. While the Review Team has not been able to give this critical area the attention it deserves we nevertheless feel that follow-up work is indicated. It would be our suggestion that Manitoba Health pursue this matter further in consultation with the RHA.

## **BOARD FUNCTIONING/ GOVERNANCE**

In order to understand the area of Board governance a little context is in order. When the RHAs were first created in 1996 they were encouraged by Manitoba Health to use a Policy Governance model (frequently referred to as the Carver model since John Carver was a leading thinker and writer in this area. Referring to it as the Carver model is only roughly accurate so the Review Team will generally use the term policy governance).

Similar to the other RHAs the Norman RHA chose to utilize this model. How it applied this model is similar to other RHAs although there are variations between the RHAs and at least one RHA indicates that they do not utilize a policy governance model. Some of these differences are significant since they were applied in an attempt to deal with some of the limitations of a policy governance model.

While we will examine aspects of this model in more detail further on in this section the following four are the essential components of a policy governance model. Typically these components are fleshed out with specific policy statements contained in a Board Policy and Procedure Manual. The four areas defined by Board approved policies include: Ends policies; Governance Process policies; Executive Limitations policies and finally, Board-CEO Relationship policies. The essential feature of the model is that it defines the governance responsibility of the Board and the operational responsibility of the CEO. Each is expected to restrict their work and responsibilities to their respective areas.

The Review Team has reviewed NRHA Board Policy and Procedure Manual. According to comments received from the Board the Manual may not be entirely up to date.

The Review Team received numerous complaints about the “Carver model”, as it was characteristically referred to, both in our interviews and in the written responses. These critical comments were received from community members, civic leaders as well as some former Board members. The essence of these critical comments was that the Board was not carrying out its

responsibility and that the CEO either by design or as a result of a vacuum left by the Board had too much power and authority.

First, we will address the comments received from some former Board members (these comments did not represent the views of all the former Board members). It should be noted that at least four Board members stated that they had left their position on the Board before their terms were up due to their frustration on how the Board functioned. (it might be noted that the Board itself believed this number was lower). One former Board member stated that the “Carver model” had been taken to a ridiculous level, that the Board was secretive, the Board members were not allowed to ask questions about the day to day operation and that there was no Board communication with the public. A number of First Nation former Board members stated that there was a lack of attention by the Board to First Nation health delivery issues. They also commented that when they tried to raise these issues they felt like they were being appeased rather than seriously listened to; there was not enough action to improve services; client complaints were not effectively addressed and their questions as Board members got minimal response. The comment was also made that they felt that the CEO “controlled the Chair” and they wondered where the CEO got all his power. The comments were made that the CEO doesn’t really listen to the Board members. One former Board member stated that the “Carver model” should be discontinued, that Board members should receive more training for their role as Board members, that the Board members should be given more discretion and the way the Board can obtain information should be expanded. Another former Board member commented that the “Carver model” is a hindrance, the CEO is the Board’s only employee and that everything comes through him, and one person (the CEO) should not be the sole spokesperson for the RHA (this was blamed on the “Carver model”).

There were community members that made equally critical comments of the Board as reflected in the “Carver model”. Comments were made that the CEO “kept the Board out of issues”. However, it was also observed that the RHA “does a very good job given the politics”. An elected official stated that Carver is not conducive to Aboriginal culture and practice. One

community member commented that the CEO ran the AGM while in his opinion that should have been the responsibility of the Chair. Also he commented that senior management made all the decisions and not the Board.

It would be the perspective of the Review Team that blaming the Carver model is a proxy for criticism of the Board and CEO. It is unlikely that community members are sufficiently informed about the details of the policy governance model to draw their conclusion – as stated it is really a proxy for other concerns. The criticism identifies a loss of confidence and trust in the Board and CEO because people don't feel that they get timely information, or that they have input or feel represented by the RHA Board. According to the comments received there are those who perceive the Board as isolated and out of touch and that the Board has delegated too much authority to the CEO. While the policy governance model may be particularly vulnerable to these kinds of criticisms other governance models may fall short in these areas as well.

In order to get the Board's perspective on policy governance and how the Board was functioning within that model the Review Team had a lengthy session with the full Board to gather information and perspective. The Review Team had prepared some 17 questions for the Board's response. The following are the highlights of this two hour session:

- In regard to the "Carver" model the Board Chair indicated that they were following a substantially modified policy governance model.
- Currently the Board has five or six vacancies. The Board has had as many as 16 members of which as many as seven have been Aboriginal representatives. Currently there are only three Aboriginal representatives on the Board.
- The Board has ten official meetings a year plus numerous informal meetings. Typically the meetings last from 2-4 hours. Due to bad weather or something similar the occasional Board meeting has been cancelled due to lack of a quorum.
- Generally the Board secretary, a senior staff person, prepares the Board meeting agenda. Typically, but not always she may consult with the Board Chair in preparing the agenda. Board members can also add agenda items at the meeting itself. Typically there is a "round

table” where Board members can share with the Board what is happening in their community.

- We were informed that the Board completes an annual self-evaluation. An online form has been made available to Board members so that they can complete their own evaluation of Board performance.
- The Board members indicated that typically a new Board member received a half day to a full day orientation. We were told that in the past current Board members have participated in the orientation for new members. The new members are also provided with a manual of information.
- There are currently five to eight District Health Councils (DHC). A number of new ones have been added including Easterville and Cormorant. Each DHC has been assigned a staff liaison and a Board member liaison. We were told that the staff member typically attends each meeting while the Board member liaison may only attend some. The DHCs have a primary role in health promotion but may participate in other health functions as well. Each Council has a small budget. The Board routinely receives the materials and suggestions/concerns from the Councils which may then get discussed at a Board meeting. The Board provided a few examples of Council activity e.g. Flin Flon DHC has done a lot of things for children; the Pas DHC produced a brochure on available health services. Some of the DHCs are having difficulty getting members for their Council.
- The workings of the Board meetings were explored. We were told that the CEO and his senior staff generally attended the Board meetings (depending on whether the Board meeting was in Flin Flon or The Pas only the one Executive Director of Clinical Services would attend). Typically the Medical Chief(s) of Staff did not attend and this was of concern to the Board. The Agenda and the Board meeting material are generally mailed a week in advance. There are a number of standing items for each Board meeting. These include the Executive Limitation reports, updates on physician services, recruitment and retention, capital issues and financial reports. Generally they also receive the quarterly quality score cards. The Chair will report on provincial issues and Council of Chair meetings. On occasion a written report is received in advance on a major issue eg. move of the medical clinic. We

were told that most of the CEO's reporting to the Board was verbal. Time is allowed for questions from the Board members.

- The Board quickly stated that they have not been doing enough to meet with stakeholders, community groups, municipal councils, civic leaders etc. Board meetings are open, and there have been guests, such as the Chief of OCN in spring, 2010. They stated that in the past they had been doing more, including somewhat regular meetings with Town Councils, but for a while have essentially not been doing any formal consultation. They were assuming that Drew was doing more of this but that in all likelihood it was very informal. (Other comments received suggest that the CEO is also not doing much of this contact). The Board has begun discussion on how to do more of this kind of interaction.
- The Board stated that while in the past they had been doing regular review of Board policies this process had fallen by the wayside. One Board member stated that he would be recommending to the Board that a Governance Committee be established by the Board. Such a Committee would take the lead in reviewing the policies, CEO evaluation, Board evaluation and other similar functions. The Audit Committee is the only Board committee that meets regularly while the Executive Committee only meets on an ad hoc basis as required. A Public Relations Committee had been established by the Board but it never really became functional. The Board also established a Planning Committee which planned some Board educational events.
- The Review Team explored with the Board how it had been involved in some recent major issues/decisions. In regard to the move of the medical clinic the Board had reviewed the six options as presented by the CEO in September 2009. They had approved at that time the preferred option which was subsequently implemented. They stated that they did not see the document that was submitted to Manitoba Health. After September, 2009 the Board did not again engage themselves in this issue. In regard to the suspension of medical privileges for Dr Sethi, the CEO had missed a step in the approved process and involved the Board too late (the CEO had invoked too long a suspension on his own when it required a Board decision). In regard to the Carr case the Board stated that they had not been involved in any discussion regarding the implementation of a follow-up plan to deal with the fall out of this

situation on staff, community partners etc. In regard to the matter of physician recruitment and retention the Board did receive verbal reports from the CEO.

- In the first interview with the Board at the beginning of the Review the Board stated that the CEO had their full support. The Board was not aware of there being a formal job description for the CEO or if there was one it was not referred to. As far as they could remember the last CEO annual performance evaluation was completed in 2008. The Executive Committee is assigned the task of completing the annual CEO performance evaluation. The Board is provided with the opportunity to pass along their comments to the Executive Committee but the whole Board does not sit down with the CEO to discuss his performance. The Board does not set annual objectives for the CEO nor is there any monitoring of CEO performance during the year. According to Board policy the CEO performance evaluation can only examine how the CEO has achieved Board Ends and done so within the Executive Limitations. It was also stated that the CEO has not provided to the Board a long term succession plan and this was of concern.

## **RECOMMENDATIONS**

No matter whether the current “Carver” policy is retained or a new governance model is selected there are a number of major issues that will need to receive priority attention. To not make significant governance changes is not an option. The major areas requiring attention are addressed in the following recommendations.

1. The Board should develop and implement systematic plans to increase its interaction with its stakeholders, community partners, First Nations organizations, Manitoba Health, civic leaders and other groups.
2. The Board should enhance its processes to address major issues thoroughly at the Board level. This will also mean that the Board will require that the CEO provide a written report for each Board meeting where major issues are outlined and options are presented.

3. The Board should improve its processes for Board self-evaluation. Improved processes should help the Board avoid a repeat of the current situation.
4. The Board should also carry out a systematic review of its own performance over the past years to determine whether it had fully carried out its governance responsibilities, how had the Board's performance, or lack of it, contributed to the current situation and identify and implement the necessary corrective steps.
5. An up to date job description for the CEO should be developed by the Board. While an old job description was found it seems not to have been utilized in assessing CEO performance. The job description should be very explicit on what is required of the CEO.
6. Annually the priority objectives should be developed by the Board in consultation with the CEO. Ends statements are not specific enough to effectively guide the performance of the RHA or the CEO. The objectives should be stated in very practical terms so that the implementation can be measured.
7. The Board should establish policies and procedures to regularly monitor CEO performance. This could include quarterly monitoring reports, quarterly meetings with the Executive Committee. This is in addition to the annual performance evaluation. The annual Board objectives should form a primary foundation for the ongoing CEO monitoring as well as the annual performance evaluation. The process for the annual performance evaluation should be changed to provide for greater involvement of the whole Board. The process should always include a major meeting of the Board with the CEO where all matters related to performance can be discussed. These recommendations have the objective of making the CEO more accountable to the Board.

8. It is the view of the Review Team that the Board will require outside assistance in dealing with the variety of issues and recommendations confronting it. Consequently we recommend that the Board engage a governance specialist to work with them.
  
9. There is no one correct governance model. Each model comes with strengths and weaknesses and one model may be more effective at one time than at another. We would recommend that with the assistance of a governance specialist the Board make a new decision on which governance model they wish to use. Given all the criticism that the "Carver" model has received it may be advantageous to move to a new governance model.

## **CEO PERFORMANCE**

In our interviews and in the documents received, a number of themes regarding CEO performance were identified. While a large number were critical there were also positive comments supporting the CEO. In this regard it is similar to the division of opinion that exists in other areas that we examined. The following are the most important feedback that we received. Many respondents indicated that they had lost trust and confidence in the RHA and its leadership. This was expressed with intensity at the public meeting but also in many of the interviews and written comments.

There were numerous comments that the CEO did not effectively engage the community and its leadership. There was considerable complaint that the CEO/RHA did not provide information to the community about RHA plans in a timely and effective manner and in a way that the community could have input in the decision making or at the very least be informed.

There is little evidence of effective relationships between many of the mayors, chiefs and other significant community leaders and the CEO. This is not to say that there aren't some but the Reviewers would have anticipated that significantly more attention would have been given to this important area by the CEO. Many indicated that they had never met the CEO, or perhaps had met once at their own initiative to discuss mutual concerns.

Consistent complaints were heard that the CEO and senior staff did not reliably and promptly respond to complaints from community members or a request for information. Many had discontinued making the effort.

Administration in the region is viewed by many as intimidating to both staff and public. We heard numerous times from community members and also staff interviewed by the Review Team that many staff would not come to see us out of fear of the consequences from the

administration. It should be noted, however, that in the end we did get the opportunity to interview numerous staff from different service and program areas.

It is also the observation of the Review Team that over time it appears that the leadership of the RHA has taken on a "bunker mentality". This further reduces engagement with the community and creates an "us and them" mentality.

During our Review it became readily apparent that the current situation, particularly as it pertains to Flin Flon, did not develop over night. Numerous individuals tracked for us their view of the steady decline of services over the past 5-10 years. As mentioned in other parts of the report the community views the lack of effective physician services where you can get a reliable family doctor and medical appointments in a timely manner as the central problem with all the other issues/services as secondary or supplementary.

However, more than one individual characterized the recent events as a "perfect storm" arousing the Flin Flon community to a fever pitch resulting in both appropriate and inappropriate and sometimes inaccurate public comments. Given the lack of trust in the RHA the worst was assumed by the community regarding these events and for many individuals they were a confirmation of the shortcomings of the CEO and the Board. The following issues, addressed in other parts of the report, are referenced here only as primary examples of this "perfect storm". The first issue is the move of the medical clinic to the hospital and among other things the lack of timely information. The second issue is the ongoing conflict and issues between Dr Sethi and the RHA in general and the CEO in particular. Thirdly is the issue of physician services and the inability to get a family physician or timely medical appointments. Lastly, the outstanding issues regarding the Carr events have never been fully addressed or resolved.

In summary, all of this adds up to continued erosion in trust and confidence in Senior Management and the Board of the RHA.

There are those, however, who are very supportive of the CEO and those who believe that the current situation will blow over. While some may agree that the CEO's communication skills are not the greatest they do not feel that the current problems should be laid at his door.

In our group interview with Senior Management they expressed support for his continued leadership. They believe that much of the criticism he is receiving is not warranted or that others are to blame.

Others drew to our attention all the things the RHA has accomplished in the past 10 years under the CEO's leadership. Numerous new services have been established and programs have been expanded. While the Reviewers' assignment did not include program review we believe the observation is correct. As one example, new primary health care centers have been established in Flin Flon and The Pas.

Additional personal comments were received. One health professional, not employed by the RHA stated "Drew has shown complete support. Drew is approachable, totally supportive and committed to health care in the region" (However, she also said "staff hide issues from him.") Another external professional stated "Drew is always cordial and professional " ( he also stated that "organized vindictiveness is being directed at Drew").

Additionally, while the effective management of any RHA presents significant challenges for a CEO given the complexity of a health delivery system, there are also frequently local characteristics and dynamics at play which present additional challenges. It is our view that such dynamics exist in this region e.g. a more northern, isolated setting, the continued competition for resources between Flin Flon and The Pas, particular difficulty in recruiting physicians that will identify with and settle down in the community and the current community unrest (we were also told that this was not the first time that the community was significantly aggravated over health issues).

In summary there is broad agreement among the parties that the current situation is doing damage to the community, to the RHA and its health services and above all is demoralizing to health care providers that deliver the health services. The situation must be dealt with and not allowed to continue.

From the perspective of the Review Team there are two possible approaches to addressing the area of RHA leadership issues. The first approach is to conclude that the current situation is an aberration and will blow over. As mentioned already that is not the conclusion of the Review Team, nor is it the sense of others. The current situation is more likely a culmination of problems that began much earlier.

The second approach is to determine that broader systemic issues are at play. This would indicate that major corrections cannot be made without significant changes at the senior leadership level. Specifically, how will the trust and confidence in the RHA be restored, how will the major physician issues be dealt with so that the community members are able to have confidence in their medical care and obtain timely appointments, how will the major issues between Dr Sethi and the RHA be resolved, how will work place problems be tackled? To successfully address these major issues will require effective leadership that has the confidence and trust of the community, partners, community and First Nation leadership and all the residents. Leadership does make a difference.

## **RECOMMENDATIONS**

1. It is the recommendation of the Review Team that significant change is needed at the most senior leadership level. Too much has happened to allow a continuation of the status quo with the hope that somehow the major issues facing the RHA will be successfully addressed.

Even as we propose this recommendation we are cognizant of the fact that there have also been many positive developments in the Region (many of these are being overlooked in the current community unrest) over the past decade.

## **SUMMARY OF RECOMMENDATIONS**

### **Physician Issues**

1. A medical staff bylaw exists and should be completely implemented.
2. A Vice President Medicine should be hired at the regional level and Chief Medical Officers should be in place at each hospital site who report to that Vice President. In the short term it may be necessary to provide external senior medical supports while the structures below are rebuilt or reinvigorated.
3. A Regional Medical Advisory Committee has to be more vigorously implemented to provide oversight to the Regional medical standards of practice.
4. Regional Standards Committees must be re-established to provide support to the Region and enable interdisciplinary discussion of patient care issues. Issues of clinical care that have not been resolved at the practice level, such as those raised to the Reviewers, should be relayed to this structure for review.
5. The College of Physicians and Surgeons should review the process of practice supervisors within small or remote regions to help ensure a nurturing environment and a focus on the quality of care.
6. Finally, the method of payment for physicians in the IMG program should be reviewed to ensure an appropriate balance between quality of care, accountability and productivity.

## SUMMARY OF RECOMMENDATIONS

### Community Relationships

1. Community Health assessment findings and learnings from quality assurance processes, particularly in acute care, should be utilized effectively and translated into appropriate strategic directions that are clear to the community.
2. Formal relationships with local administrations: Mayors, Reeves, First Nations Chiefs and others, should be established on an ongoing basis by the CEO and used to develop positive initiatives for patient care and to provide the CEO with direct knowledge of the needs and requirements of the people.
3. District Health Councils, while seen by the Board as valuable, are mainly currently used to hear reports and conduct "events"- opportunity exists to use them as a source of community input. There are annual meetings of the Councils with the Board, which have the potential to be used more effectively. This may also increase interest in membership in the Councils, to which there has been difficulty recruiting members.
4. Mechanisms such as town hall meetings, comment cards, newspaper input invitations, and on line opportunities for ideas and feedback should be explored. There is no substitute for senior staff "going out to" the community to ensure visibility , to build credibility for the Region and to ensure that the communities' wishes are considered wherever possible.

## SUMMARY OF RECOMMENDATIONS

### First Nations Concerns

1. Training in all health care disciplines in Manitoba should include awareness of aboriginal health issues and history.
2. Training programs located in northern communities should be supported wherever possible to enable qualified staff who represent the community and understand northern issues.
3. Recent Roundtable meetings among all 3 Northern RHAs with first Nations representatives were seen as a good start and should be supported. 6 Working groups have been established and are seen to have potential to improve relationships.
4. The NRHA should define its role in relation to the First Nations communities, and prioritize joint planning and service delivery to avoid duplication. Positive relationships must be developed with First Nations leadership and are essential to the Region fulfilling its mandate.
5. Designation of accountability for First Nations issues in a Senior Leadership role must occur. Both workforce representation and advocacy for culturally appropriate care must occur. This should include a standing committee that includes elders, chiefs, and the Region.
6. The Board may want to establish an Aboriginal Advisory Committee, which would provide a forum for addressing aboriginal issues.
7. Manitoba Health should encourage provincial Nursing Stations to strengthen relationships and problem solve jointly with The Pas and Flin Flon Acute Care facility staff.
8. Manitoba Health should make a concerted effort to work closely with First Nations people on planning for the transfer of the Provincial Nursing Stations from the province to the NRHA.

## SUMMARY OF RECOMMENDATIONS

### Patient Related Issues

1. Hiring practices in NRHA should be reviewed to ensure transparency and fairness.
2. Mechanisms should be found to enable out of scope Unit Manager accountability for all patient care Units. This could include use of Clinical Resource Nurse positions, red circling of incumbents, or other means, and should be jointly planned with the Manitoba Nurses Union and should not rely on attrition alone.
3. In the case of the Provincial Nursing Stations, the route of communication of concerns to Winnipeg should be reviewed, as it does not promote local problem solving or relationships and is not included in the data published by the Region, thus understating the number of concerns.
4. Consistency of acute care services across the Region should be the goal. Where volumes or finances do not permit, there must be mechanisms to share the services or personnel in order that patient care is not compromised. A Senior Clinical position at the Regional level in each of Nursing and Medicine is needed to ensure accountability for patient care. The current model of an Executive Director at each acute care site does not promote regional integration of these services, and there is little evidence of regional consistency or care practices. These positions should be visible and available to the clinical staff, and accountable for standards and quality of care across the Region.
5. An interprofessional Patient Advocacy approach to complaints management and critical incident review with support at the most senior levels is needed.
6. Continuing to increase the use of telehealth services for specialist consultations should be sought, as a means both to obtain consultation and to reduce travel cost and inconvenience to the public. Winnipeg providers need to enable this and mechanisms at senior levels to “grow” the services between NRHA and WRHA should be established.
7. Mechanisms for regular interprofessional reviews of care need to be established, particularly in acute care. This should include interprofessional review of each resuscitation event, and should include specialist physicians who are present in the Region permanently or on a locum basis where possible. Significant support and role modeling from senior nursing,

## SUMMARY OF RECOMMENDATIONS

physician and allied health staff will be necessary for this to be effective in improving care. Initial efforts by designated quality improvement staff have been made, but there is little or no physician involvement.

8. Models that include other roles such as Nurse practitioners and midwives should be considered to enable the scarce physician resources to be directed to those duties that only a physician can perform. Physician readiness for these supports is always essential. Introduction of these roles requires considerable support and education of all those involved, but could if carefully introduced, will make a significant improvement in the care available in the community.
9. The criteria for approval for Home Care should be reviewed to ensure they are fair and transparent. Client managed care should be available in the Region, and disputes over eligibility or changes in service should be referred to the Provincial Home Care Appeal Board if they cannot be resolved in the Region.

## SUMMARY OF RECOMMENDATIONS

### Flin Flon Issues

1. The new medical clinic is in operation and only down the road will its success be determined. The movement to the hospital holds potential to enable patient new centered care processes, more consistency of physician practices, and improved facilities. Efforts by the Region such as the use of volunteers, signage, introduction of pharmacy access, and public education will need to be very successful in order to obtain public support of the new location.
2. Efforts should continue to recruit Nurse Practitioners and to incorporate them into the operation of the Medical Clinic. Steps must be taken to work with the clinic doctors to effectively incorporate the Nurse Practitioners.
3. Systematic plans must be implemented to ensure that issues of physician accessibility are addressed and are effective. Specifically, this includes ensuring that individuals can obtain timely medical appointments, that people can obtain a family doctor, that the number of patients seen by the clinic doctors achieves the requirements of the contract.
4. Any improvements regarding the location of the clinic in the hospital and parking lot that are still outstanding should be reviewed and implemented in a timely manner. Movement of records from the existing Davidson Building clinic to the hospital must be accomplished in a way that does not inconvenience or cost patients, and must comply with both legislation and regulation.
5. Use of a system such as Advance Access is being implemented in the new Clinic and must be carefully monitored to ensure it meets its goals of improved access and quality of care.
6. Efficient management of the new clinic, and a resulting increase in access to physician services is essential for community confidence to be restored and the clinic to be successful.

## **SUMMARY OF RECOMMENDATIONS**

### **Finances**

1. While the Review Team has not been able to give this critical area the attention it deserves we nevertheless feel that follow-up work is indicated. It would be our suggestion that Manitoba Health pursue this matter further in consultation with the RHA.

## SUMMARY OF RECOMMENDATIONS

### Board Functioning and governance

1. The Board should develop and implement systematic plans to increase its interaction with its stakeholders, community partners, First Nations organizations, Manitoba Health, civic leaders and other groups.
2. The Board should enhance its processes to address major issues thoroughly at the Board level. This will also mean that the Board will require that the CEO provide a written report for each Board meeting where major issues are outlined and options are presented.
3. The Board should improve its processes for Board self-evaluation. Improved processes should help the Board avoid a repeat of the current situation.
4. The Board should also carry out a systematic review of its own performance over the past years to determine whether it had fully carried out its governance responsibilities, how had the Board's performance, or lack of it, contributed to the current situation and identify and implement the necessary corrective steps.
5. An up to date job description for the CEO should be developed by the Board. While an old job description was found it seems not to have been utilized in assessing CEO performance. The job description should be very explicit on what is required of the CEO.
6. Annually the priority objectives should be developed by the Board in consultation with the CEO. Ends statements are not specific enough to effectively guide the performance of the RHA or the CEO. The objectives should be stated in very practical terms so that the implementation can be measured.
7. The Board should establish policies and procedures to regularly monitor CEO performance. This could include quarterly monitoring reports, quarterly meetings with the Executive Committee. This is in addition to the annual performance evaluation. The annual Board objectives should form a primary foundation for the ongoing CEO monitoring as well as the annual performance evaluation. The process for the annual performance evaluation should be changed to provide for greater involvement of the whole Board. The process should always include a major meeting of the Board with the CEO where all matters related to performance can be discussed. These recommendations have the objective of making the

## SUMMARY OF RECOMMENDATIONS

CEO more accountable to the Board.

8. It is the view of the Review Team that the Board will require outside assistance in dealing with the variety of issues and recommendations confronting it. Consequently we recommend that the Board engage a governance specialist to work with them.
9. There is no one correct governance model. Each model comes with strengths and weaknesses and one model may be more effective at one time than at another. We would recommend that with the assistance of a governance specialist the Board make a new decision on which governance model they wish to use. Given all the criticism that the "Carver" model has received it may be advantageous to move to a new governance model.

## **SUMMARY OF RECOMMENDATIONS**

### **CEO Performance**

1. It is the recommendation of the Review Team that significant change is needed at the most senior leadership level.