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Healthy Members, Healthy Union, Healthy Communities

September 26, 2016

Brenda Ambrametz *via email: AdvisoryPanel@health.gov.sk.ca*
Tyler Bragg
Dr. Dennis Kendel
Advisory Panel on Health System Structure
Saskatchewan Ministry of Health
3475 Albert Street
REGINA SK S4S 6X6

Dear Advisory Panel Members:

On behalf of SUN's Board of Directors, almost 10,000 registered nurses in Saskatchewan and the people of the province, the Saskatchewan Union of Nurses (SUN) is enclosing our submission to the Advisory Panel on Health System Structure.

As the single largest group of direct patient care providers in the system, we believe the province's frontline registered nursing workforce offers a unique perspective on the potential challenges and opportunities that may be encountered over the course of health care restructuring.

As you will see in our attached submission, SUN believes that health system structure re-design should:

- be based on a rigorous analysis and prioritization of broader health system goals;
- design administrative, governance, and service-delivery structures to meet current and expected future population health and patient health care needs, with a view to appropriate administrative *and* clinical/care integration;
- balance the desire for greater consistency and coordination with the ability to provide services that remain accessible, accountable, responsive, and connected to the unique needs of the communities and sub-populations we serve; and
- include the province-wide application of a consistent data collection system for tracking patient and patient care outcomes to ensure we are meeting our quality and safety objectives in care delivery.

SUN and our 10,000 registered nurse members share your commitment to building a strong, sustainable health care system that will ensure the effective and efficient delivery of high quality, safe patient care to all people in Saskatchewan.

We remain available to meet with the Advisory Panel in order to discuss our submission and how we can be of assistance during this time of great transformational change.

We look forward to continued discussions on these important matters.

Yours truly,

Tracy Zambory, RN
SUN President

Enclosure

cc SUN Board of Directors
Amber Alecxe, Director of Government Relations

Written Submission to the Minister of Health's *Advisory Panel on Health System Structure*

Saskatchewan Union of Nurses

September 26, 2016

Written Submission to the Minister of Health's *Advisory Panel on Health System Structure*

On August 18, 2016, Health Minister Duncan appointed a three person *Advisory Panel on Health System Structure*. On August 29, 2016, the Panel invited public input on:

- Restructuring health regions to achieve administrative efficiencies as well as improvements to front-line service delivery;
- Opportunities to reorganize and/or consolidate clinical or health system support services currently delivered by Regional Health Authorities or other agencies;
- Reviewing legislation and other processes to ensure they adequately establish roles and accountability;
- Enhancing health and management information to observe and improve the performance of the health care system.

What follows is the Saskatchewan Union of Nurses (SUN) written submission to the Advisory Panel. In it, SUN has endeavored to address questions included in the Panel's call for consultation within the short timeframe allowed by the Panel's mandate – less than 30 days. Given SUN's views regarding pressing priorities for health and health care restructuring, this submission goes beyond the consultation framework established by the Panel. SUN trusts that any legislative changes recommended by the Panel will be the subject of separate and meaningful consultation. **SUN's recommendations can be found beginning on p. 16**.

Health Care Restructuring: Where have we been?

Health care systems in Canada have undergone periodic – even perennial – restructuring efforts over the last 25 years. Governance and administrative structures in particular have experienced substantial change, with a widespread turn to *regionalization* in the 1990s and early 2000s, and what appears to be some movement towards *re-centralization* in recent years, with uncertain results (see Kouri, 2002; Lewis and Kouri, 2004; Black and Fierlbeck, 2006; Church and Smith, 2008; Chessie, 2009; The Change Foundation, 2008; Boychuk, 2009; Collier, 2010; Born, Sullivan and Bear, 2013; Marchildon, 2015a; Van Aerde, 2016).

Saskatchewan's experience with health care restructuring is not exceptional. In common with most provinces, the 1990s and early 2000s witnessed the creation (and re-creation) of Regional Health Authorities (RHAs) that rationalized administrative responsibility for particular facilities and services within their boundaries, at the expense of a multitude of local agencies and boards, while assuming responsibility for key mechanisms of planning and allocation that were traditionally the purview of the provincial Ministry of Health.

Regionalization can be described as a restructuring of health care delivery that amalgamated elements of administrative and clinical responsibility at the RHA level, while de-centralizing aspects of decision-making power, planning authority, and governance accountability from the provincial government to the RHAs.

Regionalization was premised on making greater management coordination and multi-sectoral clinical integration responsive to needs by devolving key areas of responsibility (including service provision, human resource management, planning and accountability) from the Ministry of Health to the RHAs through global regional budget allocations (Lewis and Kouri, 2004; Marchildon, 2013).

Apart from cost containment and rationalization – key considerations in all restructuring efforts – the touted benefits of regionalization, although controversial, are well known, and included:

- Better integration of services as RHAs could integrate the care continuum and adopt a "system" perspective within a defined geographical area;
- Economies of scale and scope in the management and delivery of health care services;
- Increased local input in decision-making and greater local accountability;
- Greater health care equity within regions.[1]

[1] In most cases, including in Saskatchewan, *regionalization* was accompanied by a stated desire to shift the focus of the health care system away from fragmented and episodic care of acute illness to a holistic emphasis on population health. Actual policy change on these fronts has rarely matched the rhetoric.

These benefits generally rested on RHAs' increased capacity to set priorities, direct resources, and be responsive and accountable to specific covered populations and unique regional needs as compared to their predecessors: a distant Ministry of Health and a fragmented series of local service delivery and governance arrangements.

Health Care Restructuring: What was achieved?

The restructuring of health care in the 1990s and early 2000s was chaotic, disruptive, and conflictual for managers, employees, patients, and communities alike. From the perspective of workplace and labour relations stability, and health workforce morale, it was a difficult period that strained relationships and distracted from the core mission of the health care system: delivering high-quality and safe patient- and family-centred care.

The process did eventually produce a more stable workplace and labour relations environment, including clearer lines of authority and accountability, more unified and credible employer-side bargaining representatives, a rationalized and more coherent framework of employee representation and collective bargaining, and greater flexibility for employers to deploy and redeploy their regional workforces (see Wetzel, 2005).

This is particularly evident in the case of registered nurses and their employers, both of whom now enjoy the benefits of a province-wide bargaining unit, uniform collective agreement provisions, low barriers to labour mobility within and between regions, and relatively mature structures of representation and engagement that create the possibility for the parties to: (1) interact on the basis of a more holistic understanding of system challenges at both regional and provincial levels; and (2) progress beyond traditional adversarialism to engage in collaborative problem-solving and focus on improving staff and patient experience, improving quality, and driving down avoidable costs. These possibilities were evident in the tenor and outcomes of the last round of bargaining between SUN and the employer(s).

The importance of quality workplaces and workforce stability for the purposes of both cost containment and ensuring high-quality and safe patient care delivery has increasingly been highlighted by research. Workforce instability has been shown to represent a significant direct and indirect cost burden for the health system and to place patients at risk for poorer outcomes (Duffield *et al*, 2014).

Turnover, in particular, is very costly for healthcare organizations, accounting for as much as five (5) percent of annual operating budgets; it has been shown to reduce patient contact time and the continuity of care, to increase a range of organizational costs, and to reduce individual and organizational performance through the loss of experienced staff and by undermining teamwork and reducing team productivity (Waldman *et al*, 2004; Buchan, 2010).

The landmark Canadian study sponsored by the University of Toronto Health Services Research Unit – based on detailed hospital- and unit-level data from 41 hospitals in 10 Canadian provinces – found that the Canadian average registered nurse turnover rate (defined as the 12-month rate of voluntary transfer or resignation from a primary employment position) was 19.9%, with an average cost of $25,000 per vacancy. Costs include paying for temporary replacement and the recruitment, hiring, and orientation/ training of new staff, and the decreased productivity of new hires, as well as reduced team productivity in areas of high turnover.

The study found that higher levels of turnover are associated with decreased job satisfaction, decreased physical and mental health status of nurses, and less effective leadership and team functioning. Higher levels of turnover were also linked to increased incidence of medical errors, failure to rescue events, and prolonged lengths of stay. The study found that lowering nurse turnover can promote a more stable nursing workforce, higher levels of job satisfaction, reduced overtime, and a lower probability of medical errors (O'Brien-Pallas, Tomblin-Murphy, and Shamian, 2008; O'Brien-Pallas *et al*, 2010).

If Saskatchewan registered nurses working in hospitals experience the average rates and costs of annual turnover reported in the study, then turnover is costing the system $29.8 million annually in administrative costs and lost productivity (this excludes turnover and associated costs in non-hospital settings).

The changes to health system structure being contemplated today should, as much as possible, avoid causing uncertainty, instability, and conflict in workplaces and within the labour relations framework that defines employees' workplace representation. Changes must ensure that the union and constitutional rights of health workers are respected, and that stakeholder engagement and collaboration are improved.

We must also bear in mind that the health system is currently experiencing low employee morale and "change fatigue" as a result of a variety pressures in the system, including the strained implementation of Lean management techniques and the considerable uncertainty surrounding tightened budgets and layoff announcements. Restructuring efforts must be mindful of this context and great attention must be paid to mitigating disruptions in service delivery, ensuring timely access to care, and providing adequate transitional funding.

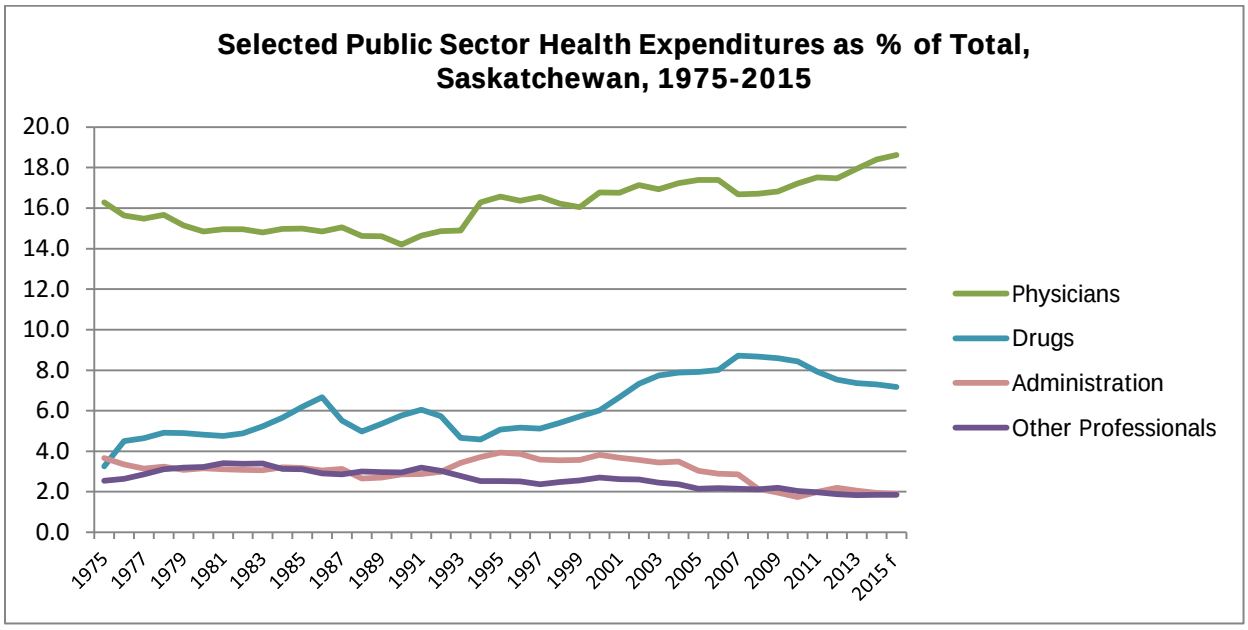
Health Care Restructuring: What should be considered?

A key stated rationale for considering a reduction in the number of health regions (possibly to 1), and consolidating the delivery of some services on a province-wide basis, is the desire to realize administrative savings and direct these savings to front-line patient care in a context of government fiscal restraint. The desire to minimize the burden of administrative costs and to ensure that as many scarce resources as possible are flowing to support front-line patient care is laudable. There has been a marked increase in care needs in the province over recent years

driven by continued demographic change, the unique and resource-intensive needs of certain populations, increases in acuity and complexity throughout the care continuum, and population growth.

When embarking on a process of health structure change, however, it is instructive to conduct an in-depth analysis of what are, and what are not, the major cost drivers in Saskatchewan's health care system. This will assist decision-makers in determining what can reasonably be achieved through administrative rationalization and, more importantly, inform an approach to structural change that puts it at the service of wider health system goals and priorities.

Taking public sector health expenditure in the province as a whole, for example, it is clear that administrative costs are not major cost drivers and have made up a relatively stable and declining portion of the spending envelope.



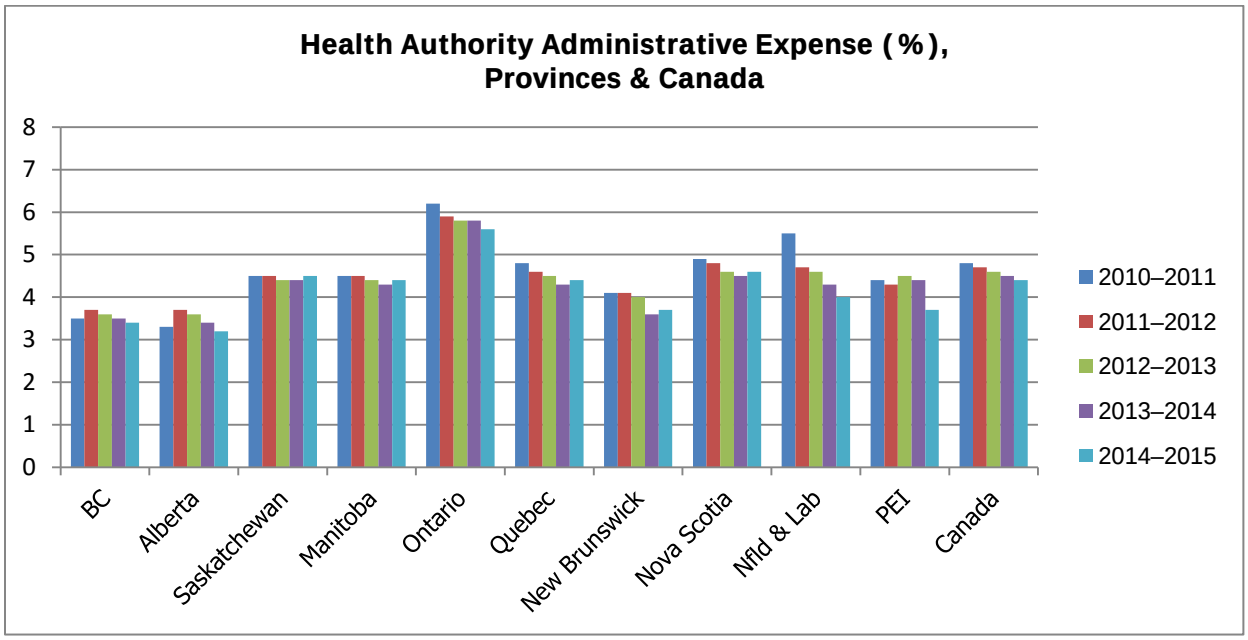
SOURCE: Canadian Institute for Health Information. *National Health Expenditure Database, 1975 to 2015*.

Looking at the administrative expense rate (%) of health regions across provinces is also important for putting Saskatchewan in comparative context. Overall, Saskatchewan health regions perform at the national average, although comparisons between provinces must be made with caution since regions have somewhat differing roles and responsibilities in different provinces which may impact on the reporting of administrative expense.

In addition, administrative expense as a proportion of total spending should be interpreted in the context of variations in per capita total spending (the denominator). For example, Alberta's relatively low administrative expense ratio in comparison to other provinces has to be read

alongside its higher total spending per capita, particularly on an age-adjusted basis, and in particular its high level of capital spending. On a per capita basis, administrative spending in Alberta has actually been above the Canadian average (Duckett, 2015: 312). This consideration should also be applied to comparisons between individual health regions.

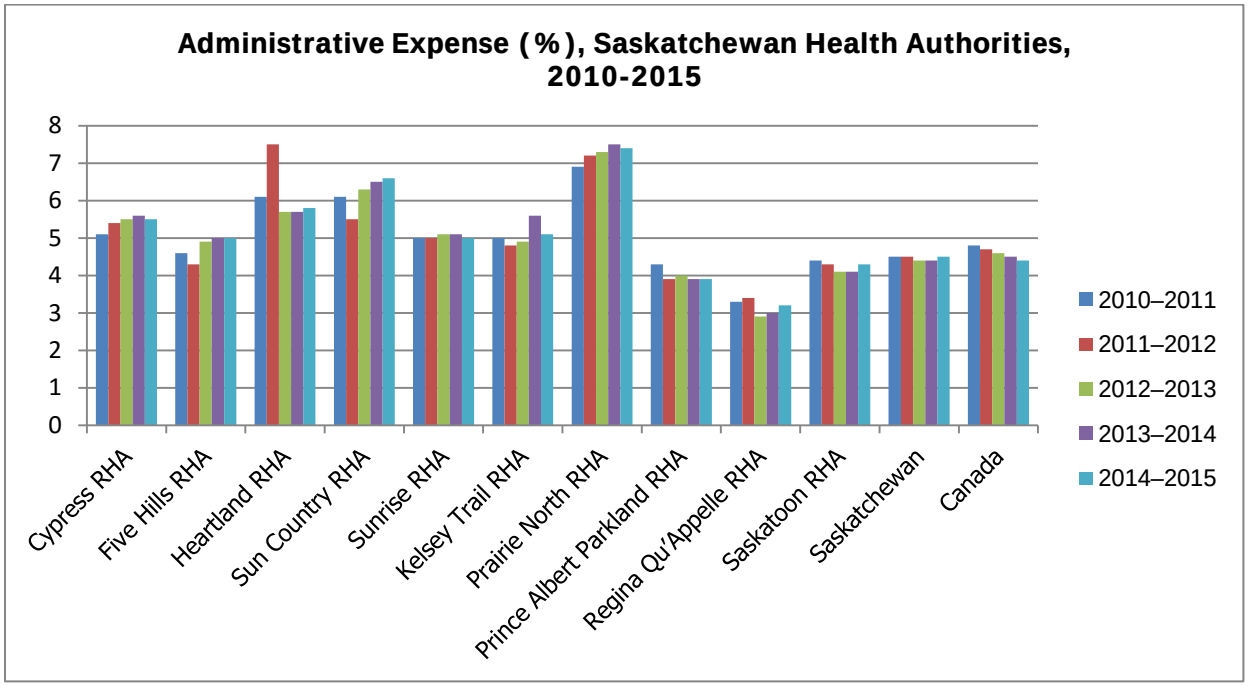
It is also important to bear in mind that Saskatchewan and Manitoba have proportionally the largest aboriginal populations among provinces, many of whom live in remote communities or in relatively impoverished urban areas in circumstances that create large health disparities (Lemstra and Neudorf, 2008). This has been known to generate above average demands on hospital and medical services such that these provinces (and certain regions within them) "holding everything else constant, would be expected to have higher per capita health costs than most other provinces" (Marchildon, 2015b: 327). This is an issue that any transformational efforts in Saskatchewan must not ignore.



SOURCE: Canadian Institute for Health Information. *Your Health System: In Depth.*

Data on the administrative expense ratio reported by individual health regions within Saskatchewan provides a regional picture of what individual RHAs spend on administration for programming and service delivery as a percentage of their total spending. There is evidence of variation in RHA administrative expense, with the ratio ranging from about 3% to about 7%, and an average administrative cost ratio of 4.5% in the last year for which data is publicly available. Variation exists between RHAs of different sizes, but also among RHAs of similar size. All comparisons must be made cautiously and in context, however, since research has shown that a considerable degree of variation in technical efficiency across health regions relates to

population and public health factors, and that focusing on operational efficiency and management factors alone may not substantially address regional efficiency gaps (Allin *et al,* 2015).



SOURCE: Canadian Institute for Health Information. *Your Health System: In Depth.*

What is perhaps clear is that the most significant financial pressures currently facing existing RHAs are occurring primarily in what are already the province's largest and arguably most integrated health regions with the greatest capacity for economies of scale – Saskatoon and Regina Qu'Appelle. Their problems do not stem primarily from large or growing administrative costs (currently in the 3-4% range).

While administrative savings are certainly possible within the current operations of the smaller regions who do tend to spend more on administration relative to total spending – these savings will be realized on the smaller (and mostly balanced) budgets of the smaller regions.

There are reasons to consider amalgamation in a favourable light – notably, the prospect of bringing the greater planning and coordinating capacity and scope economies of larger regions to bear on the operations of smaller regions, the benefits of provincially coordinated or shared services, or by building capacities in new regions created by merger – but the prospect of administrative savings may not be not be chief among them.

The greatest possible scope for absolute administrative savings would perhaps be in merging the largest health regions – Regina-Qu'Appelle and Saskatoon – which are likely to have the greatest degree of expensive administrative duplication and have certainly experienced the greatest challenges in maintaining fiscal balance given the pressure on their services. But in that case, why not move to a province-wide "super-region"?

Alberta's recent experience with health system restructuring is instructive in this regard. Looking carefully at Alberta could highlight the areas in which exercises in amalgamation or centralization may produce "value" as well as those areas where centralization might rapidly meet its limits or end up being counterproductive.

In 2008, Alberta's existing RHAs and other agencies were merged into a single province-wide health authority, Alberta Health Services (AHS). The restructuring effort was plagued by problems from the very beginning and within just a few years it was in crisis. Amalgamation was clearly driven by a narrow focus on structure and on administrative savings through rationalization on a corporate model, and perhaps by a desire for overly centralized bureaucratic control on the part of the government. This sidelined clinical and health services considerations, which at the very least might have reminded those driving the process that health care is always, to a significant extent, a local affair.

The problematic aspects of AHS's centralization were laid bare over time, and this produced a scramble to reverse direction in some areas and to re-introduce elements of regional responsiveness and decision-making: first 2, and then 5, administrative zones, then 12 regional Health Advisory Councils as well as several provincial sector-specific Councils, and an apparently aborted plan to move back to 12 operational districts.

In 2012, at the request of the Alberta Health Quality Council, which had raised concerns about access to care and alleged intimidation of physicians, the provincial government appointed a *Health Governance Review Task Force* to look into the governance problems plaguing AHS. The Task Force's report (finally released in February 2013) report is worth quoting at length:

> Over time, systemic problems and challenges in the health system too often have been answered by multiple restructuring efforts, rather than examining the issues fully, identifying the root causes and applying solutions based on evidence and experience.
>
> Restructuring has been undertaken in the past without full consideration of the reason for doing it, the risks of doing it, alternatives to doing it and the implementation strategy to do it right. Each restructuring has compromised the working relationships that have managed to develop over time and in some cases has exacerbated the systemic problems and challenges.

> It has also been exhausting, in terms of energy and capital. Too often the focus of people and resources has been placed on restructuring the system, diverting energy away from addressing the root challenges in the system. It has also diverted attention away from developing innovative ways of delivering quality services to Albertans.
>
> The cumulative effects of restructuring have been lingering change management issues, chronic instability and confusion about the roles and responsibilities of major players in the health system (HGRTF, 2013: 12).

Another report prepared by the Official Administrator appointed to lead a crisis plagued AHS following the firing of its 12-member board was less candid, but noted the following in September 2013:

> It is anecdotally reported that the structure is confusing to navigate for patients and the general public and it is not unknown for staff to not know who they report to or who they can go to for assistance and support. Community leaders have also expressed concerns that it is unclear who they should turn to inside the organization with local health delivery concerns.
>
> At the executive level from a structural point of view, there is more emphasis on corporate functions and responsibilities as opposed to clinical functions. It is also not clear how the multiple layers of the organizational structure support a focus on patients and people (which includes staff, physicians, stakeholders, partners, and the communities AHS serves) (Davidson, 2013: 5).

While there is evidence that the exercise produced administrative savings and built capacities, it is not clear that it has been worth it or that Saskatchewan should consider emulating it (Donaldson, 2010; Duckett, 2015; Marchildon, 2015a). The status quo will find few defenders, and even fewer would advocate for a return to the fragmentation of the pre-regionalization period, with its hundreds of local boards and agencies and a labyrinth of contracting relationships, bargaining units, and collective agreements. Indeed, elements of this fragmentation live on in the collection of affiliates, the value of which should be reviewed.

SUN does not have the detailed information on current operations of the health regions, their contractors, and existing shared services initiatives that would be required to provide detailed comment on matters related to specific shared or provincially organized services, particularly in the absence of concrete proposals. SUN does believe that provincial consolidation of support or clinical services must be done with a view to increasing consistency, coordination, and integration within a strengthened publicly funded and publicly delivered system.

SUN does have ample experience with the uneven and often sub-standard Information Technology (IT) infrastructure of the current health regions and existing shared services, and there is clearly room for much greater capacity, capability and consistency in IT tools to support

payroll, scheduling, and workforce planning and business measurement, for example. Equally important, however, is the need to greatly improve IT capacity to support consistent and accessible data collection and analysis with regard to patient and population health and health care needs, and to provide timely measures of quality and safety in patient care.

The greatest threat to public confidence in the system is a lack of transparency with regard to measurable system performance. Good quality and consistent data is also an absolutely crucial ingredient for setting priorities and measuring progress, and for supporting collaborative change efforts and continuous improvement. As in other areas, the IT and data needs of the health system must not be reduced to supporting administrative or management functions, but must give equal weight to creating consistent, methodologically sound, and transparent measures relevant to measuring (and improving) quality, safety, and patient and population health outcomes.

Among the most important lessons of other restructuring efforts is the need for (1) a more rigorous analysis and prioritization of broader health system goals and cost-drivers in structural change; (2) the importance of creating administrative, governance, and service-delivery structures that reflect current and expected population and patient health and health care needs, and (3) the imperative to balance existing with desired future social and geographical patterns of utilization and service-seeking, with a view to appropriate administrative *and* clinical/care integration, and (4) the need to balance the desire for greater consistency and coordination with the ability to provide services that remain accessible, accountable, responsive, and connected to the unique needs of the communities and sub-populations we serve.

Striking a balance in any system structure will be a challenge, to say the least. It is difficult work but work that is well worth embarking upon. From SUN's perspective, access and responsiveness to the varying needs of communities and populations across the province must remain at the core of Saskatchewan's health system structure. In light of the current policy mandate to reduce the number of regions, and cognizant of lessons learned in our past as well as in that of other provinces, SUN views transformational change as an opportunity to develop a structure that is administratively efficient and financially sustainable, while being designed first and foremost to improve patient care and support better patient and population health outcomes for the people of Saskatchewan.

Where then, can we look to design a system that is in fact transformational in terms of both functional and clinical integration?

Health Care Restructuring: Making change transformational

Many argue that the limits of regional health care restructuring since the 1990s have been due to the fact that it did not go far enough; in practice it became dominated by too narrow a focus on

administrative structures and short-term cost containment. In planning for and supporting a process of transformational change in healthcare, the occasion exists to broaden that lens and look for innovations within the existing structure and to champion new ways of doing things that position Saskatchewan as a leader on both a national and international scale.

From the perspective of care delivery, many of the promises of regionalization in the 1990s and early 2000s were no doubt realized to some degree, including greater integration of care along the continuum, at least administratively. A new structure of health regions can sustain the status quo in this regard, or it can provide an opportunity to revisit elements of system design and functioning that are a legacy of past restructuring efforts and their limitations.

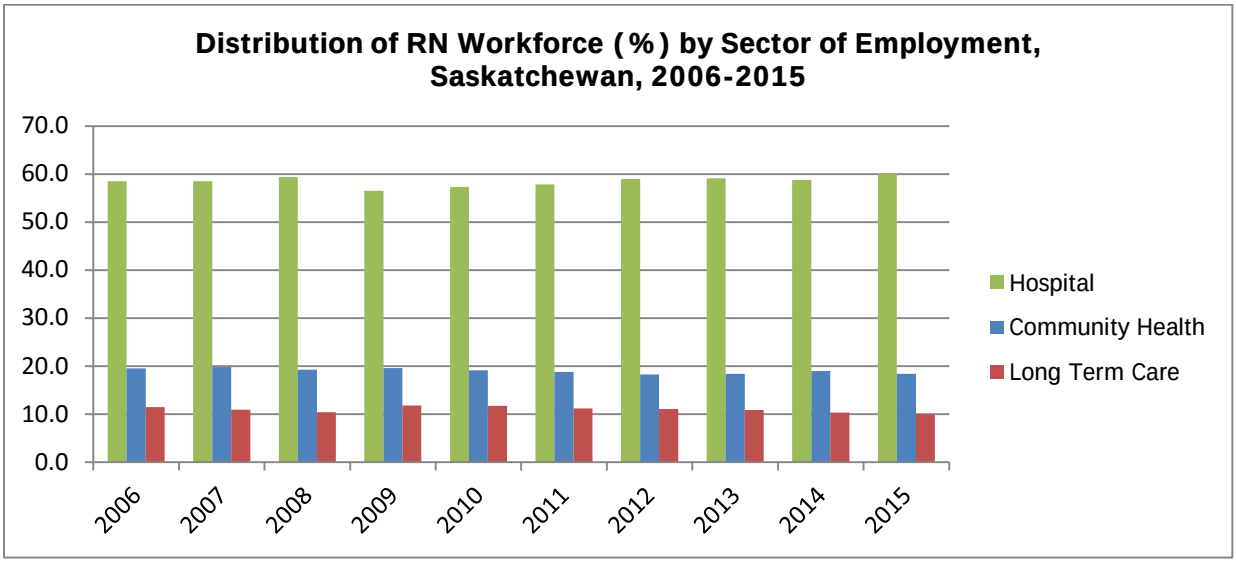
For example, although previous restructuring efforts failed to integrate a fee-for-service primary medical care "non-system" into the fabric of public health care delivery, the current exercise of "transformational change" could create opportunities to pursue this goal and should be considered. As one observer emphasizes:

> The RHAs have never been truly responsible for primary care, since the majority of primary care in Canada continues to be delivered by physicians who are paid directly by ministries of health.
>
> This organizational approach to physician payment, which has never been altered, presents an enormous challenge, given the evidence that the highest performing systems in the world are those in which effective primary care services lie at the very centre of the health system. The RHAs have never had the responsibility for the physicians who work in their hospitals. Although the statutes establishing regionalization stated that RHAs would be expected to coordinate these parts of the system, they have never had the tools or the accountability relationships to do so (Marchildon, 2015a: 237-238).

Partly as a result, relatively little progress has been made in truly integrating care across sectors and settings, or in shifting the emphasis of the health care system from acute episodic care to integrated primary and community-based care. This is true despite clear evidence about what anchors quality health care systems and best aligns with the current and future health needs of the population, and growing awareness of the need for strategies to reduce pressure in the costly acute sector. Saskatchewan, like many of its provincial counterparts across Canada, is a laggard in developing integrated primary and community-based care infrastructure and ensuring timely and appropriate access to care (Hutchison, 2013).

Evidence from the registered nurse workforce in Saskatchewan shows almost no shift overall from hospitals into community-based care in the last decade. The number of RNs working in hospitals grew almost twice as fast on average as the number working in community health care, and the number working in long-term care has flat-lined.

Growth Rates of Sectoral RN Workforce, 2006-2015			
	Community Health	Long Term Care	Hospital
Average Annual Change (%)	1.2%	0.3%	2.3%



SOURCE: Canadian Institute for Health Information. 2016. *Regulated Nurses, 2015*.

This state of affairs prevails despite growing concerns about rising acuity and complexity within the community and in the long-term care population, concerns about avoidable transfers to Emergency Departments, hospital admissions that are known to result in rapid deterioration for the frail elderly and to result in hospital overcrowding, and the prevalence of expensive episodic acute care of the chronically ill, the mentally ill, and the frail, whose needs could be managed more proactively and appropriately in a community setting (Ouslander *et al*, 2010; OECD, 2011; Needleman, 2013; Lees, 2013; McGregor *et* al, 2014; McGregor *et al*, 2015).

Saskatchewan ranks poorly compared to provincial and international peers on key health outcomes, including life expectancy, premature mortality, infant mortality, mortality due to diabetes, and suicide. Saskatchewan ranks second to last among Canadian provinces overall, and better than only one peer country: the United States. Major improvements are needed in our collective capacity to meet the health and health care needs of Saskatchewan patients and families (Conference Board of Canada, 2015).

A promising development has been a shift in many jurisdictions towards building the infrastructure for a "patient-centred health care/medical home" model based on the traditional primary care principles of access, continuity, and comprehensiveness, but with new team-based approaches to care coordination and transition care, patient self-management support, disease and population management, and evidence-based care and quality improvement processes. There is emerging evidence that aspects of this approach can improve health and health care, decrease inappropriate utilization of acute sector services and reduce overall system costs, and improve the experience of both patients and providers (Arend *et al*, 2012; Christensen *et al*, 2013; Marchildon and Hutchison, 2016).

There are many versions of the health care/medical home model, with variations based on accessibility and hours, the range of services directly provided or coordinated from practice sites, the level of integration or networking with other facilities and agencies, the roles of different providers (physicians, nurse practitioners, registered nurses, social workers, pharmacists, etc.) in care delivery and coordination, case management, and system navigation (Lindeke *et al*, 2010*;* Windel, Anderko and Kentzka, 2011).

Registered nurses, registered psychiatric nurses and nurse practitioners are well-placed in terms of their competencies and holistic approach to patients and families to play key roles in the health care/medical home and other sites of community care as both providers and coordinators of care, within interdisciplinary and nurse-led teams, and between sites and services and through care transitions when coordination is especially important (Laughlin and Beisel, 2010; Hass, Swan, and Haynes, 2013; Hass and Swan, 2014; Trehearne, Fishman, and Lin, 2014; Smolowitz, 2015).

This innovative approach is one of the most promising strategies to increase timely and appropriate access to care, and to build inter-disciplinary clinical capacity in the community to meet patient and population needs with reduced recourse to the Emergency Department and other acute care services (Saskatchewan Ministry of Health, 2016).

Building integrated primary and community-based care infrastructure on the health care/medical home model could advance in a "low rules" environment initially, with a variety of models chosen for implementation based on contextual factors, provided that systematic and transparent measurement and evaluation is built into the process to identify the strengths and weaknesses of different approaches and to build on and spread best practices.

This approach has long existed in small pockets in the province and some years ago Saskatchewan added more pockets. An agenda of "transformational change" provides an excellent opportunity to be more bold, and just as the need is now greater and the rationale stronger than ever, there is also evidence that some of the traditional barriers may be lower than they have ever been (SMA, 2016).

Another example of an innovation that is worth championing and spreading province-wide in the process of transformational change is the joint RQHR-SUN Regularization Initiative.

Regularization is premised on continuous improvement processes that evaluate patient care needs, human resources, workplace policies and processes, and other factors that impact patient care and staffing patterns. The initiative relies on evidence-based collaborative problem-solving, transparency, and flexibility in the application of the collective agreement to:

- Provide a composite picture of the nursing care needs of patients based on the stability, predictability, complexity, and intensity of their conditions;
- Map barriers to patient- and family-centered care delivery and patient flow, and undertake corrective actions;
- Pursue initiatives to foster a stable, appropriate, and engaged registered nurse workforce and reduce turnover/churn, wage-driven premiums, and other avoidable costs.

Beginning in 2014, RQHR and SUN jointly engaged the University Health Network (Toronto) to conduct a Patient Care Needs Assessment (PCNA) review on two inpatient medical units. The review was completed in 2015 for Internal Medicine (3D) at Regina General and Family Medicine (4A) at Pasqua. Recommendations were made and have been implemented to improve staff scheduling and unit-level routines, and to standardize service-line processes with respect to roles, orientation, and certification to ensure that staff have timely and consistent access to important professional practice supports. Since this work has begun:

- Staff engagement and communication has improved, with many of the improvement ideas being generated from those who provide direct care. In relation to these efforts, staff satisfaction has subsequently increased.
- On Family Medicine (4A), Regularization has helped to inform and support the piloting of the new model of Accountable Care that has already reduced lengths of stay and improved patient satisfaction.
- Since the project began in 2014, external staff turnover from Internal Medicine (3D) has been reduced from well over twice, to less than half, the regional and medicine service line averages.
- In 2015-2016, overtime per FTE in 3D was nearly 18% lower than the medicine service line average. If this level of overtime could be spread and replicated in the medicine service line as a whole, annual overtime costs in the service line would be reduced by more than $300,000.

- In 2015-2016, Family Medicine (4A) had a rate of internal churn that was below the average for the medicine service line. If this rate of internal churn could be spread and replicated in the medicine service line as a whole, it could produce an administrative saving in the service line of approximately $940,000.

These small examples based on an initial pilot in two inpatient units show the promise that systematic collaborative problem-solving has to not only improve patient care and staff satisfaction but to achieve cost savings.

Based on the successes in 3D and 4A, in 2016 RQHR and SUN began spreading the Regularization model to Regina's Emergency Departments, which are facing intense human resource and quality/patient flow challenges in the face of rising service demands. RQHR and SUN have engaged Dr. Maura MacPhee as an external academic consultant to lead an innovative research project to develop a patient care needs assessment and workload tool tailored to the unique environment of the Emergency Departments. Progress to date includes:

- Unit-level collaborative problem-solving sessions and data collection have been undertaken with the assistance of regional Kaizen facilitators to identify and address environmental barriers to patient- and family-centered care, patient flow, and workforce stability, sustainability, and satisfaction.

- A number of improvement projects are being undertaken to: provide for inter-site staff mobility; improve scheduling and orientation to address junior-senior mix and Charge Nurse coverage; reduce turnover and manage predictable vacancies; improve the availability of supplies and equipment; reduce patient flow bottlenecks related to diagnostics and physician routines; and improve staff engagement and patient experience.

- In 2015-2016, registered nurses worked 21,092 hours of overtime in the Regina Emergency Departments to meet rising patient visit volumes, which have increased by nearly 10% since 2013-2014. If 50 percent of these care hours could be filled at straight-time instead, this would reduce costs by more than $469,700.

Regularization is a promising example of how collaborative problem-solving, combined with dedicated research and data support, can drive improvement and cost reduction. Spreading and scaling up this innovative initiative could contribute a great deal to a transformational change agenda.

Recommendations:

As Ken Fyke has remarked, reflecting more broadly on the history of health restructuring: "Stucture must be designed to achieve a strategy that includes a clear mission or purpose. […] Too many governments have made the structure an end in itself" (as quoted in The Change Foundation, 2008: 4).

It is SUN's hope and goal that any transformational approach, and corresponding system design, will be guided by a clear vision of improved, integrated, and holistic patient care, better engagement of both providers and the public in meeting the challenges of our public health care system (including the major cost drivers), and coordinated strategies to plan for and achieve improved patient/provider/population outcomes for the patients and families of Saskatchewan. This is where the greatest efficiencies are to be found: in *Better Care, Better Value, Better Teams, and Better Health.*

Regardless of the specific health system administrative structures, governance relationships, or service delivery changes that emerge from the Panel's recommendations, these changes should be considered, evaluated and implemented on the basis of their potential to contribute to wider system goals.

Health system structure change should help to create or improve the capacity to:

1) Balance regional responsiveness and the ability to tailor services and engage in local innovation and experimentation with the need to ensure consistency and coordination, achieve economies of scale and scope where appropriate, and facilitate the spreading of proven innovations and best practices.

2) Improve access and quality in care and services for diverse population needs, with special attention to appropriateness of use, and to integrated primary and community-based care infrastructure, to reduce acute and institutional care sector volumes and wait times;

3) Implement holistic and integrated clinical and social strategies for managing chronic disease, meeting the needs of an aging and changing population, and serving unique urban, rural, northern and aboriginal health and health care needs;

4) Increase coordination between health and other agencies in pursuing innovative approaches to reduce health inequalities, address the social determinants of health, and tackle the costly burdens placed on the health care system by inadequate social provision;

5) Proactively evaluate and plan health human resources needs and build the capacity to implement and evaluate appropriate care models and inter-disciplinary teams in a

variety of settings based on clear and complementary roles, best practices, and evidence of appropriateness;

6) Engage stakeholders and front-line staff in ongoing collaborative problem-solving focused on measuring patient needs, mapping and overcoming environmental barriers to patient- and family-centred care and patient flow, and pursuing strategies to foster a stable, appropriate, and engaged workforce and reduce turnover/churn, wage-driven premiums, and other avoidable costs. SUN and RQHR's joint Regularization Initiative can and should be replicated and spread.

7) Improve transparency and build the capacity to collect and analyze consistent data on safety and quality (including core nursing sensitive patient outcomes), and to use evidence to drive collaborative change in health care delivery. Systematic and ongoing monitoring and transparent evaluation of system performance, innovative practices, new models, and quality improvement projects is essential. This requires evaluative and research capacity and may benefit from arms-length relationships.

8) Minimize disruption to workplaces and labour relations by respecting the constitutional and representation rights of employees, and by improving stakeholder and staff engagement and participation.

9) Reinvigorate and refocus the values of this vital public service and keep Saskatchewan's health system accessible, universal, comprehensive, publicly funded and administered, and delivered on a non-profit basis.

As the largest group of health care professionals, with important competencies that span the entire continuum of care, registered nurses will be key to successful system re-design. The Saskatchewan Union of Nurses looks forward to further discussions regarding changes to the health system structure as the Panel develops concrete proposals.

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