Health Accord
for Newfoundland & Labrador

Our Province.
Our Health.
Our Future.

A 10-Year Health Transformation

THE BLUEPRINT
Summaries of Implementation Recommendations

This place which we call Newfoundland and Labrador has been the homeland for Indigenous peoples for many centuries. We respectfully acknowledge the island of Newfoundland as the ancestral homelands of the Mi'kmaq and Beothuk. We recognize the Inuit of Nunatsiavut and NunatuKavut and the Innu of Nitassinan, and their ancestors, as the original peoples of Labrador.

We offer our respect and appreciation to the Indigenous peoples who have inhabited and continue to live on this land. We thank you for your care for and teachings about Earth and our relations. May we honour those teachings.

We strive for respectful relationships with all the peoples of Newfoundland and Labrador as we search for collective healing and true reconciliation and together honour our beautiful land and sea.

Citation
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June 2022

The Honourable Andrew Furey
Premier of the Province of Newfoundland and Labrador
The Office of the Premier
Confederation Building, East Block
P.O. Box 8700, St. John's, NL A1B 4J6

The Honourable John Haggie, MD
Minister of Health and Community Services
Department of Health and Community Services
Confederation Building, West Block
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Dear Premier Furey and Minister Haggie,

On 17 February 2022, we submitted to you the Health Accord NL Report (February 2022): *Our Province. Our Health. Our Future. A 10-Year Health Transformation*. We now present to you the companion Report entitled *Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Blueprint*.

Our recommendations present implementation ideas for the Calls to Action which are outlined in four distinct categories: social determinants of health, a rebalanced health system, pathways to facilitate change, and governance. The document includes suggested timelines, estimated investments, potential sources of funding, and integrating accountability structures. Our recommendations are divided into two Sections. Section A provides a set of summaries for the major action areas, briefly outlining the rationale, responsibility, policy, structure, benefits, investment, and implementation timeline for each one. Section B gives the more detailed implementation ideas from each of the strategy committees and working groups of the Task Force.

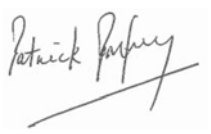
Foundational to the Calls to Action is our belief that we can improve health for Newfoundlanders and Labradorians (i) by making changes in the social, economic, and environmental conditions that affect our health, and (ii) by rebalancing our health care system across community, hospitals, and long-term care. Our belief is based on a wide body of evidence (provincial, national, and global) and our extensive public engagement. Our recommendations include a transitional structure to begin the implementation process, pending the needed legislation for a more permanent governance structure. The expectation is that the implementation will be completed within five years, with the transformation in improved health outcomes and health equity becoming evident within ten years.

The final component of our work is an archive of all the evidence which informed the work of Health Accord NL: evaluation summaries of health and social systems, input from our engagement activities, formal presentations and testimony by stakeholders and experts, reports, and research findings. The Evidence Archive is now publicly available online, will be easily accessible, and will certainly grow over time.

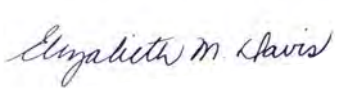
We have completed the task which you entrusted to us. We express gratitude to the members of the Task Force, the strategy committees, and the working groups who developed recommendations with attention to the lenses of inclusion, quality, and integration and to the twelve guidelines outlined in chapter four of the Health Accord Report. We also thank the staff members of Quality of Care NL and the creative design team of Perfect Day.

The committed, generous, and competent work of the Health Accord team combined with insight from members of the public of all ages from across the province, practitioners and workers in our health system, workers in our education and social systems, members of community groups and municipalities, and the media have challenged us and encouraged us. We thank them and you for trusting in us to do this work on behalf of all Newfoundlanders and Labradorians.

Respectfully submitted,



Patrick Parfrey



Elizabeth M. Davis

Health Accord
for Newfoundland & Labrador

Key Messages

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

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

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

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

- Since November 2020, Health Accord NL has gathered evidence, focused its work in six committees and four working groups, and engaged with thousands of people across the province. Fifty-seven Calls to Action were contained in *Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Report* submitted to Premier Furey and The Honourable John Haggie, Minister of Health and Community Services in February 2022.

- The Health Accord Report called for action on improving specific social, economic, and environmental conditions affecting our health; providing better, more timely access to health care; and developing a more integrated, technologically enhanced, and sustainable health system.

- In this report, the six committees and four working groups of the Health Accord outline implementation recommendations for the 59 Calls to Action (the original 57 Calls to Action and two additional Actions based on new learning and further thought).

- The Blueprint is divided into two sections:

  Section A provides summaries of the areas that require the most focus if we are to improve the health of Newfoundlanders and Labradorians over the next 10 years. The summaries provide high level detail about how we could move forward and the resources that would be required to do so.

  Section B provides more detailed recommendations from the strategy committees and working groups to facilitate implementation of the Calls to Action.

- Major actions related to the social determinants of health include reduction of poverty, food and housing insecurity, assurance of inclusion, investment in children and youth, integration between the health system and schools, age-friendly communities, an integrated continuum of care for seniors anchored in the community, an integrated approach to wellness and disease prevention, and a reduction in the impact of the health system on the environment.

- Actions on rebalancing the health system include an integrated approach to mental health and addictions, better care in the community using collaborative Community Teams, sustainable specialty care and bringing care to the people through virtual care and visiting specialists, a provincial frail elderly program including an interprofessional team approach in long-term care facilities, an integrated air and road ambulance system with a virtual emergency system, and appropriate use of health interventions.

- Pathways to facilitate change include Regional Social and Health Networks, support for the community sector, improved quality of care by the development of a Learning Health and Social System, an integrated provincial health information and virtual care system, a focus on workplace readiness, recruitment and retention of health providers, and a new structure of health governance.

- The Blueprint is not meant to be a prescriptive action plan; rather, recommendations for actions that will occur over time with final decisions taking into account reasonableness, new evidence, consideration of divergent opinion and preferences, and public transparency. Our recommendations are not the end point. They mark the beginning steps which will be amended as engagement or new evidence deems necessary.

- Health Accord NL recommends that its 59 Calls to Action be implemented in the next five years, but understands that health transformation will take at least 10 years.

- Our hope is that, whether partners agree on the implementation details or not, they will see themselves in it and be motivated to engage. Only with continued engagement will we be able to develop the action plans required to improve our health.

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

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

Abbreviations

ACP: Advanced Care Paramedic
ADHD: Attention Deficit Hyperactivity Disorder
ALC: Alternate Level of Care
ATIPPA: Access to Information and Protection of Privacy Act
CAYAC: Children and Youth in Alternate Care
CEO: Chief Executive Officer
COPD: Chronic Obstructive Lung Disease
CSH: Comprehensive School Health
CSSD: Department of Children, Seniors and Social Development
CT: Computerized Tomography (i.e., CT scan)
CTG: Clinical Translational Genomics
CYCH: Child and Youth Community Health
ECC: Department of Environment and Climate Change
EVT: Endovascular Therapy
GBI: Guaranteed Basic Income
GHG: Greenhouse Gas
HCS: Department of Health and Community Services
HSHS: Healthy Students Healthy Schools
ICU: Intensive Care Unit
LHSS: Learning Health and Social System
NLCHI: Newfoundland and Labrador Centre for Health Information
PCP: Primary Care Paramedic
PHA: Provincial Health Authority
RHA: Regional Health Authority
RHC: Regional Health Council
RSHN: Regional Social and Health Network
SANE: Sexual Assault Nurse Examiner
SDH: Social Determinants of Health

Health Accord
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Our Province. Our Health. Our Future.

A 10-Year Health Transformation:

THE BLUEPRINT
Summaries of Implementation Recommendations

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Health Accord NL Calls to Action

Please note that the numbering of Calls to Action in Section A and Section B is not the same as the numbering in The Report as the sequencing of Actions has been changed to recognize the impact of new and recent ideas.

Social Determinants of Health Implementation Recommendations		
Call to Action		**Report Cross Reference**
1	Increase **awareness and understanding of the social determinants of health** to change attitudes and bring about action among decision-makers regarding the direct impact on population health as well as community and economic well-being.	Action 6.1
2	**Integrate the social determinants of health** together with a rebalanced health system into all governance, policy, program, and infrastructure decisions that influence health.	Action 6.2
3	Ensure that Newfoundlanders and Labradorians have a **liveable and predictable basic income** to support their health and well-being, integrated with provincial programming to improve food security and housing security.	Action 6.3
4	Take an aggressive and proactive approach to addressing the **climate emergency** through increased awareness, focused planning, aligned resources, and effective accountability mechanisms.	Action 6.4
5	Take immediate action to create a provincial **Pathway for Inclusion**, shaping an inclusive health system within an inclusive society.	Action 6.5
6	Create a **continuum of education, learning and socializing, and care for children and youth** (from prenatal to adulthood) (the wording of this Action has been revised since the release of The Report).	Action 7.1

Call to Action		Report Cross Reference
7	Develop **one model of community health services for children and youth** with complex health needs and a more integrated approach to respond to health needs of children and youth in care.	Action 7.2
8	Ensure that the families of children in Newfoundland and Labrador have some form of a **liveable and predictable basic income** to support their health and well-being, integrated with provincial programming to improve food security and housing security (this echoes Action 3, but adds more depth with respect to children and youth).	Action 7.3

Aging Population Implementation Recommendations		
Call to Action		**Report Cross Reference**
9	Develop and implement a formal **Provincial Frail Elderly Program** to address the critical need of our population.	Action 8.1
10	Implement and support an **integrated continuum of care** to improve the effectiveness and efficiency of care delivery, improve health and social outcomes for older adults and older adults with disabilities, and support older adults to age in place with dignity and autonomy.	Action 8.2
11	Take immediate steps to identify and respond to **ageism** in our province including support for the development of age-friendly communities that enable Newfoundlanders and Labradorians to age positively.	Action 8.3
12	Develop and implement provincial **legislation, regulation and policy** required to provide appropriate, quality, and accessible care and protection for older persons in Newfoundland and Labrador.	Action 8.4

Community Care Implementation Recommendations		
Call to Action		**Report Cross Reference**
13	Connect every resident of Newfoundland and Labrador to a **Community Team**, providing a central touchpoint of access and a continuum of care.	Action 9.1
14	Improve **coordination of care** across the health and social systems by enhancing communication and system navigation.	Action 9.2
15	Place greater emphasis on **health promotion and well-being, the social determinants of health, and chronic disease management**.	Action 9.3

Hospital Services Implementation Recommendations		
Call to Action		**Report Cross Reference**
16	Reorganize the services provided at the 23 **health centres** in the province to reflect population needs utilizing a principles-based and criteria-based approach.	Action 9.5
17	Establish better **integrated, team-based care** by arranging hospital service delivery into a network consisting of community, regional, and tertiary hospitals that offer timely access to a full array of services.	Action 9.7
18	Realign core specialty **health services** in facilities to match the current and future needs of the population in the province to enhance continuity of care based on the changing needs in the community and on the changing demographics.	Action 9.8

Call to Action		Report Cross Reference
19	Optimize the utilization of the **Janeway Hospital**, by improving access to pediatric services, by creating linkages with Community Teams for vulnerable children and youth province-wide, and by incorporating Women's Health acute care beds (the wording of this Action has been revised since the release of The Report).	Action 9.9
20	**Enhance care across the continuum** to ensure that access to appropriate and high quality care and service is available to patients/clients/residents in the most appropriate setting and to minimize the need to travel to obtain appropriate services, or receive timely or affordable care.	Action 9.11
21	Develop explicit statements of system processes and expected **standards of care** to ensure integrated and accessible clinical program services delivered in a comprehensive, province-wide system.	Action 9.12
22	**Renew hospital services** by improving coordination and flow of health and social system information between hospitals and the community and by maximizing the use of integrated digital technology and information systems.	Action 9.13
23	Design one provincial, modern, integrated **air and road ambulance** system with a central medical dispatch (this Action has been revised since the release of The Report).	Action 9.15

Quality Health Care Implementation Recommendations		
Call to Action		**Report Cross Reference**
24	Foster a **culture of quality** and establish a comprehensive, effective, and sustainable **Learning Health and Social System.**	Action 11.8
25	Improve **accountability structures** within the health and social systems to focus on achievement of better health outcomes.	Action 11.5
26	Establish the **NL Council for Health Quality and Performance** to improve health and social systems, which fully incorporates principles of diversity, inclusion, and integration.	Action 11.4
27	Design a **long-term evaluation plan** related to the implementation of Health Accord NL (based on its Calls to Action) to determine whether the actions undertaken are achieving the objectives of each strategy.	Action 11.6
28	Identify, document, address, and track **indicators of social determinants of health** in Newfoundland and Labrador, in an ethically transparent and publicly accessible manner, at the point of care in the health system and at community, regional, and provincial levels.	Action 11.7
29	Establish a pharmacist-supported model to **improve appropriateness of medication use and continuity of care** in the community, in long-term care, and in hospitals. Support the creation of a National Pharmacare Program.	Action 9.4
30	Establish **pathology and laboratory medicine** as a provincial networked service based on hub-and-spoke modelling.	Action 9.10

Call to Action		Report Cross Reference
31	Develop and implement **a five-year plan for improvement in mortality rates for cancer, cardiac disease, and stroke** over the next 10 years, led by the provincial programs for these disease entities.	Action 9.14
32	Create an **Occupational Health Clinic** with linkages to the Community Teams.	Action 9.6
33	Develop **new or enhanced health care programs** in midwifery, sexual health, sexual assault, oral health, and hospice care.	This is a new Action that has been developed since the release of The Report

Digital Technology Implementation Recommendations		
Call to Action		**Report Cross Reference**
34	Modernize foundational **information technology** systems.	Action 10.1
35	Adopt and leverage **virtual care** technologies.	Action 10.2
36	Develop a **Provincial Digital Technology Strategy and Policy** to guide e-technology development and implementation.	Action 10.3

Workforce Readiness Implementation Recommendations		
Call to Action		**Report Cross Reference**
37	Through consultation with stakeholders, create a **Provincial Health and Social Sector Human Resource Plan.**	Action 10.4
38	Create **Workforce Transition Guiding Principles** for all health and social sector employees and physicians to provide workforce security and protection (the wording of this Action has been revised since the release of The Report).	Action 10.5
39	Create a health and social sector environment that enables all providers to **work to the highest scope of practice** within their education and/or training.	Action 10.6
40	Create a **strategic recruitment plan** that will ensure health care providers are in place to offer stable direct care and services to patients/clients/residents and families in a rebalanced health and social system, while at the same time providing work-life balance for employees.	Action 10.7
41	Create **strategies that will engage, stabilize, and retain the current and future health and social system workforce**. Ensure strategies support inclusion of under-represented groups and quality of care in the provision of service.	Action 10.8
42	Create an **environment that values leadership and management** and inspires those with potential to lead. This includes creating value in management positions and succession planning for those with leadership and management potential to receive training and mentorship.	Action 10.9
43	**Leverage existing evidence and data** in the health and social systems and expand this knowledge base where evidence and data do not already exist. Use the evidence and data in strategy development.	Action 10.10

Education Implementation Recommendations		
Call to Action		**Report Cross Reference**
44	Develop and apply clear **guiding principles** in all education development and delivery initiatives.	Action 10.11
45	Develop and deliver **education and continuing education programs** that use an integrated, inclusive, and collaborative care model where practitioners learn and practice together. This requires integration across curricula and across programs throughout the learning experience.	Action 10.12
46	**Update and renew curriculum** for health and social system practitioners to help them better understand the importance of the social determinants of health, quality assessment and improvement, care of older adults, digital technology, and patient-centered care and to better prepare them to deliver equitable, interprofessional care to the full scope of their practice.	Action 10.13
47	Provide **education and resource support** to the people of the province to facilitate their full participation in a modernized Learning Health and Social System.	Action 10.14

Governance Implementation Recommendations		
Call to Action		**Report Cross Reference**
48	Create a **Provincial Health Authority** to provide province-wide planning, integration, and oversight of the health system and to deliver province-wide programs such as the ambulance system and information systems.	Action 11.1
49	Create **Regional Health Councils** that (i) have the level of authority needed to address the organization and quality of health care delivery at the regional level, (ii) are sensitive to local and regional variations, and (iii) facilitate engagement with patients/clients/residents and with members of the public (including youth) to ensure that the health system is responsive to the identified health needs of the people of the region.	Action 11.2
50	Establish a **Regional Social and Health Network** in each region of the province which is responsible for the linking of various organizations that influence health and health outcomes (e.g., health systems, social programs, municipalities, schools, police, recreational programs, arts and cultural programs, community sector non-profit and voluntary groups, and private sector businesses).	Action 11.3
51	Develop a holistic and integrative **Provincial Data Governance Model** which includes a strategy that defines a vision for how data will be used to improve the health and social systems of Newfoundland and Labrador in a transparent and accountable manner.	Action 11.9
52	Create a robust **change management strategy** led by a well-resourced change management team with the participation of the provincial government, policy-makers, health and social systems, individual providers, and the public to ensure the responsible implementation of the Health Accord's Calls to Action and to sustain beneficial, equitable, and system-wide change.	This is a new Action that has been developed since the release of The Report.

Call to Action		Report Cross Reference
53	Within the leadership structures of government departments, the health system, social systems, and the Regional Social and Health Networks, develop an **integrated change management approach to improve health outcomes and health equity**. This approach should focus on shifting from health system responsibility for health outcomes to shared responsibility of the health and social systems together with health educational institutions, municipalities, community organizations, and the private sector.	Action 10.15
54	Invest in **change management to initiate and maintain Community Teams** so that they provide care across the spectrum of health care including children in need, patients/clients with disabilities, and frail elderly persons (this Action has been revised since the release of The Report).	Action 10.16
55	Invest in **change management and training in digital technology** across the spectrum of health providers and institutions, all regions of the province, and communities.	Action 10.17
56	Establish a **transitional governance structure** to begin preparations for the implementation of Health Accord NL.	Action 11.10

Finance and Intergovernmental Affairs Implementation Recommendations		
Call to Action		**Report Cross Reference**
57	Provide a **five-year plan of short-term, medium-term, and longer-term priorities** that influence financial decisions taken by government within the fiscal envelope of the province to ensure long-term improvement in health outcomes and the strengthening of health equity needed for a thriving and prosperous province.	Action 10.18
58	Develop a **provincial strategic plan to immediately engage with the federal government** for funding of a basic income approach, climate change actions, childhood development programs, meeting the needs of the aging population, Community Teams for primary care, and increased broadband penetration to communities.	Action 10.19
59	**Begin action immediately** on initiatives needed to rebalance the community, long-term care, and hospital system.	Action 9.16

Foreword

The Health Accord's Interim Report, *A Call to Action to Transform Health* (16 April 2021), outlined a three-phase process, developed to ensure that its work would be carried out in a thorough, inclusive, holistic, integrated, and evidence-informed manner. The first phase was the setting of the overall vision and direction for the Accord. The vision and direction, decided after five months of extensive engagement with a broadly representative group of people, responded to a compelling case for change rooted in serious health inequity experienced by Newfoundlanders and Labradorians. The Interim Report cautioned that pursuing the vision and the direction would mean a significant culture shift for the health system, for other social systems, for government, and for the people of the province.

The second phase of the work was the identification of the key Calls to Action which would take the Health Accord into this new direction, pursuing a vision for improved health, health outcomes, and health equity. The completion of this phase was outlined in *Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Report*, submitted to Premier Andrew Furey and Minister John Haggie on 17 February 2022. This Report identified fifty-seven Calls to Action which reflect acceptance of and interventions in social determinants of health and the reimagining of a higher quality health system that rebalances community, hospital, and long-term care services. It outlined three lenses of inclusion, quality, and integration which guided the creation of the Health Accord.

Given the multiple options possible to develop the recommendations and the various pathways to implementation, the main Report also outlined twelve guidelines which were combined with the three lenses to help guide the completion of the work.

Twelve Guidelines
Culture of compassion
Patient/client/resident focus
Health of Indigenous peoples
Clear lines of accountability
Recognition of the Health Accord as a holistic integrated approach
Progressive implementation process
Accountability for reasonableness
Ongoing performance monitoring, evaluation, and public reporting

Consideration of impacts on workers in the health and social systems
Involvement of members of the public and community-based organizations in implementation
Financial accountability
Collaboration

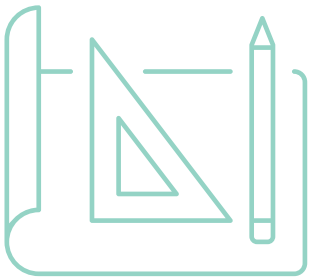
Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Blueprint describes the third phase of the Health Accord's work, the creation of implementation recommendations for each of the 59 Calls to Action (two new Actions were added based on further evidence and new learning).

The implementation recommendations were developed by the Health Accord's six strategy committees (social determinants of health, community care, hospital services, aging population, quality health care, and digital technology) and four working groups (finance and intergovernmental affairs, workforce readiness, education, and governance). The recommendations were collated into four components: social determinants of health, a rebalanced health system, pathways to facilitate change, and governance. A five-year timeframe was set for the implementation (a graphic summary of the timelines is included in this document).

The Blueprint is divided into two sections. Section A gives a set of summaries for the major action areas while Section B gives more detailed implementation recommendations. The evidence which informed these recommendations is provided online in the Evidence Archive, the final Health Accord document.

In the implementation of these recommendations, one of the guiding principles is accountability for reasonableness. Given that the implementation will happen over time, final decisions must take into account new evidence, consideration for divergent opinions and preferences, and public transparency.

The work of the Health Accord Task Force is now complete. The next stage, the implementation of the Health Accord through the response to its Calls to Action, must now begin. It will take commitment, energy, wisdom, and persistence from government, our health and social systems, municipalities, community groups, the private sector, the media, and the people of the province if the vision and the needed transformation in health are to be realized. We must take seriously the compelling case for change in our province. Let us make this Health Accord a reality among us, helping our province become a healthier place today and for the generations of Newfoundlanders and Labradorians to come.



Section A

Summaries of Implementation Recommendations for the Major Calls to Action

Health Accord
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Introduction

This first section of the implementation recommendations begins with two summaries: an implementation overview, and financial implications and interdependence with the federal government followed by The Timelines for Implementation provided in Fig 4. The twenty-seven summaries which follow are collated within four subsections: social determinants of health, a rebalanced health system, pathways to facilitate change, and governance.

The Task Force had six strategy committees (social determinants of health, community care, hospital services, aging population, quality health care, and digital technology); four working groups (workforce readiness, education, governance, and finance and intergovernmental affairs); and three lenses in which to view the Health Accord (inclusion, quality, and integration) (Fig 1).

Each subsection contains a case study which personalizes the transformation imagined from the implementation of the Calls to Action contained within that subsection. Each summary follows the same nine-part template: an introduction, a rationale, responsibility, policy, structure, benefits, investment, an implementation timeline, and cross-references to Section B. Graphs, charts, and images help strengthen the key messages in each summary.

The summaries in Section A are intended to give a simple, concise overview of the implementation recommendations related to the Calls to Action. In addition to twenty-one summaries which address specific Calls to Action, there are six summaries which relate to themes threaded through many Calls to Action: integration with Indigenous communities, the impact of the community sector, an integrated approach to mental health and addictions, an integrated approach to wellness and disease prevention, navigators within the health system, and change management.

The Health Accord itself assumes an integrated approach. It must be considered in its entirety since it has been developed in a holistic manner, relying on connections among all the components. However, as can be seen in these summaries, there will be more flexibility with the recommendations, giving possible options for the best approach to implementation. The process of implementation should be public and fully transparent with ongoing engagement of all those whose health is affected by the policies and decisions made and with flexibility for revisions in light of new circumstances and new evidence.

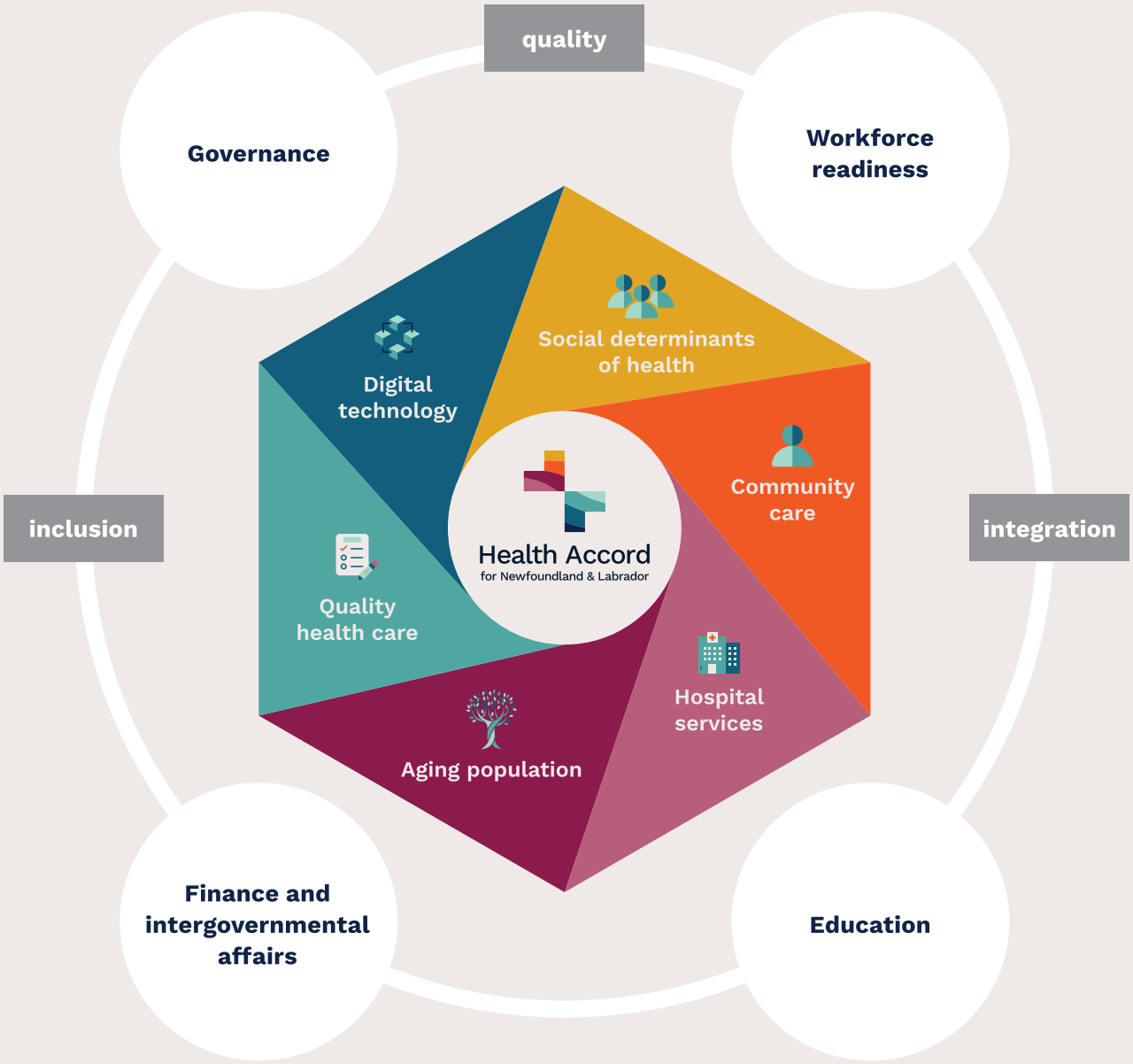

Fig 1. Health Accord NL structure

On April 7, 2022, the Honourable Siobhan Coady, Minister of Finance, presented Budget 2022. Within the budget, Minister Coady acknowledged the work of Health Accord NL and indicated that resources would be provided to support various initiatives prioritized in the Health Accord Report. Complete details of Budget 2022 may be found at: www.gov.nl.ca/budget/2022/.

Health Accord NL was pleased to see government take action on important initiatives that will be core to the success of Health Accord NL implementation. One such initiative was the announcement to transition to a Provincial Health Authority (PHA).

As the PHA is referenced throughout the recommendations, it is with the assumption that the recommendation to create a PHA has already been accepted. As such, The Blueprint recommendations pertaining to the PHA are made with the understanding that government will use them as they move forward in establishing the PHA.

It is understood by Health Accord NL that other structures recommended throughout The Blueprint will need to be accepted by government before any action can be taken. To be respectful of such decision-making processes, Health Accord NL references current structures throughout the recommendations as roles and responsibilities are discussed. For example, in many places, the role of Regional Health Authorities is referenced. This is to ensure that we are not being presumptuous about which Health Accord NL recommendations may or may not be accepted and implemented by government. As Health Accord implementation rolls out, entities cited as having particular roles and responsibilities as well as the roles and responsibilities themselves may change to align with what is envisioned.

I. Health Accord NL

Health Accord NL places the person and the family at the center. Their health is influenced by the community in which they live; the medical and social systems that serve them; the social, economic, and environmental factors to which they are exposed; and the pathways that facilitate connections among these various elements that support health.

A Summaries of Implementation Recommendations for the Major Calls to Action

1. Health Accord NL: Overall Implementation Summary

Introduction

There is a compelling case for change in our health and social systems. Our life expectancy is over two years less than that of the rest of Canada (driven by the highest provincial rates of death caused by cancer and cardiovascular disease). Newfoundland and Labrador also has the highest rates of chronic diseases in seniors and medical complexity in children. The province has the highest per capita spending and worst health system performance in the country. Concerns about sustainability are evident in the high numbers of vacancies for health providers and the high turnover and locum rates for physicians. The province has experienced unprecedented demographic change, particularly a reduction in population in rural areas, due in large part to the cod moratorium. The fiscal capacity of the province to pay for change is limited by the large provincial debt. The health impacts of climate change are becoming more evident.

Health Accord NL provides 59 Calls to Action related to the social determinants of health (SDH), the health of children, the aging population, community care, hospital services, quality health care, digital technology, workforce readiness, education, finances and interdependence with the federal government, and governance. The feasibility of responding to these Calls to Action is dependent on new investment, new or reallocated funding sources, and the time period over which change is undertaken.

The fiscal position of the province demands a measured approach over five years. The province's interdependence with the federal government for new funding opportunities is critical. The transformation of the health and social system requires a more strategic use of the current health system budget as well as targeted strategic investments in the social determinants of health.

Rationale

1. Many of the problems that the Health Accord examined are longstanding and require action. Doing nothing will result in further deterioration of health outcomes and the health system. Examples include lack of attention to the SDH, poor access to community and primary care, overburdened emergency care, a fragmented air and road ambulance system, and an outdated health information system. Other problems requiring solutions include care for children at risk, care for frail elderly persons, sustainability of some hospital services, inappropriate use of health care interventions, and recruitment and retention of providers.

2. Some of the Calls to Action are dependent on major policy decisions. These include provision of up-front financial investment to obtain downstream benefits, an approach to basic income, a new health information and virtual care technology system, and conversion from multiple ambulance operations into one integrated province-wide service.

3. Several Calls to Action concern culture change and are not dependent on financial investment: the assurance of inclusion in our society, acting on ageism, and creating a balanced health system that emphasizes compassion, becomes more integrated and inclusive, and develops a focus on quality.

4. Other Calls to Action are dependent to a major extent on funding support from the federal government. See Summary 2, Health Accord NL: Financial Implications and Interdependence with the Federal Government.

Responsibility

We are all responsible for cultural change and for trying to make the health and social systems more compassionate, more inclusive, more integrated, and of higher quality. The provincial government is responsible for policy decisions and funding, influenced by the democratic process. The provincial government is also responsible for making strategic plans to engage with the federal government, not only in areas of primary importance to the federal government but also in increasing federal health transfers.

Policy

The biggest policy issue is the decision to provide up-front investment in change to provide downstream improvements in health outcomes and efficiency. This also applies to the best or most feasible approach to a reasonable basic income capable of reducing poverty levels: a choice between a guaranteed basic income, or a gradual approach to supporting the most vulnerable groups. Another policy is the degree to which the primarily publicly funded integrated air and road ambulance system is a publicly delivered (and more costly) entity or a privately delivered system.

Structure

Improvement in health in the province will require change in how we manage the SDH and the structure of the health care system. Figure 2 shows that the bridge to better health outcomes and increased health equity depends upon balance across two major pillars (interventions in the SDH and integration across the sectors in the health system) supported by the building blocks that facilitate change.

The Health Accord recommends that the Provincial Health Authority (PHA) be responsible for all elements of the system that require a provincial perspective. Regional Health Councils (RHCs) should be responsible for care delivery in hospitals, the community, and in long-term care in their regions. In support of this structure, the Health Accord recommends the creation of new Regional Social and Health Networks (RSHNs) as networking tables responsible for engaging leaders across social and health systems to ensure focus on the specific health priorities and concerns in their respective regions. Health Accord NL also recommends the creation of The NL Council for Health Quality and Performance that will be responsible for reporting on quality of care, supporting and advocating for a Learning Health and Social System (LHSS), and providing a plan to evaluate the Health Accord over time.

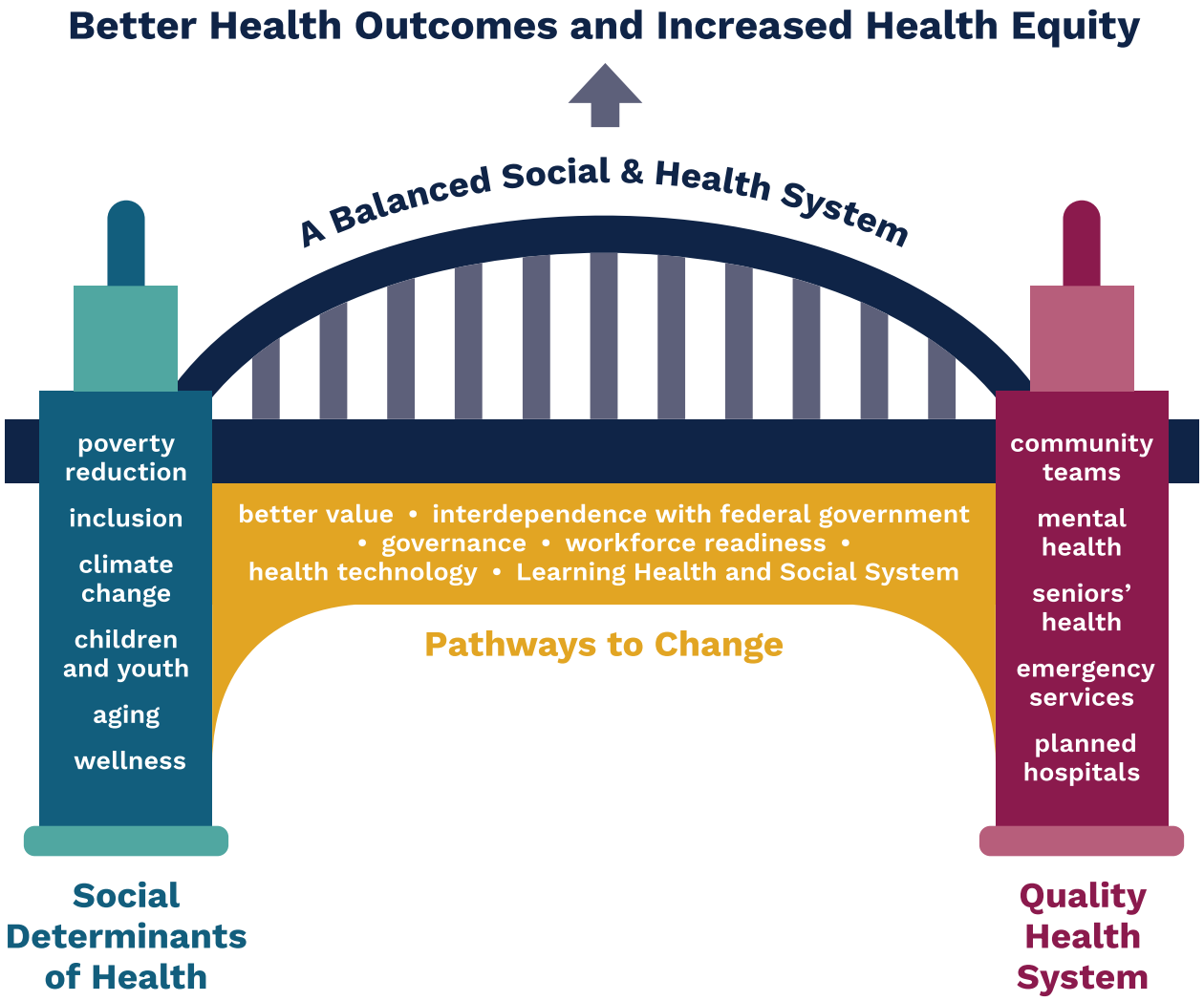

Fig 2. The bridge to better health outcomes and increased health equity

Investments

The net new annual investments required to implement the Health Accord are shown in Fig 3 (p 10) and are exclusive of major new income policies which are outlined in Table 1. Both tables use today's dollars and are not indexed for future cost increases. More detail is provided in Table 5 in Summary 2, Health Accord NL: Financial Implications and Interdependence with the Federal Government and, more specifically, in the individual summaries.

Health Accord NL implementation will require an increase in net new investment during the first five years. However, the second five years will see a substantial decrease in net new investments, supporting the policy that up-front investment will lead to downstream efficiency (Fig 3).

Fig 3. The net new overall investments to implement Health Accord NL over 10 years in today's dollars, exclusive of new income policies

Notes:

1. Costs related to areas such as inflation, collective agreement increases, HST, one-time costs to transition to an integrated ambulance system, and costs of interprofessional teams in long-term care facilities are not incorporated.

2. Some investments will have different impacts on the financial position of the province. For example, it is expected that a portion of investments related to a new health information and virtual care system may be capitalized.

The investment required for the new income policy for 2022/23 advocated by Health Accord NL is in Table 1. Implementation of the Guaranteed Basic Income (GBI) is dependent on federal government funding.

Table 1. Financial implications of changes to income policy advocated by Health Accord NL

Income Policy	Investment in millions 2022–23
Guaranteed Basic Income (GBI)[1,2]	$845
NL Income Support Indexing[2]	$4.1
NL Seniors' Benefit Indexing[2]	$1.1
NL Low Income Supplement	$1.3

Notes:

1. An alternative to GBI is a gradual approach with provision of a basic income to people and families at higher risk of poverty.
2. The percentage increase used for indexing is based on the average inflation rate for 2020 and 2021 which is 1.9%.

Benefits

- An increase in social spending will narrow the gap in life expectancy between the province and Canada. However, this will take time. In the interim, reduction in rates of poverty, food insecurity, and homelessness should occur.
- Action on early childhood development, an integrated child health and education system, and better care for children at risk will improve child health.
- Creation of age-friendly communities, an improved continuum of care for elderly persons, and a Provincial Frail Elderly Program will improve well-being for older persons, decrease adverse outcomes, and change care from a medicalized model to a geriatrics-informed model.
- Improvement in access to primary and urgent care through Community Teams, reduction of emergency room visits and hospitalizations, improvement of health outcomes particularly in high risk and vulnerable groups, and retention of providers will occur if the recommended steps are taken.

- Enhanced sustainability of hospital services with providers working in a more attractive workplace, improved access to specialty care through virtual care and visiting specialists, and new programs will result in improved outcomes in relevant areas.

- Creation of a modern, integrated air and road ambulance system will provide faster access to emergency services, with care delivered from home to the emergency department supported by paramedics and a virtual emergency system.

- Implementation of a new health governance structure to support this model will result in decreased inappropriate use of health resources, improved health system performance and efficiency, and integrated health and social systems.

- Launching of a modern health information and virtual care system that is integrated across regions, systems, and provider groups will facilitate virtual care and integrate social and health systems in a way that improves access of people to care and decreases adverse events.

- Development of a Health and Social System Human Resource Plan together with an interprofessional, lifetime learning approach should increase recruitment and retention rates and enhance workplace satisfaction and quality.

Implementation

Figure 4 (pg 30–40) provides the timelines envisaged for the implementation of recommendations. It outlines the key recommendation deemed critical to mobilizing the health care transformation that is envisaged throughout the Accord. It is not reflective of every Call to Action or objective nor has every Call to Action or objective been costed at this time. These implementation recommendations and the costing estimates provided in Summary 2 are key to moving forward with the Health Accord. After two to three years, an assessment supported by the Health Accord evaluation should be completed to determine the next set of priority needs to be addressed.

Legislation

New legislation will be required for a number of actions including the continuum of long-term care, the National Pharmacare Program (federal), the new governance

structures, the NL Council for Health Quality and Performance, and the Regional Social and Health Networks. Replacement or amendment of existing legislation may be necessary.

Table 2. Legislative Impacts of Health Accord NL Calls to Action

Direction	New or Amended Legislation Required	Possible Amendments to Existing Legislation
Life with Economic Security (Action 3)	• New legislation for basic income • Amendments to Labour Standards Act	• Income and Employment Support Act • Medical Care and Hospital Insurance Act
Climate Emergency (Action 4)		Acts impacting Fisheries, Forestry, Agriculture, Energy and Technology, Transportation and Infrastructure, Municipalities, and Environment
Pathway for Inclusion (Action 5)		Human Rights Act, 2010
Integrated Models of Care for Children and Youth at Risk (Action 7)		Children, Youth and Families Act
Progressive Aged Care Legislation, Regulation, and Policy (Action 12)	• New legislation for care and protection for older persons • New legislative framework for home care, supportive housing for seniors, personal care homes, and long-term care facilities	Advance Health Care Directives Act
National Pharmacare (Action 29)	• Canada Health Act • New federal Pharmacare Act	• Pharmaceutical Services Act, 2016 • Pharmacy Act, 2012
Occupational Health Clinic (Action 32)		Workplace Health, Safety and Compensation Act

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Direction	New or Amended Legislation Required	Possible Amendments to Existing Legislation
Provincial Integrated Air and Road Ambulance System (Action 23)		Emergency Health and Paramedicine Services Act
Scope of Practice (Action 39)		Seventeen Acts regulating health professionals
Collaborative Education Development and Delivery (Action 45)		• Council on Higher Education Act • Memorial University Act • College Act, 1996 • Private Training Institutions Act
Provincial Health Authority (Action 48)	• New legislation for Provincial Health Authority • Amendments to Independent Appointments Commission Act	• Health and Community Services Act • Public Health Protection and Promotion Act • Regional Health Authorities Act
Regional Health Councils (Action 49)	New legislation for Regional Health Councils	
Regional Social and Health Networks (Action 50)	New legislation for Regional Social and Health Networks	
NL Council for Health Quality and Performance (Action 26)	New legislation for NL Council for Health Quality and Performance	
Accountability for Improved Health Outcomes (Action 25)		• Transparency and Accountability Act • Public Health Protection and Promotion Act • Patient Safety Act • Health and Community Services Act • Emergency Health and Paramedicine Services Act

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Direction	New or Amended Legislation Required	Possible Amendments to Existing Legislation
Provincial Data Governance Model (Action 51)		• Personal Health Information Act • Access to Information and Protection of Privacy Act, 2015

Notes:

1. In implementing the recommendations outlined by Health Accord NL, other acts may need to change (e.g., 'health-in-all-policies', climate emergency, one inclusive society, care for children and youth at risk).

2. See Appendix C for a more complete list of the recommended new or amended legislation.

Cross-References

Section A:

- Health Accord NL: Financial Implications and Interdependence with the Federal Government

Section B:

- Social Determinants of Health Implementation Recommendations
- The Aging Population Implementation Recommendations
- Community Care Implementation Recommendations
- Hospital Services Implementation Recommendations
- Quality Health Care Implementation Recommendations
- Digital Technology Implementation Recommendations
- Workforce Readiness Implementation Recommendations
- Education Implementation Recommendations
- Governance Implementation Recommendations
- Finance and Intergovernmental Affairs Implementation Recommendations

2. Health Accord NL: Financial Implications and Interdependence with the Federal Government

Introduction

A measured approach to implementation over five years so that change can occur responsibly is prudent in light of efforts being made to improve the fiscal position of the province. In year six to year ten, evaluation of the impact of the Calls to Action will inform planning and further implementation of change. Critical is the province's interdependence with the federal government, which creates social policy and funds interventions aimed at improving the social determinants of health (SDH) and provides the Canada Health Transfer and targeted funding for multiple priorities. The priorities of Health Accord NL overlap substantially with the priorities of the federal government as outlined in the Prime Minister's mandate letters to his Ministers (Table 3, pg 23–27) and in the 2022 agreement between the Liberal Party of Canada and the New Democratic Party, (Table 4).

Rationale

Multiple Calls to Action are dependent to a major extent on the federal government (e.g., reduction of poverty, food insecurity and housing insecurity, amelioration of climate change, early childhood development, long-term care, Community Teams and broadband penetration in the province). In addition, through the Canada Health Transfer and targeted funding for multiple priorities, the federal government influences actions in health care delivery.

Responsibility

The provincial government is responsible for making strategic plans to engage with the federal government in areas important to both levels of government and in advocacy for increased federal health transfers.

Policy

The biggest policy issue is the decision to provide up-front investment in changes to improve health thus obtaining downstream improvements in the health outcomes of people in Newfoundland and Labrador and in efficiency. These decisions must first be made at a provincial level and, consequently, a strategy evolved on how to engage with the federal government in areas of mutual interest. Particular policy decisions must be made regarding the most feasible approach to a basic income. Policy decisions on program funding should avoid funding with limited horizons to ensure program continuity and effectiveness.

Table 3 (pg 23–27) outlines how priorities of the federal government in the Prime Minister's mandate letters in December 2021 to his federal Ministers (Health; Seniors; and Families, Children and Social Development) compare with the Health Accord Calls to Action. Thirty-four health and social priorities of the federal government overlap with the Calls to Action of the Health Accord.

There is a similar coincidence of priorities between the Supply-and-Confidence Agreement (2022–2025) by the Liberal Party of Canada and the New Democratic Party and those of Health Accord NL (Table 4).

Table 4. Coincidence of priorities between Supply-and-Confidence Agreement (2022–2025) by the Liberal Party of Canada and the New Democratic Party in Parliament and those of Health Accord NL as outlined in the Summaries

Initiative in Supply-and-Confidence Agreement	Implementation Summary of Health Accord NL
New dental care program for low-income Canadians	New health care programs
Universal National Pharmacare	Appropriate use of health interventions
More primary care doctors and nurses	Community Teams

Continued on next page

Initiative in Supply-and-Confidence Agreement	Implementation Summary of Health Accord NL
Mental health support	An integrated approach to mental health and addictions
Aging at home; Safe Long-Term Care Act	Better health in older persons
Better data	A Learning Health and Social System
Affordable housing initiatives	Poverty reduction
Early Learning and Child Care Act	Investing in children and youth
Tackling the climate crisis	Health impacts of the climate emergency
Just transition agreement	Just transition agreement

Structure

An evidence-based, holistic, short-term and long-term strategic plan to engage with the federal government on funding in areas of mutual interest is needed. Led by the Deputy Minister for Intergovernmental Affairs and the proposed Senior Executive (Health Accord), and integrated with the Deputy Ministers from the many relevant departments, such a proactive strategy would require the approval of Cabinet and could involve working with like-minded provinces in a collaborative approach to the federal government.

Investments

Estimated net new investments associated with implementing the Calls to Action (excluding income support programs) are presented in Table 5. All investments are listed in today's dollars without adjustment for inflation. Years two and three see the highest net investments required. These investments span multiple government departments, as change will be necessary to improve social, economic and environmental factors in addition to health care. These amounts are equivalent to about 1% of the current total provincial budget ($9.3B 2021/22 projection from the 2021 Fall Fiscal Update) (Fig 5). After year three, the size of additional financial investments required to implement Health

Accord NL decreases. By year ten, the additional financial investment for implementation of Health Accord NL is expected to represent a nominal increase of 0.2% on the overall 2021 annual provincial budget. This does not include the investments needed for a publicly operated ambulance system if that is government's preferred delivery method.

Table 5. Estimated net new investments (savings) to implement Calls to Action (in Millions), in today's dollars, exclusive of new income support programs

Calls To Action	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
	$M	$M	$M	$M	$M	$M	$M	$M	$M	$M
Community Care	12.0	18.0	28.0	28.0	28.0	28.0	28.0	28.0	28.0	28.0
Acute Care	(2.0)	(5.7)	(14.8)	(22.3)	(26.6)	(29.3)	(31.8)	(34.4)	(37.0)	(39.6)
Aging	3.2	7.3	10.4	11.0	11.5	11.3	11.7	12.0	12.4	12.7
Quality	1.5	2.0	2.0	2.0	2.2	2.2	2.2	2.2	2.2	2.2
Digital	3.7	27.5	39.4	32.0	21.1	10.9	3.4	(1.7)	(3.7)	(5.3)
Social Determinants of Health	17.9	25.6	25.7	25.7	25.7	25.1	25.1	25.1	25.1	25.1
Human Resources	4.0	6.0	8.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0
Education	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Governance	2.3	3.8	3.8	(2.1)	(7.6)	(13.1)	(18.6)	(18.6)	(18.6)	(18.6)
Total	43.3	85.2	103.2	85.0	65.0	45.8	30.7	23.3	19.1	15.2

Notes:

1. Acute care includes hospitals, new programs, and air and road ambulance system.
2. Brackets () indicate an overall reduction in investments.
3. Costs related to areas such as inflation, collective agreement increases, HST, one-time cost to transition to an integrated ambulance system, and costs of interprofessional teams in long-term care facilities are not incorporated.
4. Some investments will have different impacts on the financial position of the province. For example, it is expected that a portion of investments related to a new health information and virtual care system may be capitalized.

Fig 5. Percentage of current provincial budget estimated to implement the Calls to Action, over 10 years, exclusive of new income support programs

Notes:

1. The 2021/22 provincial budget projection is $9.3B based on the 2021 Fall Fiscal Update.

The estimated investment for a Guaranteed Basic Income (GBI), or some alternative basic income program for Newfoundland and Labrador, is considered separately from the other program items. A GBI for Newfoundland and Labrador has been estimated to be an investment of $845M (equivalent to 9.1% of the 2021 provincial budget). An investment of this magnitude would only be possible with support of the federal government. An alternative to GBI is a gradual approach, with provision of a basic income to people and families at the highest risk of poverty. A targeted approach like this would be less expensive but would result in far too many people living below the poverty line.

Health Accord NL also recommends indexing income support programs. In year one, the cost for income support would be $4.1M; for seniors' benefits, $1.1M; and for low-income supplement, $1.3M.

The net new investments should take account of potential revenue from the federal government. The federal government's election platform contained commitments to addressing concerns in the following areas: Canada Mental Health Transfer, access to primary care, substance use disorders, support for workers, long-term care, expensive drugs for rare diseases, virtual services, home and community care, and backlogs of surgeries and procedures. For Newfoundland and Labrador, these commitments from Canada could see revenues of at least $365M which, if distributed over five years, could amount to $73M per year.

The Canada Health Transfer amounts to 18.7% of Newfoundland and Labrador's health spending. All provinces are seeking an increase from the average current transfer to the provinces (20% of provincial health spending) to 35% of provincial health spending. For Newfoundland and Labrador (based on 2020/21 Canada Health Transfers) an increase in Canada Health Transfers to 35% would represent an annual increase of $387M while an increase to 30% would represent an annual increase of $250M.

Limitations of the financial projections:

1. Transition investments for ambulance integration have not been included in the figures above, as further analysis and policy are required. Extra costs of a publicly funded ambulance workforce compared with a workforce employed by private operators have not been included.

2. Estimates are compiled using today's known investments and best evidence. There is an assumption that some Calls to Action will not require new funding and can be accomplished with current system resources and directed effort.

3. Future government policy decisions may impact cost estimates.

4. Estimates for savings in acute care are difficult because they depend on repurposing of beds or a change in how services are delivered. Reallocation of savings will not be possible until the changes are made and savings are realized.

5. There is a heavy reliance on federal funding. The exact policies with federal funding envelopes have not been determined. The extent of increases to the Canada Health Transfer is unknown.

6. The fiscal capacity of the province to pay for new initiatives is limited without reallocation of current funding or new federal funding support.

Benefits

Up-front investment in the priorities of the Health Accord will lead to downstream benefits for the province through better health outcomes and increased efficiency. The fiscal benefits gained in relation to creating a modern health information and virtual care system, implementing effective Community Teams, and making more appropriate use of health resources are likely to be underestimated. The potential fiscal benefits do not include those arising from actions on the SDH as these benefits are likely to be realized over the long term (beyond year five).

Though benefits are likely underestimated, it is important to note that the province will face some limitations in reducing the per capita spending on health due to:

1. low population density, especially in Labrador, which makes Labrador more similar to a territory than a province in estimating costs of health care delivery;

2. a high proportion of the population living in rural areas (42%) relative to the Canadian rate (18%), with higher per capita costs in rural hospitals compared to urban hospitals;

3. a high proportion of the population who are seniors (22.3%), compared to the Canadian rate (18%), for whom per capita costs for health care are nearly four times that of costs for younger people.

If the Calls to Action of Health Accord NL are implemented in an integrated, holistic, and comprehensive manner, the value of health and social spending will be increased through maximizing improvements in health outcomes, as outlined in Summary 1, Health Accord NL: Overall Implementation.

Implementation

Initial and longer-term implementation steps are outlined in Fig 4 (pg 30–40), but they are contingent on the fiscal capacity of the province. An increase in federal funding from the Canada Health Transfer and funding for targeted

priorities of the federal government will provide the financial capacity for up-front investment. In the absence of this federal funding, implementation of the Health Accord will occur at a slower pace than is optimal.

Table 3. Priorities of the federal government outlined in the Prime Minister's December 2021 mandate letters to the Ministers of Health; Seniors; and Families, Children and Social Development compared to Health Accord NL Calls to Action

Topic and Evidence	Federal Mandate Letters	Health Accord Call to Action
Climate Change and Health	...whole-of-government effort to reduce emissions, create clean jobs and address the climate-related challenges...	
		Action 4: Take an aggressive and proactive approach to addressing the climate emergency...
Inclusion	...implement the United Nations Declaration on the Rights of Indigenous Peoples and to work in partnership with Indigenous Peoples to advance their rights... In support of the Indigenous Early Learning and Child Care system, continue to invest in Aboriginal Head Start in Urban and Northern Communities Program. ...collaborate with various communities, and actively seek out and incorporate in your work, the diverse views of Canadians...women, Indigenous Peoples, Black and racialized Canadians, newcomers, faith-based communities, persons with disabilities, LGBTQ2...	
		Action 5: Take immediate action to create a provincial Pathway for Inclusion, shaping an inclusive health system within an inclusive society. **Summary 27, Integration with Indigenous Nations**
Reproductive and Sexual Health	...ensure that all Canadians have access to the sexual and reproductive health services they need, no matter where they live...	
		Summary 16, New Health Care Programs Midwifery, sexual health clinics, and sexual assault nurse examiners

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Mental Health and Addictions	...establish a permanent, ongoing Canada Mental Health Transfer...
	Summary 10, An Integrated Approach to Mental Health and Addictions
Economic Security	...work toward a better future where everyone has a real and fair chance at success and no one is left behind. ...commitment to old age security, increase the Guaranteed Income Supplement for seniors—provide recommendations for establishing an Aging at Home Benefit...
	Actions 3/8: Ensure that Newfoundlanders and Labradorians have a liveable and predictable basic income...programming to improve food security and housing security.
Human Resources	...increase funding to provinces and territories to strengthen our universal public health system, ensure health care workers are supported and recruited across the country... Supporting provinces and territories to hire new family doctors, nurses and nurse practitioners
	Action 37: Through consultation with stakeholders, create a Provincial Health and Social System Human Resource Plan. **Action 40:** Create a strategic recruitment plan... to offer stable direct care and services...providing work-life balance... **Action 41:** Create strategies to engage, stabilize, and retain the current and future health and social system workforce... inclusion of underrepresented groups...
Critical Care Services	Investing in supporting initiatives that will help to speed access to care for critical services...
	Action 20: Enhance care across the continuum to ensure that access to appropriate and high quality care and service is available... to minimize the need to travel to obtain appropriate services...

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Health Information and Virtual Care	Expanding virtual care, helping to cover digital infrastructure and other system improvements so that Canadians can access virtual medical consultations or remote monitoring: ...and advance an integrated, comprehensive and patient-centric strategy... ...create a world-class health data system that is timely, usable, open-by-default, connected and comprehensive...
	Action 34: Modernize foundational information technology systems. **Action 35:** Adopt and leverage virtual care technologies. **Action 36:** Develop a Provincial Digital Technology Strategy... **Action 55:** Invest in change management and training in digital technology... **Action 22:** Renew hospital services by improving coordination and flow of health and social system information between hospitals and the community...
Community Teams	Collaboration with provinces and territories will be key to ensuring the primary care system is positioned for the future... Expanding the number of family doctors and primary health teams in rural communities and working to give rural communities greater access to a full suite of health and social services professionals
	Action 13: Connect every resident of Newfoundland and Labrador to a Community Team providing a central touchpoint of access and a continuum of care. **Action 39:** Create a health and social system environment that enables all providers to work to the highest scope of practice...
Aging Population	...working to improve the quality and availability of long-term care. ...negotiate agreements with provinces and territories...support efforts to improve the quality and availability of long-term care homes and beds... develop national standards and a Safe Long-Term Care Act... ...train up to 50,000 new personal support workers and raise wages. ...take concrete actions to support seniors who want to age at home... ...Implement the New Horizons for Seniors Program... ...Assist community-based organizations in providing practical support that helps vulnerable seniors...

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Aging Population	**Action 9:** Develop and implement a formal Provincial Frail Elderly Program...
	Action 10: Implement and support an integrated continuum of care... support older adults to age in place with dignity and autonomy.
	Action 11: Take immediate steps to identify and respond to the ageism in our province, including support for the development of age-friendly communities...
	Action 12: Develop and implement provincial legislation, regulation, and policy required to provide appropriate, quality, and accessible care and protection for older persons...
Research	...develop a plan to modernize the federal research funding ecosystem to maximize the impact of investments in both research excellence and downstream innovation...
	Action 1: Increase awareness and understanding of the social determinants of health...
	Action 43: Leverage existing evidence and data in the health and social systems and expand this knowledge base...
	Action 27: Design a long-term evaluation plan related to the implementation of the Calls to Action...
Quality	Work with partners to take increased and expedited action to monitor, prevent and mitigate the serious and growing threat of antimicrobial resistance...
	Action 24: Foster a culture of quality and establish a comprehensive, effective, and sustainable Learning Health and Social System.
	Action 26: Establish the NL Council for Health Quality and Performance...
	Action 25: Improve accountability structures within the health and social systems to focus on achievement of better health outcomes.
Pharmacare	Continue engaging with willing provinces and territories towards national universal pharma care...
	Action 29: Establish a pharmacist-supported model to improve appropriateness of medication use and continuity of care... Support the creation of a National Pharmacare Program.

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Occupational Health	...protect Canadians from harmful chemicals... ...implement an action plan to protect Canadians, including firefighters, from exposure to toxic flame retardants found in household products.
	Action 32: Create an Occupational Health Clinic with linkages to the Community Teams.
Health Promotion	Recognizing that a healthy population is key to reducing vulnerability to health events, promote healthy eating by advancing the Healthy Eating Strategy...
	Action 3: Ensure that Newfoundlanders and Labradorians have a liveable and predictable basic income...improve food security and housing security **Action 15:** Place greater emphasis on health promotion and well-being, the social determinants of health, and chronic disease management. **Summary 9, An Integrated Approach to Wellness and Disease Prevention**
Disabilities	...accelerate the development of the National Autism Strategy.
	Action 54: Invest in change management to initiate and maintain Community Teams so that they provide care across the spectrum of health care including children in need, patients/clients with disabilities...
Children and Youth	...the creation and sustainability of a Canada-wide Early Learning and Child Care System... Ensure that Indigenous people have access to a culturally appropriate Indigenous Early Learning and Child Care System. Implement the Community Services Recovery Fund Advance the Social Innovation and Social Finance Strategy ...develop a National School food strategy and work to a national school nutritious meal program... ...ensure mental health supports are accessible to children and youth...
	Action 6: Strengthen efforts to create a continuum of education, learning and socializing, and care for children and youth (from prenatal to adulthood). **Action 7:** Develop one model of community health services for children and youth with complex health needs and a more integrated approach to respond to health needs of children and youth in care. **Action 8:** Ensure that the families of children in Newfoundland and Labrador have some form of a liveable and predictable basic income to support their health and well-being, integrated with provincial programming to improve food security and housing security.

Cross-References

Section A:

- Health Accord NL: Overall Implementation

Section B:

- Social Determinants of Health Implementation Recommendations
- The Aging Population Implementation Recommendations
- Community Care Implementation Recommendations
- Hospital Services Implementation Recommendations
- Quality Health Care Implementation Recommendations
- Digital Technology Implementation Recommendations
- Workforce Readiness Implementation Recommendations
- Education Implementation Recommendations
- Governance Implementation Recommendations
- Finance of Intergovernmental Affairs Implementation Recommendations

Health Accord NL: Timelines for Implementation of Major Actions (Fig 4)

Culture change:
The key changes that will improve health and health outcomes involve culture change, a process that will require 10 years and longer.

The culture change derivative from the Health Accord is the need to embed awareness of the impact of the social, economic and environmental factors on health together with a rebalanced health system that focuses on compassion, quality, and integration.

There will also need to be progress on our cultural approaches to inclusion, ageism, well-being, climate change, workforce readiness, and public engagement along with active participation in pathways that facilitate change, particularly a Learning Health and Social System (LHSS) and change management.

An iterative process to support change:
The implementation of recommendations requires an iterative process of policy development, action, evaluation, and changes in policy based on evaluation.

In the short term (year 1), policy development, informed by the recommendations of the Health Accord, should be dominant across the social determinants of health (how we live, where we live, how we relate, how we invest in our future, how we provide better care to seniors), the rebalanced health system (community care, hospital services, seniors' care, the air and road ambulance system), pathways to facilitate change (health information and virtual care, workforce planning and development, education, and governance). However, action can be taken in areas where policy has been determined and the need is great. This includes increased social spending, 'health-in-all-policies', action on climate change plan, care in correctional facilities, integration of the health system and school health, initiation of Regional Social and Health Networks, Community Teams, collaborative models for urgent care, effective bed management, provincial acute care standards, new health care programs, improvement in the continuum of care for seniors, a start to frail elderly programs, a provincial virtual emergency system, a provincial human resources plan, recruitment and retention initiatives, and education initiatives.

In the medium term (years two to three), action on new policies will be dominant and evaluation can start. In particular, actions required include providing capacity and research in SDH, reducing the environmental footprint of the health system,

fostering inclusion, implementing a well-being strategy, providing provincial programs for children at risk, implementing the Healthy Students Healthy Schools program, extending Community Teams, provision of sustainable specialty care, integrating the air and road ambulance system, integrating a continuum of care for seniors, initiating Centres of Excellence on Aging, starting the integrated health information and virtual care system, implementing the human resource plan, implementing the collaborative education model, and starting the new governance system.

In the longer term (four to five years), policies should be amended based on evidence, the major Calls to Action should be fully implemented, participation in the LHSS across sectors should be increasing, and SDH metrics should be integrated into the system.

In the long term (six to ten years), an emphasis on cultural change should continue with a sustained focus on SDH, increased social spending, full implementation of a LHSS, public and stakeholder engagement, a focus on workforce readiness, continuation of consistent change management, and evaluation to inform the next health and social system plan.

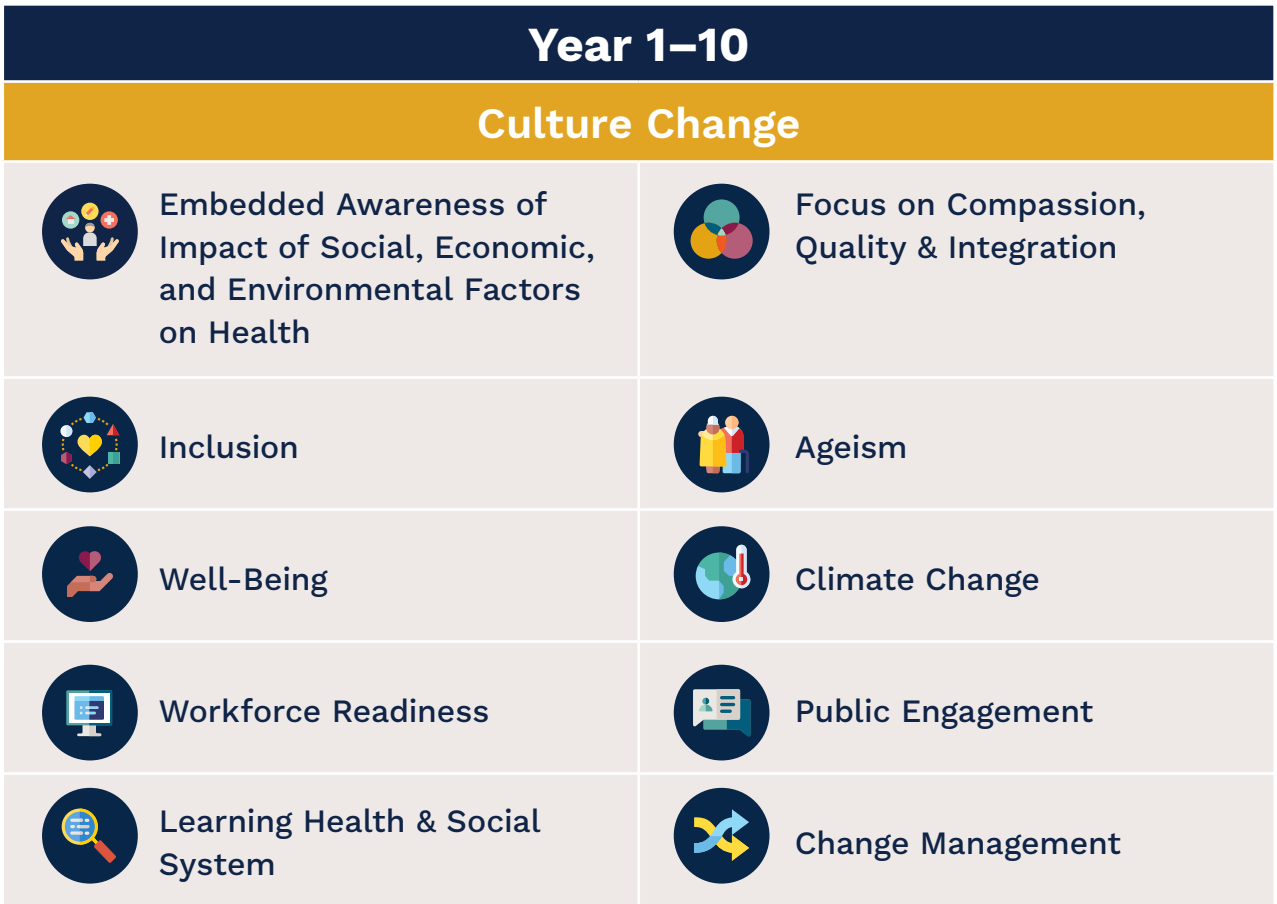
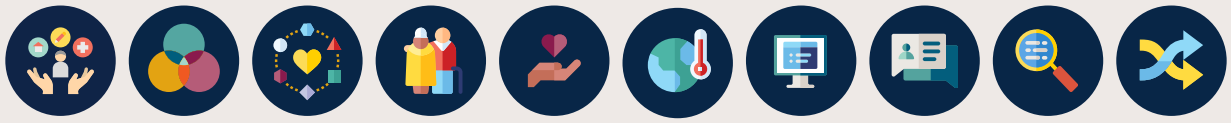


Fig 4. Timelines for Implementation of Major Actions (continued on next page)

Year 1

Culture Change



Policy

Social Determinants of Health

How We Live

- Social determinants of health literacy, behaviours, practices
- Income support and processes
- Food security and housing security as health equity issues
- Guaranteed basic income plan and advocacy
- An integrated well-being strategy
- Social determinants of health research capacity

Where We Live

- Social determinants of health research capacity in community organizations and community sector planning
- Awareness of impact of climate change on health
- Reduction of environmental footprint of health system

How we relate

- Defined pathway for inclusion
- Zero-tolerance policy on racism in province and in health system
- New policies for inclusion

Invest in Our Future

- Continuum of education, learning, socializing and care for children and youth
- Healthy Students Healthy Schools Program within Comprehensive School Health Framework
- Provincial approach to health and health support for children at risk

Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

Rebalanced Health System

Community Care

- Clarity on roles within Community Teams (including navigators) and affiliations with private providers
- Integration of social determinants of health
- A well-being strategy
- New programs: occupational health clinic; oral health; midwifery; sexual health clinics; hospice care

Hospital Services

- Provincial approach to provision of specialty programs
- Plan for sustainable specialty care
- Specialty care outreach using virtual care and travelling clinics
- Integrated air and road ambulance system with central medical dispatch
- Provincial virtual emergency service

Seniors

- Provincial Frail Elderly Program
- Integrated continuum of care
- Plan for providers engaged in care of the elderly
- Enhanced Home Support
- Secretariat for Seniors

Pathways to Change

Health Information & Virtual Care

- Integrated health information and virtual care system
- Digital technology strategy and data governance
- Broadband throughout province linked with federal strategy
- Digital literacy and support teams for clients and practitioners
- Plan LHSS

Workforce Planning & Development

- Health and social workforce strategy
- Providers to work to full scope
- Workforce transition guiding principles
- Promotion of value of leadership and management
- Change management approach

Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

Pathways to Change

Education

- Guiding principles for education development and delivery initiatives
- Collaborative education development and delivery mode

Governance

- Roles of Provincial Health Authority and Regional Health Councils in health system
- Establishment of Regional Social and Health Networks
- Engagement to support governance
- Review of legislation on health and social systems
- Stronger support for engagement of community sector
- Strategic engagement with federal government

Action

Social Determinants

- Social determinants of health prioritized at provincial and federal tables
- Increased social spending
- Indexed income supports
- Increase in social workers for programs to end homelessness
- 'Health-in-all-policies' within government and beyond
- Implementation of Climate Change Action Plan
- Integration of health system and school health
- Improved mental health and health programs in correctional facilities
- Further implementation of well-being strategy

Rebalanced Health System

Community Care

- Clarity on roles within first group of 6–8 Community Teams
- Collaborative models for urgent care at health centres
- Development of focus on frail elderly adults
- Reproductive health and sexual health
- Initiation of affiliation agreements with private providers

Hospital Services

- Alignment of acute care beds in low occupancy hospitals and health centres
- Bed management to reduce alternate level of care and medical length of stay
- Provincial acute care standards
- New health care programs
- Provincial pathology and laboratory medicine program
- Baby-friendly obstetrics program

Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

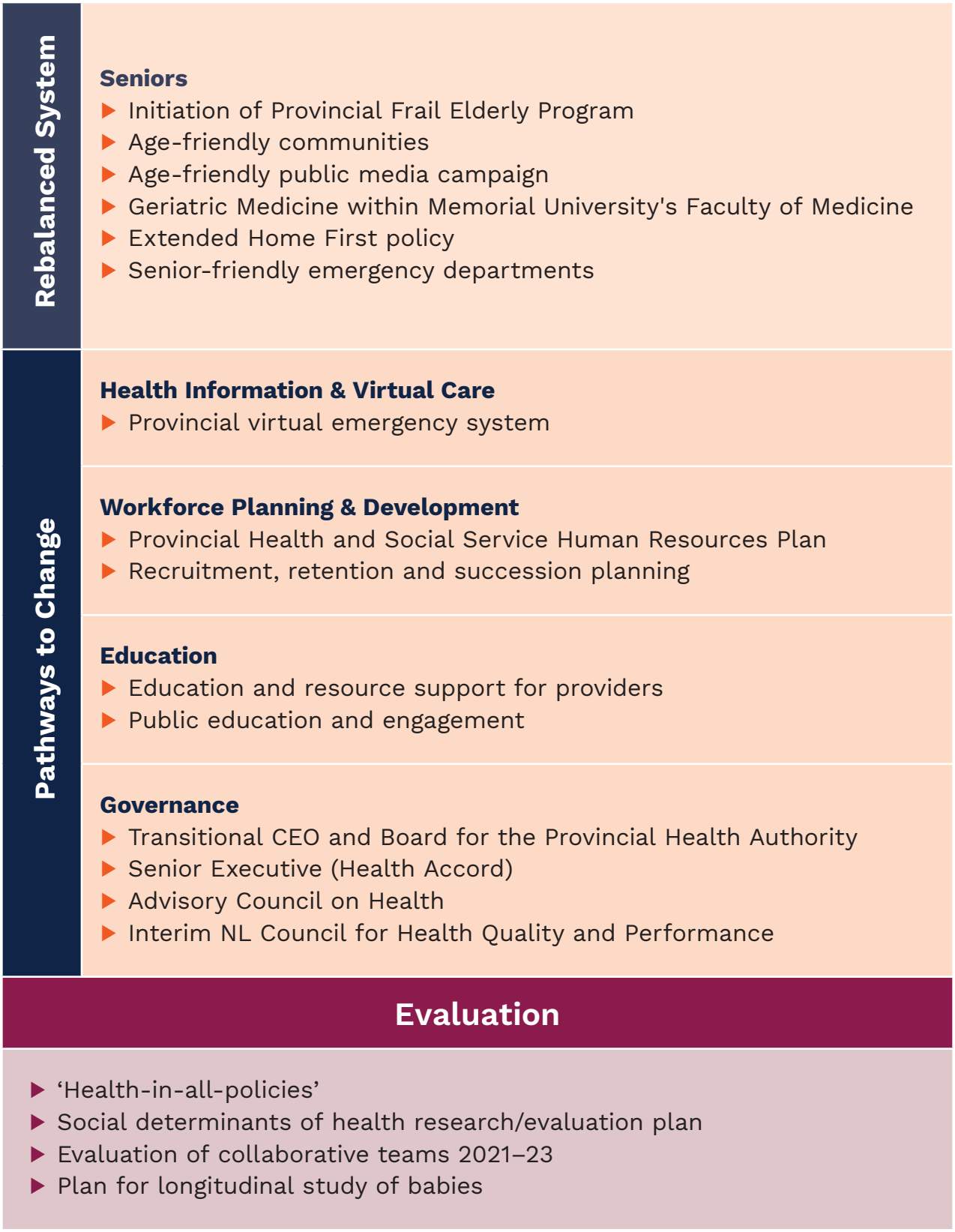


Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

Year 2–3

Culture Change

Policy

Social Determinants

- Support for basic income, living wage, and decent work
- Social prescribing pilot
- Policies amended based on evidence and engagement
- Development of a Just Transition Framework
- Legislation on basic income and employment

Rebalanced System

Community Care
- Interventions to ensure actual practice is best practice

Hospital Services
- Interventions to ensure actual practice is best practice

Seniors
- Legislation to protect older adults
- Legislation for home care, supportive housing, personal care homes, long-term care facilities

Pathways to Change

Health Information & Virtual Care
- Innovation pathways
- Social determinants of health data into existing information systems
- Expanded Personal Health Record
- Expanded provincial standardized virtual care policies
- Support for Community Teams

Workforce Planning & Development
- Review of human resource plan in year 3

Fig 4. Timelines for Implementation of Major Actions (continued on next page)

Pathways to Change

Education

- Education and training plan to support an interprofessional approach to care for older adults
- Collaborative governance structure across health professional programs and learning environments

Governance

- Policy on Regional Social and Health Networks formalized from experience in the first two years

Action

Social Determinants

- Increased social spending
- Advocacy for guaranteed basic income
- Social workers for programs to end homelessness
- Initiate research and capacity in social determinants of health
- Reduce the environmental footprint of the health care system
- Identify and address racism and exclusion throughout health system
- Implement well-being strategy
- Province-wide programs for children at risk
- Implement Healthy Students Healthy Schools Program
- Oral health for children

Rebalanced Health System

Community Care

- Additional 6–8 Community Teams
- Integrate actions on social determinants of health
- Well-being interventions
- Amend roles of Community Team providers based on evaluation
- Create social navigators and clinical navigators for Community Teams
- Establish a pharmacist-supported model for appropriate medication use

Hospital Services

- Align specialty services for sustainability
- Specialty outreach using virtual care and travelling clinics
- Develop better integrated team-based care
- Enhance emergency services with appropriate skill mix
- Implement integrated air and road ambulance system
- Implement virtual emergency system
- Sustain focus on bed management

Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

Rebalanced System

Seniors
- Strengthen integrated continuum of care
- Adopt "Senior-Friendly Care Framework" for all hospitals
- Strengthen interprofessional teams within long-term care facilities
- Initiate regional Centres of Excellence on Aging
- Sustain the focus on age-friendly communities

Pathways to Change

Health Information & Virtual Care
- Start to implement integrated plan
- Build LHSS

Workforce Planning & Development
- Enable providers to work at full scope
- Implement Human Resource Plan
- Engage effectively with providers

Education
- Implement collaborative education model
- Public and stakeholder participation in LHSS
- Provincial Choosing Wisely Canada designation for the health system

Governance
- Appoint the permanent Provincial Health Authority
- Appoint the Regional Health Councils
- Create legislation for Regional Social and Health Networks
- Create legislation for NL Council for Health Quality and Performance

Evaluation
- Measure, track and publicly report social determinants of health indicators
- Develop measures to assess exclusion
- Strategy for health and social system using evidence
- Evaluate programs for children with intellectual and learning disabilities
- Start longitudinal study with a cohort of babies born in the first year of the Health Accord implementation
- Metrics for health and social system human resources
- Measures for health quality and system performance
- Report to the House of Assembly on general measures of health system performance and specific areas of concern
- Provide institutions and providers information on quality of care

Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

Year 4–5

Culture Change

Policy

Social Determinants of Health, Rebalanced System, Pathways

- Amend policies based on evidence and engagement

Action

Social Determinants

- Increase social spending
- Fully implement policies on inclusion, environment, economic security, children, elderly persons
- Advocate for guaranteed basic income
- Integrate health system and school health

Rebalanced Health System

Community Care

- Fully implement Community Teams
- Connect every resident who wishes to a Community Team
- Fully integrate Public Health into Community Teams
- One model of community health services for children and youth
- Align services at health centres with needs of communities

Hospital Services

- Provide sustainable specialty services
- Fully implement integrated air and road ambulance
- Fully implement virtual care and virtual emergency system
- Align beds with need
- Provide best practice bed management

Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

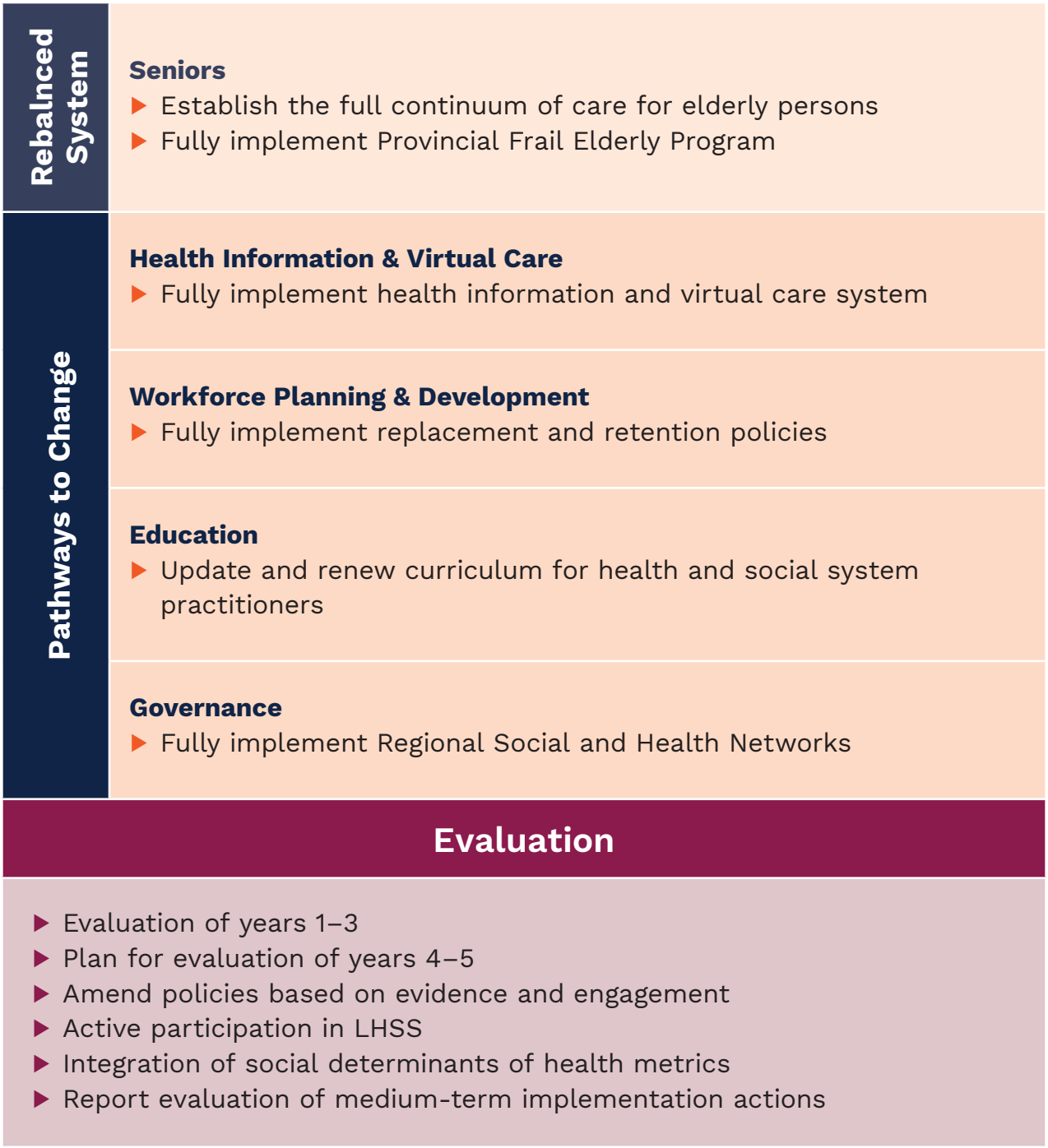


Fig 4. Timelines for Implementation of Major Actions **(continued on next page)**

Year 6–10

Culture Change

- Embedded Awareness of Impact of Social, Economic, and Environmental Factors on Health
- Focus on Compassion, Quality & Integration
- Inclusion
- Ageism
- Well-Being
- Climate Change
- Workforce Readiness
- Public Engagement
- Learning Health & Social System
- Change Management

Policy	Action	Evaluation

- Sustain focus on social determinants of health culture shift
- Increase social spending
- Fully implement LHSS
- Continue public and stakeholder engagement
- Continue focus on workplace readiness
- Address ongoing barriers to change
- Continue evaluation of Calls to Action
- Continue change management
- Begin planning for the next 10 years

Fig 4. Health Accord NL: Timelines for Implementation of Major Actions

II. Social Determinants of Health

The social, economic and environmental factors that influence health include poverty, food insecurity, homelessness, exclusion, climate change, early childhood development, education, and ageism.

A Summaries of Implementation Recommendations for the Major Calls to Action

Case Study: The Importance of the Social Determinants of Health for Darla

Darla was born this morning in Corner Brook. What happens in her next few years will influence her performance in school, her social and emotional development, her later work life, her life expectancy, and her lifelong health. **What can we do to ensure that Darla has the best foundation for a good life?**

We will have built the system so that **Darla's mother already received good care** while she was pregnant, was supported by baby-friendly services when Darla was born, and will receive good care in the six weeks after Darla's birth. **Darla will become part of a program that links her with health care professionals who work together to provide care from her earliest years**. In school, she will be part of a school health program which recognizes the links between health and education and encourages healthy lifestyle choices.

If Darla has complex health needs, we want these to be identified early so that she can receive proper health care. **We want Darla to be served by a community health program which brings together a team of health professionals who include Darla's family in her care.**

If Darla must be taken from her home for her safety and protection, we want Darla to receive **ongoing team-based health support.** We also want Darla's **family to receive the services they need** so that she can return safely home.

We will do what we can to ensure that Darla's family has access to a good, stable income and that Darla never becomes a child living in poverty. We want her to be part of a strong social network, never excluded because of her gender, race, religious beliefs, abilities, place of birth, or language. **We want her to live in a healthy and safe natural environment.**

Darla and **every child born in Newfoundland and Labrador today** deserves all of this from their very first years. If our society does this for every child, we will have **healthier children in a healthier and more thriving province.**

3. Social Determinants of Health: A Culture Shift

Introduction

Social determinants of health (SDH) is the name given to the conditions in which people are born, live, grow, eat, exercise, learn, work, play, and age. These social, economic, and environmental factors have more influence on health (60%) than the health system (25%); or genetic make-up and biology (15%) (Fig 6).

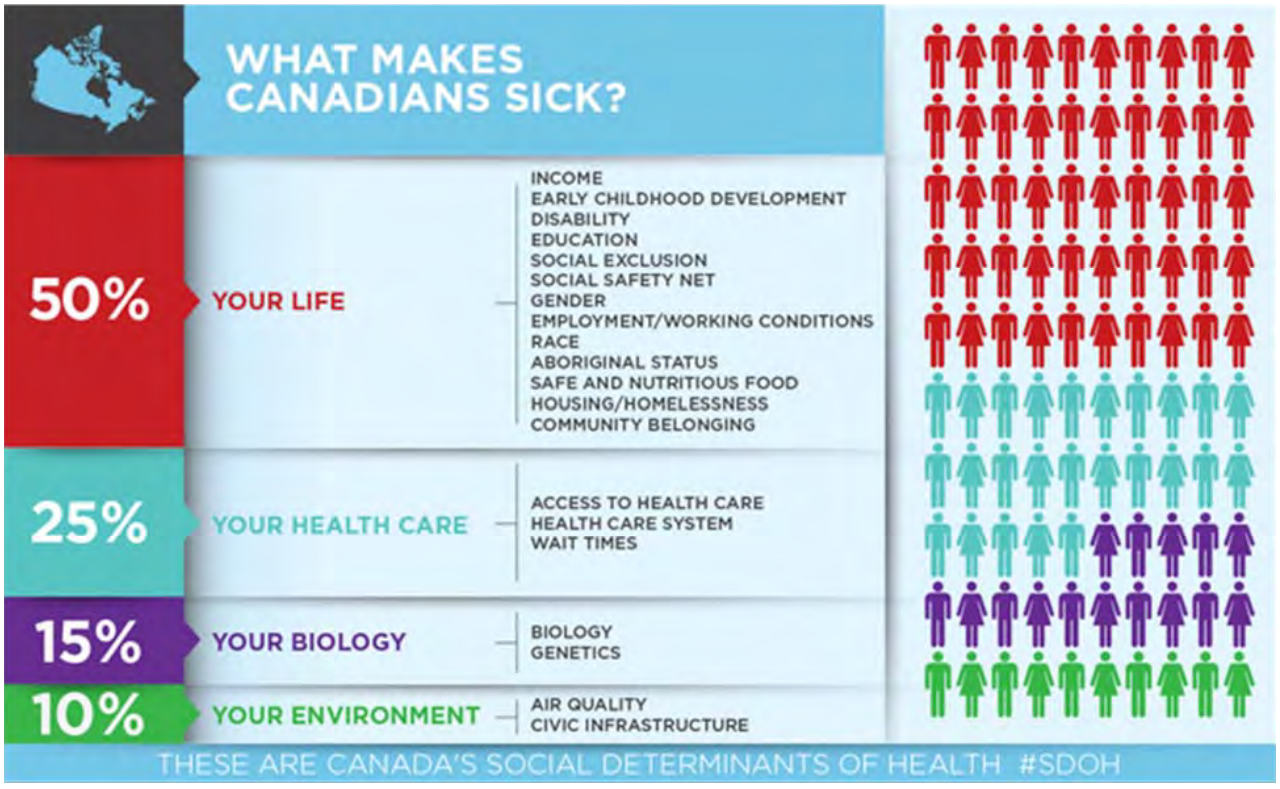


Fig 6. The relative influence of one's life, health care, biology, and environment on what makes a person sick

Rationale

The health, health outcomes, and health equity of the people of Newfoundland and Labrador are not as good as the health of people elsewhere in Canada. Despite the global evidence about the impacts on health, we continue to focus more on the health system and its share of human and financial resources than we do on interventions related to these factors.

Our thinking must change so that we integrate the SDH into all governance, policy, program, and infrastructure decisions that influence health — in government, in public systems (health, income support, education, justice, environment), in community (municipalities and community sector organizations), and in the private sector. If we fail to do this, we will not be able to improve our health outcomes and, therefore, we will not be able to achieve economic prosperity or thrive socially in our province.

Responsibility

Because social, economic, and environmental factors affect so many aspects of our lives, responsibility for the cultural shift falls to people across all areas of society through what is sometimes called a 'health-in-all-policies' approach. These decision-makers include individuals in their own healthy behaviours and practices, businesses in their decisions which influence the health of their employees and customers, community sector organizations in the mandates they choose, municipalities in building healthy communities, and government departments and publicly funded social systems in how they carry out their responsibilities. Increased attention to SDH requires an all-of-government approach led jointly by the Department of Children, Seniors and Social Development (CSSD) and the Department of Health and Community Services (HCS) but including all government departments.

Policy

Health Accord NL is calling for greater awareness of and intervention in the SDH. Targeted research will help determine the factors which most influence health in our province. Ongoing evaluation will help adjust the implementation of the Health Accord when new evidence emerges either from research or from

engagement with members of the community. Research and evaluation should be supported by linked information systems for both patient/client/resident care and secondary uses with improved access to SDH data for all partners.

One important resource should be the identification and tracking of indicators related to social, economic, and environmental conditions which are made public in an ethical, transparent, and understandable manner. This should help measure the success of the implementation of the Health Accord. All persons affected by the steps in implementation should have the chance to participate in the process, with respect for differing views and space given to consider divergent opinions.

Support should be given to individuals to sustain healthy behaviours and practices; to public, community, educational, and private organizations to adopt a 'health-in-all-policies' approach; and to municipalities to use a SDH lens in their healthy communities approaches.

Structure

Regional Social and Health Networks (RSHNs) (see Summary 18, Pathways to Facilitate Change: Regional Social and Health Networks) are proposed by Health Accord NL to carry out a mandate to provide leadership in bringing about the culture change among municipalities, community groups, businesses, and social systems (health, education, and justice) at the regional and local levels.

In the transitional phase for the implementation of the Health Accord Calls to Action, there are recommendations for a Senior Executive (Health Accord) and an Advisory Council on Health to link the Health Accord with the implementation team. The Senior Executive, with the advice of the Premier's Advisory Council on Health, should facilitate initiation of the RSHNs. The RSHNs would be given the mandate over the next three years to gradually determine the best way forward to achieve the cultural shift needed to transform health.

The scope of changes needed should also require each government department to review its mandate to determine how its work has an impact on health. The Department of Children, Seniors and Social Development has already begun to ensure that it is taking a 'health-in-all-policies' approach. The Senior Executive (Health Accord) will work with all Ministers and Deputy Ministers to define the best structure to ensure the cross-sectoral approach needed.

Health Accord NL is also recommending a policy position in HCS to support municipalities in implementing a 'health-in-all-policies' approach.

Investments

Given the extent of change required, investments for enabling the cultural shift are difficult to assess. An estimated $0.8M in year one, then $1.0M annually thereafter, is needed to focus the cultural shift through enhanced research, a long-term evaluation program, and the development and publishing of SDH indicators. These steps should be put in place immediately. Investment for the RSHNs is outlined in Summary 18, Pathways to Facilitate Change: Regional Social and Health Networks.

Benefits

As awareness grows about the impact of social, economic, and environmental conditions on overall health outcomes and healthy equity in our province, more attention and resources will be directed to interventions in those conditions which can be positively influenced and can improve health (e.g., poverty reduction, food and housing security, climate change, social inclusion, early childhood care and education, and age-friendly communities).

Implementation

The first step should be an all-of-government acceptance of the need for this shift in thinking and in resource allocation as well as the introduction of the RSHNs, led by the transitional governance structures (see Summary 29, Governance: Transitional Structures). The next step should be the development of the province's strategic approach to federal funding programs related to social, economic, and environmental factors. These two steps should be supported by the immediate introduction of enhanced research, a long-term evaluation plan, and the development of publicly accessible indicators related to social, economic, and environmental influences on health.

Cross-References

Calls to Action: 1, 2, 28, 50, 56

Section A:
- Pathways to Facilitate Change: Regional Social and Health Networks
- Governance: Transitional Structures

Section B:
- Social Determinants of Health Implementation Recommendations
- Governance Implementation Recommendations

4. Social Determinants of Health: Poverty Reduction

Introduction

The health, health outcomes, and health equity of the people of our province are not as good as the health of people elsewhere in Canada. Social, economic, and environmental factors influence 60% of the health of populations. If we are to make any improvements in health in Newfoundland and Labrador, we must act on the factors which we can influence including poverty levels, food security, housing security, climate change, social inclusion, early childhood development and care, and ageism. In this summary, we address the first three factors all of which are related to poverty reduction.

Rationale

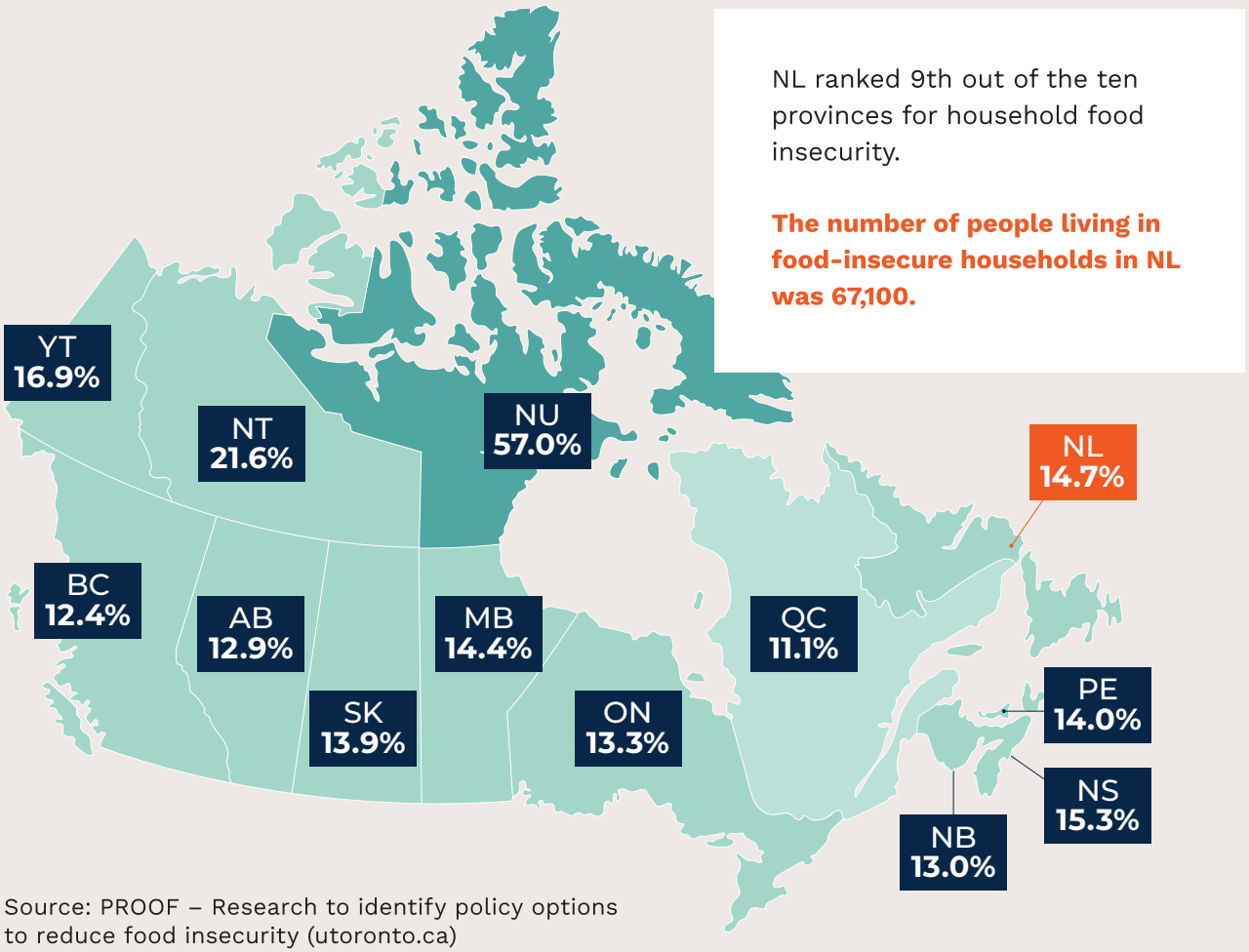
Poverty is the most important factor linked to adverse health outcomes and health inequity. At high risk of poverty are under-served populations, including Indigenous persons, individuals with disabilities, individuals with mental illness, single parent families, and seniors. Poverty is expensive, robs people of dignity, prevents people from having their basic needs met, and hurts us all.

Poverty has profound cumulative effects throughout a person's lifespan. Extreme poverty impacts how the body and mind develop and alters the fundamental architecture of the brain. Children who experience poverty have an increased likelihood of chronic illnesses and a shortened life expectancy. We see gaps in key aspects of learning, knowledge, and socio-emotional development, starting in infancy. Children living in poverty lag behind their peers at kindergarten entry and ultimately are more likely to drop out of school and less likely to obtain post-secondary education. They are more likely to experience food insecurity and are less likely to receive preventative medical and dental care. Children

from families living in poverty are more likely to become adults living in poverty themselves.

Unattached individuals who are not part of an economic unit have among the highest rates of poverty. Single individuals represent the greatest proportion of clients for income support, a shift from twenty years ago.

Food insecure households have poorer self-rated health, poorer mental and physical health, poorer oral health, and greater stress, and are more likely to suffer from chronic conditions such as diabetes, hypertension, and mood and anxiety disorders. Newfoundland and Labrador has the second highest rate of food insecurity among the ten provinces (Fig 7). St. John's has the highest rate of food insecurity of 34 urban regions of Canada (Fig 8).



Source: PROOF – Research to identify policy options to reduce food insecurity (utoronto.ca)

Fig 7. Household food insecurity by province and territory in Canada, 2017/18

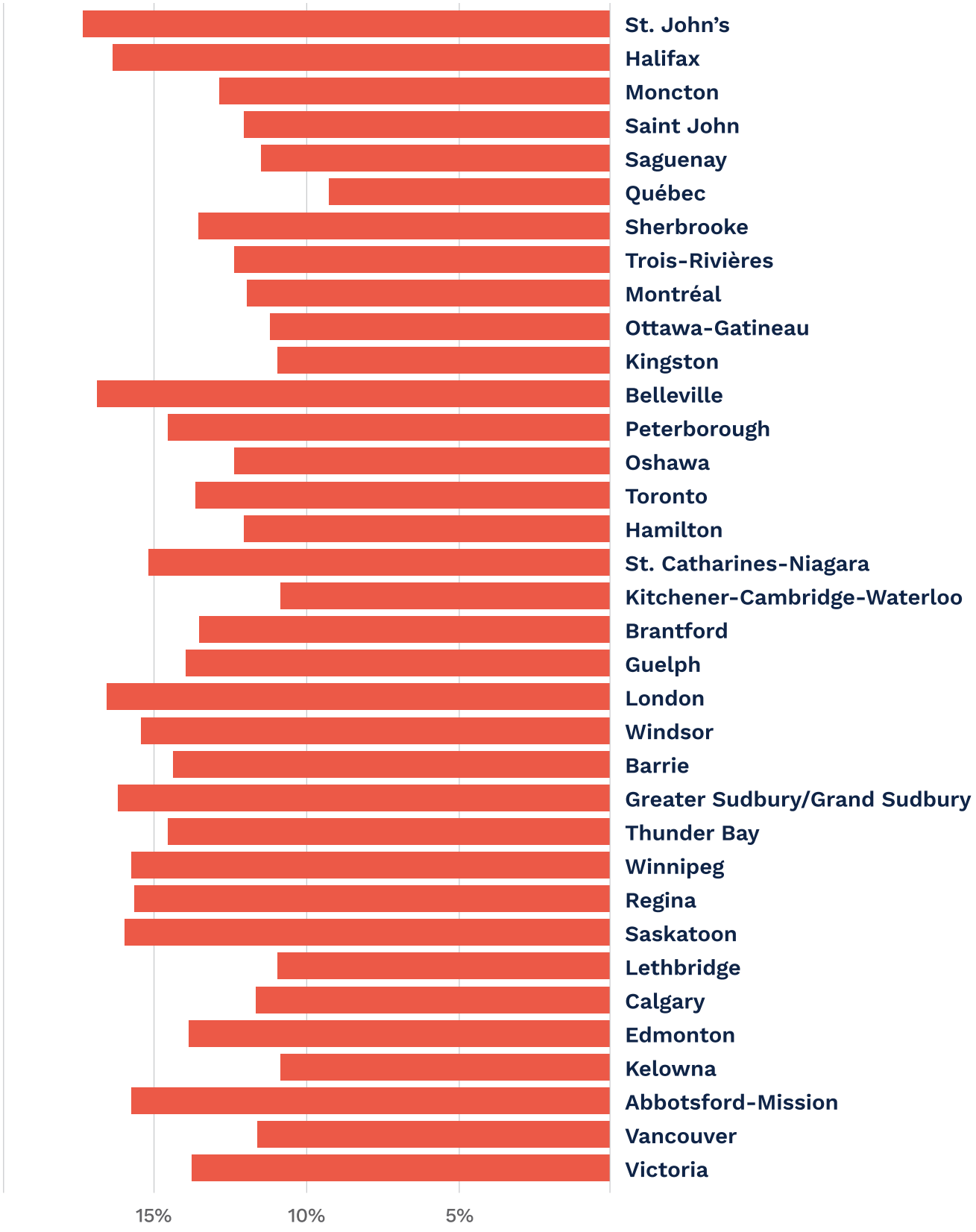


Fig 8. Prevalence of household food insecurity by census metropolitan regions in Canada, 2017/18

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

Access to housing and housing benefits is a recurring barrier preventing persons from moving out of poverty. Housing insecurity includes people who are in housing that is unaffordable, in need of major repairs, or unsuitable for the size and composition of their household. Chronic homelessness refers to people who experienced homelessness for at least six months over the past year or have recurrent experiences of homelessness over three or more years. There are long waitlists for subsidized housing and other social housing programs. Rent is becoming increasingly unaffordable. Some individuals stay in violent situations in order to remain housed. Persons who have unmet housing needs include sole caregiver families, recent immigrants, Indigenous persons living off-reserve, and older persons.

Income adequacy is more than income level. As costs go up for basics such as food, gas, or heating oil, people with little to no buffer to a decrease in the purchasing power of their income are at greater risk of food insecurity and housing insecurity. Without access to credit, savings, or assets, households have only one option which is to adjust their consumption if they experience a negative budget shock. Relief is a reactionary tactic to address budget shocks and is inadequate for lower income households that experience frequent budget pressures. A preventative strategy like basic income is needed for these households, which allows them to have “consumption insurance” comparable to access to credits, savings and assets held by higher income households.

Responsibility

Because so many aspects of our lives are affected by social, economic, and environmental factors, responsibility for intervention in poverty reduction, food security, and housing security is distributed across all areas of society: individuals, private sector businesses, community sector organizations, municipalities, the provincial government, and the federal government.

Increased efforts to make a positive difference in these three areas will require an all-of-government approach led by the Department of Children, Seniors and Social Development (CSSD) (including the Newfoundland and Labrador Housing Corporation) and the Intergovernmental Affairs Secretariat. Families with children and youth, as well as youth who have left the family home but are living in poverty, must be engaged in the development of such policies and actions.

The tax system and minimum wage levels are also factors that have an impact on income levels and on poverty. The Department of Finance has a responsibility to consider the implications as they make policy decisions related to these two areas.

Policy

Targeted areas for action to improve health include broad-based interventions and specific areas of improvement:

i. reducing poverty through providing a liveable, reliable, and predictable income for individuals and families;

ii. recognizing and addressing food insecurity and housing insecurity as health equity issues;

iii. strengthening the poverty reduction strategy through the government's newly constituted Well-Being Plan, facilitating access to income support, and reintroducing indexation of income support rates to inflation;

iv. addressing gaps relating to subsidized rates for childcare for children who do not attend regulated daycare facilities including a role for a pre-kindergarten program;

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

vi. considering other policy options such as increased minimum wage, increased low-income tax thresholds, increased earning exemptions and liquid asset limits for income support clients, and strengthening of tenants' rights through new approaches to tenant protection and rent stabilization.

The introduction of a basic liveable, reliable, and predictable income for persons living below the poverty line can be approached either as a guarantee for all or through a gradual approach, beginning with subgroups such as persons with disabilities, single parent families, and persons with chronic mental illness and eventually including all persons living in poverty.

Structure

The first steps in implementation are:

1. conducting a formal assessment of the most effective approach to achieving a basic income for all individuals and families living below the poverty line;

2. developing a more integrated, comprehensive, and strategic approach to securing and utilizing the federal funds currently provided through multiple programs.

Two specific interventions recommended for the health system are the piloting of social prescribing and the introduction of social navigators at the Community Team level.

Social prescribing is an emerging form of referral from health professionals (e.g., family physician, nurse practitioner, hospital-based practitioners) which recognizes the impact of the social determinants of health on a person's health and the importance and diversity of social care. It is a means of focusing on the person's strengths and their interests to strengthen their health and well-being. One example of social prescribing in action is a wellness program and community garden in St. John's, a partnership between the Anglican Cathedral in St. John's on whose grounds the garden is located and an Eastern Health team which focuses on people living with mental health issues and addictions.

Social navigators in Community Teams will be a resource for practitioners and patients/clients in connecting the person to a range of social and community-based supports (see Summary 23, Pathways to Facilitate Change: Social Navigators and Clinical Navigators).

Investments

An initial step related to a Guaranteed Basic Income (GBI) for Newfoundland and Labrador is the formal assessment of the most strategic and affordable approach (costs $0.05M). Either approach — the immediate inclusion of all persons and families living below the poverty line or a gradual approach focused on subgroups of families or individuals — will require federal government support. Given the population of our province, it is possible that the province could become a pilot project for a GBI, either alone or with the other Atlantic Provinces.

Several recent studies published by the Parliamentary Budget Officer of the federal government suggest that a GBI for all persons in this province living below the poverty line would be $845M annually (see Social Determinants of Health Implementation Recommendations). The impacts of this program will not be immediately seen. However, over time, the consequences of the investments on poverty for people's health and their use of health care services will emerge. This would be offset downstream by reducing a similar amount of money spent on the consequences of poverty. While the upstream investment seems a large

amount, it is worth noting that this amount is 27% of the amount presently spent for the health system budget annually.

An additional step towards poverty reduction is the indexing of income support payments. The investment for indexation has been estimated at $4.1M in year one.

The investment for programs to reduce poverty in the areas of food, housing and transportation range from $11.3M in year one, $17.7M in year two, and $17.9M in years three to ten.

Benefits

The concept of health equity means ensuring that everyone has the opportunity to be as healthy as possible. The World Health Organization defines health equity as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically.” Health inequity is socially determined, inhibiting people from making the most of their potential. Support for health equity seeks to reduce inequalities and to increase access to opportunities and living conditions conducive to health for all.

- Income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours.
- It decreases the demand for health care services through improvements in nutrition, housing, and safety.
- It improves human capital development, starting in early years, through improved school attendance, capacity to learn, intellectual and physical development.
- It reduces insufficient treatment of medical conditions that might arise due to financial barriers (e.g., delays in seeing physicians because of lost work time when there are no sick benefits, access to prescription drugs, incorrect dosing of medications to make them last longer, costly dental treatments). The personal investments (to individuals and their families) of non-treatment, delayed treatment and worsened health are significant (e.g., physical or psychological pain, stress, care burden on the family, implications for children, time off work, or an inability to engage in productive work and other activities).

Improving health equity between people in Newfoundland and Labrador and the rest of Canada and among people within the province is socially just, leads to better population health, decreases pressure on the health system, and has social and economic benefits.

Implementation

The intentional focus on interventions in poverty reduction, food security, and housing security as direct influences on health outcomes and health equity should begin immediately. This will take time to implement, but the beneficial effects will come in the long term and will last. Many programs currently funded by the federal government relate to these issues. A feasible approach to a basic income will be contingent on federal government policy and funding.

Complementary to any strategic plan for engagement with the federal government, the Health Accord endorses the continued approach to strengthening the province's poverty reduction strategy (or Well-Being Plan) and facilitating the income support process, now being undertaken by CSSD.

Cross-References

Calls to Action: 3, 8

Section A:
- Pathways to Facilitate Change: Social Navigators and Clinical Navigators

Section B:
- Social Determinants of Health Implementation Recommendations

5. Social Determinants of Health: Pathway to Inclusion

Introduction

Social exclusion refers to specific groups being denied the opportunity to participate in society because of limitations to social, cultural, and economic resources. It too often leads to a vicious cycle of discrimination, harassment, victimization, and other forms of marginalization. Socially excluded persons are more likely to be unemployed, earn lower wages, have less access to health and social services, and have fewer means of furthering their education. Evidence shows that discrimination and exclusion from any part of our society has highly detrimental effects on mental health, resulting in anxiety, sadness, depression, despair, feelings of guilt and emptiness, loss of interest, eating disorders, and chronic stress-related ailments. Excluded groups have little influence upon decisions made by governments and other institutions. They are unable to make positive contributions to the wider community, an opportunity lost for the whole society.

Rationale

Table 6 provides a list of the participants in the Health Accord's Inclusion Symposia. Health Accord NL Co-Chairs were told repeatedly that current education and training programs within and outside the health system in Newfoundland and Labrador are inadequate in addressing racism, discrimination, and bias in health care. This is true for multiple groups including Indigenous persons, older adults, persons with disabilities, 2SLGBTQIA+, migrants, persons living in poverty, incarcerated individuals, rural residents, women, youth, and Francophones.

Table 6. Participants in Health Accord NL Inclusion Symposia

- NL Housing Corporation
- NL Human Rights Commission
- NL English School District
- Provincial Advisory Council on the Status of Women
- Newfoundland And Labrador Organization of Women Entrepreneurs
- Office of Women and Gender Equality
- YWCA St. John's
- Provincial Action Network on the Status of Women
- Learning Disabilities Association of NL
- Momentum Development Support
- EmpowerNL
- Coalition of Persons with Disabilities NL
- Perinatal Mental Health Alliance
- NL Association of the Deaf
- Department of Immigration, Population Growth and Skills
- Internationalization Office – Memorial University
- Work Global Canada
- Older Workers NL
- Aging Research Centre (ARC)
- NL Association for Community Living
- St. Patrick's Mercy Home
- Newfoundland and Labrador 50+ Federation Inc.
- Salvation Army Glenbrook Lodge
- Connections for Seniors
- End Homelessness St. John's
- Newfoundland and Labrador Sexual Assault Crisis and Prevention Centre
- Royal Canadian Mounted Police
- Community Education Network and Associates
- Nunatsiavut Government
- NunatuKavut Community Council
- Flat Bay Band
- Labrador Friendship Centre
- Miawpukek First Nation
- Turnings
- Stella's Circle (Just Us Women's Centre)
- Anti-Racism Coalition of NL (ARC-NL)
- Addressing Islamophobia in NL
- Hindu Community of Newfoundland and Labrador – Hindu Temple
- Federation des Francophones de Terre-Neuve-et-Labrador
- Black Lives Matter – NL
- Quality of Care NL/NL SUPPORT
- Sharing Our Cultures Inc.
- Safe Harbour Outreach Project
- Department of Health & Community Services
- Department of Children, Seniors & Social Development
- Labrador Affairs Secretariat
- Eastern Health
- Western Health
- Labrador-Grenfell Health
- Central Health
- Seniors NL
- WelcomeNL (program by Municipalities NL)
- Community Sector Council of NL
- Easter Seals NL
- Transition House Association of Newfoundland and Labrador
- YMCA NL
- Quadrangle NL
- Retired Teachers' Association of NL
- City of St. John's Seniors' Advisory Committee
- Quality Living Alliance for Seniors (Personal Care Home Owners)
- Newfoundland Aboriginal Women's Network
- People of the Dawn Indigenous Friendship Centre

Newfoundland and Labrador has no procedures to report exclusion and no specific indicators of the extent of inequity in our health system. Indigenous peoples and other groups experiencing exclusion in health care are typically not part of health leadership and decision-making processes and have not been engaged appropriately in care delivery models. Almost every group speaking about inclusion during our public engagement sessions and stakeholder meetings echoed the same message, “Nothing about us without us” (a rallying cry which began to be used by the disability movement in the 1990s).

Responsibility

Like all social factors influencing health, social inclusion is the responsibility of all members of the society. However, government should set the direction by affirming a province-wide, zero-tolerance policy on racism and exclusion. A health system with a strong commitment to health equity should also model an inclusive environment. The recommended Regional Social and Health Networks would be mandated to lead the focus on the pathway to inclusion in the regions of the province.

The mandate for the recommended Senior Executive (Health Accord) would include responsibility for ensuring that an implementation plan is in place to create the pathway to inclusion. This work will build on existing initiatives, including The Human Rights Act (2010), The Accessibility Act (2021), the Office of the Privacy Commissioner, the Office of the Child and Youth Advocate, and the Office of the Seniors’ Advocate as well as many community sector organizations who advocate for social inclusion.

Mainstream media also play a significant role in advancing social inclusion and are invaluable partners in supporting and championing the province’s pathway to inclusion.

Policy

Government can lead the way in developing an effective inclusion lens for new and existing policies, programs, and environments with full participation of excluded groups. In doing so, it will build on existing work. Studies show that three areas are key to ensuring social inclusion:

i. Economic: levels of unemployment and poverty, income distribution, population mobility, health, life satisfaction and sense of security, and government responsiveness to issues of poverty and disadvantage.

ii. Political: levels of political participation and social involvement, including the extent of volunteerism and the development of social capital, understood in terms of networks, norms and social trust that facilitate coordination and cooperation for mutual benefit.

iii. Socio-cultural: levels of consensus and divergence on issues of local, regional, provincial, and national significance.

The health system can provide leadership in creating a culture of equity and inclusion demonstrated through the values, language, and behaviours of people working in the system and the reports of patients, clients, and residents. It can formalize and integrate across the system responsive means of engagement, knowledge collection, knowledge transfer, and participation for groups experiencing health inequities in a “meeting people where they are” approach.

Structure

Designated persons or teams responsible for health equity at local, regional, and provincial levels should be given the mandate to address issues of health inequity in meaningful ways that support an equitable Learning Health and Social System (LHSS). Each organization or facility within the health system would be directed to carry out an annual assessment of racism and exclusion with the goal of gradually but persistently building a responsive “Equity Culture” program.

Investments

There should be direct investments associated with provision of public awareness campaign materials, designated educational and awareness programs within government departments and public sector organizations, support for participation on boards and other decision-making bodies, and implementation of the Indigenous Health Framework. The estimated investments for these initiatives are $0.41M in years one and two, and $0.35M in year three to year ten.

Benefits

For any society to prosper, social inclusion is essential. It leads to economic growth that is inclusive and spread across the population, improved mental and physical health, reduced investments of health and social services, improved employment outcomes, and increased productivity in workplaces.

Implementation

The concerns expressed to the Health Accord Task Force indicate that, despite good work already underway, this explicit focus on a pathway to inclusion must begin immediately. The issue is not cost. Rather the issue is an intentional approach to creating a more inclusive society in this province with measures to assess improvement where exclusion exists. Consistent with the commitment to "Nothing about us without us," the early implementation should include affirmative action in proactively naming persons from excluded groups on Boards and councils.

Cross-References

Calls to Action: 5

Section B:
- Social Determinants of Health Implementation Recommendations
- Governance Implementation Recommendations

6. Social Determinants of Health: Health Impacts of the Climate Emergency

Introduction

A multi-disciplinary body of research-based evidence consistently indicates significant direct and indirect harms and health impacts from the global climate emergency.

Fig 9. Gender equality today for a sustainable tomorrow — the link between gender, social equity and climate change, International Women's Day, 2022

The World Health Organization has stated unequivocally that climate change is the single biggest health threat to humanity. Climate change negatively affects the social, economic, and environmental determinants of health including clean air, safe drinking water, access to nutritious food, and secure shelter as well as livelihoods, equality, and access to health care and social support structures.

Climate change is responsible for increasingly frequent and extreme weather events, such as heatwaves, storms and floods, the disruption of food systems, increases in diseases or infections that are naturally transmissible from vertebrate animals to human (e.g., HIV, Ebola virus, and the coronavirus that causes COVID-19), increases in food-borne, water-borne, and vector-borne diseases (e.g., malaria, Zika virus, and dengue), and mental health issues.

Figure 10 shows how climate change affects health in Canada. These climate-sensitive health risks are disproportionately felt by the most vulnerable and disadvantaged people, including Indigenous people, women, children, ethnic minorities, poor communities, migrants or displaced persons, older populations, and those with underlying health conditions.

Source: The 2019 Lancet Countdown on Health and Climate Change: Policy brief for Canada, Canadian Medical Association

Fig 10. Influence of climate change on health in Canada

In our province, the social and health effects of climate change are already being felt from changes in ice conditions, freeze-thaw cycles, and vector-borne disease. People in Labrador have experienced the most dramatic changes and increases to health risks.

Rationale

The effects of climate change are already being observed in Newfoundland and Labrador and are expected to increase. This is often not apparent to residents, and the desire to act has been limited. Observable provincial changes include increased permafrost melting, flooding, and damage to infrastructure, reduced sea ice, coastal erosion, threats to peat bogs as a carbon capture resource, and animal habitat changes. Climate change also has a very direct impact on food security because it impacts the availability and affordability of food. Many of these changes are more pronounced in northern and coastal areas where the accessibility of traditional land-based activities (i.e., fishing, hunting, and gathering) has already been negatively impacted.

The health care sector itself creates from 4.6% to 5.2% of greenhouse gas (GHG) emissions in Canada and represents an opportunity for dedicated action to support population health in this province. Health care pollution stems both from direct activities, such as energy-intense hospital operations, as well as from indirect activities linked to health care, such as procurement and waste management. Health care also contributes environmental hazards in the manufacture and disposal of pharmaceuticals and biohazardous products, including inhaled anesthetics that are themselves potent GHGs.

Responsibility

While the Government of Newfoundland and Labrador has one Minister and department responsible for Environment and Climate Change, the government plan takes a whole-of-government approach to tackling climate change. Actions within this plan will be led by departments and agencies across government, in

collaboration with partners. The Department of Environment and Climate Change (ECC) coordinates reporting on the outcomes of the climate action plan, with input from various departments, including the Departments of Fisheries, Forestry and Agriculture; Finance; Industry, Energy and Technology; and Transportation and Infrastructure. Given the increased awareness of health impacts of climate change, the Department of Health and Community Services (HCS) must become a more active and engaged partner in the climate change plan and action.

The health system should initiate a focused plan to reduce its environmental footprint, beginning with a clearer understanding of the environmental performance of health care. These emissions can be mitigated by actions related to renewable power sources for its many buildings, building design for new construction or renovation, travel and transportation, local and sustainably sourced food, pharmaceutical waste, waste management (including cardboard, plastics, and other materials; food, and pharmaceuticals), water and sanitation, and sustainability in procurement policies.

Policy

There is need for ongoing education on climate change, related to climate change adaptation and mitigation technologies and policies so that individuals, the private sector, communities, and the public sector have the knowledge, impetus, and support to engage in positive climate action.

Recognizing that the oil industry in this province is an important source of employment, any move to the green economy should include attention to a "Just Transition." Natural Resources Canada states that a "Just Transition involves preparing the workforce to fully participate in the low-carbon economy while minimizing the impacts of labour market transitions, identifying and supporting inclusive economic opportunities to support workers in their communities, and including workers and their communities in discussions that affect their livelihoods."

The health system should become more self-aware, taking more intentional action to reduce its environmental footprint.

Structure

We suggest that a policy position be introduced in ECC dedicated to climate impacts on health. This position would link closely with HCS in attending to ways of identifying and addressing the health impacts of climate change in our province.

Investments

The investments of the policy position in ECC, opportunities for decreasing the environmental footprint for the health system, and increased public awareness of the need for attention to mitigating climate change have been estimated at $1.9M in year one, $2.0M in year two, and $1.9M in years three to ten. There may be federal funding opportunities to support a decreased environmental footprint for provincial health care facilities.

Benefits

Attention to reducing the negative effects of climate change will be essential to ensuring the health of the generations of Newfoundlanders and Labradorians to come. Ongoing education on climate change, evolving in response to knowledge gaps, new information, and demographic changes will ensure that individuals, corporations and businesses, communities, and regions have the impetus and support to engage in positive climate action. While we are not a large partner in this global effort, we can be stewards of our ocean and wetlands in ways that will have larger positive impact than our population size would suggest. Our dependence on the ocean will be well served if we protect that ocean into the future.

Implementation

The recognition of health impacts of the climate emergency will take time to be embedded in the awareness of the people of the province. The first step is the formal link between ECC and HCS. The strategic approach to the federal government would include initiatives related to climate action, given Canada's commitment to reach ambitious targets by 2030 in line with the Paris Agreement confirmed at COP26 in Glasgow in 2021.

Cross-References

Calls to Action: 4

Section B:
- Social Determinants of Health Implementation Recommendations

7. Social Determinants of Health: Investing in Children and Youth

Introduction

The province of Newfoundland and Labrador has experienced a stark demographic shift over the past thirty years with a reduction in the number of children under the age of 15 years from approximately 200,000 to 70,000 with some areas of the province seeing over 70% decline in numbers. Children in this province also have a significantly higher level of medically complex needs than the Canadian average.

Early childhood experiences have strong immediate and longer lasting biological, psychological, and social effects upon health. Children and youth who have access to healthy food, physical activity, quality education, health care, and positive parenting tend to be healthier and better equipped for the challenges they face growing up. Adolescence can be a period of vulnerability as young people transition from the dependence of childhood to the independence of adulthood. During this time, young people take control of their health and education, enter the job market, and become independent members of society.

While there have been ongoing improvements in the support for children and youth, there are growing concerns globally that this young generation are facing an uncertain future marked by climate change, ecological degradation, migrating populations, conflict, pervasive inequalities, and predatory commercial practices, all of which threaten the health and the future of children in every country.

Rationale

The following description of a well-known longitudinal study highlights the importance of investing in children from the very beginning of their lives.

The Minnesota Longitudinal Study of Risk and Adaptation, a 45-year study of children born into poverty, offers a number of lessons for practitioners. Among these are the potency of early relationship experiences for predicting developmental outcomes and the fate of early experience following developmental change. This study describes the lawfulness of both continuity and change in development, why early experience is so powerful, why change can be difficult, and why it is nonetheless possible.

Despite what we know about the importance of early childhood development and care, the influence of the education system on the ongoing health of children and youth, and the need for particular attention to children and youth at risk, there are concerns which must be addressed if we are to ensure the ongoing health of children and youth.

In the Health Accord's engagement with young people, they expressed concerns about mental health and stress with long waiting lists for care, drug use and addictions among increasingly younger children, wait lists for diagnosis and services for children with Attention Deficit Hyperactivity Disorder (ADHD), lack of support and encouragement for physical activity and a healthy diet in the school setting, poverty and economic security for their families, and the need to ensure that they have a voice in all the decisions which have an impact on their lives.

Without the supports needed in childhood and youth, the consequences are not only experienced by the child but become intergenerational. Every consequence of growing up in poverty acts as another barrier for someone to rise above the poverty line. Children from families living in poverty are more likely to become adults themselves living in poverty — the sad consequences of intergenerational poverty. Intergenerational trauma is trauma passed down through generations. If an experience is overwhelming, unresolved, or significantly impacts one's life, it can be transmitted to one's children and then their children for generations. Because the human brain develops in direct response to the environment, the emotional responses of the parent will affect the developing brains of their offspring.

The consequences of intergenerational poverty include birth and developmental issues, food insecurity, unsafe living conditions, and increased risk of violence, incarceration, and victimization.

Interdisciplinary health care for children in care is limited. The existing Children and Youth in Alternate Care (CAYAC) Clinic in Eastern Health is a multi-disciplinary, multi-agency clinic that provides health services for children in alternate care whose health needs are high but are often under-recognized and neglected. This clinic cannot meet all the needs even within the Eastern region. This type of clinic does not currently exist in other regions of the province. Newfoundland and Labrador has 1,500 children and youth, at any one time, who need protective intervention and require an out of home placement. Children in care have higher medical, emotional, developmental, and educational needs.

Responsibility

Responsibility for the care, protection, and education of children and youth is held jointly by the Departments of Education, Health and Community Services, and Children, Seniors and Social Development. There is a whole-of-province responsibility as well in the care for children expressed in the well-known proverb, “It takes a village to raise a child.”

The Department of Children Seniors and Social Development is responsible for children in care. The Department of Health and Community Services and Regional Health Authorities (RHAs) have a responsibility for health programs for children in care. CAYAC Clinics will require collaboration between the Janeway Hospital and Community Teams.

Policy

Five focuses for action were highlighted in the broader engagement with the public:

i. Strengthened implementation of childhood health and education policy direction and programs accessible to all children and provided by public health nurses in conjunction with their provision of the Healthy Beginnings Program.

ii. Implementation of health promoting programs in schools throughout the province linked with support for a Health Promoting School approach (Healthy Students, Healthy Schools) based on the Comprehensive School Health (CSH) Framework.

iii. Greater integration between the school system and the health system, particularly for children with complex health needs.

iv. Stronger interprofessional team support for children and youth at risk (those who live outside their homes for their protection and safety and those with medically complex needs). The health and social vulnerability of children in care threatens to have lifetime consequences unless intervention occurs in childhood. Children with disabilities require early intervention in life to reduce lifelong impacts.

v. Focused attention on basic income, housing security, and food security to reduce poverty for families in the province.

Fig 11. Areas of focus for investment in children and youth

These policies and actions are most effective for and targeted toward those families with greater poverty: single parent households, households with more than three children, new immigrants, Indigenous children, and children up to age two. Public health nurses currently have contact with over 98% of families with children under five years of age because they provide childhood immunizations

and assessment under the Healthy Beginnings Program. Through provincial review of standards and further enhancement of the Public Health role, there are more opportunities for early intervention in the years prior to school attendance, helping avoid situations which may lead to children needing to be taken from their homes for their protection.

In all these endeavours, it will be important to engage families with children and youth in the development of policies and actions. Youth who have left the family home and are experiencing health concerns or poverty must also have a voice in the development of these policies and programs.

The recent federal-provincial agreement on subsidized rates for children attending regulated daycare facilities has the potential to strengthen childcare in the province and to extend the pre-kindergarten program. However, there are gaps which must be addressed relating to subsidized rates for children attending unregulated daycare facilities (the majority of facilities providing this service in the province) and for children living in small or remote communities.

Given the learnings from other longitudinal studies (see above for the Minnesota Longitudinal Study of Risk and Adaptation), the initiation of and commitment to a longitudinal cohort study in this province (starting with newborns) to examine health outcomes over time would inform more specific policy direction related to the children of Newfoundland and Labrador.

Structure

The action related to a basic, predictable, liveable income for families and individuals has been described in Summary 4, Social Determinants of Health: Poverty Reduction. A renewed governance structure for Healthy Students Healthy Schools will facilitate the use of the CSH Framework in schools (Fig 12).

For children with complex health needs, one province-wide model of Child and Youth Community Health (CYCH) Services (including families) is needed with central intake and access and a streamlined organizational structure. We strongly support the implementation of the recommendations set out in the December 2021 report by the Office of the Child and Youth Advocate entitled, “A Special Kind of Care” related to children in care with complex health needs or disabilities.

An interprofessional province-wide program, modeled on the CAYAC Clinic, will provide health support to children and youth in care. The CAYAC Clinic in

Eastern Health needs expansion to serve all children requiring service in Eastern and extension to Central, Western and Labrador-Grenfell with linkages to Community Teams.

Fig 12. Comprehensive School Health Framework

Investments

The combination of investments includes:

i. implementation of the comprehensive school health program (includes public health nurses in schools for five years) — year 1, $0.25M; and $0.5M annually thereafter;

ii. provision of provincial funding to increase the number of childcare providers licensed in the province — $2M annually;

iii. implementation of interprofessional province-wide programs to provide health support to children and youth in care, modeled on the CAYAC Clinic — year 1, $0.9M; and $1.8M annually thereafter (expansion at Eastern Health will be $0.5M with $1.3M to expand to each of the other three regions);

iv. inclusion of the voices of youth living in poverty, who have left the family home, in any policy and program development and new services targeted toward and effective for this population — participatory investments of $0.05M annually for five years;

v. investments related to the longitudinal cohort study — $0.2M annually.

These investments total up to $3.4M for year one as positions could not be in place until Oct 2022, $4.6M for years two to five, and $4.1M annually thereafter.

The investments related to basic liveable income are included in Summary 4, Social Determinants of Health: Poverty Reduction.

Benefits

The benefits of having children begin life with strong support, development, and care are evident. In the words of the World Health Organization, “Successful societies invest in their children and protect their rights, as is evident from countries that have done well on health and economic measures over the past few decades. Just as good health and nutrition in the prenatal period and early years lay the foundation for a healthy life course, the learning and social skills we acquire at a young age provide the basis for later development and support a strong national polity and economy.”

Implementation

The steps should begin immediately to attend to the issues relating to universal access to early childhood education (with priority given to children in under-served families), and integration between the health system, the education system and CSSD programs for children who enter school with health needs or who develop health problems during their school years.

The planning and initiation of CAYAC Clinics should include the expansion of the Eastern Health clinic to serve all children in care in that region and the establishment of similar clinics in Central, Western and Labrador-Grenfell Health with one provincial intake and linkages to Community Teams in the respective regions.

It is recommended that there be an immediate and more intensive approach to extending the Healthy Students Healthy Schools Program to all schools in the province with its focus on healthy eating, increased physical activity, support for social, emotional, and mental health, and the development of a more responsive health curriculum.

Health Accord NL recommends the initiation of a longitudinal study related to health outcomes with the first cohort being with children born in the province in the first year of implementation.

Cross-References

Calls to Action: 6, 7, 8

Section A:
- Social Determinants of Health: Poverty Reduction

Section B:
- Social Determinants of Health Implementation Recommendations

8. Social Determinants of Health: Better Health in Older Persons

Introduction

There has been a rapid increase in the number of seniors over the past fifty years in the province. In 2020, there were 116,228 Newfoundlanders and Labradorians 65 years or older, representing 22.3% of the population. In 2021, this proportion was estimated to be 23.6%. This number will continue to increase as more “baby boomers” come into this age group. The province as a whole and our health system have not adapted well to the increased numbers or to the increased percentage of the population who are elderly.

The impact of ageism (the stereotyping, prejudice and discrimination towards people on the basis of age) was a commonly discussed concern among individuals and groups speaking on behalf of the province’s older population during the Health Accord process (Fig 13). There were far too many stories of older people having decisions made for them, being forced into care options that were not their choice, being separated from loved ones, being indirectly forced to give up work before they were ready, and experiencing discrimination, social isolation, and belittling remarks. The ability to “Age in Place” was perhaps the most common request heard throughout engagement sessions.

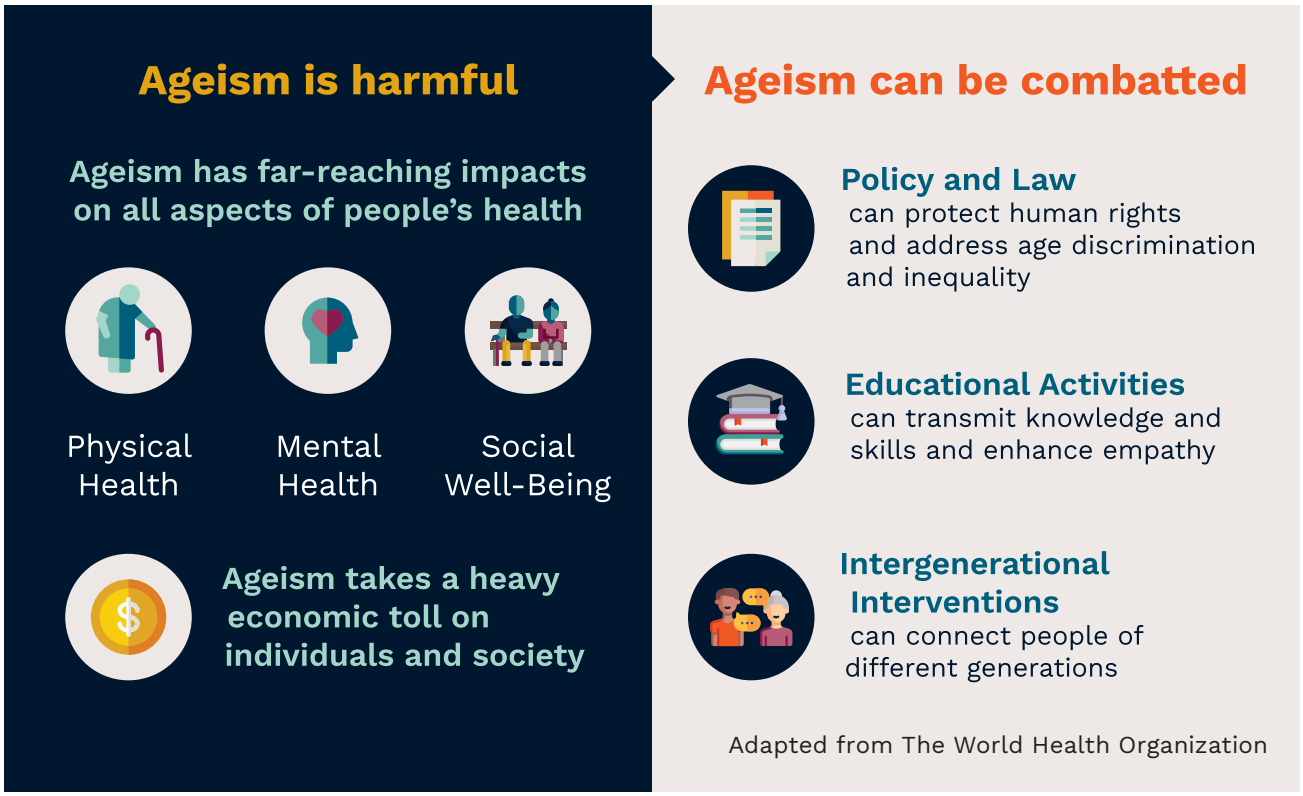


Fig 13. The impact of and needed response to ageism

Rationale

Five strategic objectives have been identified by the World Health Organization Global Strategy on Ageing and Health to end ageism:

i. commitment to action on healthy ageing in every country;

ii. developing age-friendly environments;

iii. aligning health systems to the needs of older populations;

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

v. improving measurement, monitoring, and research on healthy ageing.

Important in the achievement of these objectives will be the need to address eight domains that truly define an age-friendly community: outdoor spaces and buildings, transportation, housing, social participation, respect and social

inclusion, civic participation and employment, communication and information, and community support and health services.

Creating more age-friendly communities will enable more seniors to age in their homes or at the community level. They will receive more equitable services that are without bias or discrimination. Age-friendly communities will also benefit from the increased contributions of seniors who, throughout the Accord process, have demonstrated their ability and willingness to give back to their communities. Finally, as more seniors age in their communities, there will be less demand on health and supportive-living services, a factor that will be necessary as the province responds to the growth of the seniors' population over the next five-to-ten years.

It is noted that Newfoundland and Labrador is one of the few provinces without legislation specific to long-term care or care of the elderly. A modern legislative framework (Act and Regulations) is also needed for home care, supportive housing for seniors, personal care homes, and long-term care facilities.

Responsibility

Improving the health status of older persons in our province requires the commitment of many people across and throughout the health and social system, and successful partnerships with communities, community organizations, and Indigenous governments.

Government departments critical in leadership related to ageism and age-friendly communities are Children, Seniors and Social Development (through their Seniors and Aging Division), Newfoundland and Labrador Housing Corporation, Municipal and Provincial Affairs, and Health and Community Services.

Policy

There are three areas in which policy must be developed:

i. a formal Provincial Frail Elderly Program within the health system (see Summary 14, A Rebalanced Health System: A Provincial Frail Elderly Program);

ii. an integrated continuum of care;

iii. steps to end ageism and build age-friendly communities.

The continuum of care for older adults is an approach that considers the main social and health supports needed as people age. It is based on a person-centered and family-centered care philosophy. It is an approach focused on wellness and on building and maintaining people's physical and mental function and capacity. The continuum starts with self-care and considers the impacts of the social determinants of health (SDH) of the person in the home and the community.

Figure 14 shows the elements of this continuum. They are:

1. In the community: expansion of home support, a defined Home First policy approach to care using a staged implementation approach with priority on seniors assessed as having higher rehabilitation potential, and the availability of longer-term residential options.

2. In the health system: broad-based Community Teams; rehabilitation, restorative, respite, and end-of-life care options; certified senior-friendly emergency departments; early acute care discharge planning; interprofessional teams in long-term care facilities; and integrated health information systems. Within the health system, there is need for the nurturing of a non-ageist culture of caring through promotion, policy, education, communication, and inclusion (through a seniors' lens).

There is need to broaden vaccination, pharmaceutical, dental, vision, and foot care coverage for older adults. Greater attention must be paid by individuals, families, and care providers (including those in Community Teams) to the discussion and of completion of Advance Health Care Directives early in the health care process.

To end ageism and to build age-friendly communities, the first steps are:

i. acknowledge that ageism exists;

ii. provide education about the stereotype, including education at the early school age level;

iii. ensure the knowledge is translated into action at individual, community, regional, and provincial levels.

The Age-Friendly Newfoundland and Labrador Communities Program assists communities in Newfoundland and Labrador to support changing demographics by developing and implementing policies and plans, undertaking projects that

Health & Aging in the "Right" Place

The Continuum of Residential Options

At Home
Self-Care

At Home With Support
of family and/ or community caregivers

Congregate Living
Such as seniors' housing, personal care homes, or specialized group homes

Living in Person-Centered Care Facility
Such as long-term care

Hospice or End-of-Life Care
Such as home hospice, palliative care

Strong Links to Community

Interaction With Health Care

Fig. 14 Continuum of care for older persons

enable residents to age in place, and facilitating the creation of age-friendly communities. Communities like Clarenville and St. John's have shown this is quite possible by working together with available community resources. Additional supports and resources are necessary for the expansion of this program throughout the province. Education is required for community leaders and planners on how to integrate age-friendly and universal design principles into existing planning mechanisms and tools.

The application of universal design principles will assist in developing age-friendly communities, engaging government departments, municipalities, and the private sector in ensuring the needs and potential limitations of older persons are taken into account when designing buildings, walkways, transportation systems and other aspects of the built environment.

Advocacy, education, and support are needed to give community sector groups, volunteers, and private businesses the understanding and tools they need to become more engaged in creating and supporting age-friendly communities. An age-friendly public media campaign with specific focus on awareness and prevention of ageism, the benefit of age-friendly communities, and the significant social and economic contribution of seniors will strengthen the whole-of-province support for this needed culture shift.

The right legislative, regulatory, and policy structure is needed to ensure consistent and standardized action and accountability mechanisms necessary to keep moving forward. This will mean the development of new legislation to enshrine the rights of older adults and establish an accountability structure for an integrated, transparent, and coordinated approach to quality care. It will require an additional legislative framework (Act and Regulations) for home care, supportive housing for seniors, personal care homes and long-term care facilities.

Structure

In addition to the introduction of legislation to enshrine the rights of older adults, it is recommended that there be a new approach to integration of the role of the many departments within government whose policies and programs have an influence on the health of older persons. Such an approach may be a Seniors' Secretariat or an entity with a similar function. This new approach would be jointly developed by the Department of Children, Seniors and Social Development (through their Seniors and Aging Division), the Department of Health and Community Services, and the Office of the Seniors' Advocate in consultation with the Senior Executive (Health Accord).

Among its responsibilities would be advocacy for implementation of the Provincial Frail Elderly Program and partnerships with various groups for the identification of residential options for seniors in both urban and rural areas, increased government investment and support for age-friendly communities (Municipal and Provincial Affairs and Newfoundland and Labrador Housing Corporation), establishment of targeted development programs for volunteers who support older people in their communities (municipalities and community-based groups), and incorporation of local businesses into age-friendly planning at the community level.

Given the extent of cultural change required to create and sustain an age-friendly society in our province, it is recommended that an annual Seniors' Summit be established to bring together partners to share accomplishments, monitor Health Accord implementation, and identify ongoing challenges related to the well-being of seniors in the province

Investments

Table 7 provides the investments required to implement the steps identified above and includes investments for the Provincial Frail Elderly Program described in Summary 14, A Rebalanced Health System: A Provincial Frail Elderly Program.

Table 7. Annual new investments to support better health in older people (in Millions), in today's dollars

Year One	Year Two	Year Three	Year Four	Year Five	Year Six	Year Seven	Year Eight	Year Nine	Year Ten
$3.2M	$7.3M	$10.4M	$11.0M	$11.5M	$11.3M	$11.7M	$12.0M	$12.4M	$12.7M

Benefits

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

Implementation

The move to ending ageism, creating age-friendly communities, and strengthening the continuum of care for older persons has already begun in this province. To make that move more focused and more effective, the steps identified in Section B, Aging Population Implementation Recommendations should begin immediately since they will take time to implement. Attention should be given to the development of the needed legislation, the setting up of a structure within government to better link the efforts across government departments, and the challenge to the health system to become more accountable for senior-friendly services and frail elderly programs, including emergency services and Centres of Excellence on Aging in hospitals and in Community Teams.

Cross-References

Calls to Action: 9, 10, 11, 12

Section A:
- A Rebalanced Health System: A Provincial Frail Elderly Program

Section B:
- Social Determinants of Health Implementation Recommendations
- Aging Population Implementation Recommendations

9. Social Determinants of Health: An Integrated Approach to Wellness and Disease Prevention

Introduction

The proportion of deaths from non-communicable diseases continues to increase globally — 74% of total deaths in 2019 (Fig 15).

Unhealthy lifestyles can cause, contribute to, or exacerbate major illness such as cardiovascular disease, cancer, chronic kidney disease, chronic obstructive lung disease (COPD) and mental illness. Lifestyle risk factors which contribute to adverse health outcomes include smoking, excess alcohol use, drug and other addictions, unhealthy diet, sedentary lifestyle, and mental stress. The rates of unhealthy lifestyles in Newfoundland and Labrador, relative to the other Canadian provinces, are high (Table 8).

The reduction of adverse lifestyle factors and the embrace of healthier living are complex goals and impacted by many factors, some not necessarily within the control of the individual. Lifestyles are affected by the social determinants of health including socioeconomic status and level of education, family and social networks, gender, age, interpersonal influences, and characteristics of the community in which one lives.

Regional Health Authority surveys of people in Newfoundland and Labrador report recognition of the importance of these factors in their own lives, but they are not optimistic about personal improvement because of the expense of intervention, lack of resources in their region, or sufficient will power to change their behaviour.

Each year, an average of **36.2 million people die of non-communicable diseases** (NCDs), equivalent to 68 percent of global deaths.

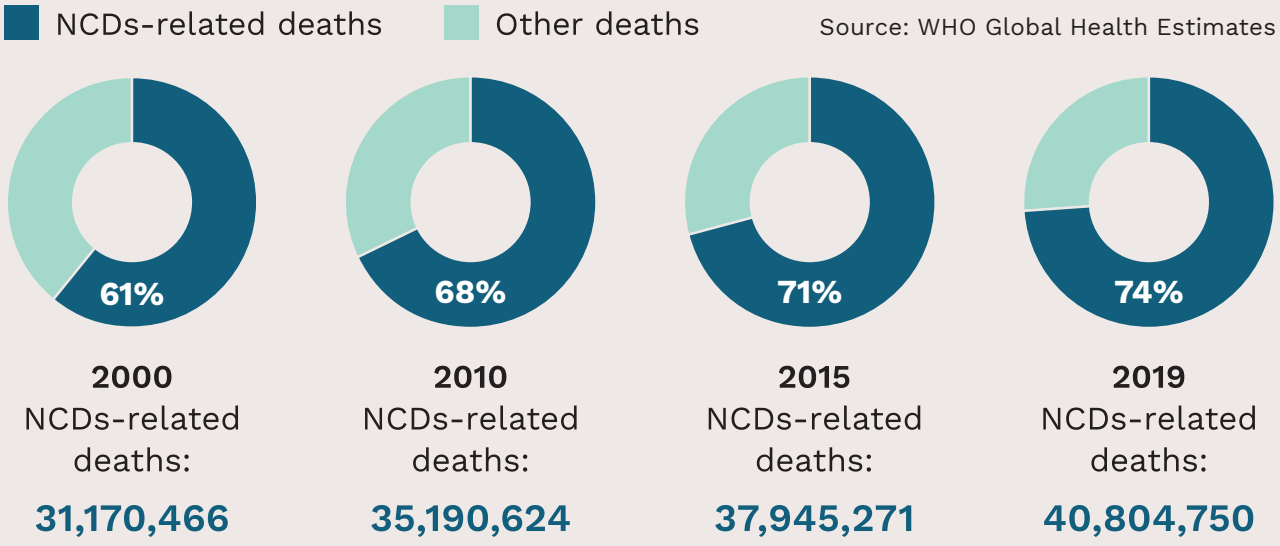


Fig 15. Percent of deaths globally from non-communicable diseases (NCDs) from 2000 to 2019

Table 8. Social determinants of health and lifestyle factors in Newfoundland and Labrador compared to Canada, with ranking among the 10 provinces for 2017/18

		CAN	NL	NL Rank
Employment	Unemployment rate	6.0%	14.8%	10
Income	Living on low income	8.7%	9.7%	9
Education	Post-secondary education	58%	49%	9
Family	Children living in lone-parent family	19.2%	23.2%	8
Healthy Eating	Fruit consumption at least once per day	66.5%	56.3%	10
	Vegetable consumption at least once per day	55.9%	34.1%	10

Continued on next page

		CAN	NL	NL Rank
Physical Activity	Adults (age 18+): 150 minutes per week	56.0%	49.4%	10
	Youth (age 12–17): 60 minutes per day	57.8%	51.0%	9
Obesity in Adults	Reported obesity in adults (% BMI > 30)	19.8%	29.8%	10
Alcohol Use	Heavy drinker	19.3%	26.7%	10
Current Smoker	Daily	11.3%	16.7%	10
Breastfeeding	Exclusive, at least 6 months	34.5%	20.6%	10
Stress	Most days quite a bit or extremely stressful	21.4%	14.9%	1
Belonging	Somewhat or very strong sense of belonging	68.9%	77.8%	1

Rationale

Social and economic conditions strongly influence these individual lifestyle factors, e.g., inability to eat healthy food because it is unaffordable, reduction in suicide rates associated with consistent income support during the COVID-19 pandemic, and limited community infrastructure available for exercise during the winter.

The educational system has a constructive role to play in educating school children regarding healthy lifestyles, illness prevention, and enhancing wellness of the population. It can provide timely support, care, and education on coping techniques to relieve anxiety, stress, and mental health issues in school children, healthy eating education and eating options in the school setting, opportunities for exercise, and participation in sports. Opening all of the province's 250+ school gym facilities after hours for community or rental use will provide an indoor space for activities in many communities in this province.

In the health system, Community Teams will provide individual-, family- and group-focused lifestyle improvement and prevention interventions, with linkages to private providers and community groups whose expertise is in the wellness area. Communities and municipalities can influence health and well-being through exercise and age-friendly communities inclusive of effective

programming. Increased rates of walking and cycling can be promoted through municipal planning, design, and active transportation infrastructure.

Wellness Coalitions organized by the Regional Health Authorities (RHAs) have had broad community reach, despite a small budget of $0.5M. Novel health promotion activities to support people with addictions have been provided in Eastern Health including forms of social prescribing. Lessons can be learned from the Great Northern Peninsula Community Place Program, its vision for community care and for aging, and its multi-sectoral strategy. Developing and implementing wellness programs in rural communities is exemplified by the efforts of the Wellness Centre and Foundation in Bonavista.

Responsibility

Prevention of disease through action on lifestyle factors is the responsibility of all engaged in improving health in the province, including but not limited to: the provincial government, RHAs, private health providers, the education system, the child protection system, municipalities, the community sector, the justice system, the family, and the individual.

Policy

The linkage of poverty and food security to adverse lifestyle factors and poor health outcomes supports action in these areas. Policies on enhancing the potential beneficial role of the educational system are necessary. Use of schools for community programming and investment in community infrastructure to support exercise and social interventions will be helpful. Innovation in approaches by Community Teams and RHAs, and linkages with private providers and community organizations in wellness and prevention are indicated.

Structure

For poverty interventions see Summary 4, Social Determinants of Health: Poverty Reduction. Schools will deliver education-specific wellness interventions. Community Teams will have a major role to play in health promotion and prevention. The integration of private providers who work in the wellness industry will need

innovative linkages with Community Teams. The Wellness Coalitions of the RHAs and community groups linked to wellness will be strengthened. Exercise-friendly and age-friendly communities will be a focus together with improvements in local food production. Regional Social and Health Networks (RSHNs) will be critical in focusing social programs, education, health, municipalities, and communities on improving lifestyle factors in a region. Field catalysts will facilitate the ability of community groups to engage in the RSHNs.

Investments

The required investment for reduction of poverty is provided in Summary 4, Social Determinants of Health: Poverty Reduction. The education initiatives will be part of the Department of Education budget. Community Team endeavours will be included in their budgets. The budget for Wellness Coalitions is small and should be increased. Strengthening of community groups in wellness and prevention is addressed in Summary 19, Pathways to Facilitate Change: Impact of the Community Sector. Community efforts on wellness will be developed by communities. The investments to develop RSHNs and hire field catalysts are included in Summary 18, Pathways to Facilitate Change: Regional Social and Health Networks. Funds from the sugar sweetened beverage taxes should be allocated to initiatives related to food security and healthy eating. A ‘health-in-all-policies’ approach across the spectrum of employers with a focus on wellness will not require a great deal of money but will induce culture change.

Benefits

Improvement in rates of smoking, excess alcohol use, addictions, obesity, unhealthy eating, and mental stress will reduce the incidence of non-communicable diseases, improve overall health outcomes, and life expectancy. These changes will take time, particularly for lifestyle factors that are intergenerational.

Implementation

A multi-faceted, coordinated, effort across multiple sectors and communities, using a ‘health-in-all-policies’ approach and establishing RSHNs, should start immediately. The effort needs perseverance and consistency into the future.

Cross-References

Calls to Action: 3, 6, 8, 15, 50

Section A:

- Social Determinants of Health: Poverty Reduction
- Pathways to Facilitate Change: Impact of the Community Sector
- Pathways to Facilitate Change: Regional Social and Health Networks

Section B:

- Social Determinants of Health Implementation Recommendations
- Community Care Implementation Recommendations
- Governance Implementation Recommendations

What can we do to ensure that Darla has the best foundation for a good life?

III. A Rebalanced Health System

The major components of the health system are mental health services, community care, emergency services, acute care hospitals, and long-term care.

A Summaries of Implementation Recommendations for the Major Calls to Action

10. A Rebalanced Health System: An Integrated Approach to Mental Health and Addictions

Introduction

A special dimension of the compelling case for transformation of health and the health system in Newfoundland and Labrador is that of mental health. Throughout the Health Accord NL Report, "health" is an inclusive term, understood in accordance with the World Health Organization definition as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Physical health and mental health are included within this definition. In the words of the US Surgeon General, David Satcher, "There is no health without mental health."

Concerns about mental health were raised consistently in our engagement with the public through five series of town halls, through special symposiums including one with high school students, and through conversations with many organizations around the concept of inclusion. Mental health was consistently identified among their greatest health concerns, sometimes paired with addictions.

There is a national public health overdose crisis across Canada with people who use substances, such as opioids, cocaine, and methamphetamine, experiencing higher rates of fatal overdoses and other harms. According to the Public Health Agency of Canada, the vast majority of opioid-related deaths continue to be accidental, and more than half also involved the use of a stimulant (e.g., cocaine, methamphetamine), underscoring the polysubstance nature of the overdose crisis. While the numbers of deaths and hospitalizations related to opioid addition for Newfoundland have not increased dramatically, there is evidence from organizations which provide programs for persons experiencing substance use harm that the numbers are growing. We now know

that there is a direct relationship between mental health and addictions which is further nuanced by the social determinants of health (SDH) such as poverty and early childhood development, requiring strong linkages with other sectors such as justice, family and children services, social services, and education.

In his mandate letter to the federal Minister of Health in December 2021, Prime Minister Trudeau included the following direction: "establish a permanent, ongoing Canada Mental Health Transfer, to help expand the delivery of high-quality, accessible and free mental health services, including for prevention and treatment."

Rationale

Health Accord NL did not include an in-depth exploration of mental health and addictions in the province because of an intensive study begun in 2015 and completed in 2017 by an All-Party Committee of Government (Fig 16). That All-Party Committee conducted a full review of the provincial mental health and addictions system to identify gaps in services and areas for improvement. The Committee heard from people throughout Newfoundland and Labrador who have experienced mental illness and addictions, their loved ones, advocates, community agencies, Indigenous communities, Regional Health Authorities (RHAs), health care providers, and the public.

Fig 16. Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador

In March 2017, the All-Party Committee on Mental Health and Addictions released *Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador*. The report outlined 54 recommendations that address service gaps and support what is currently working well in the mental health and addictions system in the province. On June 30, 2017, government released *Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador* and committed to immediately responding to all the recommendations. Public health interventions like naloxone access and training, supervised consumption sites and safer supply programs, as well as evidence-based treatments, like opioid agonist therapy (all invaluable in preventing overdose deaths and reducing harms experienced by people who use substances) have been integrated in this *Action Plan*. In January 2022, the Minster of Health and Community Services (HCS) confirmed that all the recommendations of the Action Plan would be implemented by March 2022.

Given that this work was begun five years ago and that government now deems *Towards Recovery* to have been implemented, it will be important to assess not only the process and outputs but the outcomes of the implementation of the recommendations. The ongoing planning and work related to mental health and addictions must be integrated with Health Accord NL and become an essential element in the implementation of the Community Teams envisioned by the Health Accord. The approach at the heart of the Health Accord Calls to Action provides the opportunity to truly integrate mental health and addiction services across the spectrum and, in particular, within the Community Teams, inclusive of promotion and prevention.

It has been established that people with mental health and substance use problems frequently seek hospital-based services, including emergency services. Mental health and substance use are often associated with other life challenges such chronic health problems. It is also important to note that there are other risk factors such as the impact of trauma and adverse childhood experiences along with the broad range of SDH. It is estimated that 14% of Canadian children and youth experience mental health problems and yet fewer than 25% actually access services, leading to a need for more robust inclusion of mental health within the education system. Intimate partner violence is the most common form of violence experienced by women, highlighting the importance of mental health inclusion outside the health system. Similar statistics exist within the criminal justice system, where the vast majority of newly admitted offenders within federal correctional institutions meet the criteria for at least one mental disorder, with substance use disorders being the most prevalent.

Public health officials stress the need to respond to substance use harms by strengthening community and individual resilience through ensuring adequate and affordable housing for all, facilitating social connection in communities, supporting positive child and youth development, and addressing the stigma associated with substance use. Stigma in the healthcare sector contributes to and directly impacts substance-related harms, as people who feel judged may not seek help, or may receive inadequate care when they do seek help. Consistent with the Health Accord's belief that inclusion is integral to better health and health outcomes, key to responding to this crisis at the personal level is compassionate, comprehensive, culturally-informed, and person-centred care.

Responsibility

The Department of Health and Community Services has overall responsibility for the delivery of services related to mental health as well as the implementation of *Towards Recovery*. It delegates some of this responsibility to the Regional Health Authorities (RHAs). Under the new governance structure recommended by Health Accord NL, that delegated responsibility would be to the Board of the Provincial Health Authority (PHA) and the Regional Health Councils (RHCs). While a great deal of progress has been made in the reduction of stigma and discrimination towards those experiencing mental health and substance use problems, further work is needed. It is therefore recommended that there be representation of people with lived experience related to mental health and addictions as members of the Board of the PHA and the RHCs. A Provincial Mental Health and Addictions Advisory Council and a Recovery Council have been established for *Towards Recovery*. If one or both of these Councils remain in place, there must be a link between them and the Health Accord implementation process.

It is understood that mental health goes well beyond being just a health issue. Therefore, as with all health policy and directions, other government departments and agencies have a shared responsibility, including the Department for Children, Seniors and Social Development, the Department of Education, and the Department of Justice and Public Safety. Consideration should be given to establishing a separate department related to Mental Health and Addictions (e.g., federal government's Department of Mental Health and Addictions, Manitoba's Mental Health and Community Wellness). It should also be noted that many community sector organizations play a key role in supporting persons with mental illness and addictions.

Policy

Among the potential policy directions noted within the Health Accord Report are the following:

i. Recognition of the part mental health plays in the lives of children with complex health issues and children and youth in care and the importance of an improved integration across the health system, the education system, and CSSD programs in responding to these issues.

ii. The link between mental health and addictions and homelessness and the need to support a full range of supportive housing needs including support for a Housing First approach and increased availability of mental health supports in the community to reduce reliance on hospital beds to meet housing needs. The closure of the Waterford Hospital and the resultant decrease in bed capacity must also be taken into account in addressing supportive housing needs.

iii. The increased risk of mental health issues for non-European migrants.

iv. The lack of understanding of mental health issues for older persons.

v. The increasing mental health impact of the climate emergency globally and, most visibly today, in Labrador.

vi. Actions to address the root causes and broader conditions to help prevent substance use harms.

vii. Further research on the associations between opioid medication, pain, and mental health conditions.

viii. A stronger place for mental health and addictions in the curricula for initial and ongoing education for health professionals.

ix. Recognition of the impact of poverty and social exclusion on mental health and substance use.

Health Accord NL also endorses the proposed Canada Mental Health Transfer as one more resource for strengthening the province's response to improved mental health outcomes.

Structure

The Health Accord Report strongly supports a role for the Community Teams (which are at the heart of its vision for a rebalanced health system) in health promotion, illness prevention, and primary care for mental health. It also recommends a key role for community hospitals which are closest to the people in their communities as well as a resource responsibility for regional hospitals and the tertiary care centres.

As Community Teams begin to be implemented, this is a prime opportunity to include mental health and substance use in a meaningful way. People with mental health and addictions problems are more likely to first seek help from their primary care provider. Having expertise on these Teams and training for all staff in screening for mental health and substance use can make a substantial difference in the provision of comprehensive and inclusive services.

Investments

In 2020/21, $236.5M was spent in mental health and addictions, which represented 7.1% of total health care spending in Newfoundland and Labrador. This is up from 5.7% in 2016/17 before the launch of *Towards Recovery*. The target spending is 9%, comparable to the Canadian average.

Investments have been allocated for the implementation of *Towards Recovery*. We recommend that these investments be reviewed and integrated with investments related to the implementation of the Health Accord Calls to Action. There is a clear responsibility for all government departments to show how mental health is being addressed and funded to ensure that the integrated and innovative approach championed both by *Towards Recovery* and by Health Accord NL is inclusive of all dimensions of health including mental health and addictions.

Benefits

As promised in *Towards Recovery*, the benefits of ensuring that the policy directions mentioned above in the overall Plan would strengthen a comprehensive, evidence-based, integrated, person-centered system that provides the right care, at the right time and in the right place, implemented in collaboration between community groups, government departments, and the RHAs.

Implementation

It is the recommendation of Health Accord NL that *Towards Recovery* be integrated with the response to the Calls to Action from Health Accord NL to ensure an ongoing coordinated approach to mental health and addictions. As part of that integration, there should be an evaluation of the outcomes related to the implementation of *Towards Recovery*, with the possibility of further public consultation as part of that evaluation.

Promotion of safer opioid prescribing by providers and within health systems should be a focus of the LHSS together with more effective and equitable pain management. Within Community Teams, removal of barriers to treatment for substance use disorders should occur. Collaborations within the Regional Social and Health Networks could identify community based solutions to the substance use and overdose crisis including public safety approaches.

Cross-References

Calls to Action: 3, 4, 7, 13, 14, 17, 20, 45, 46, 49, 58

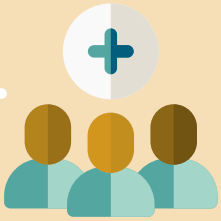
Section B:
- Social Determinants of Health Implementation Recommendations
- Community Teams Implementation Recommendations
- Education Implementation Recommendations
- Governance Implementation Recommendations

Case Study: Stroke Care for Anne and John in a Rebalanced Health System

As our population in Newfoundland and Labrador grows older, we will experience higher numbers of strokes. **How will the rebalancing of the health system as envisioned by Health Accord NL ensure that there is quality care for Anne and John when each one has a stroke?**

Early this morning, Anne seems confused. Her mouth is drooping, her arm is weak, and her voice is slurred. **Her husband Mark quickly realizes that something serious is happening and calls the provincial health line. The ambulance with an advanced care paramedic arrives quickly.** They assess Anne's condition and transport her immediately to the nearest hospital which is in Corner Brook, deciding that it would not be helpful to stop first at the local health centre.

At the Hospital, a CT scan shows that Anne has had an ischemic stroke (caused by a blood clot). **Because she arrived at the hospital within four and a half hours of the beginning of her stroke, she immediately receives the powerful clot busting treatment, tPa, which partially reverses her stroke.** The hospital in Corner Brook has a new regional stroke unit where the health team follow a treatment plan for Anne's rehabilitation and her return home. Her rehabilitation includes strengthening exercises, speech and swallow therapy, and training for balance and walking.



After two weeks at the Hospital, Anne is able to return home. **The physician from the Stroke Unit has spoken with the Community Team for Anne's area and given them good advice on how to support Anne and Mark when she comes home.** The occupational therapist on the Community Team helps Mark make some changes in the house to make things easier for Anne, and the physiotherapist recommends strengthening and exercise routine that can be completed in her home. The Community Team is available for both Anne and Mark when they have questions or concerns.

On the previous Wednesday evening, John shows some of the same symptoms that Anne had. **Because he is living alone, it takes him awhile to get to the phone and call for help. By the time the ambulance arrives and they are ready to transport him to the nearest hospital (Clarenville Hospital), six hours have passed.** A CT scan shows that John has had an ischemic stroke. It is too late to give the tPa treatment.

John is sent immediately to the Health Sciences Centre in St. John's. He receives Endovascular Therapy (EVT) which removes the clot from his carotid artery. He remains in hospital for a few days and is then transferred to the Miller Centre where he receives rehabilitative care.

Within a couple of weeks, after the team at the Miller Centre consults with the Community Team in his area, John returns home. The social worker ensures that he has home care support to help him with his recovery. It soon becomes clear that, despite all the support, John cannot continue to live alone. **The Community Team works with John to find a suitable personal care home where he is able to receive the ongoing support he needs to live a full life.**

11. A Rebalanced Health System: Community Teams

Introduction

A Community Team is an interprofessional group of providers who provide person-centered, longitudinal, comprehensive community care to all people in their region. As access to primary care and recruitment and retention of providers in the community are major concerns, the implementation of Community Teams across the province is a priority of Health Accord NL.

Rationale

The creation of Community Teams and better integration of current primary care structures are necessary to connect every person in the province to a system that provides a continuum of care in the community, coordinates care across the health and social systems, promotes health and well-being, acts on the social determinants of health (SDH), manages chronic diseases, and provides integrated care to children at risk and frail elderly persons.

Responsibility

The successful implementation of Community Teams will depend on community participation and provider collaboration, Regional Health Authority (RHA) coordination and planning, provincial policy and funding, and federal financial support in both the short term and long term. It is envisaged that within the regions, communities and providers will determine the optimal structure of their Team, with this coordination and planning overseen by the RHA. The RHA would then apply for funding from the Department of Health and Community Services (HCS).

To determine funding, HCS should use a set of predetermined criteria (such as number of unattached patients with primary care needs, overall number of providers available for the population needing service, and planning to provide required services — urgent care, care for children at risk, care for frail elderly persons, reproductive health, and sexual health) to determine funding. Programs for enhancing and augmenting existing primary care clinics and affiliating them with the broader Community Team structure will also need to be undertaken.

Policy

Community Teams will be at the center of the rebalanced health system. They will integrate current resources in the community and add additional resources as needed. The 23 current health centres will be integrated into Community Teams.

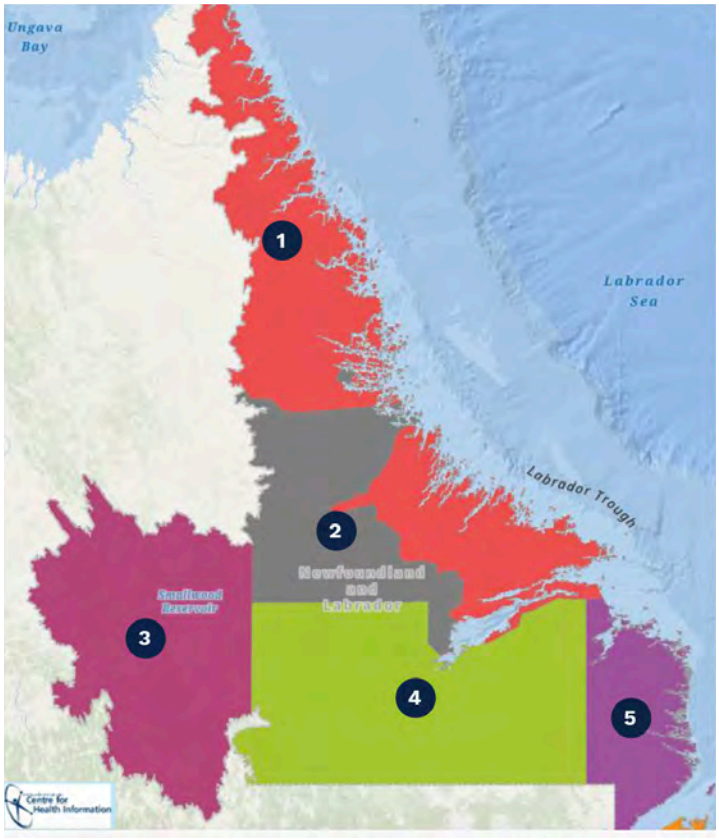
Based on the multiple criteria of policy, need, structure, cost and ability to pay, Community Teams should be created and augmented incrementally over five years. Policy should be informed by the experience of the existing primary care teams as well as the four collaborative teams announced in fall 2021 by the provincial government.

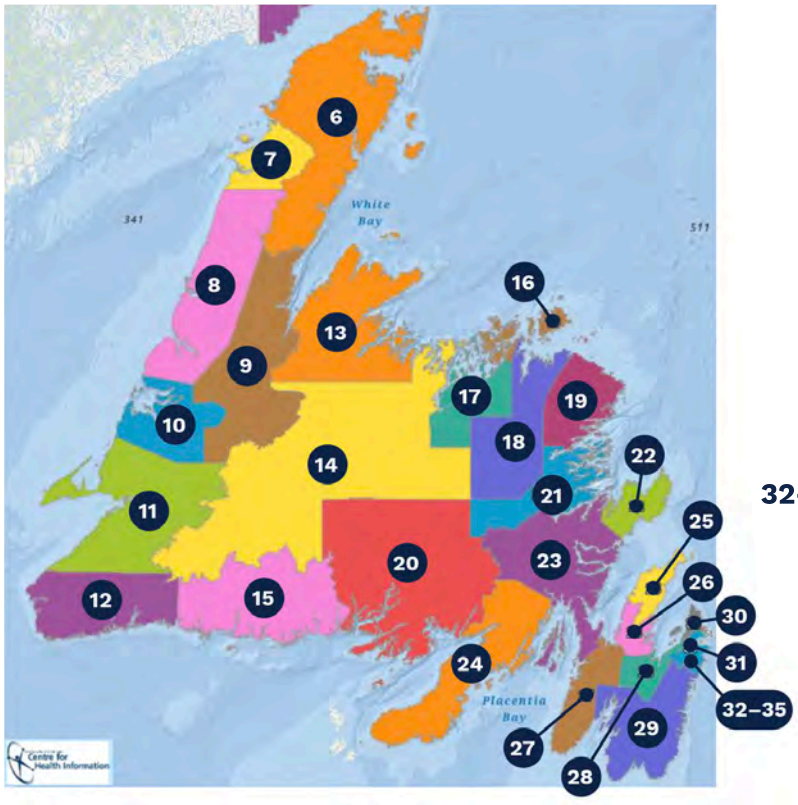
Structure

Figure 17 shows the proposed areas of the province for Community Teams. Team structure will be influenced by the local resources currently available, with the addition of new resources determined by need. As the first Community Teams are implemented, evaluation will begin to examine Team functioning and the effect of new positions such as navigators and new roles for pharmacists.

A greater focus on preventative care and chronic disease management will include programs such as *BETTER* for preventative care (an evidence-based approach to chronic disease prevention and screening, focusing on cancer, diabetes, cardiovascular disease and their associated lifestyle factors) and *Inspired* for lung disease (a program of education and support for people with COPD and their families). Funding for these programs will be part of the overall Community Team budget.

The role of the social navigators and of clinical navigators should be imbedded in the Community Team (see Summary 23, Pathways to Facilitate Change: Social Navigators and Clinical Navigators).





1 Northern Labrador
2 Innu Communities
3 Labrador West
4 Happy Valley-Goose Bay
5 South/Southeast Labrador
6 Northern Peninsula
7 Port Saunders area
8 Bonne Bay
9 Deer Lake/White Bay
10 Corner Brook – Bay of Islands
11 Bay St. George
12 Port aux Basques
13 Baie Verte/Springdale area
14 Grand Falls area
15 Burgeo
16 Fogo/Twillingate area
17 Lewisporte area
18 Gander/Gander Bay area
19 Brookfield to Centreville area
20 Harbour Breton area
21 Gambo to St. Brendan's
22 Bonavista
23 Clarenville and area
24 Burin Peninsula
25 Carbonear/Old Perlican area
26 Bay de Verde Peninsula South
27 Placentia/Whitbourne area
28 Paradise/CBS and area
29 Southern Shore
30 Portugal Cove/Torbay area
31 Mount Pearl
32–35 St. Johns metro

Fig 17. Proposed areas for Community Teams for Newfoundland and Labrador

Investments

The provincial government will determine the annual size of the fiscal envelope for new resources to be used for Community Teams. Funding will vary across Teams depending on the resources currently available, types of new resources that need to be added (e.g., family physician, nurse practitioner, nurse, physiotherapist, occupational therapist, psychologist, social worker, pharmacist, administrative support, manager, social navigator, clinical navigator), size of the catchment population, geography, infrastructure and information technology needs, and resources available from restructuring of health centres.

Capacity to pay is influenced by the contributions of the federal government (estimated at $12M per year), reallocation of funds already being spent in the health system, and the fiscal capacity of the provincial government to add new money to the system. New investments that could be made are: year one, $12M; year two, $18M ($12M plus an additional $6M); and years three to ten, $28M ($18M plus an additional $10M) annually.

Benefits

There are multiple benefits of team-based community care including:

i. improved continuity of care and enhanced timely access to primary care;

ii. improved care for persons with complex needs, including children at risk and frail elderly persons;

iii. improved health outcomes from disease prevention, chronic disease management, and action on SDH;

iv. decreased hospitalization and emergency room utilization, resulting in improved access to hospital and emergency services;

v. improved use of health care interventions;

vi. improved workplace satisfaction for providers, facilitating sustainable community care and provider retention.

Implementation

Year one: Initiate planning in all regions for Community Teams starting with those regions and communities with the highest need. Provide funds for six to eight new or augmented Teams with an estimated fiscal envelope of new funding of $12M. Negotiate affiliation agreements with family practices who will participate in the Community Teams.

Year two: Fund an additional six to eight new or augmented Teams with a further addition of $6M.

Years three to ten: The base amount already allocated by the provincial government prior to year one of the Health Accord for collaborative teams plus an accumulated amount of $28M for the new Community Teams ($6M for year one, $12M for year two, and an additional $10M for subsequent years) should be provided annually. This is with the understanding that, by year five, all thirty-five Community Teams have been established. Funding for new or augmented Teams will be based on the experience of the collaborative teams and Community Teams, the size of the fiscal envelope available for further new or augmented Teams, the efficiencies obtained by the health system, and the needs of the remaining regions.

Cross-References

Calls to Action: 9, 13, 22, 32, 35, 37, 39, 42, 45, 46, 49, 54

Section A:
- Pathways to Facilitate Change: Social Navigators and Clinical Navigators

Section B:
- Community Care Implementation Recommendations
- Hospital Services Implementation Recommendations

12. A Rebalanced Health System: Health Centres

Introduction

There are 23 health centres in Newfoundland and Labrador, which provide a mix of primary care, support for emergency response, acute care beds, long-term care beds, and laboratory and medical imaging services. Support for emergency response is provided in one medical clinic on the island and coastal clinics in Labrador.

It is the intention that, with the transformation recommended by Health Accord NL, health centres will become integrated into Community Teams and focus more on urgent same-day care rather than emergency care (e.g., strokes, heart attacks, trauma).

In considering emergency services provided at health centres, it is necessary to distinguish major emergencies from minor emergencies. A major emergency consists of an injury or illness that could potentially lead to death, disability, or permanently diminished quality of life (e.g., signs of stroke, chest pain, loss of consciousness, severe bleeding, injury to the neck or spine, persistent high fever, compound fractures, head or eye injury, deep lacerations, severe burns, or injuries with paralysis, confusion, severe bleeding, or unconsciousness). Such injury or illness requires highly trained medical professionals equipped to manage severe and life-threatening conditions. Therefore, major emergencies need to get to an emergency department as fast as possible facilitated by an integrated air and road ambulance system, advanced care paramedics, and a virtual care emergency service.

Minor injuries and illnesses are not life-threatening, but they can be painful or uncomfortable. Some examples include minor cuts, bruises, minor burns, sprains, pulled muscles, mild fractures, headaches, minor infections, prolonged cold and flu symptoms, or mild asthma attacks. They can be treated at health centres.

Rationale

There are four issues that must be addressed with respect to health centres:

i. challenges which health centres currently face;
ii. hours of operation;
iii. provision of emergency services;
iv. presence of acute care beds and long-term care beds.

Health Accord NL is not recommending the closure of any of the province's 23 health centres which are geographically well-positioned across the province. However, sustainability of service provision in health centres is presently being challenged by recruitment of providers, driven by unattractive work life balance, high levels of call, lack of support locally and provincially, and isolated geography. The recommended establishment of Community Teams will improve sustainability of the health centres since the health centres will be integrated in the broader services provided by the Community Teams.

Health centres within 60–90 minutes of a hospital, serving catchment populations of fewer than 5000–6000 people, should provide a mix of services including urgent care and response to minor emergencies, and could be open 12 hours daily. In this instance, there is not a need to respond to major emergencies because reasonable access to a hospital is already available.

Health centres which are more than 90 minutes from a hospital, in addition to providing a mix of services including urgent care, have an additional responsibility in stabilizing and facilitating the transfer of emergency patients to the nearest hospital. They could be open 24 hours daily. In these health centres, 24-hour family physician-based emergency care is difficult to sustain, particularly on islands and in regions with small catchment populations. Consequently, collaborative care models with an appropriate mix of health care providers (such as physicians, nurse practitioners and advanced care paramedics), linked to virtual care, will be necessary to stabilize the patient or transfer the patient directly to a hospital emergency department.

Occupancy of acute care beds in some health centres is less than the optimal rate of 85%, and the rate of alternate level of care is greater than the provincial rate of 20% and the Canadian rate of 15%. Consequently, alignment of the number of beds with need will be necessary over time. Acute care beds should only exist in health centres with 24-hour, seven-days a week urgent care.

Long-term care beds which are located at health centres will remain open at these centres since one of the goals of Health Accord NL is keeping long-term care as close to the community as possible.

Responsibility

Policy on integration of health centres into Community Teams and funding of Community Teams rests with the Department of Health and Community Services (HCS).

In the short term, the Regional Health Authority (RHA) should begin to align the model of urgent/same-day care and acute care beds needed in some health centres. Together with the development of and input from Community Teams, the RHA should plan how collaborative care models can deliver urgent care in more distant, isolated health centres, and transfer patients with emergencies to hospitals.

Policy

Sustainability of emergency care services in health centres is uncertain because of difficulty in recruitment of providers. The integration of health centres into Community Teams is a necessary step in addressing this sustainability challenge.

Decisions with respect to hours of operation (12 hours or 24 hours daily) will be dependent on distance from a hospital, size of the catchment population, and geography (such as island location).

Health centres have the responsibility for responding to minor emergencies. They are not staffed nor equipped to respond to major emergencies. For those health centres which are distant from a hospital, however, there is a responsibility for stabilizing and facilitating the transfer of emergency patients to the nearest hospital. Carrying out this responsibility with the challenges of maintaining family physician-based emergency care will require developing new models of collaborative care. These new models for both emergency support and urgent care comprise a mix of family physicians, nurse practitioners and advanced care paramedics, dependent on the availability and recruitment of providers. Therefore, the models may vary from centre to centre.

Alignment of acute care beds at health centres will be in accordance with availability of providers, optimal occupancy rates, and the needed reduction in alternate level of care beds. The latter is essential in ensuring appropriate levels of care for patients presently in alternate levels of care.

Long-term care beds should remain in place at health centres.

Funding reallocation from restructuring of health centres to other components of Community Teams is recommended to provide primary and urgent care in an interdisciplinary manner to the local population.

A central medical dispatch, an integrated ambulance system, a virtual emergency system, and the creation of strong Community Teams are essential elements supporting the new approach to treatment of major and minor emergencies at health centres.

Structure

Figure 18 (pg 108–109) with data provided by the provincial government, shows the hospital, health centres, long-term care facilities, medical clinics, and community health offices in the province.

Investments

Provision of new urgent/same-day care models and the repurposing of acute care beds should enable funds to be transferred to meeting local health needs using Community Teams.

Estimates of money available to transfer to Community Teams are difficult because they depend on the acceptance of collaborative urgent care models and a repurposing of beds. The following are estimates made by the finance and intergovernmental working group. Funds to reallocate from health centres to Community Teams are estimated at year one, $1.6M; at year two, $4.8M; at year three, $9.6M; and at year four and onward, $12.8M annually.

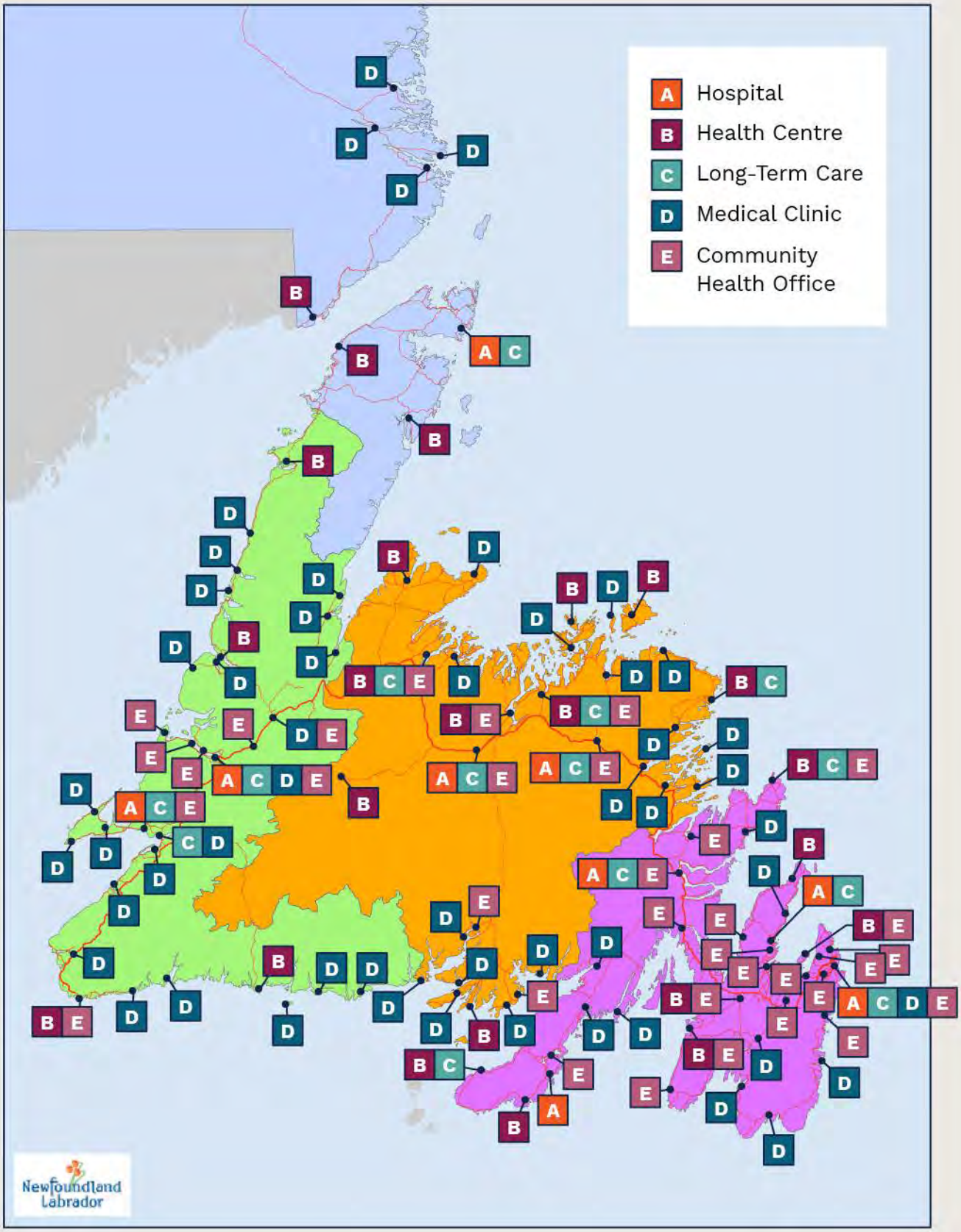


Fig 18. Health and community services provided in Newfoundland (A) and Labrador (B)

Fig 18. Health and community services provided in Newfoundland (A) and Labrador (B)

Benefits

Health centres are close to the communities which they serve and are an invaluable component of the health system.

The provision of urgent care in health centres, using different collaborative care models, should improve workplace quality and help sustainability and retention of Community Teams. The strengthening of Community Teams by reallocation of funds should have the benefits expected from Community Teams outlined previously, such as improved primary care, disease prevention, and chronic disease management. Clarity with respect to the health centres' role in support for emergency care will enable a more rapid and appropriate response to major emergencies, improving outcomes for persons with strokes, heart disease, and trauma.

Implementation

In the short term, 12-hour models of urgent/same-day care could be introduced in some health centres and one clinic, and acute care beds (if provided) repurposed in these centres. Because of current sustainability concerns, new 24-hour collaborative care models, supported by virtual emergency services, will be needed in the short term in some regions and can be planned as components of Community Teams in the medium term. Complementary but essential components of this implementation plan include ambulance system transformation with a central medical dispatch, a virtual emergency system, and the creation of strong Community Teams.

Cross-References

Calls to Action: 9, 10, 13, 14, 16, 18

Section B:
- Community Care Implementation Recommendations
- Hospital Services Implementation Recommendations

13. A Rebalanced Health System: Acute Care Hospitals

Introduction

There are 13 acute care hospitals in the province, with six serving catchment populations less than 30,000 people, four serving populations from 40,000 to 75,000, and three hospitals (Health Sciences Centre, St. Clare's, and the Janeway) in St. John's providing a mix of secondary services locally and regionally and tertiary care services provincially. The Waterford Hospital and Miller Centre are not included in this analysis. Carbonear General Hospital has a potential catchment population of 60,000 (if the Southern Shore, St. Mary's Bay, and the Placentia/Whitbourne area are included), but many of the residents in this catchment population go to St. John's for services.

See Summary 14, A Rebalanced Health System: A Provincial Frail Elderly Program, and Summary 16, A Rebalanced Health System: New Health Care Programs, for innovations recommended for acute care hospitals.

Rationale

Sustainability of current hospital services, because of difficulty in recruitment and retention of providers, is a concern, particularly in Labrador-Grenfell Health and Central Health. Recruitment and retention are influenced by having reasonable work-life balance and work rotations, collegial support both locally and provincially, an adequate volume of work to maintain skills, an attractive workplace environment, and acceptable remuneration.

The two hospitals in Central Newfoundland, serving similar sized populations of around 46,000 each, are experiencing difficulty in sustaining some specialty

services on two sites and have little bed capacity to grow. In Central Health, rotation of obstetrics services has occurred between the two sites because of insufficient providers, and recruitment for general surgery has been difficult.

Low volumes of inpatient surgeries occur in community hospitals. Table 9 shows the number of surgery stays and procedures undertaken by the hospital analyzed by surgical specialty in the seven community hospitals. The number of general surgery procedures undertaken in a year in Burin and Stephenville is low, as it is in the three geographically isolated hospitals of Labrador-Grenfell Health.

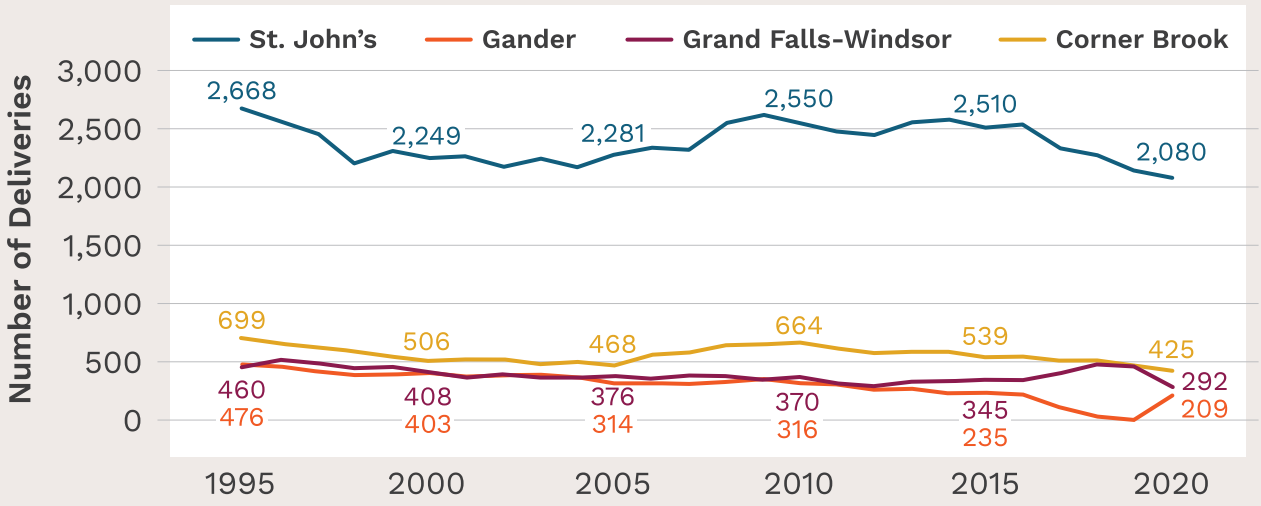
Table 9. Number of surgical stays and procedures undertaken while in hospital by surgical specialty in the seven community hospitals, 2019/20

Hospital	Surgery Stays	In Hospital Procedures	General Surgery	Gynecology
Carbonear	310	371	303	68
Clarenville	247	354	292	62
Burin	170	228	164	64
Stephenville	109	145	145	0
St. Anthony	249	322[#]	129	22
Labrador City	93	131	81	50
Happy Valley-Goose Bay	141	178	130	48

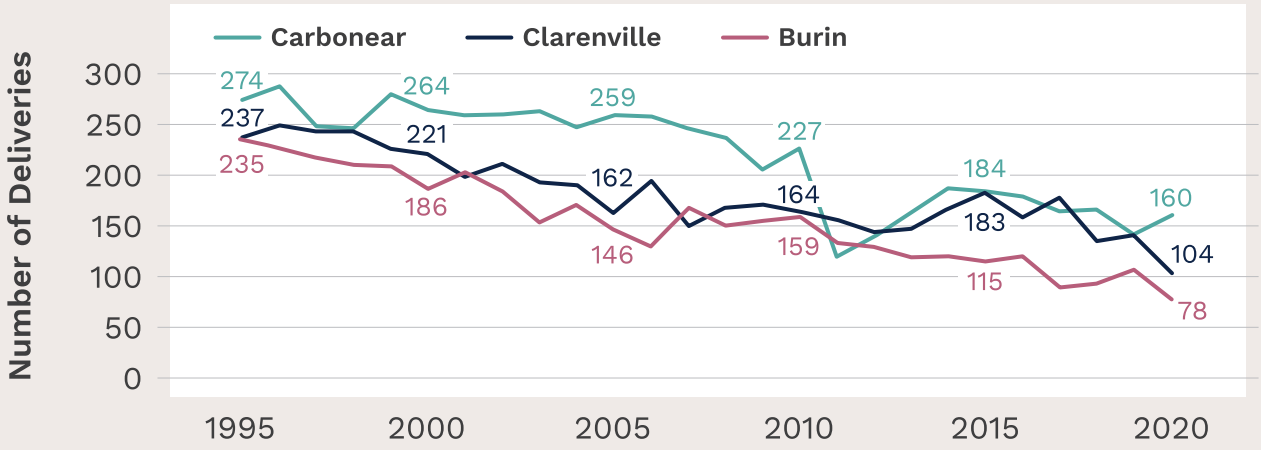
[#] includes 124 orthopaedics procedures and 46 ENT procedures.

Figure 19 shows the number of births over the last 25 years in the obstetrics units of the four large hospitals and of the community hospitals of Eastern Health and of Labrador-Grenfell Health. Substantial decreases in number of births have occurred, particularly in the community hospitals units. In 2020/21, the number of births in Burin was 84; Clarenville, 100; St. Anthony, 40; and Labrador City, 68.

A. Large Hospitals



B. Three community hospitals of Eastern Health



C. Three hospitals of Labrador-Grenfell Health

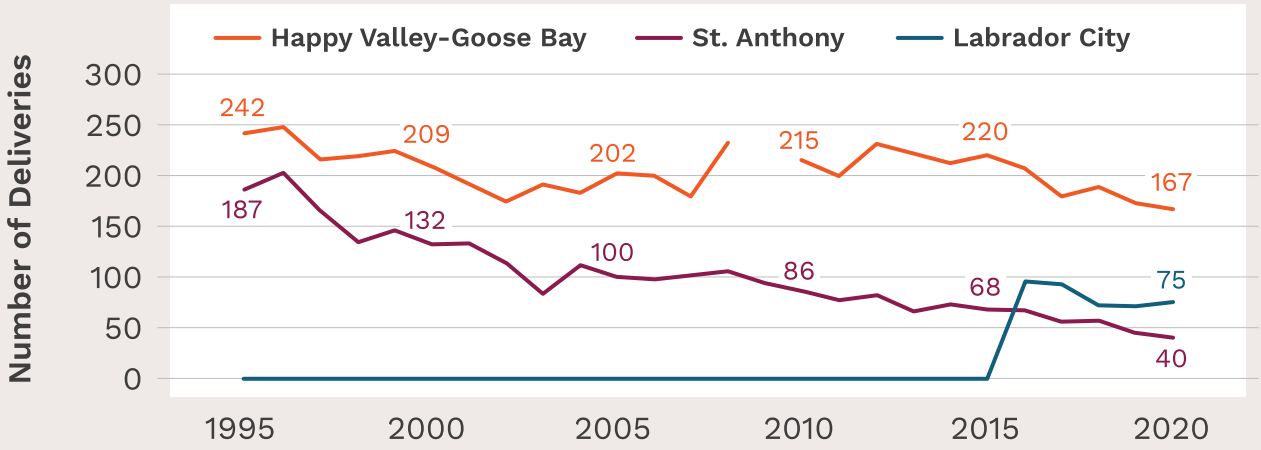


Fig 19. Births from 1995–2020 in the four large hospitals in the province (A), the three community hospitals of Eastern Health (B), and the three hospitals of Labrador-Grenfell Health (C)

The optimal occupancy rate of a hospital is around 85% as less than 85% is an inefficient use of hospital resources, whereas above 85% not only delays access, but it creates a difficult workplace environment and prevents addition of new services. Alternate level of care (ALC) refers to the proportion of beds occupied by patients not receiving acute care but needing and not receiving alternate services. The provincial rate of ALC is high (20% of beds). The high numbers of patients waiting for services related to the management of frailty are unacceptable.

The Health Sciences Centre in St. John's has an occupancy rate of 93% but an alternate level of care rate of 7.4%. High occupancy rates exist in Gander, Grand Falls-Windsor, and Stephenville, related to long lengths of stay and high numbers of patients receiving alternate levels of care. The lengths of stay and rates of alternate level of care are well above the Canadian average. A high occupancy rate also exists in Happy Valley-Goose Bay, but this may be alleviated somewhat by the addition of six beds for mental health. Occupancy rates less than 85% occur in the Janeway Hospital and the three community hospitals of Eastern Health.

Table 10 shows the catchment populations, number of beds, occupancy rates, and alternate level of care (ALC) in the 13 hospitals in the province.

Table 10. Utilization of hospital beds in the province, 2019/20

Location		Catchment Population	Beds	Occupancy	ALC
Eastern Health					
St. John's	a. Health Sciences Centre	233,345	345	92.9%	7.4%
	b. St. Clare's Mercy Hospital		192	82.3%	17.7%
	c. Janeway Child Health Centre		72	55.6%	0.0%
Carbonear General Hospital		40,119	72	73.4%	14.0%
Burin Peninsula Health Care Centre		18,762	35	53.6%	13.1%
Dr. G.B. Cross Memorial Hospital		26,129	41	76.0%	14.9%

Continued on next page

Location	Catchment Population	Beds	Occupancy	ALC
Central Health				
James Paton Memorial Hospital	45,985	85	98.2%	29.2%
Central NL Regional Health Centre	46,540	115	98.5%	32.5%
Western Health				
Western Memorial Regional Hospital	48,350	201	88.4%	38.1%
Sir Thomas Roddick Hospital	28,980	44	91.4%	22.7%
Labrador-Grenfell Health				
Charles S. Curtis Memorial Hospital	12,701	42	83.0%	28.0%
Labrador Health Centre	13,718	25	97.0%	21.7%
Labrador West Health Centre	9,870	15	84.1%	15.0%

Note:

- Hospital catchment population may vary depending on service because all services are not provided at all hospitals.

Responsibility

The Regional Health Authorities (RHAs) are responsible to the Department of Health and Community Services (HCS) for planning future services and optimizing use of acute care services. The responsibility will shift to a shared responsibility between the Provincial Health Authority and Regional Health Councils if the Health Accord NL recommendations for governance are accepted.

With respect to concerns about sustainability related to low volumes of patients and challenges in recruiting and retaining health care providers, engagement in the planning of sustainable hospital services is the responsibility of:

- Eastern Health for the specialty needs of the population in the Burin, Clarenville, Bonavista region;
- Central Health in the provision of one regional hospital on two sites without unnecessary duplication of services;
- Western Health in the provision of surgery services to the catchment population of Stephenville hospital, in partnership with Corner Brook;
- Labrador-Grenfell Health in the provision of and access to specialty services in the Labrador-Grenfell region, whose catchment populations for the three hospitals are geographically isolated.

Policy

Health Accord NL recommends the establishment of better-integrated, team-based care. It envisions arranging hospital service delivery into a network consisting of regional and tertiary hospitals offering an array of specialty services, complemented by community hospitals offering a sustainable range of services.

It also recommends realignment of core specialty medical services in facilities to match the current and future needs of the population in the province. The change in specialty services in the current hospital system should create a new enhanced model while providing continuity of care, based on the changing needs in the community and the decrease in population. Strategies addressing a planned hospital system, location of services, interventions to keep care close to home, and standards for provincial acute care services are required to achieve the objectives.

Health Accord NL recommends substantial acute care planning. This planning should be led by the RHAs initially and later by the Regional Health Councils. This planning must include the relevant program areas potentially affected, to determine how to sustain programs in vulnerable areas. Communities should be engaged in the planning process. Workplace Transition Agreements may need to be negotiated for staff members affected by the changes.

Beds should be repurposed in sites consistently operating at less than 85% occupancy rates, and best management practice must be deployed to obtain lengths of stay and rates of alternate level of care closer to the Canadian

average. New programs in regional hospitals to provide focused care for frail elderly patients and persons with strokes are essential as well as programs for rehabilitation and restorative care.

Structure

Seven hospitals in rural Newfoundland and Labrador are community hospitals (Carbonear, Clarenville, Burin, Stephenville, St. Anthony, Labrador City, and Happy Valley-Goose Bay). There are three regional hospitals located in larger centres (St. John's, Central Newfoundland, Corner Brook), and there is one tertiary hub located in St. John's. In the central region, one regional hospital on two sites (Gander and Grand Falls-Windsor), without unnecessary duplication of services, is envisaged. In St. John's, both secondary and tertiary adult acute care services are distributed across two sites (Health Sciences Centre and St. Clare's) and children's services in one site (Janeway).

In St. John's, the Waterford Hospital provides secondary and tertiary services related to mental illness and addictions. The Miller Centre, the province's main rehabilitation centre, provides inpatient and outpatient care to assist people disabled by injury or disease to reach and maintain their best possible level of functioning through therapeutic interventions and rehabilitation.

Investments

Estimates for savings in hospital costs are difficult because they depend upon the repurposing of beds or centralization of some specialty services. The following are the assumptions of the finance and intergovernmental affairs working group.

- Starting in year one, repurposing of beds in hospitals with low occupancy could provide $8.7M annually for reallocation to other programs in the region.

- In years two to five, centralization of some general surgery and obstetrics services, because of difficulties with sustainable staffing, may be needed. Cost reductions associated with this restructuring may amount to $6.8M annually by the end of five years and should be reallocated for the provision other services in the region.

- A targeted approach to improvement in length of stay and reduction in rates of patients waiting for ALC could reduce cost by $15.6M annually after seven years if beds are reduced by 100 in the province. This is a conservative target since matching the Canadian rates would mean a reduction of over 300 beds. The new investments for a Provincial Frail Elderly Program are provided in Summary 14, A Rebalanced Health System: A Provincial Frail Elderly Program.

Benefits

Better bed management will facilitate the addition of new services for frail elderly patients, restorative care, stroke care, and rehabilitation. Alignment of bed numbers with need should not only improve efficiency in hospitals with low occupancy, but should also improve workplace quality because hospitals consistently at 100% occupancy are difficult to work in. Services with attractive on-call rotations that preserve work-life balance should appeal to providers and be sustainable. Successful recruitment and retention efforts are the key to sustainability of secondary level services throughout the province.

Implementation

1. Repurposing of beds for hospitals with low occupancy should occur. Because occupancy is 56% in the Janeway and over 90% at the Health Sciences Centre, it is recommended that there be a transfer of women's health inpatient beds to the Janeway Hospital. Consequent repurposing of some adult beds in St. John's may be possible.

2. A consistent targeted approach in all the hospitals to improvement in length of stay in medicine beds and reduction in ALC rates is necessary and must involve senior management and the medical staff. A focus on best practice bed management should target a reduction of 100 beds in the province within five years.

3. The addition of a Provincial Frail Elderly Program with three regional centres should focus on reducing ALC rates, in collaboration with management and medical staff. Implementation of enhanced stroke care in regional hospitals in Western Health and Central Health is recommended.

4. Creation of a single regional hospital on two sites in Central Health and the addition of a Centre of Excellence on Aging require discussions and planning by the RHA, with engagement from providers in the program areas and members of the communities served by the RHA. Health Accord NL proposes, as a starting point for ongoing discussion among key stakeholders, the following realignment:

    - Both hospitals would continue to provide secondary acute and ambulatory/outpatient specialty services. The services would be program-based — one program for each service across the two hospitals.

    - Specialty services such as orthopedic surgery, urology, ophthalmology, and otolaryngology would remain in the hospital at which they are currently provided unless there is a compelling reason for change.

    - There would be one Obstetrical Program for the region. Obstetrical inpatient services would be provided at one location only (Grand Falls-Windsor). Midwifery would become an integral component of all obstetrical services in the region, would provide pre-natal, delivery, and post-natal care for mothers who choose this service, and would remain based in Gander with outreach to Grand Falls-Windsor and other communities in the region.

    - There would be one Geriatrics Program for Central Health. The Centre for Excellence on Aging would be based in one location (Gander), closely connected to care for older persons at Grand Falls-Windsor and serving as a resource for community teams and primary care providers across the region.

5. Innovative approaches will be necessary to sustain general surgery in the three geographically isolated Labrador-Grenfell Health hospitals. These approaches can be facilitated by a province-wide approach to provision of surgery services directed by the Provincial Health Authority.

6. Sustainability of surgery and obstetrics services in some hospitals is a concern. Service planning is necessary in the event of provider vacancies, because recruitment will be difficult for specialty services with small volumes of patients. Planning for provision of same-day services on one site and inpatient services on another site for hospitals geographically contiguous to each other should be led by the RHA with input from the relevant programs.

Planning for sustainability is necessary for:

i. General surgery in Burin-Clarenville-Bonavista region and in the Stephenville-Corner Brook region.

ii. Inpatient obstetrics in Carbonear (where the majority of mothers in the catchment area go to St. John's to deliver), Burin, Clarenville, St. Anthony, and Labrador City (where the number of annual births is low) and Central Health (which currently rotates across two sites).

iii. Consideration for provision of obstetrics services for Fermont, QC (population 2,500), in Labrador City, which is 23kms from Fermont. This would increase the number of births in Labrador City to about 100 per year, making the obstetrical service more sustainable.

iv. Sub-specialty surgery and pathology services in St. Anthony (because of small numbers of patients).

7. Three regional Intensive Care Unit (ICU) programs are recommended, staffed by an interdisciplinary team with the commensurate skills to deliver specialized ICU care. In community hospitals, beds currently designated as ICU beds are actually Special Care beds as they do not have the interdisciplinary staff to deliver ICU care and their current admissions are largely not reflective of a need for ICU care.

8. Province-wide approaches to specialty services such as surgery, obstetrics, and ICU are recommended and must include attention to provincial standards of care, approaches to sustainability of programs, and provision of virtual care and visiting specialists. This should ensure a comprehensive approach to care delivery across the province.

Cross-References

Calls to Action: 14, 17, 24, 25, 34, 42, 45, 46, 48, 49, 55, 59

Section A:
- A Rebalanced Health System: A Provincial Frail Elderly Program
- A Rebalanced Health System: New Health Care Programs

Section B:
- Hospital Services Implementation Recommendations

14. A Rebalanced Health System: A Provincial Frail Elderly Program

Introduction

In Newfoundland and Labrador, programs for frail elderly persons are rudimentary despite 23.6% of the population being 65 years and older in 2021. Many frail elderly people are admitted to acute care hospitals and subsequently deemed to be receiving an alternate level of care (ALC) because they need care other than acute care. The time spent in an acute hospital is prolonged, and rates of ALC are high compared to other provinces. The frequency of hip fractures and management after surgery contribute to this problem. Future increased hospital utilization will be driven in part by the aging of the population unless our approach to frail elderly persons changes. An integrated, interdisciplinary, Provincial Frail Elderly Program, involving both Community Teams and hospitals, is a key action envisaged by Health Accord NL.

Rationale

The increased care requirements associated with frailty in the population will require prevention, assessment, and management interventions in the community, health centres, and hospitals. Although not all frailty is related to older persons, in this summary the focus is on older persons living with frailty. Geriatrics-informed decisions on the use of drugs and other interventions, including those for patients at the end-of-life, will be necessary. Geriatric programs to start new interventions and geriatrics training for providers in Community Teams will be essential to prevent and manage frailty.

Responsibility

The Department of Health and Community Services (HCS) and Regional Health Authorities (RHAs) are responsible for frail elderly programs encompassing Community Teams, long-term care, and hospital care.

Policy

The aging of the population in Newfoundland and Labrador requires health care providers trained in management of frail elderly persons and in end-of-life care to provide appropriate and efficient care. A shift from medicalized models of care to geriatrics-informed care is urgent, with standardized assessments and care plans (based on the complexity and multiple characteristics of frailty). All 13 emergency departments should be formally certified as senior-friendly. Regional Centres of Excellence on Aging will integrate geriatrics care, restorative care, rehabilitation, and approaches to reduction in ALC. The management of patients after hip fracture surgery should be a responsibility of these Centres.

Structure

Figure 20 outlines the proposed Provincial Frail Elderly Program. Three regional geriatrics units are needed with responsibilities for management of frail elderly patients in hospitals together with outreach to the other hospitals and integration with Community Teams and the development of a new approach for care for seniors in Labrador. The regional units will have additional responsibilities for stroke care units, restorative care, rehabilitation, and reduction of ALC rates. Senior-friendly emergency departments are necessary. The Community Teams require family physicians, nurse practitioners, registered nurses, allied health professionals, and other providers trained in geriatrics to prevent and manage frailty.

Long-term care facilities are an essential component of the Provincial Frail Elderly Program. There is need for a stronger community team model in such facilities with good connections across the integrated continuum of care. They must have a well-prepared, empowered and appropriately compensated workforce. Long-term care facilities must be fully engaged in the Learning Health and Social System, the newly imagined health information and virtual care system, and a research program focused on areas such as community team models of care in

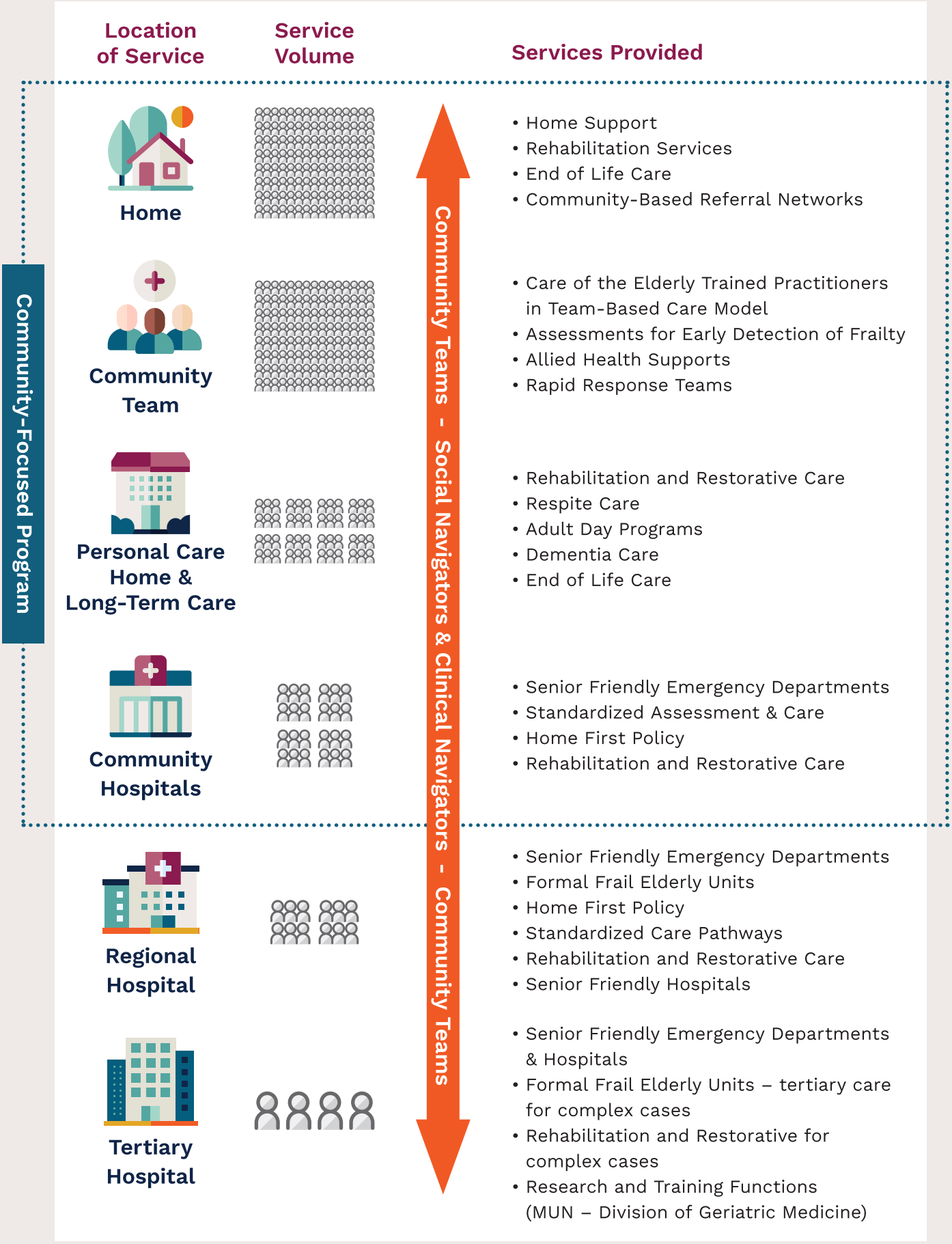


Fig 20. An integrated Provincial Frail Elderly Program

long-term care facilities, polypharmacy, a culture of inclusion as a principle of care, and innovative approaches to dementia-inclusive care facilities.

Investments

The investment required for the Provincial Frail Elderly Program are provided in Summary 8, Social Determinants of Health: Better Health in Older Persons.

Benefits

Prevention of frailty and better management of frail elderly persons in their communities will prevent hospitalization and emergency room use. A geriatrics-informed approach to care in the community will reduce unnecessary use of health interventions. A geriatrics-informed approach to frail elderly patients in hospitals, particularly in prevention of deterioration, will decrease length of stay, ALC, and transfers to long-term care. These steps should strengthen health outcomes and improve health equity for older persons.

Implementation

1. Planning for the Frail Elderly Program should start immediately, with recruitment of geriatricians over time as they are trained. Family physicians with enhanced skills in the care of older persons and other trained providers should be a component of all Community Teams.

2. In Central and Western Newfoundland, Centres of Excellence on Aging with development of interdisciplinary teams for geriatrics, stroke care, rehabilitation, and restorative care should evolve over the next five years. An appropriate model of care for frail elderly persons in the Labrador-Grenfell region should be developed.

Cross-References

Calls to Action: 9

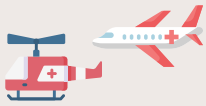
Section A:
- Social Determinants of Health: Better Health in Older Persons

Section B:
- Aging Population Implementation Recommendations
- Community Care Implementation Recommendations
- Hospital Services Implementation Recommendations

15. A Rebalanced Health System: Air and Road Ambulance Services

Introduction

The current air and road ambulance service in the province is fragmented (Fig 21). The road ambulance system has 60 operators completing 80,000 transports per year. A central medical dispatch centre exists only for metro St. John's and Carbonear, which completes one third of all provincial calls annually. Ambulance staff do not connect with hospitals by virtual technology (except by telephone).



Road Ambulance		
Operators	RHA	13
	Private	25
	Community	22
Bases		83
Ambulances		179
Dispatch Systems		diverse
Bases with ≤ 1 emergency call per day		56%

Air Ambulance		
Government Air Ambulance		2 planes
Private Airlines		2
Helicopter		shared use, visual flight rules
Managed by	Gov. Depts	2
	RHAs	2
Contractors for out-of-province transports		as needed

Fig 21. The fragmented air and road ambulance system in Newfoundland and Labrador

The air ambulance system is also fragmented and comprises a mix of two private operators on short-term contracts and government owned air ambulance fixed-wing aircraft. In Happy Valley-Goose Bay, the medical flight team is available only 14 hours a day. Helicopter use is limited to daylight hours (visual flight rules only).

There are 13 hospital emergency rooms, all of which have a CT scanner. People with emergencies (such as strokes, heart attacks, and trauma) require transfer from home or distant health centres as quickly as possible to one of the hospital emergency rooms to obtain the care they need.

Rationale

An integrated, modern, responsive, high-quality air and road ambulance system will require:

1. governance through the Provincial Health Authority to provide strong oversight as change occurs with responsibility for performance-based outcomes;

2. a management structure to manage the system and to create and obtain performance-based outcomes;

3. integrated road ambulance with an appropriate skill mix of advanced care and primary care paramedics;

4. one provincial central medical dispatch centre utilizing dynamic deployment of ambulances to provide optimal provincial coverage resulting in best possible response times;

5. long-term commitment to integrated fixed wing and 24-hours-a-day, seven-days-a-week helicopter services (instrument flight rules);

6. a provincial virtual emergency service;

7. an electronic patient care record integrated with hospital and community electronic records.

Responsibility

Policy and funding decisions should be the responsibility of the Department of Health and Community Services. Operational oversight decisions are the responsibility of the Provincial Health Authority (PHA).

Policy

Management of change in the ambulance system requires expert industry knowledge, which could be provided by a private operator or a consolidated public management group within the PHA. Integration of road ambulance will need a decision on whether all current private and community employees become public employees. The additional cost of this change is estimated in the range of $20–25M annually.

Expansion of the number of advanced care paramedics (ACPs) will require an increase in seat numbers in the current training program. Advanced care paramedics should work to the full scope of their practice inside and outside health facilitates. Current emergency medical responders may upgrade to primary care paramedics (PCPs) or transition to a non-emergency transportation system as greater numbers of PCPs and ACPs become available to replace them.

The integrated air ambulance will require long-term service agreements or the purchase or lease of a fixed wing aircraft by the province, and a decision on the relative role of private and public air ambulances. The province's one virtual emergency system may be directed from one site or several sites.

Structure

There are several components of the structure for the integrated ambulance system:

- one integrated system, using dynamic deployment from a provincial medical dispatch centre;

- aircraft availability and medical flight team for 24 hours per day at two bases (St. John's and Happy Valley-Goose Bay);
- a contract for a helicopter service that can fly 24 hours per day;
- improved skill mix of paramedics from the current level of 8% ACPs to 30% ACPs and ultimately 70% PCPs. This will take time depending on the recruitment of paramedics;
- a virtual emergency system throughout the province accessible by health providers from the community, ambulance, or health facility;
- electronic patient records integrated with the ambulance system;
- an appropriate level of air ambulance staffing based on patient care needs.

Investments

Currently, the road ambulance system costs $68.5M per year and the air system $11.5M per year. One-time transition investments for an integrated system are not included but would be required should this system transition in 2023/24. New investments include the replacement of the road ambulance fleet at $5M annually ongoing as well as $3.5M annually for staff and operational expenses for the expansion of the central medical dispatch. If all the staff of the road ambulance system are to become public employees, it is estimated that this will cost an additional $20–25M annually as noted above. Inclusion of 24-hour a day helicopter service could likely decrease the cost of a fixed wing private contract.

Benefits

An all-professional skill mix of PCPs and ACPs will enable care to commence from the first point of patient contact prior to reaching a hospital emergency room and will result in better patient outcomes. One integrated ambulance system, using dynamic deployment from a provincial medical dispatch centre, will provide better response times, faster access to a hospital emergency room, and greater efficiency. Availability of a medical flight team for 24 hours per day at two bases (St. John's and Happy Valley-Goose Bay) and a modern helicopter that can fly 24-hours a day will improve access to hospital emergency rooms from remote areas of the province.

Implementation

Year one:

- Make major policy decisions on the type of delivery system, create the necessary service agreements, develop the implementation plan, and create the infrastructure.
- Recruit additional ACPs and PCPs, graduating from the provincial program and elsewhere, to enhance the skill mix as emergency medical responders and PCPs transition, resign, or retire.
- Initiate the virtual emergency system.
- Locate a 24-hour a day medical flight team in Labrador.

Year two:

- Implement the integrated air and road ambulance service.
- Continue to recruit advanced and primary care paramedics.
- Enhance the scope of the virtual emergency room system.

Cross-References

Calls to Action: 16, 18, 23, 37

Section B:
- Hospital Services Implementation Recommendations
- Community Care Implementation Recommendations
- Digital Technology Implementation Recommendations
- Workforce Readiness Implementation Recommendations
- Education Implementation Recommendations

16. A Rebalanced Health System: New Health Care Programs

Introduction

New or improved programming is required to address service gaps with the goal of improving outcomes in areas with recognized need for improvement.

Eight key areas are recommended for innovation:

i. **Create a Provincial Stroke Program with optimal treatment of ischemic stroke and dedicated regional stroke units. Newfoundland and Labrador is the only province without an endovascular thrombectomy (EVT) program.**

ii. **Create a Clinical Translational Genomics Program to identify and treat high risk families with genetic diseases, particularly cardiac disease and cancer.**

iii. **Support the creation of a Cardiac Centre of Excellence.**

iv. **Plan a Provincial Occupational Health Clinic for individuals with workplace injury or illness.**

v. **Develop policy, plan, and implement change to obstetrical services including integration of midwifery and planning related to sustainability of services.**

vi. **Expand sexual health programs province wide.**

vii. **Develop a stepped approach to more comprehensive dental care for low-income families and oral health promotion within the community.**

viii. **Determine the need for and feasibility of hospice care in the province.**

A: Improve services for stroke, cancer and cardiac disease

Rationale

Among the ten Canadian provinces, age-standardized mortality rates in Newfoundland and Labrador are the highest for cancer, cardiac disease and stroke. These are the most frequent natural causes of death. Table 11 shows the age-standardized mortality rates for the top eight natural causes of death in Canada.

Table 11. Age-standardized Mortality Rates per 100,000 Population for Canada and NL and Provincial Rank of NL for the Most Common Natural Causes of Death in Canada

	CAN	NL	NL Rank
Malignant neoplasms	190.0	222.3	10
Diseases of the heart	123.6	167.8	10
Cerebrovascular diseases	31.4	44.2	10
Chronic lower respiratory diseases	30.4	40.9	8
Influenza and pneumonia	19.5	25.9	9
Diabetes mellitus	16.1	34.1	10
Alzheimer's disease	14.6	10.8	5
Nephritis, nephrotic syndrome, and nephrosis	8.4	16.6	10

Note: More commonly used terms are as follows: cancer (malignant neoplasms), stroke (cerebrovascular disease), and kidney disease (nephritis, nephrotic syndrome, and nephrosis).

Responsibility

The Department of Health and Community Services (HCS) is responsible for funding and policy development. The Provincial Health Authority (PHA) is responsible for provincial standards and operational responsibility for the diverse objectives of cardiac, stroke and cancer programs.

Policy

Reduction in mortality rates due to cardiac disease, stroke, and cancer depends upon improvement in the social determinants of health (SDH) and in prevention, but clinical events resulting from these diseases can also have better outcomes with better care.

Structure

Create a Provincial Stroke Program with the objective of matching actual practice with best practice, particularly in ischemic stroke (improved thrombolysis rates and an immediate start to endovascular therapy — EVT) and dedicated regional stroke units. Eastern Health has a stroke unit at the Health Sciences Centre. Western Health at Western Memorial has an eight-bed stroke unit but requires further resources for a full interdisciplinary team and appropriate nursing care. Central Health does not have a stroke unit and would need to repurpose eight current beds.

A planned Clinical Translational Genomics (CTG) program will focus on identifying germ line mutations in families at high risk of having a genetic disease, particularly those with cardiac disease or cancer, and mutations in tumours to guide therapy. The CTG program needs secure funding for genomics expertise and clinical leadership to identify and treat high-risk families for cardiac disease, cancer, and other diseases, and to guide therapy in patients with mutations causing disease.

A Cardiac Centre of Excellence will provide an organized hub of tertiary services within a spoke network enabling equitable and expanded ambulatory access to cardiac care.

Investments

The EVT Program at Eastern Health is planned within the current Eastern Health budget. Eight bed stroke units at each of Western Health and Central Health, a total of 16 beds, would be an investment of $2.7M annually. The investment for hiring the required expertise in the Clinical Translational Genomics is $0.9M annually.

Benefits

Thrombolysis dissolves blood clots in the carotid artery, and EVT removes the clot under image guidance. Both treatments improve clinical outcomes, reduce disability, and save lives. Better stroke care units and rehabilitation will also improve stroke outcomes.

The CTG program will repatriate genetic testing to the province, will help prevent adverse cancer and cardiac outcomes in families at high risk, and help target beneficial therapies for cancers based on genetic markers.

A Cardiac Centre of Excellence will improve access to cardiac interventions and bring cardiac care closer to the patient through virtual care and visiting clinics no matter where they live in the province.

Implementation

1. A Provincial Stroke Program inclusive of regional stroke units and EVT should start in year one.

2. As the Clinical Translational Genomics program already has the technology for DNA sequencing and interpretation, a physician and laboratory lead should be hired in year one, with subsequent necessary expertise hired in the medium term. A full complement of clinical geneticists will be necessary.

3. The plans for the Cardiac Centre of Excellence and for the Cancer Care Program can evolve over the next five years within the budget envelope that will be provided by HCS.

B: Provincial Occupational Health Clinic for Individuals with Workplace Injury or Illness

Rationale

Stakeholders have identified a strong need to build enhanced occupational health services to achieve better physical, mental, and social outcomes for injured workers and to ensure injured workers receive the right help at the right time. There are no dedicated Occupational Health Clinics in the province.

Responsibility

The Department of Digital Government and Service NL and WorkplaceNL are responsible for exploring the benefits of establishing a dedicated occupational health clinic.

Policy

Perform a feasibility study on implementing a comprehensive occupational health clinic to target workplace disability.

Structure

If an independent Occupational Health Clinic linked to WorkplaceNL is created, it must have links to the Community Teams. To assess the association between occupational exposure and disease causation, linkage to research expertise at Memorial University is recommended.

Investments

The Occupational Health Clinic is estimated to cost $1.5M annually. This would be paid by WorkplaceNL through increased employer premiums.

Benefit

An Occupational Health Clinic would help decrease chronic work-related disability and improve rates of return to work.

Implementation

Immediately conduct a feasibility study on the establishment of a Provincial Occupational Health Clinic in consultation with Workplace NL.

C. Midwifery Services

Rationale

Midwives provide care from early pregnancy through to at least six weeks postpartum for women and their infants. They encourage normal physiologic birth and the appropriate use of technology while also promoting health and wellness in women, babies, and families through education and support, with respect for the social, cultural, and physical aspects of the woman's life. Midwives generally work in pairs or small teams, providing on-call coverage 24-hours a day, 7-days a week, 365-days a year.

A Cochrane review of models of midwifery care found that women who received midwifery-led continuity of care had fewer interventions, same or better birth and neonatal outcomes, and increased satisfaction compared to those accessing standard maternity care.

Midwifery care in Newfoundland and Labrador is limited in comparison to other provinces with the only registered midwifery program being provided in Gander within the Central Health region. This program was established in December 2019 and is carried out by three to four midwives. Despite having the largest number of births in the province, St. John's does not provide a midwifery service.

An Innu Round Table Secretariat has formed a Midwifery Steering Committee with the goal of reintroducing midwives to Sheshatshiu and Natuashish in Labrador, and possibly birthing to Sheshatshiu, drawing on Innu Elders' knowledge of

birthing practice to support training of Innu midwives. This work is currently underway with the participation of Labrador-Grenfell Health.

Policy decisions are needed around the location of midwifery services and funding for them.

Responsibility

Policy concerning provision and funding of midwifery is the responsibility of HCS. Operationalization of these policies is the responsibility of the Regional Health Authorities (RHAs).

The Newfoundland and Labrador Council of Health Professionals governs the regulation of midwifery in registration, professional standards, quality assurance, complaints, and discipline.

Policy

Extension of regulated and publicly funded midwifery is linked to co-operation with obstetrics units and approval by RHAs. Provision of choice to mothers, when feasible, is dependent on an integrated approach to obstetrics services.

A provincial policy on the location and funding related to midwives is needed in the short term. Its development must include consultation among obstetric units, midwives, decision-makers, and mothers.

Structure

Midwifery should be one component of planning and decision-making related to maternity services in general. Its potential role in areas of the province where sustainability of services is a concern related to volume of births, proximity to obstetrical support, and needs of the local population should be explored.

Investments

Investments would be calculated and added once locations are determined. However, a sustainable team of four midwifes costs approximately $0.7M annually.

Benefits

Midwifery has been shown to reduce health care costs, promote health and health education, and empower families to play an active role in their health care for improved outcomes and experiences. Care by midwives results in reduced hospital stays, fewer interventions, fewer instrumental births, and increased rates of breastfeeding exclusivity. In addition to reducing costs of maternity services, midwifery services can impact the long-term health of clients and their newborns, and in turn reduce future health care costs. By providing additional support in breastfeeding, midwives impact the long-term health of mothers, babies, and of the province as a whole.

Families in this province would benefit from the opportunity to avail of midwifery care during their childbearing years to optimize their health in pregnancy, childbirth, the postpartum period and beyond.

Implementation

In the short term, policy and implementation decisions on the role of midwives should be made following discussion involving HCS, obstetrics programs in the RHAs, family physicians doing obstetrics, the Association of Midwives of Newfoundland and Labrador, and mothers.

In the medium term, integration of midwifery into regions that will help sustain services or provide choices to mothers can occur, influenced by agreed upon policy and provision of funding.

D: Sexual Health

In this section we will discuss both sexual health clinics and the need for Sexual Assault Nurse Examiners.

i. Sexual Health Clinics

Rationale

Sexual health clinics provide services related to birth control, pap testing, abortion counselling, testing for sexually transmitted and blood-borne infections (STBBI), and gender affirming care. In Newfoundland and Labrador (unlike other provinces), there is only one full-time sexual health clinic which is operated by Planned Parenthood in St. John's. This means that people outside the St. John's region have very limited access to sexual health services.

Sex education in schools is being provided by classroom teachers, often untrained in this subject matter, resulting in experiences uncomfortable for both students and teachers.

Responsibility

Funding for sexual health clinics is the responsibility of the HCS. Provincial sexual health clinics could be delivered in partnership with Planned Parenthood.

Policy

Access to sexual health services outside the St. John's region should be a priority. Integration among Community Teams, schools, and training of teachers and physicians is important. Access to birth control and antibiotics through sexual health clinics should be facilitated.

Structure

A provincial sexual health service should be provided in five areas of the province (St. John's, rural Eastern, Central, Western, and Labrador) with outreach to other communities through visiting clinics and virtual care. The integration of sexual health care into Community Teams will be necessary.

Investments

Investment is to be determined and will be based on service demand in each area of the province. Engagement with Planned Parenthood is recommended.

ii. Sexual Assault Nurse Examiners

Rationale

A Sexual Assault Nurse Examiner (SANE) is a registered nurse with advanced training and education in medical and forensic assessment of sexual assault survivors. Within a sexual assault program, a SANE is available for emergency response, 24-hours a day, 7-days a week. The nurse is authorized to create sexual assault examiner kits, to care up to five days post-assault (for evidence collection) and beyond (for medical needs), to do a medical and forensic examination if the patient chooses, to collect evidence and maintain the chain of custody, to provide prophylaxis for sexually transmitted diseases and pregnancy prevention if required, to provide information and support for involvement of the police, and to make referrals to community resources if needed.

St. John's has the only standardized SANE program in the province. Most regions of the province, including Labrador which has a higher average of sexual assaults per capita, do not have SANEs. Areas outside St. John's that do have such nurses provide limited services due to the absence of provincial program standardization.

Collection of comprehensive data, specifically socio-demographic data that can be disaggregated, will increase awareness of the extent of this criminal offense and the harm it causes and will strengthen policy and programming for both prevention of the crimes and treatment of persons whose lives are negatively affected by the crimes.

Responsibility

Funding for training of Sexual Assault Nurse Examiners is the responsibility of HCS and operationalization the responsibility of the RHAs.

Policy

The need for Sexual Assault Nurse Examiners is current policy, but there are gaps in service delivery.

Structure

A provincial program for assessment and treatment of sexual assault survivors is needed. Within that program, which would provide provincial standards for care, there would be Sexual Assault Nurse Examiners with appropriate training available to all hospital emergency departments in the province.

Investments

The appointment and training of Sexual Assault Nurse Examiners can happen within existing emergency department budgets within the overall RHA budgets.

Benefits

Without proper support and response, persons who have been sexually assaulted will experience even greater impacts on their health outcomes: mental distress, negative social interactions, profound impact on their daily life, a negative view of the justice system, negative physical health impacts, and shame and self-blame.

Feedback from the St. John's SANE program shows satisfaction with the immediacy of care, gratitude for options given, support for being able to make informed decisions about their medical care and follow-up options, feelings of acceptance with treatment in a non-judgmental manner, support for the choices made, and a sense that their emotional needs were met.

Implementation

In the short term, a provincial program for sexual health with provincial standards should be implemented, and a Sexual Assault Nurse Examiner should be located in each region and available to all hospitals in that region.

E. Oral Health

Rationale

Oral health is an integral component of health care, but dentistry has been omitted from Medicare funding from the beginning. In Newfoundland and Labrador, there is a universal Children's Dental Health Program for those aged up to 12 years. There are three dental programs for individuals with low income (two for those aged 13–17 and one for older people), which provide a limited number of services, and a universal Surgical Dental Program for medically necessary services. Both the Aging Population Committee and the Community Care Committee of the Task Force have called for action on oral health in Newfoundland and Labrador. A preventative approach to oral health is a necessity with a community-based approach to oral health and wellness.

Responsibility

The Department of Health and Community Services, in collaboration with the federal government, holds responsibility for policy related to oral health.

Policy

In March 2022, the federal government announced a new dental program for low-income Canadians starting with children aged up to 12 years in 2022, adding youth 13–17 years, seniors and persons living with a disability in 2023, and full implementation by 2025 for families with income less than $90,000 annually (with no payment required for those with household incomes less than $70,000 per year).

In collaboration with Community Teams, preventative dental care should be expanded into the community with special attention to schools and seniors. Oral health education needs to be integrated into Healthy Schools Programs.

Structure

Publicly funded dental services in the province will be augmented.

Investments

Coverage will be dependent on the federal government investments.

Benefits

More comprehensive dental care and community-based oral health promotion will lead to an improvement in oral health and well-being and in overall health, particularly in people previously unable to pay for dental services.

Implementation

1. In 2023, expansion of comprehensive dental care to low-income youth aged 13–17 years, seniors and persons living with a disability will occur, with full implementation of the program to include all people with low income by 2025.

2. Federal funding for children aged up to 12 years would facilitate reallocation of current provincial funding in this area to improving oral health in the community.

3. Integration of oral health prevention and promotion should occur within Community Teams.

F. Hospice Care

Rationale

The Canadian Institute for Health Information (CIHI) reports several studies of Canadian adults which indicate that 75 per cent of people want to die in their own home. Palliative care home supports are provided for this purpose. However, this is not always possible, and many individuals die in institutions. Hospice palliative care is provided in Newfoundland and Labrador in hospitals and in long-term care facilities.

A residential hospice is a care-giving facility outside the formal health system that provides a home-like environment for patients who are at the advanced stages of a life-limiting illness. Community residential hospices provide palliative care services by a team of interdisciplinary health care service providers with specific palliative care expertise. Residential hospices provide support 24-hours a day, 7-days a week, at no cost to the patient. Hospices also offer support for family members and can provide outreach to the community to support people to die in their own home.

There are approximately 100 residential hospices across Canada with no operational hospice in Newfoundland and Labrador at the present time. A community-based group in Grand Falls-Windsor is in the process of constructing a 10-bed hospice with the opening date set for the spring of 2023. The cost to complete the Hospice project is estimated to be $7.6M with $3M committed by the provincial government and the remaining amount raised through donations. The operating costs are estimated at $1.6M with the provincial government providing an annual grant of $1.3M and the remaining amount secured from fundraising activities.

Responsibility

Residential hospices across Canada are usually owned by non-profit community-based organizations which have registered charity status. Their funding comes in part from provincial health budgets, in part from fundraising, and in part from volunteer services.

Policy

Residential hospices should be available in the province where there is a population base to support such a hospice, where community support is evident, and where operational funding is secure.

Structure

The St. John's region could have a population to support the provision of hospice care. Following evaluation of the experiences in St. John's and Grand Falls-Windsor, extension of hospice care to other regions could be considered.

Investments

Capital and operating investments of hospice care will be determined based on the number of beds needed for the population base in the geographic area being served.

Benefits

Provision of residential hospice care should focus on the needs of the patient and family and reduce unnecessary medical interventions. It can ease the burden of caregiving on families and ensure individuals experience their final moments in a dignified home-like environment, supported by pain management, professionally trained staff, and family and loved ones.

Implementation

The determination of the feasibility of a hospice in the St. John's region should be undertaken, together with an evaluation of the approach to hospice care in Grand Falls-Windsor.

Cross-References

Calls to Action: 7, 18, 24, 31, 32

Section B:
- Hospital Services Implementation Recommendations
- Quality Health Care Implementation Recommendations
- Community Care Implementation Recommendations
- Aging Population Implementation Recommendations

17. A Rebalanced Health System: Appropriate Utilization of Health Care Interventions

Introduction

Appropriate utilization of health care interventions addresses underutilization of effective interventions and overutilization of unnecessary or harmful interventions. International evidence shows that 20–30% of interventions in health care are of low or no value, including drugs, laboratory testing, and medical imaging.

Examples of inappropriate utilization of health care interventions include:

- antibiotics given to patients with viral infections, which are harmful because of the development of bacterial resistance to antibiotics;
- polypharmacy in the elderly, which occurs frequently in Newfoundland and Labrador and is often unsafe;
- diagnostic testing without an appropriate indication, which is not only wasteful, but also harmful if a test is falsely positive in the absence of an overt disorder;
- CT scanning without an appropriate indication, which is harmful because of the cancer potential of radiation;
- technology for laboratory testing in the province far outweighing the need;
- failure to use continuous glucose monitoring in Type 1 diabetics, often associated with limited access to the monitors;
- failure to use thrombolytic agents in ischemic stroke.

In Newfoundland and Labrador, the unnecessary use of multiple health care interventions is the highest in Canada (Table 12).

Table 12. Overutilization and underutilization of health care interventions in NL and in Canada

	CAN	NL	NL Rank
% of adults ≥65 years taking ≥5 medications	31.1	39.2	10
Antibiotics dispensed in the community (DDD/1,000 inhabitant days)	17.9	29.1	10
Chronic use of benzodiazepines in adults ≥65 years per 1,000 population ≥65 years	14.6	53.6	9
Age-sex standardized rate of antipsychotic use per 1,000 population ≥65 years	54.0	59.1	9
% of persons who have written a plan or document on health care wanted at end of life	43.0	22.3	10
% of requests by patients for unnecessary tests and treatment	59	63	8
Thrombolysis rates for ischemic stroke	19	11	8 (of 8)
CT Scans Performed per Thousand Population in 2019/20	143	190	—

Source: Commonwealth Fund surveys, 2016 to 2019

Rationale

Both overutilization of unnecessary and underutilization of beneficial drugs, tests, and interventions are major reasons for an evidence-based approach to change in practice. Quality of Care NL has been created to focus on getting the right intervention to the right patient at the right time. Choosing Wisely NL is a component of Quality of Care NL that is linked to Choosing Wisely Canada and aimed at reduction in use of unnecessary interventions. Quality of Care NL will play a role in the Learning Health and Social System (LHSS) to match actual practice with best practice in the social system, Community Teams, long-term care and hospitals (see Summary 20, Pathways to Facilitate Change: A Learning Health and Social System).

Both overutilization of unnecessary drugs and underutilization of beneficial drugs are major reasons for including pharmacists in Community Teams and other facilities.

The proposed new structure for Pathology and Laboratory Medicine was designed to provide oversight and accountability for service quality and appropriate utilization of laboratory testing.

Responsibility

Quality of Care NL is a Memorial University entity co-funded by the Canadian Institute for Health Research and the provincial government. The proposed NL Council for Health Quality and Performance (The Council) will be responsible for support and advocacy of a LHSS to improve appropriate utilization of health interventions using Quality of Care NL and NL Centre for Health Information (NLCHI) skills (see Summary 21, Pathways to Facilitate Change: The NL Council for Health Quality and Performance).

The health care delivery system will provide accountability mechanisms for more appropriate use of health care interventions. Community Teams and long-term care facilities will develop communication methods with providers to integrate measures into their work to improve quality of care. Hospitals will be responsible for improved effectiveness of current accountability mechanisms.

Integration of pharmacists into Community Teams will be the work of the Regional Health Authority (RHA). Pathology and Laboratory Medicine will be a provincial program.

Policy

i. Quality of Care NL is funded until 2026, but a decision by the provincial government is necessary to sustain the program thereafter.

ii. A Provincial Choosing Wisely Program delivered by the Provincial Health Authority (PHA) and supported by Quality of Care NL should be integrated across the health system.

iii. The effectiveness of pharmacists in optimizing drug utilization will be evaluated in the initial Community Teams to determine how best to use pharmacists in Community Teams.

iv. Investigation of funding models linked to outcomes should be investigated.

Structure

Quality of Care NL will be directly linked to The NL Council for Health Quality and Performance and the LHSS.

Pathology and Laboratory Medicine will be a province-wide networked service, under a single administration using a hub-and-spoke model. However, this change will not affect the current locations where the public provide their laboratory samples. For Laboratory and Pathology Medicine, high throughput technologies will be available at three regional hospitals, with rightsized technologies for the other hospitals, and small, rapid, point-of-care testing technologies at health centres.

Community Teams have a responsibility for improved utilization of health care interventions in areas such as drug utilization, imaging, and laboratory testing.

Investments

It is difficult to estimate the savings that could be obtained through better use of health resources because this depends on the integration of a quality lens in care delivery, the effectiveness of the LHSS, responses of providers to advice and information, and the effectiveness of accountability mechanisms. However, there is substantial potential for savings from decreased use of unnecessary interventions.

It is anticipated that these programs will reduce unnecessary use of health care interventions sufficiently to pay for these programs over time and will likely provide savings.

The new annual investments required for The Council and Quality of Care NL are in year one (2022/23), $1.5M; in years two to four, $2.0M; and in year five and, thereafter, $2.2M. However, it is anticipated there would be cost avoidance as a result of the unnecessary use of health care interventions in the delivery system which could be repurposed to pay for these programs over time.

Benefits

More appropriate use of drugs, tests, and imaging will improve the health care received by patients/clients/residents and will ultimately improve their health outcomes. Quality of Care NL and the LHSS will match actual practice with best practice. Health benefits in relation to investments on drugs, tests, imaging, and other interventions will increase, thereby enhancing the value of spending.

Two examples illustrate these benefits. The addition of pharmacists to Community Teams will help reduce unnecessary drug use and increase beneficial drug use. A Provincial Pathology and Laboratory Medicine Program will reduce unnecessary tests that are of little value. Point-of-care testing will provide the patient with faster results than the current system does.

Implementation

1. Immediately start a formal LHSS in the care delivery system linked to Quality of Care NL and NLCHI and supported by The Council for Health Quality and Performance.

2. Implement a Provincial Choosing Wisely Program through the PHA.

3. Add six pharmacists to the 12–16 Community Teams envisaged in years one and two.

4. Create a Pathology and Laboratory Medicine Program in year one and complete organizational change in year two.

Cross-References

Calls to Action: 24, 26, 29, 30, 34, 36

Section A:

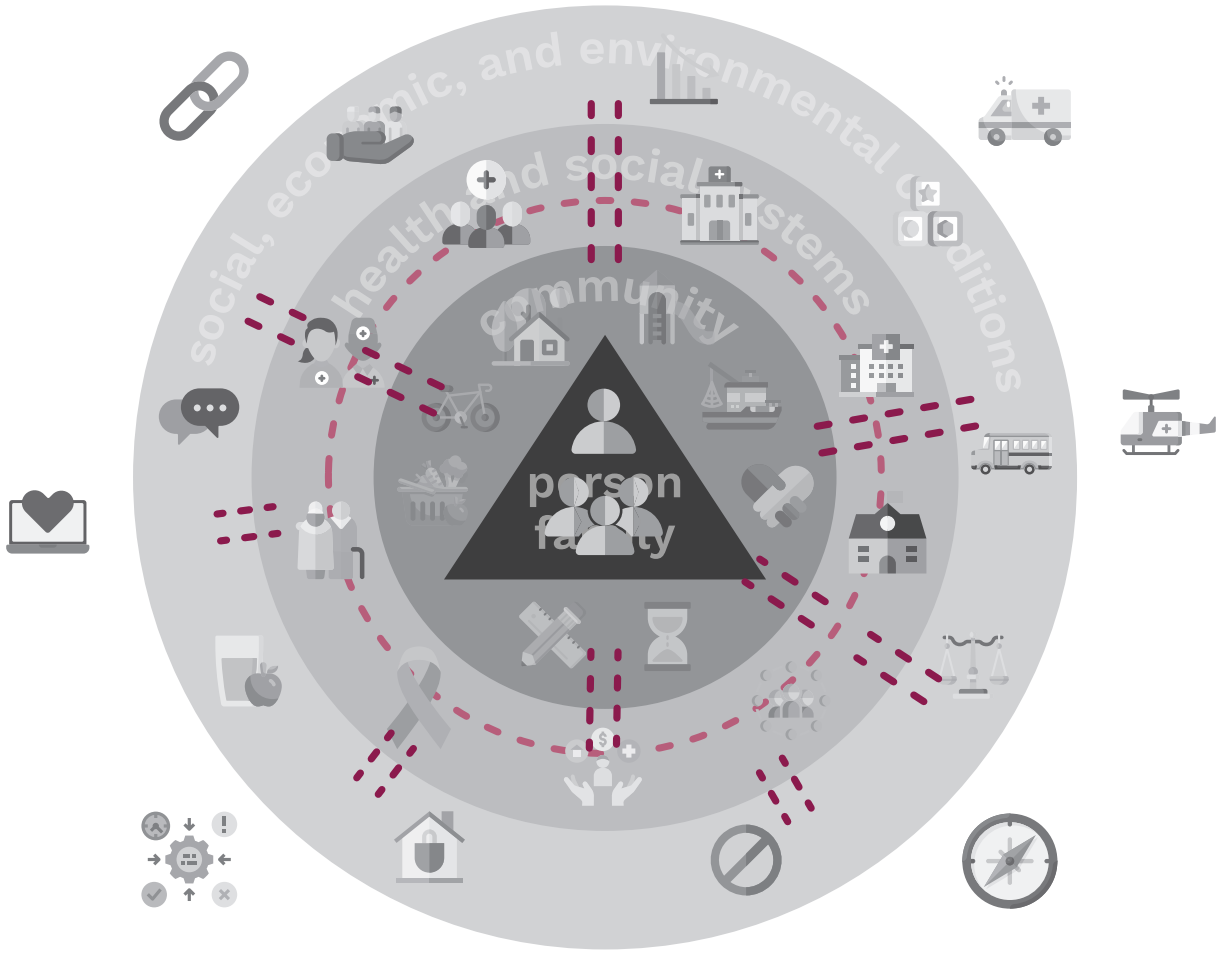
- Pathways to Facilitate Change: A Learning Health and Social System
- Pathways to Facilitate Change: NL Council for Health Quality and Performance

Section B:

- Quality Health Care Implementation Recommendations

How will the rebalancing of the health system ensure that there is quality care for Anne and John when each one has a stroke?

IV. Pathways to Facilitate Change

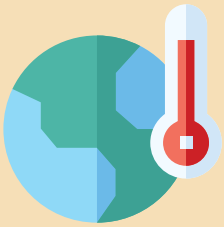


The pathways to facilitate change include Regional Social and Health Networks, the community sector, a Learning Health and Social System, a modern health information and virtual care system, social navigators and clinical navigators, health provider readiness and education, change management, and governance.

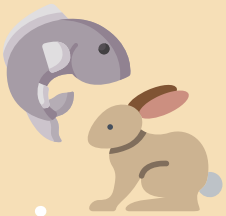
A Summaries of Implementation Recommendations for the Major Calls to Action

Case Study: Regional Social and Health Networks Support Joe, Amy and their Family

Regional Social and Health Networks have been established in every community in the province as recommended by Health Accord NL. **How does this Regional Social and Health Network make a difference for Joe and Amy and their family in northern Labrador?**



Joe and Amy live in Nain with three teenage children and elderly parents. They are concerned about the effect that the rising sea temperatures are having on their family. They are afraid that their children will forget their Inuit traditions for hunting and fishing and will choose to leave to live elsewhere. Joe's mother has said to them, **"The ice reminds us of who we are and where we came from. What will we do when it is gone?"**



Northern Labrador is warming at a quicker pace than most places in the world, and northern Nunatsiavut is losing its ice coverage faster than anywhere in the Canadian Arctic. Joe and Amy have been told that by 2050 Nain will have four times as many thaw days in April as now — a huge problem because they use the ice as a highway for months on end. One of their elders has said publicly, "The ice is our highway, and when that gets disrupted, so does life on the north coast."

Joe and Amy are finding some hope in the new Regional Social and Health Network that has just been established in northern Labrador. It brings together people from their area who are interested in protecting and improving the health of the people around them. The AngajukKak (leader) of their community, the administrator of their Regional Health Council, the principal of their school, the senior RCMP officer, and others come together regularly to talk about health concerns, see what they can do together, and figure out how they can get their organizations to act differently to bring about change.

The members of the network are listening to the people of the northern communities as they decide on priorities for the coming year. One of these will likely be the climate crisis — how the people can better understand it and what they can do to protect themselves as it continues. Another will probably be ways to better support teenagers as they face major life decisions about staying or leaving their communities. They want to make certain that the new integrated ambulance system really responds to the special challenges the people face in Nain. They are wondering about better ways to use OK Radio and TV to give people the opportunity to talk about health matters and to receive some good advice on ways to improve health.

Amy thinks that this new network will give the people of Nain and surrounding communities a way to have their voices heard by the organizations within their communities who have the power to influence decisions that affect their health. She hopes that the members of the network will really listen to what people think, focus on what really matters, and make a real difference in the lives of the people.

18. Pathways to Facilitate Change: Regional Social and Health Networks

Introduction

People's health can be positively influenced by providing employment, better housing, nutrition, recreational opportunities, and social inclusion, by shaping the physical environment, and by reducing incidences of racism, sexism, and childhood trauma. These are the factors that have the largest impact on our health outcomes. The province will be better served by a system that is able to benefit from the combined and added value that occurs when the right groups are talking to each other and aligning available resources to proactively address challenges that cannot be dealt with by one group alone.

Regional Social and Health Networks (RSHNs) are a key element in helping create a culture shift to focusing more intentionally on these social, economic, and environmental conditions which influence health, health outcomes, and health equity. These Networks are not governing boards, but they are tables where conversations happen and where priorities are set by senior leaders from all those groups which have an influence on health.

Rationale

Although there is global evidence about the greater impact on health from the social determinants than the health system, since the introduction of Medicare in Canada, much more emphasis has been given to the importance of physicians and hospitals in addressing health outcomes. Substantially more money and resources are directed to the health system than to addressing the causes of adverse health outcomes and inequity.

To bring about the cultural shift in thinking and acting that is needed, initiatives are needed at the local, regional, and provincial levels to help focus on the social determinants of health (SDH). In jurisdictions such as Wales and Scotland, one such initiative has been the establishment of tables at the regional level to begin the conversations, to identify region-specific priorities, and to encourage action across all sectors.

Responsibility

Provincial legislation gives the mandate for addressing the SDH to the Minister of Health and Community Services (HCS). However, it would not be appropriate for the health system to take the lead role in initiating the RSHNs since the intention is to find a better balance between the health systems and other social systems. Therefore, it would be important that the initial steps be taken at the Cabinet level advised by the Senior Executive (Health Accord) if that position is supported by Government.

Once the RSHNs are initiated, since they are new not only to Newfoundland and Labrador but to Canada, their first two to three years will be a learning period to assess where best to position their accountability and the source of their funding. The NL Council for Health Quality and Performance would take responsibility for the ongoing evaluation of the RSHNs across the province.

Given the uniqueness of the RSHNs, government will need to monitor the Networks to ensure that the participants remain engaged and that the Networks do not become simply an advisory body in which participation is optional.

Policy

The entities involved in the RSHNs would include the publicly funded health system, personal care homes, family physicians, private health care providers, social programs, Indigenous communities, municipalities, schools, police, recreational programs, arts and cultural programs, community sector groups, and private sector businesses. There would be a core group of participants for all the Networks across the province. Other groups unique to the region but having an influence on health in the region would be added.

The participants can be understood as falling within five categories (Fig 22):

i. public sector at the provincial and federal levels (e.g., Health and Community Services, Children, Seniors and Social Development, Service NL, Education, Fisheries, Forestry and Agriculture, Justice and Public Safety, Tourism, Culture, Arts and Recreation, Transportation and Infrastructure, NL Housing Corporation, libraries, Royal Newfoundland Constabulary, Workplace Health And Safety Compensation Commission, Fisheries and Oceans, Natural Resources, Royal Canadian Mounted Police, and Department of National Defence);

ii. private sector;

iii. Indigenous communities;

iv. municipalities;

v. community sector dealing with such issues as housing, food security, health advocacy, public libraries, sports organizations, recreation, and cultural heritage.

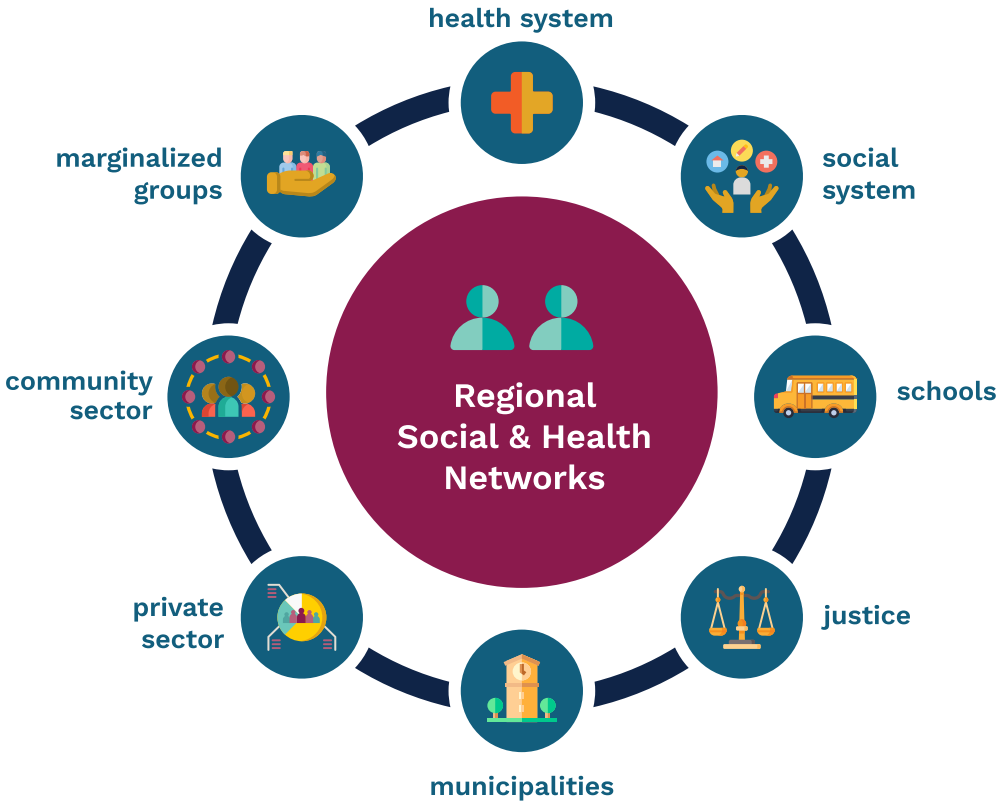


Fig 22. Regional Social and Health Networks in which a convenor and field catalyst bring together the leaders of the health system, social system, schools, justice, municipalities, private sector, community sector, marginalized groups, and others in the region.

The representative for each group at the table would be the senior leader of that group in the region. These leaders can then bring information back to their own organizations to determine where they can better align services with the other stakeholders to improve health outcomes. A convenor would support the work of each Network. A field catalyst would work with the community sector groups in each region to facilitate their determination of who would best represent them at the Networks, possibly on a rotating basis.

Although legislation will be needed to sustain the RSHNs, it is suggested that the two-year to three-year period of learning be completed before the legislation is framed.

Further discussion is needed to determine how these RSHNs are connected to each other and how they focus at the provincial level.

Structure

There are two structural changes needed: the creation of the RSHNs for each region each with a convenor, and the appointment of the field catalyst to work directly with the community sector groups to determine the most effective approach to their participation in these Networks.

Investments

The annual investments for the RSHNs (assuming five regions) would be $1.4M. It would cover the investments of the conveners, field catalysts, and expenses for the members of the Network not covered by their own organizations.

Benefits

The RSHNs will strengthen the connection between the rebalanced health system and the SDH and help refocus the awareness of what will make a difference in improving health outcomes and health equity for the people of Newfoundland and Labrador. They will ensure that the regional differences created by the geographic dispersion of the population of the province are highlighted in all government policy related to health. They will help shape new ways for the voices of the people most at risk of ill health to be heard.

Implementation

It is recommended that the RSHNs be established in year one as soon as the regions are identified. This will allow a period of two to three years of learning before the legislation is created. The evaluation plan for the effectiveness of the Networks should begin as soon as they are created.

Cross-References

Calls to Action: 50, 56

Section A:
- Governance: An Approach to the Health System
- Governance: Transitional Structures

Section B:
- Governance Implementation Recommendations

How does this Regional Social and Health Network make a difference for Joe and Amy and their family in northern Labrador?

19. Pathways to Facilitate Change: Increasing the Impact of the Community Sector

Introduction

The community sector is the heartbeat of communities. Often referred to as the non-profit, voluntary sector, it is complex and diverse with a broad range of purposes. It comprises thousands of organizations including charities, incorporated non-profits, informal voluntary groups, social enterprises, and cooperatives which are woven into every facet of our daily life (Fig 23). Every day each of us benefits from their contributions.

Fig 23. Types of non-profit voluntary organizations

Non-profits exist in every community. They provide place-based services and help to break down barriers. They have diverse roles: sports, recreation, social, health and mental health services, and support to children, youth, women, and seniors. They span arts, culture,

heritage, and environmental issues. They attract tourism, build trails, parks, and animal shelters. They maintain search and rescue teams and manage small craft harbour services. They offer social activities, social connections, and friendship. They bring people together in faith-based and religious activities. The community sector is often the early warning signal, drawing attention to emerging and important issues. It advocates for specific populations, addresses poverty and social justice, and provides support to vulnerable people. Organizations run food distribution programs, offer housing, and establish thrift shops and meal programs.

Figure 24 (p 164) gives a summary overview of community sector organizations across Newfoundland and Labrador categorized according to their primary activities. This listing comes from the Community Sector Council's online directory. Non-profits range from small completely volunteer groups to quite large providers of essential services. They deliver services, identify emerging needs, raise and distribute funds, promote volunteerism and civic engagement, and influence policy and program initiatives. They touch every aspect of our lives.

Voluntary associations empower people. They help build stronger communities. Community organizations exist to serve a public benefit and often emerge from the spontaneous coming together of people in a common cause. They are self-governing, independent, and distinct from formal institutional structures.

A distinguishing feature of the sector is its labour force, which is both paid and unpaid. The sector is community-driven, led by thousands of individuals who serve in unpaid leadership roles on Boards of Directors and as volunteers. Non-profits employ people all around the province. In 2019, Newfoundland and Labrador Statistics Agency estimated that approximately 16,000 people were employed collectively in non-profit groups.

In the most recent release from Statistics Canada based on a 2018 survey, close to half of our population 15 years of age and older reported volunteering within an organization while an additional 35%

reported informal volunteering. Only 20% reported not having any engagement. A growing body of research indicates that volunteering provides individual health benefits and that people who volunteer have improved mental health and physical health, greater longevity, higher functional ability, and lower rates of depression later in life.

Source: Community Sector Council NL, online directory (April, 2022)

Fig 24. Community sector non-profit organizations by category in Newfoundland and Labrador, April 2022

Rationale

Some community organizations work directly to improve health and health outcomes. Others engage in activities, which have an impact on health. Community groups influence our daily lives. A vital, sustainable community sector with its multitude of organizations positioned in every community is essential to the transformation of our health, placing a greater emphasis on the social determinants of health (SDH), and the rebalancing of our health system.

Community organizations are well-positioned to divert people away from hospitals and long-term care facilities. Some community organizations work directly to improve health and health outcomes, such as smoking cessation, healthy lifestyles, peer support for mental health and addictions, or public awareness of specific illnesses, while others are engaged in activities, which have an impact on health, such as adequate housing, food security, social inclusion, or employment and the alleviation of poverty.

Figure 25 (p 166) shows the focus, qualities, features and functions of non-profit voluntary organizations.

Throughout the Health Accord Report and in almost every Call to Action, community groups are identified as key resources. They were actively involved as participants in stakeholder conversations and as key informants for the Task Force, strategic committees, and working groups. They were consistently invited together with public sector organizations, private sector businesses, Indigenous communities, and municipalities to consider 'health-in-all-policies' approaches within their organizations. They were specifically identified as having key roles in creating age-friendly communities and in helping improve health for older persons, as local links with Community Teams, as sources of education for the public in helping bring about a culture shift to recognizing the SDH as having significant influence on health outcomes, as conduits to reaching vulnerable persons in the community, and, in some instances, as organizations which provide health services.

Community sector groups are identified as essential participants in the Regional Social and Health Networks (RSHNs) envisioned by Health Accord NL. These Networks will be established to bring together all those organizations which have an ability to influence the health of the people in the region in order to set priorities and influence actions to address gaps.

Fig 25. The focus, qualities, and health-related functions of non-profit voluntary organizations

Policy

For many non-profits, a major challenge is planning for the future because of tenuous sustainability. This is related to funding instability and heavy reliance on short-term, project-based funds. Many organizations, in fact, have little access to any funding. Few are fully self-sufficient. In this context, it can be extremely difficult to set meaningful long-term priorities or commitments. They work in a policy landscape which does not always recognize the unique features, governance structure, opportunities, and constraints they face.

Short-term funding creates an administrative burden on staff and volunteers working to secure funding. The success rate of funding applications can be quite low, especially as competition accelerates. This is particularly so in securing federal funding. The insecurity of funding also leads to staff insecurity, high turnover rates, and retention difficulties. The annual funding cycle, short-term projects, and inability of organizations to deploy their funds in a streamlined and consistent manner is not good practice nor good policy making. Multi-year funding cycles with less focus on short-term projects and support for improved management and accountability practices will strengthen the community sector.

Volunteers leading community organizations may be wary of assuming responsibility and risk if they are not protected from liability. Many small organizations cannot afford to purchase officers' and directors' liability insurance policies.

The Health Accord Report endorses the need for additional resources to support organizations and the valuable work of community groups and to provide needed educational and training opportunities to enable active participation in the implementation of the Calls to Action. Dedicated capacity and skills to shape a 'health-in-all-policies' approach within individual organizations and capacity to collaborate with government agencies and with other health professionals will be paramount. Stable and predictable funding, especially guaranteed multi-year funding (with corresponding accountability frameworks), is essential for the security of community organizations to continue to meet their mandates in an efficient and effective manner.

A greater emphasis on research and development and opportunities for thought leadership will be required to support innovation. A willingness to support experimentation and a learn-as-we go approach to evaluation and accountability will be important. Strong support for convening people, well-trained field catalysts to enable community conversations, and give-and-take in determining

and setting priorities will be the key to transformation. Some central services such as auditing services, liability insurance for Boards of Directors, and governance education are additional resources which provide support.

Government's commitment to the fundamental and important role of the community sector must be reflected in action to ensure that issues are addressed effectively, proactively, and in a timely manner. This could be achieved by building a longer-term strategy to give greater and more consistent capacity to organizations to fully participate in addressing the many social determinants of health. In this way, they can fulfil objectives to collaborate, partner, and work together to find ways to get best value for money.

Structure

The creation of RSHNs will provide access for community groups to influence priorities and policies in their region. Field catalysts will facilitate the integration of community groups with the Networks.

Benefits

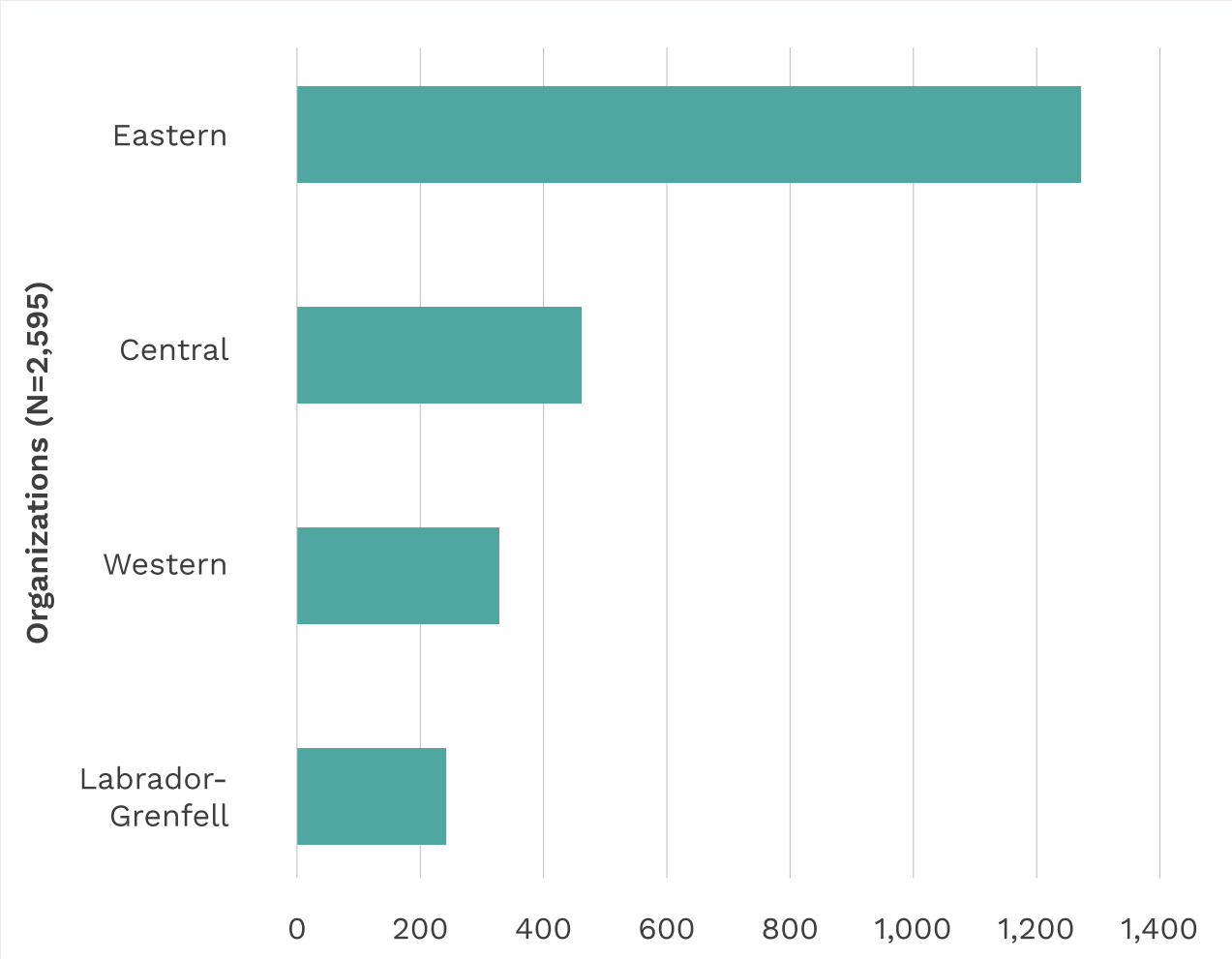
Non-profits deliver services, identify emerging needs, raise and distribute funds, promote volunteerism and civic engagement, and influence policy and program initiatives. They touch every aspect of our lives, faith, social connections, and community development. They are the social, economic, cultural, and environmental fabric of communities.

The community sector knits together the perspectives and engagements of many people and thus has a strong potential to nurture and spread change. The sector is creative, adaptable, and nimble, displaying extraordinary resilience. Non-profits are essential to building stronger communities and supporting people. The community sector fosters innovative ideas from experienced leaders who understand intimately the needs of their communities, their clients, organizations, and residents.

Of significance is the role that the community sector plays in driving economic activity. In much the same way as other small and medium-size businesses, non-profits flow money back into the economy. They seed economic development. They create employment and offer education and learning

opportunities. Often the primary employer in communities, they are the catalyst around which other economic activity emerges, and they frequently attract new funding into the province from federal government sources, research institutes, foundations, and other funders.

Figure 26 shows the distribution of community sector organizations, providing benefits to their communities across the four health regions in the province. The listing is collated from the Community Sector Council's online directory.



Source: Community Sector Council NL, online directory (April, 2022)

Fig 26. Community sector non-profit organizations allocated by health regions in Newfoundland and Labrador, April 2022

Bringing that innovation, flexibility, energy, and adaptability to the Networks with the public sector, private sector and Indigenous communities will strengthen the culture change needed in our understanding of the factors that most influence health and will support the extension of that culture shift throughout the whole community.

Investments

The investments for strengthening the participation of community sector groups are provided in Summary 9, Social Determinants of Health: An Integrated Approach to Wellness and Disease Prevention, and in Summary 18, Pathways to Facilitate Change: Regional Social and Health Networks. Additional investments are identified in other action areas, most notably the Implementation Recommendations for Social Determinants of Health, Governance, and Digital Technology.

Implementation

In year one, as RSHNs are being created, appropriately trained field catalysts should be employed by the networks to work closely with all the community organizations in the region. These field catalysts can bring together the organizations in a local or community area, facilitate their identification of priorities related to improved health in the area, enable them to find a creative approach to their participation in the network, and ensure that together they can provide a greater impact than they would if working alone.

The RSHNs in turn can provide opportunities for groups to participate in change management from the bottom up and in this networked environment. Year one will also provide more clarity about the ways in which the networks link across the regions and to government.

The first two to three years will be a learning period to see how community sector organizations can best become part of the RSHNs and how these Networks can strengthen the community sector in their region. Most important will be long-term commitment and sustainability for community-based services, planning and priority setting, new initiatives, and collaborations to build and sustain momentum.

Cross-References

Calls to Action: 2, 11, 13, 14, 36, 41, 47, 49, 50, 53, 56

Section A:
- Social Determinants of Health: An Integrated Approach to Wellness and Disease Prevention
- Pathways to Facilitate Change: Regional Social and Health Networks

Section B:
- Social Determinants of Health Implementation Recommendations
- Digital Technology Implementation Recommendations
- Governance Implementation Recommendations

20. Pathways to Facilitate Change: A Learning Health and Social System

Introduction

Learning health systems are health care systems in which knowledge generation processes are embedded in daily practice to produce continual improvement in care.

The vision of Health Accord NL for better health in the province links action on the social determinants of health (SDH) and a reimagined health system. To achieve this new and broader vision, Health Accord NL proposes a Learning Health and Social System (LHSS).

One of the three major lenses through which the Health Accord viewed its Calls to Action was that of improving quality within six major domains: safety, efficiency, effectiveness, timeliness, inclusion, and patient-centeredness (Fig 27).

Fig 27. Domains of health quality

Rationale

The requirements of a LHSS include a culture of learning and improvement (Fig 28), engaged patients/clients/residents as well as members of the public, digital capture, linking and timely sharing of relevant data, timely production of research and evaluation evidence, appropriate decision supports and knowledge translation, competencies for rapid learning and improvement informed by implementation science, aligned governance, financial resources, and delivery arrangements.

Fig 28. A culture of learning and improvement

The iterative processes required in a LHSS are shown in Fig 29. These requirements also apply to a learning social system but with the additional challenges that ensue from a lack of aggregate data on social, economic and environmental factors within regions and specific data on the individual characteristics and behaviours of persons.

Fig 29. A Learning Health and Social System

Responsibility

Development of an effective LHSS within the province depends on engagement of patients/clients/residents, members of the public, and providers, and actions of the health and social delivery systems (programs, management, and governance). Digital capture, linking, and sharing of data are the responsibility of NL Centre for Health Information (NLCHI). Quality of Care NL has expertise in evaluation, research and knowledge translation. The NL Council for Health Quality and Performance (The Council) has a role in supporting and advocating for a LHSS (see Summary 21, Pathways to Facilitate Change: NL Council for Health Quality and Performance). The Regional Health Authorities (RHAs) are currently

responsible for acting on evidence to improve quality, particularly actions to obtain better health outcomes. In the future, the Regional Health Councils (RHCs), if implemented, would assume this responsibility.

Policy

The elements of a LHSS already exist in the province, but the key is creating a culture of quality throughout the health and social systems.

A learning social system is a novel challenge particularly as the integration of health and social systems is envisaged as essential in improving health and health outcomes. Consequently, development of expertise on evaluation of the SDH in regions and aggregation of individual measures will be necessary.

Structure

There are several processes within hospitals that are already involved in evaluation, decision supports, and quality control with attendant accountability structures. A focus on improving health outcomes, developing competencies for using evidence for learning and improvement, and provider accountability for better utilization of health resources is necessary. Extension of these processes and a focus on quality in Community Teams, in long-term care, and in the social system should be included in the new health governance structures recommended by the Health Accord. The LHSS should be viewed as a shared approach, integrated across the delivery systems, The Council, NLCHI, Quality of Care NL, patients/clients/residents, members of the public, and others.

Investments

The LHSS will depend on refocusing current resources within the delivery systems, a modern health information and virtual care system (see Summary 22, Pathways to Facilitate Change: A Modern Health Information and Virtual Care System), The NL Council on Health Quality and Performance (see Summary 21, Pathways to Facilitate Change: NL Council on Health Quality and Performance), and development of expertise on measurement of the SDH.

Benefits

The overall health and efficiency benefits that may arise from the Calls to Action are dependent on the development of a culture of quality, exemplified by the creation of an effective LHSS.

Implementation

Attention to enhancing the LHSS should begin immediately with the creation of The NL Council for Health Quality and Performance, planning within the RHAs, and integration with NLCHI and Quality of Care NL.

The interim CEO and Board for the Provincial Health Authority should support and advocate for a LHSS as a priority.

Development of expertise on the SDH within Quality of Care NL should start immediately in collaboration with other partners in the province.

Cross-References

Calls to Action: 21, 24, 25, 26, 29, 31, 42, 54, 55

Section A:
- Pathways to Facilitate Change: A Modern Health Information and Virtual Care System
- Pathways to Facilitate Change: NL Council for Health Quality and Performance

Section B:
- Quality Health Care Implementation Recommendations
- Digital Technology Implementation Recommendations
- Governance Implementation Recommendations

21. Pathways to Facilitate Change: NL Council for Health Quality and Performance

Introduction

The value of health spending in Newfoundland and Labrador is not realized when determined by the rate of adverse health outcomes and the ranking of health system performance in relation to per capita spending on health. Many jurisdictions in Canada and internationally have introduced organizations mandated to address quality issues with substantial evidence of benefit. A core tenet for the proposed NL Council for Health Quality and Performance (The Council) is that transparency of reporting to the public by a trusted third party on utilization and health outcomes will stimulate institutions and providers to improve. A second tenet is that The Council should focus on quality and performance of both the health system and the social system. An evaluation plan created and implemented by The Council will be particularly important during the implementation of the Calls to Action of the Health Accord.

Rationale

Accountability for improved outcomes is the responsibility of the health and social systems, but this is dependent on receipt of relevant information on quality across the spectrum of the sectors.

Reporting on quality and performance to the public should include general measures of system performance and more specific information on the areas of most concern. Reporting to governance structures and institutions should include aggregate information on program quality and performance. Reporting to providers should contain provider-specific data.

Improvement in health outcomes will depend on creating a culture of quality through development of a Learning Health and Social System (LHSS) that receives good information, acts to improve health outcomes based on the information, re-measures the quality indicators, and maintains an iterative process for quality improvement.

Evaluation of implementation of the Calls to Action of the Health Accord as an ongoing process will be critical to identifying barriers and facilitators for ultimate success (see Summary 20, Pathways to Facilitate Change: A Learning Health and Social System).

Responsibility

The decision on whether to create The Council, and whether it should be a statutory body or not rests with the provincial government. The Council will be responsible for reporting on quality and performance, with information obtained through direct linkage with Quality of Care NL; supporting and advocating for a LHSS in partnership with the health and social delivery systems; and creating and implementing an evaluation plan for Health Accord NL. Quality of Care NL, in partnership with NL Centre for Health Information (NLCHI), will be responsible for evaluating projects in both the health and social sectors, for participating in the LHSS, and for participating in the evaluation of the implementation of the Health Accord.

Policy

Creation of a culture of quality in the health and social systems requires not only structural changes, but a more focused approach to health outcomes in hospitals, with extension of this focus to community care, long-term care, and social care and support. A combination of bottom-up advice from providers and programs and a top-down approach to development of a LHSS will be necessary.

Structure

The Council should be a small organization with a Board of no more than nine evaluation, research and clinical experts, and members of the public, and three

staff members (CEO, LHSS Program Manager, and Evaluation Program Manager). The CEO with the Chair of The Council would report to the House of Assembly. The Council will be directly linked to Quality of Care NL, a research and evaluation entity within Memorial University, and funded independently of The Council.

The LHSS will be an endeavor of the health and social systems but will be advocated for and supported by The Council and Quality of Care NL.

Accountability for improved outcomes rests with the Regional Health Authorities (RHAs) or the new governing structures approved by government following the recommendation of Health Accord NL.

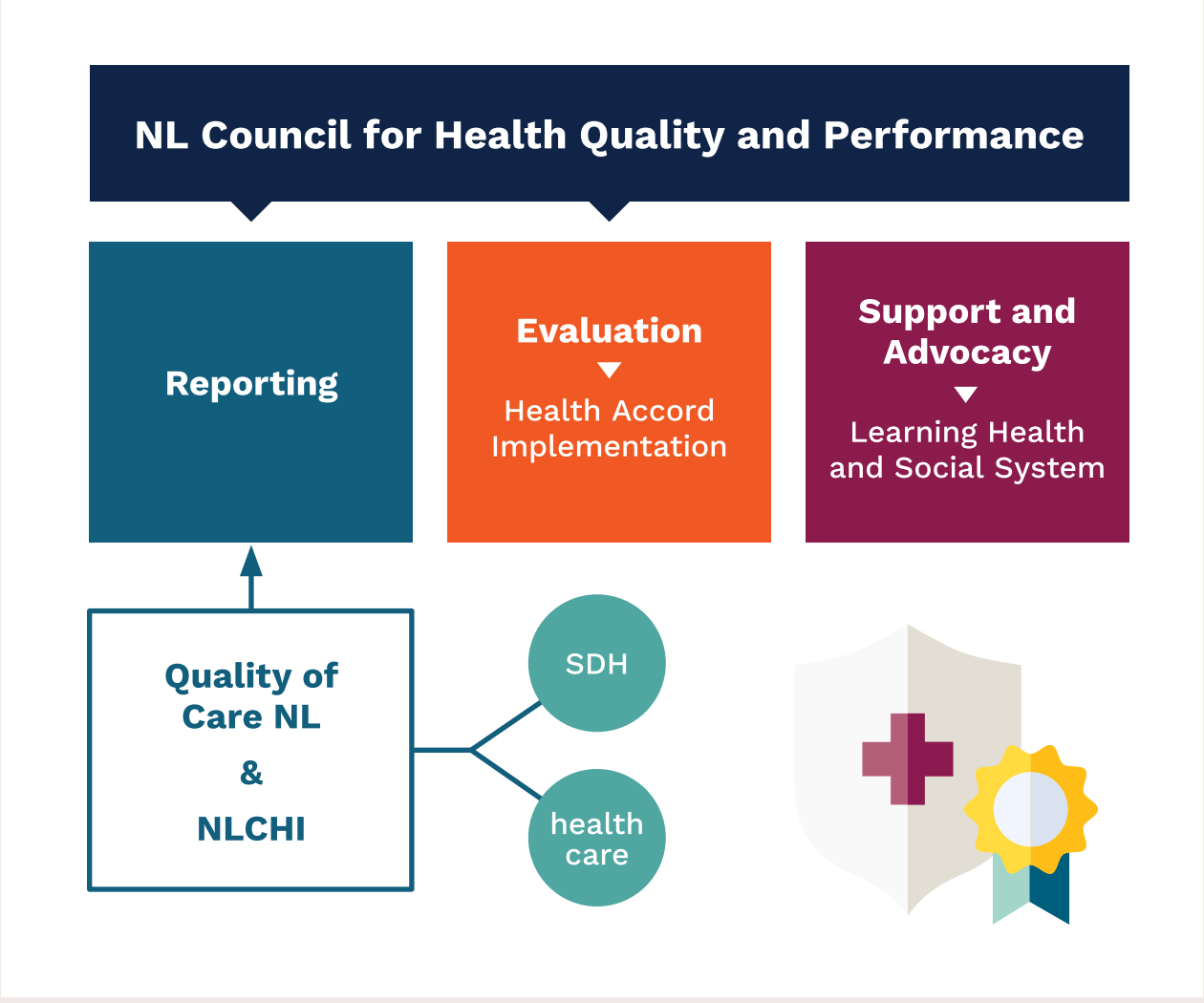


Fig 30. Roles of the NL Council for Health Quality and Performance

Investments

The investment for The Council for 2022/23 is estimated at $0.3M in year one and $0.7M annually over the subsequent nine years. After the initial year, it is expected that the cost of The Council will pay for itself with corresponding cost reduction in the health care delivery system. These investments were also included in the Summary 17, A Rebalanced Health System: Appropriate Utilization of Health Care Interventions.

Benefits

The Council, together with a LHSS, will embed a culture of quality which will improve health outcomes and system performance, increase utilization in the use of beneficial interventions, decrease utilization of unnecessary care, and improve the value of health spending. Quality of Care NL, in partnership with NLCHI, will carry out evaluation and research in both health and social systems, which will support The Council, the LHSS, and the evaluation plan.

Implementation

1. The appointment of a Board for The Council and hiring of three staff members should occur in the short term.

2. In collaboration with The Council, Quality of Care NL should start a program of evaluation on the social determinants of health in association with appropriate program leads.

3. The evaluation plan for the Health Accord should start immediately with identification of baseline measures in both the health and social systems.

4. A short-term priority is to provide leadership on the development of a LHSS.

5. Legislation for a NL Council for Health Quality and Performance should be passed in year two, followed by annual reporting to the House of Assembly.

Cross-References

Calls to Action: 2, 24, 26, 27, 29, 30, 34, 36

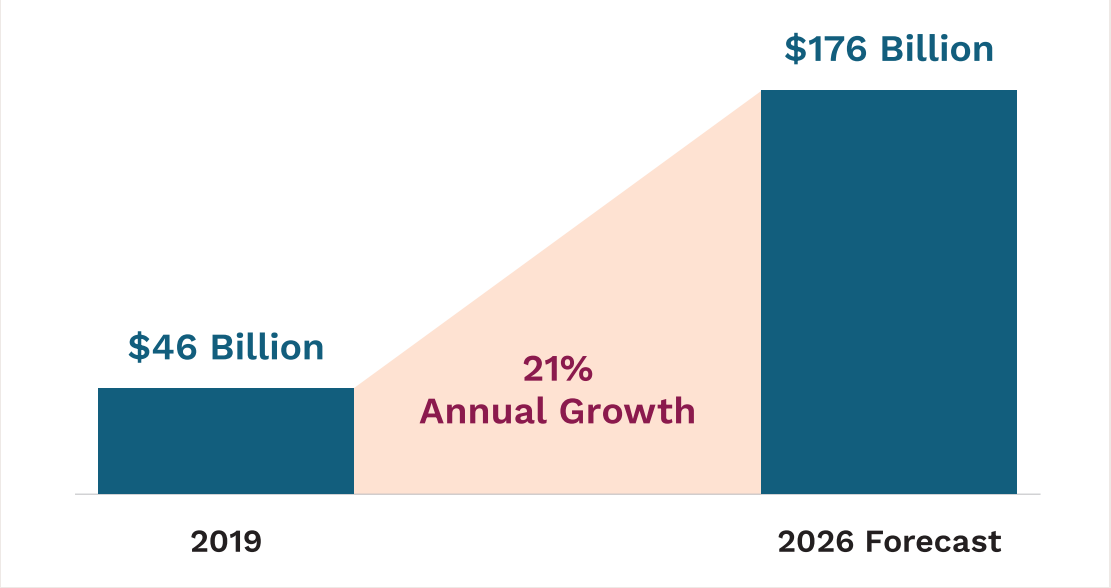
Section A:
- Pathways to Facilitate Change: A Learning Health and Social System
- Governance: Transitional Structure

Section B:
- Quality Health Care Implementation Recommendations
- Governance Implementation Recommendations

22. Pathways to Facilitate Change: A Modern Health Information and Virtual Care System

Introduction

Global investment in telemedicine solutions for health care is increasing dramatically (Fig 31).



Source: Capital Group, Statista. As of 4/30/20/ Forecast includes impact of COVID-19.

Fig 31. Global telemedicine market size

The current health information systems in institutional settings (hospitals, health centres, and long-term care) in Newfoundland and Labrador have been in place for decades. However, they lack the ability to meet modern clinical and administrative requirements.

They are not fully integrated across Regional Health Authorities (RHAs). Within RHAs, they are not integrated across hospitals, health centres, long-term care facilities, and community.

They also do not include information on the social determinants of health (SDH), do not have the capacity to integrate (necessary for many of the Health Accord's recommendations), and are unable to facilitate virtual care. The transparency of a Learning Health and Social System (LHSS) depends on a modern health information and virtual care system.

Governance of the health system by the Provincial Health Authority (PHA) requires one source of data that is centralized, integrated, and consistent.

Rationale

There are currently over 700 separate electronic health care systems in the province. A modern health information and virtual care system would provide many more functions via one system.

Modernization is necessary for many reasons including:

- improvement in virtual care by enabling adoption of virtual care technologies when appropriate. In addition to other benefits, this improvement will be necessary to bring virtual care to the community, to integrate Community Teams, and to enable the virtual emergency system;
- integration of both the health and social systems ultimately resulting in one provincial comprehensive record for each person, which provides consistency for both patient/client and provider;
- modernization of digital health tools to improve appropriateness of and access to health care delivery;

- provision of health information, including test results, directly to the patient/client through a patient/client portal;
- reduction in the number of single purpose systems, thus enhancing clinical workflows for both providers and patients/clients;
- replacement of outdated enterprise-wide systems such as finance and human resources, to integrate regions and across sectors (hospitals, health centres, long-term care, and community);
- requirement for one set of financial, human resources, supply chain, and decision-support data needed by the PHA;
- achievement of cyber security requirements.

Responsibility

Policy and funding are the responsibility of the Department of Health and Community Services (HCS). Operationalization would be the responsibility of the PHA.

Policy

The implementation of a digital technology strategy does not depend primarily on capital expenditure for technology. There is an option to lease various applications that have annual licensing investments. Up-front expenditures will be necessary prior to obtaining savings from efficiencies in later years (through RHA cost reduction and reduction in the cost of supporting the existing systems).

A holistic approach to expenditures on digital technology will be necessary for care in hospitals, virtual emergency services, air and road ambulance services, community care, virtual care, integration across regions and systems, health care administration, and interventions on the SDH.

Structure

Every element of the health and social system will be influenced by virtual technology. Therefore, it is crucial to have one provincial structure implementing one provincial health and social sector information system.

Figure 32 outlines our vision for the health information and virtual care system in the province.

Social
Economic
Environmental
Education
Community
Lifestyle Factors

Community Linkages
Acute Care • Specialty Care
Lab/Diagnostic Imaging
Long-Term Care/Home Care
Pharmacy • Mental Health
Other Health Care Providers

Fig 32. Integrated health information and virtual care system

Investments

It is estimated that, over five years, total investments will be $198.3M, of which $44.3M will be available from current resources and cost avoidances of $30.3M will be realized. Thus, the net new five year investment will be $123.7M (year one, $3.7M; year two, $27.5M; year three, $39.4M; year four, $32.0M; and year five, $21.1M).

Table 13. Digital technology financial requirements for 5-year implementation (in Millions), in today's dollars

	2022/23 $M	2023/24 $M	2024/25 $M	2025/26 $M	2026/27 $M	Five year total:
New Expenses	7.5	34.5	55.1	55.1	46.1	198.3
Existing Revenue sources	(3.8)	(7.0)	(9.5)	(11.5)	(12.5)	(44.3)
RHA cost reductions			(6.3)	(11.5)	(12.5)	(30.3)
Total revenue and cost reductions	(3.8)	(7.0)	(15.8)	(23)	(25.0)	(74.6)
Net New	3.7	27.5	39.4	32.0	21.1	123.7

Note:

1. Brackets () indicate the source of reduction in new expenses.

The expenditures include $78M for acute hospital care and long-term care facilities, $5M for the virtual emergency system, $25M for community care, $6.5M for virtual care, $6M for integration, and $16M for administration. As much as 50% of these investments are related to change management, training, and human resources, not to the actual technology.

- A PHA and one provincial digital system will enable efficiencies in back office functions in years four to seven of $5.5M to $22M annually (estimates based on previous studies for 2015). These cost savings may be conservative as wage increases since 2015 have not been considered. There are other areas which are difficult to quantify but will likely produce additional savings, particularly for people, processes, and technology.

Benefits

Virtual technology is a resource for the modernization of the health system and is critical to the province's capacity to transform health.

There are many benefits of new digital systems including:

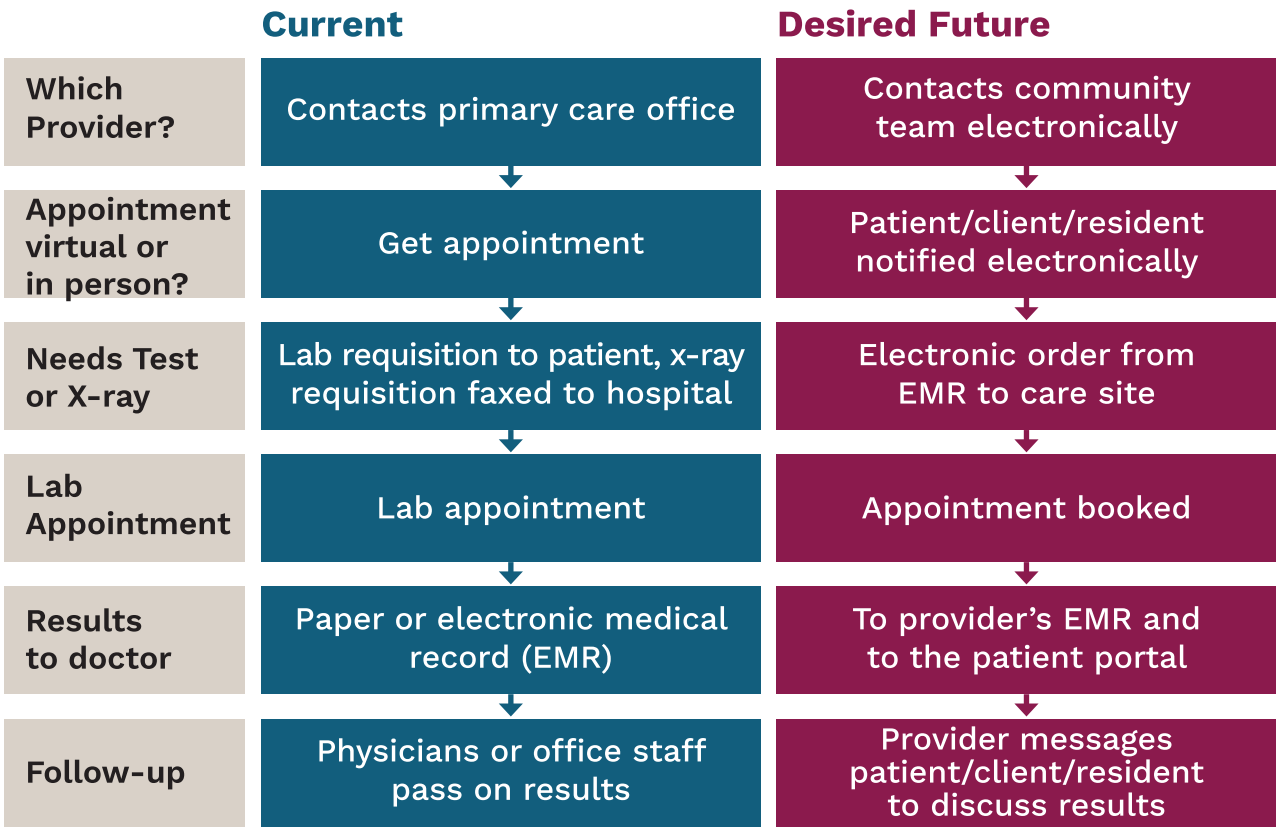
- better and faster access to care and improved coordination and efficiency (Fig 33, p 188);
- better patient/client/resident outcomes from a LHSS with transparent use of accurate data collected with integrity and consistency;
- improved recruitment and retention of providers by having a modern working environment including digital ordering, secure messaging, and the capacity to view patients' or clients' or residents' full interaction within the system;
- connection of the patient/client to the Community Team, and, in turn, of team members to each other;
- connection of the patient/client/resident to the providers in the three levels of hospitals, resulting in savings on patient/client travel and bringing care closer to home;
- linkages between the health and social systems;
- direct access for patients/clients/residents to their health information, access that is currently unavailable;
- reduction in cost through the integration of administrative structures across the province.

Implementation

1. Year one: planning such as criteria, scope and details of a request for proposal (net new investment $3.7M);

2. Years two and three: implementation and change management (net new investment in year two, $27.5M; and in year three, $39.4M)

3. Years four and five: completion of the modern health information and virtual care system (net new investments in year four, $32.0M; and in year five, $21.1M). The investments are exclusive of expenditure reductions above from more efficient back office functions.



Pain Points	Advantages to Desired Future
May only be able to enter care path via a family physician (FP) or nurse practitoner (NP)	Less delay
Getting through to a clinic can be a challenge	Less manual processing
Setting up a virtual visit other than by telephone is not easy	More flexibility in timing
Regional Health Authorities' (RHA) systems can't accept electronic orders, lots of paper requisitions and faxes, sometimes misplaced leading to delay	Avoids paper, faxes, and possible lost requests
Booking systems are inefficient, there is either no triage process or a cumbersome one	At all points in the process all users are aware of the status
Patients waiting to hear when tests are booked often call FP offices	Patients/clients/residents have ready access to appointments
Patients cannot easily track their own results	Patients/clients/residents have ready access to results

Fig 33. Comparison of the current pathway for a person using Community Teams for a health-related concern to the desired future using e-technology

Cross-References

Calls to Action: 2, 9, 13, 14, 22, 23, 24, 26, 28, 34, 36, 55

Section B:
- Digital Technology Implementation Recommendations
- Governance Implementation Recommendations

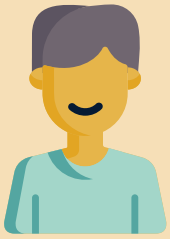
Joan

Case Study: Navigation to support Joan and Bobby through the Rebalanced Health System

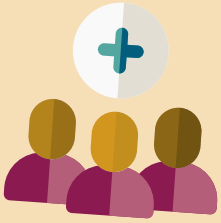
Health Accord NL has reimagined the province's health and social systems, creating better ways of navigating these complex systems. **What does this mean for Joan and Bobby who have complex health needs and need ongoing care?**

Joan is a seventy-year-old woman with heart disease, diabetes, and the beginnings of dementia. She lives with her daughter Betsy who works in a low-paying, stressful job. **A Community Team with a family physician, nurse practitioner, mental health worker, and social worker know Joan and Betsy well. The social worker and dietitian support Betsy by helping her understand her mother's health issues and giving her advice on food and activities.** They work closely with the home care providers who support Joan during the day.

Using virtual care technology and helped by the team's nurse practitioner, Joan will have follow-up appointments with her geriatrician without facing a long trip to St. John's. The community team members include Joan's situation in their regular consultations with the geriatrician and team at their regional hospital. **A clinical navigator and a social navigator who are members of the team help Betsy work her way through all the health and social pathways linked with Joan's care.**



Bobby



Bobby has been slow in reaching his milestones and has just started kindergarten. **The Community Team who have followed Bobby since his birth have already touched base with the school health team to alert them about his mental health issues.** Bobby's parents and the two teams have mapped out a health plan for him. Bobby has a voice in these conversations. They know when one team or the other takes the lead role in supporting Bobby. They keep each other informed about his progress. They link with the Janeway team when specialty care is needed, sometimes using virtual care and sometimes visiting in person. **The two teams provide ongoing advice to Bobby's parents and his older sister.** A social navigator helps Bobby's parents deal with the complexities of the school and health systems which work together for Bobby's health.

Medical students, nursing students, and other health professional students come to the Community Teams as part of their education. **They support the Community Teams by asking challenging questions and developing research projects on areas of concern about health in the region.**

23. Pathways to Facilitate Change: Social Navigators and Clinical Navigators

Introduction

In the rebalancing of the health system within the context of social, economic, and environmental impacts on the health of individuals as well as populations, two new and distinct roles are envisioned for navigators.

Social navigators will be part of interprofessional Community Teams, where they will work alongside other health care staff to identify patients/clients with social issues affecting their health and connect them with needed resources.

Clinical navigators, also part of the Community Teams, will ensure the continuum of care for the patient/client cared for by the Community Team across all health care services accessed by the patient/client such as acute care (inpatient and emergency), rehabilitation, long-term care, and community support services with a particular focus on vulnerable populations including frail elderly persons.

Rationale

The Health Accord's vision for improved health and health outcomes includes attention to both the social determinants of health and the rebalancing of the health system. Two challenges related to patient/client care are inherent in this vision.

The first challenge relates to the complexity and design of existing health and social programs which present barriers to access, misalignments, transition

gaps, and disincentives to employment. There are unacceptable and avoidable silos which are making an already difficult situation even more challenging. Social navigators have been identified as an additional resource in the midst of this complexity. These navigators will be part of Community Teams where they will work alongside other health care staff to identify patients/clients/residents with social issues affecting their health and connect them with needed resources.

Potential points of contact for the patient/client with needs related to the social determinants of health (SDH) are identified by the social navigators:

i. a non-clinical team member interacts with a patient/client during the health care visit (e.g., a registration clerk learns that a patient/client needs assistance with transportation)

ii. a clinical staff member identifies a patient/client with a significant social barrier to health as part of the clinical encounter (e.g., a nurse learns that a patient is homeless and unable to pay for medication; a family physician learns that a patient has a disability which could qualify for a tax credit application; a pharmacist learns that a patient/client could qualify for additional insurance coverage for medications; a team member identifies a patient/client who would benefit from more home supports)

iii. a patient/client is assessed for SDH proactively, as part of an initial assessment for care management or because of an event suggesting a social barrier to care (e.g., a patient who has frequent emergency department visits or who requires unanticipated early readmission to hospital).

This information was adapted from a comprehensive approach for addressing the SDH of patients at Kaiser Permanente Northwest in Portland as described in a journal article by Nicole Friedman and Matthew Banegas, (Perm J 2018;22:18-095).

Some of the most common problems identified, based on experience from other jurisdictions, are likely to be inadequate material (including financial) resources, need for assistance accessing community resources, family stress, food insecurity, housing insecurity, fall risk, caregiver stress, and literacy challenges (Fig 34).

The second challenge lies in navigation for the patient/client within the Community Team and among the other components of the health system to which the patient/client will be referred. Identification of the most appropriate health professional within the Community Team, collaboration among the

practitioners within the team, and connection with providers in private practice will be facilitated by the clinical navigator. The clinical navigator will also assist with and facilitate the continuum of care, that is, the transition of care from emergency or inpatient settings such as hospital, rehabilitation facilities, and long-term care facilities to home or to a more appropriate facility.

Clinical navigators work in collaboration with the members of the Community Team. They assess health needs and identify community resources. They identify barriers when treatment goals are not met, the treatment plan is not being followed, or important appointments are missed. They identify patients/clients who are overdue for visits or laboratory tests and referrals, contact patients/clients, and arrange for follow-up services. They serve as patient/client advocates and assist in identification and improvement of service delivery (Fig 34).

The clinical navigator will ensure that all relevant clinical information is shared with the service being accessed and communicate as necessary with the relevant providers. Critical points of transition such as admission, transfer, and discharge will require particular attention to ensure seamless and continuous care for the patient/client.

Common problems will relate to appropriate medication use, social and family supports, and ensuring access to levels of care appropriate to each patient/client.

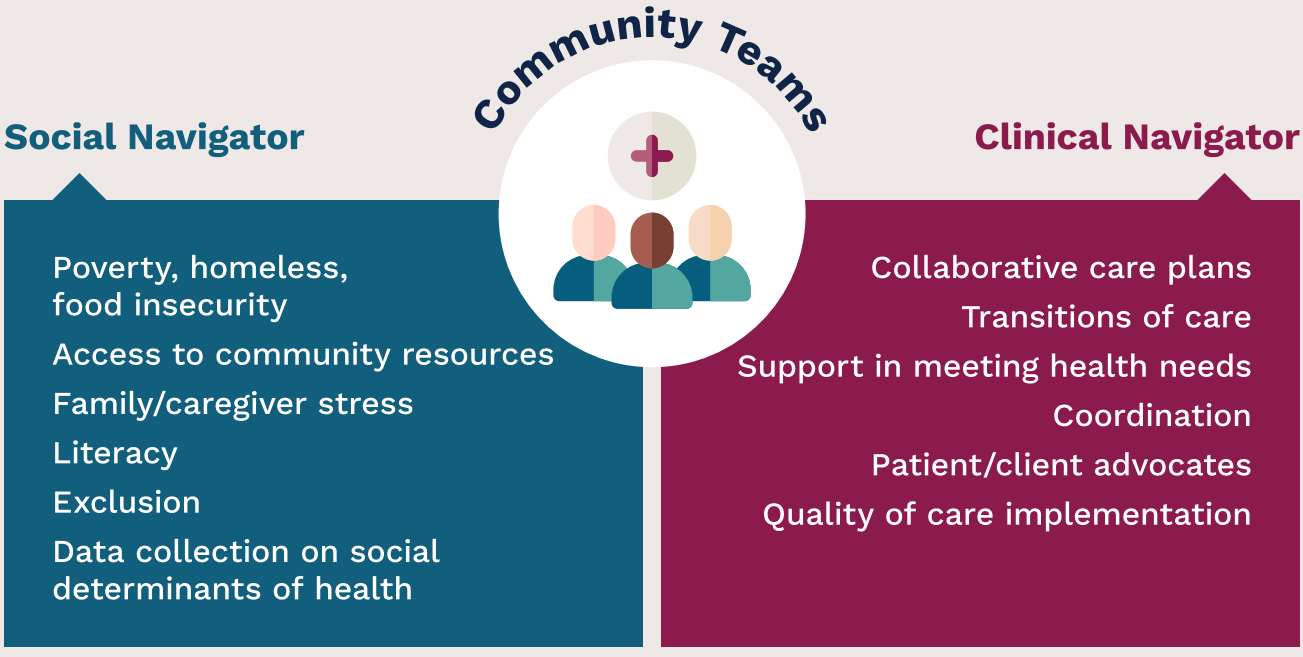


Fig 34. The areas on which social navigators and clinical navigators will focus

Responsibility

Both navigator roles should be assigned within the Community Teams which are components of the publicly funded health system and directed by the proposed Regional Health Councils.

Policy

Each Community Team should have both a social navigator and a clinical navigator whose role descriptions are noted above under “Rationale.” Social navigators should be trained in several areas of competence including motivational interviewing, trauma-informed care, and mental health first aid. Navigators should normally have a bachelor or graduate degree in public health, social work, community health, or a related social science discipline. The navigator should be knowledgeable about the range of resources available and ensure that appropriate referral and subsequent follow-up takes place.

Clinical navigators should be nurses, either registered nurses or licensed practical nurses, with experience in community nursing, acute care, or geriatric care. They should be competent in working independently and exercise clinical judgment in interactions with practitioners, patients/clients, and their families. They should have the ability to allocate authority and/or task responsibility to appropriate team members.

Skills which would be beneficial for both groups of navigators include problem-solving, conflict management, negotiation, effective communication, teamwork/collaboration, cultural competence/safety, case management, planning, and time management.

Structure

The social navigator and the clinical navigator would be assigned from the complement of social workers and nurses allocated to the Community Team. Some responsibility for clinical navigation would also reside within the role descriptions of the other health professionals in the Community Team.

For both positions, an integrated health information system across all levels of care will be essential for accurate and timely identification of such interactions.

Benefits

Throughout the Health Accord public engagement, the word “silo” marked the many interactions within the health system and between health and social systems. The social navigator and clinical navigator positions should be focused on identifying and remedying these gaps and silos among the practitioners within the Community Team and within the broader health and social system with a view to enhancing care and improving outcomes.

The failure to acknowledge the influence of social, economic, and environmental factors on the health of persons and populations should be addressed from multiple perspectives. One such perspective relates to the link between these factors and the health system. Navigators help make these linkages when the patient/client is actively engaging with one or more Community Team practitioners. Not only does the navigator identify the links but also facilitates the connection to the appropriate programs or service outside the health system. The navigator also plays a role in helping use the compiled point of care data with appropriate protections for secondary uses (research, evaluation, policy, and decision-making).

Investments

Two full-time positions for each Community Team at the salary level of a social worker or nurse should be needed. These could be embedded in the investments among the positions identified for a Community Team.

Implementation

Since both navigator positions are embedded in the Community Teams, they should be implemented and evaluated as the Community Teams are implemented.

Cross-References

Calls to Action: 3, 10, 13, 31, 40

Section A:
- A Rebalanced Health System: Community Teams

Section B:
- Community Care Implementation Recommendations
- Aging Population Implementation Recommendations

What does this mean for Joan and Bobby who have complex health needs and need ongoing care?

24. Pathways to Facilitate Change: Improvement in Workforce Readiness and Education

Introduction

In 2021, there were 43,700 health and social sector jobs in the province (20% of all jobs). Nearly 9% of Regional Health Authority (RHA) positions are vacant (double the prior average vacancy rate over a seven-year period). Considering the worldwide shortage of health care workers, sustainability of community and hospital services, particularly in rural areas, is a concern. Recruitment and retention of providers is multi-faceted but is linked directly to work-life balance, workload and burnout. Access to basic and continuing education and development are important factors related to recruitment and retention.

Regional Health Authority employees worked over 850,000 hours of overtime in each of 2019/20 and 2020/21, up from 740,000 hours in 2018/19. While some of this overtime is a direct response to the COVID-19 pandemic, much overtime is the result of workforce vacancy rates. The use of physician locums costs more than $23M annually. Locums serve two purposes, either to fill in physician vacancies or relieve permanent physicians while on leave. High vacancy and overtime rates result in inconsistent providers caring for patients, an exhausted workforce, and more expensive care.

Rationale

Multiple actions are required to improve the availability and retention of human resources in health, from the perspectives of (i) matching the number and mix of providers with need, and (ii) improving workplace well-being (Table 14).

More detail is provided in Section B Workforce Readiness Implementation Recommendations.

Table 14. Actions needed to recruit and retain providers in the health system

Actions
▶ Provincial human resource plan
▶ Workplace transition guiding principles
▶ Work to the full scope of practice
▶ Comprehensive recruitment strategy
▶ Strategies to engage and retain the current and future workforce
▶ An environment that values leadership and management
▶ Evidence and data in strategic human resource planning

Actions on provider education are necessary to provide a high performance health system with informed interprofessional team-based care in a province with a geographically diverse and high rural population (Table 15).

More detail is provided in Section B Education Implementation Recommendations.

Table 15. Actions needed on provider education

Actions
▶ Collaborative education development and delivery model
▶ Providers with a strong interprofessional learning experience
▶ A provincial program for clinical placements
▶ Updated curriculum content

Several of these actions require no new funding.

Responsibility

The Department of Health and Community Services (HCS) is responsible for the human resource plan for the health sector, legislation concerning scope of practice of these providers, and policy in relation to the other objectives, particularly recruitment. The Department of Children, Seniors and Social Development (CSSD) is responsible for the human resource plan for the social sector. The Department of Immigration, Population Growth, and Skills is responsible for supporting immigration for positions in both health and social sectors. The delivery systems have a major role to play in engagement of the current workforce, creating an environment that values leadership, and delivering collaborative continuing education. Health sciences faculties in various institutions support the human resources plan by upgrading curriculum content and collaborating with the delivery systems on continuing education.

Policy

The human resource plan will inform the number of training positions necessary to meet the need for providers and inform the required immigration strategies. Enhanced employment incentives to recruit and retain local Newfoundlanders and Labradorians and strategies to support the permanent workforce required for implementation of hub-and-spoke models of care are preferable to spending on overtime and locums. Strategies to strengthen management and leadership that inspire those with potential to lead will be necessary to implement change, improve quality, integrate across services, engage successfully with providers, and improve continuing education. Collaborative governance among faculties and schools with updated curriculum content will facilitate interprofessional care and continuing education.

Structure

A provincial office for recruitment was announced in January 2022 with the appointment of an Assistant Deputy Minister for Health Recruitment and Retention. The office will need input from and responsiveness to all regions of the province. From an education perspective, provision of continuing interprofessional health care education to teams in their practice environments, together with integrated clinical placements with central coordination, will be necessary.

Investments

Implementation of recruitment initiatives will require investments of $6.5M annually; engagement of the current workforce, $2.9M annually; and strengthening leadership, $0.6M annually. Achievement of education objectives will require investment of cost $0.7M annually.

Benefits

The actions outlined should increase the availability, recruitment, and retention of health care providers; match the numbers and mix of providers with need, enhance interprofessional team functioning, improve work satisfaction and workplace happiness, decrease burnout, and improve quality of care.

Implementation

Work on all objectives above should start in year one as stabilization of the workforce is very important for an effectively functioning health system, for a healthy workplace for staff and physicians, and for successful implementation of other actions outlined in the Health Accord. However, implementation of all tactics will be gradual. Therefore, funding is estimated as follows: year one, $4.7M; year two, $6.7M; year three, $8.7M; and year four and beyond, $10.7M.

Cross-References

Calls to Action: 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47

Section B:
- Workforce Readiness Implementation Recommendations
- Education Implementation Recommendations
- Community Care Implementation Recommendations

25. Pathways to Facilitate Change: Change Management

Introduction

Change management is a collective term for all approaches to prepare, support and help individuals, teams and organizations in making organizational change. Solid change management will result in a change in attitudes, approaches, buy-in, beliefs and, ultimately, in culture. Change management is difficult and requires dedicated effort and resources over a sustained timeframe. It will be critical in the implementation of the Calls to Action of the Health Accord.

There is an evidence-informed compelling case for change. Five elements provide the key to the transformation:

i. focusing on health, not simply health care, with attention to social, economic, and environmental factors that have the biggest effect on health;

ii. rebalancing the health system;

iii. finding the leadership and the energy to undertake substantial change;

iv. listening to the voices of the people for whom the health and social systems exist, and continuing to integrate the learnings from their lived experience with evidence and innovations;

v. providing an environment that is fertile for health and social system change while at the same time ensuring that employees and physicians have protection and security.

The provincial government has initiatives either in place or being developed: a 'health-in-all-policies' approach, a well-being strategy, initiatives to address systemic barriers to homelessness, a plan to ameliorate climate change, home first programs for seniors, collaborative teams for primary care, and a health sector human resource plan. These initiatives are necessary and support the Health Accord Calls to Action.

The desired improved outcomes for the health of the people of Newfoundland and Labrador will not occur without transformational change at every level of our health and social systems. This change will not occur without a very deliberate implementation plan for change for each Call to Action. Public and stakeholder engagement must continue if change is going to be understood, implemented, and successful in improving health outcomes.

Rationale

To bring about the vision, culture shift, and transformation which Health Accord NL believes are essential for improvement in health, health outcomes, and health equity in Newfoundland and Labrador, twelve intersecting and dynamic components are key (Table 16):

Table 16. The key actions for success in the implementation of Health Accord NL

Key Actions for Success
▶ Communicate the vision and key principles of Health Accord NL
▶ Establish clear goals and objectives for every Call to Action
▶ Set the intention and expectation for change within every system and every sector

Continued on next page

Key Actions for Success
▶ Identify the leadership, expertise, and resources required to guide change
▶ Involve in the change process the people for whom the health and social systems exist
▶ Leverage the advantages of digital and virtual technology
▶ Remove barriers and empower people
▶ Be persistent and consistent
▶ Be guided by accountability for reasonableness
▶ Measure the outcomes and change strategy based on the evidence
▶ Adopt and adapt to change both in what is delivered and how it is delivered
▶ Endorse a life-long learning process

While leadership at every level is accountable for implementing change management, evidence shows that having a guiding team (coalition) accountable for overseeing the change management process brings about greater success in achieving the desired outcome. The guiding coalition whose members are educated in change management approaches provides support for leaders, develops processes that are flexible in diverse sectors, ensures attention to the components noted above, and identifies obstacles that are preventing progress. By its presence, the guiding coalition models the new culture that is needed.

Responsibility

Leading this change is the responsibility of the provincial government, but participation must occur at every level of society — policy makers, health and social system delivery, individual providers, and the public. This process requires the breaking down of siloes and must engage:

i. all government departments, but in particular, lead departments such a Health and Community Services; Children Seniors and Social

Development; Education; Justice and Public Safety; Immigration, Population Growth and Skills; and Environment and Climate Change;

ii. the health system at the provincial and regional levels;

iii. the social systems at the provincial and regional levels, including the social sector, the Newfoundland and Labrador Housing Corporation, the education system, and the justice system;

iv. community sector organizations;

v. municipalities;

vi. unions and professional associations;

vii. private sector businesses;

viii. leaders at all levels of organizations — boards, executive teams, managers, staff, volunteers, and union leaders.

A robust change management strategy led by a well-resourced change management team will complement this system-wide expectation. Together, these elements not only will create the capacity for successful implementation of the Calls to Action, but will also sustain beneficial change.

Policy

Change management is an intentional approach to ensuring that change, once identified as needed, is carefully implemented and sustained over time. It responds both to the broader implications of change and to the ways in which individuals, teams, and organizations help reshape the culture, implement the change, and adapt to it.

Social network theory offers new insights into change management, which involves elemental building blocks of nodes and links. The nodes represent the persons, the links indicate the relations among them. The often-invisible webs of relationships within health and social systems can be invaluable resources in managing change. The proven principles of change management are provided in Table 17.

Table 17. Proven principles of change management

Principles of Change Management
▶ Use evidence-based approach to change
▶ Engage employees in the creation of the change management plan
▶ Identify the sponsor(s) and change champions of change management plan
▶ Provide transparency and open communication regarding the change to the general public and all stakeholders
▶ Provide training and support as required
▶ Create an implementation roadmap
▶ Invite participation and feedback
▶ Monitor and measure progress and adjust approach to change as required
▶ Ensure policies will support change in policy, decision-making, and the practice of providers

Structure

The change management strategy will require human resources and operational capacity to carry out the work. The overall transformation should be initiated by implementation of the transitional governance structures (see Summary 29, Governance: Transitional Structures).

The Deputy Minister of Health and Community Services, the Deputy Minister of Children, Seniors and Social Development, the interim CEO of the PHA, and the Senior Executive (Health Accord) should be responsible for establishing the change management strategy required to implement the Calls to Action.

The execution of change strategies to create the needed culture shift will be required at every level and facet of the system and throughout the entire Health Accord implementation process. Therefore, the change management guiding team should be established with a full-time director and a team made up of leaders from the Department of Health and Community Services, the Department of Children, Seniors and Social Development, each of the Regional Health Authorities (subsequently the RHCs), the NL Centre for Health

Information (NLCHI), Memorial University, College of the North Atlantic, major unions, and professional associations linked with the health and social systems. The team should be supported by policy leads from other key government departments (e.g., Education, Justice, Environment and Climate Change, Municipalities, Finance).

To ensure a manageable number for the guiding team, the change strategy team should identify a representative group of no more than ten members from the above groups. The guiding team should create formal and innovative relationships with these groups.

The guiding team should engage directly with the Deputy Ministers of Health and Community Services and Children, Seniors and Social Development, the interim CEO of the PHA, and the Senior Executive (Health Accord) to operationalize the required change strategies and provide support to facilitate suggested changes.

To support change management processes, the change management guiding team should utilize data and knowledge translation methods to enable clear communication of change pathways, goals, objectives and timelines (see Summary 29, Governance: Transitional Structures).

The transformation imagined by Health Accord NL will need change management at several levels.

Examples include:

i. Attention to the connection between interventions in the social determinants of health (SDH) and the rebalancing of the health system.

    - ◇ Develop within the leadership of government departments and within the health system and social systems, an integrated change management approach focused on shifting from health system centric responsibility for health outcomes to a shared responsibility of the health system and the social systems. This must include health educational institutions, municipalities, community organizations, and the private sector.

ii. Creation of Community Teams across the entire province.

    - ◇ Invest in change management to initiate and maintain Community Teams so that they integrate the people, communities, providers, and facilities across the spectrum of health care.

- ◇ Encourage the membership of the Community Teams, which will include a mix of existing health care professionals and additional team members, to work in a different manner than they do today to enable all members to work as a highly functioning team. Failure to invest in effective change management will likely predispose Community Teams to failure.

iii. The use of digital technology to enhance health.

- ◇ Invest in change management and training in digital technology across the spectrum of health providers and institutions, all regions of the province, and communities. The cost will be primarily driven by replacing providers while they are being trained.

- ◇ Establish quick response teams (both technical and digital support teams) to lead change management and to roll-out new technology. Change management will be important for the public as it relates to inclusion, choice (the patient/client has the choice of virtual care or in-person care), and access to their personal health record. Limiting the change management process and education will predispose to failure.

Investments

1. Identify a Director of the Change Management Guiding Team reporting jointly to the Deputy Ministers of Health and Community Services and Children, Seniors and Social Development, with direct connections to the interim CEO of the PHA and the Senior Executive (Health Accord).

2. Build a Guiding Team of leaders from the Department of Health and Community Services, the Department of Children, Seniors and Social Development, each of the RHAs (subsequently the RHCs), the NLCHI, Memorial University, College of the North Atlantic, major unions, and professional associations linked with the health and social systems.

3. All positions described within the Guiding Team currently exist and can be attached to the Guiding Team from within their respective organizations, with the exception of the Director role, which will require funding for three years.

4. Costs of change management described in this summary are embedded in various other implementation Summaries in this section.

Benefits

- As a result of the focus on change management, cultural change will occur, particularly as it relates to inclusion, achievement of quality outcomes, and integration across and within systems. This will require time, perseverance, and leadership. Such a cultural change is essential, however, to achieve better health outcomes and improved health equity.

- Change management, executed well, will:

    - create a structure to implement the Calls to Action and provide a process to engage the public and all stakeholders;

    - facilitate evaluation of the implementation process.

Implementation

1. When the transitional governance structures have been established, identify the Director, Guiding Team members, and support staff. This work should include the creation of change management frameworks and plans, both within government and at the health and social system delivery levels, as well as formal relationships with all the organizations identified above.

2. Partnership with the transitional governance team to develop a change management plan in accordance with the sequence and nature of implementation activities should be created.

3. Structures and work plans within health and social sector delivery to support and drive change at every level inclusive of change management education should be established.

4. A change management plan for implementation of the Calls to Action that includes proven principles of change management should be developed.

5. Public and stakeholder engagement should continue.

6. Progress on implementation plans should be reviewed quarterly.

7. The goals and objectives of the change management plan should be aligned with the evaluation strategy to be executed by the NL Council for Health Quality and Performance.

8. Data capture, analysis, and communication processes necessary to measure progress and monitor performance should be established.

9. Annual progress on Calls to Action should be evaluated by the NL Council for Health Quality and Performance.

10. An iterative loop of change management plans, evaluation of progress, and change in plans based on evidence should be repeated for five to seven years until the Health Accord is substantially complete and a new plan is required.

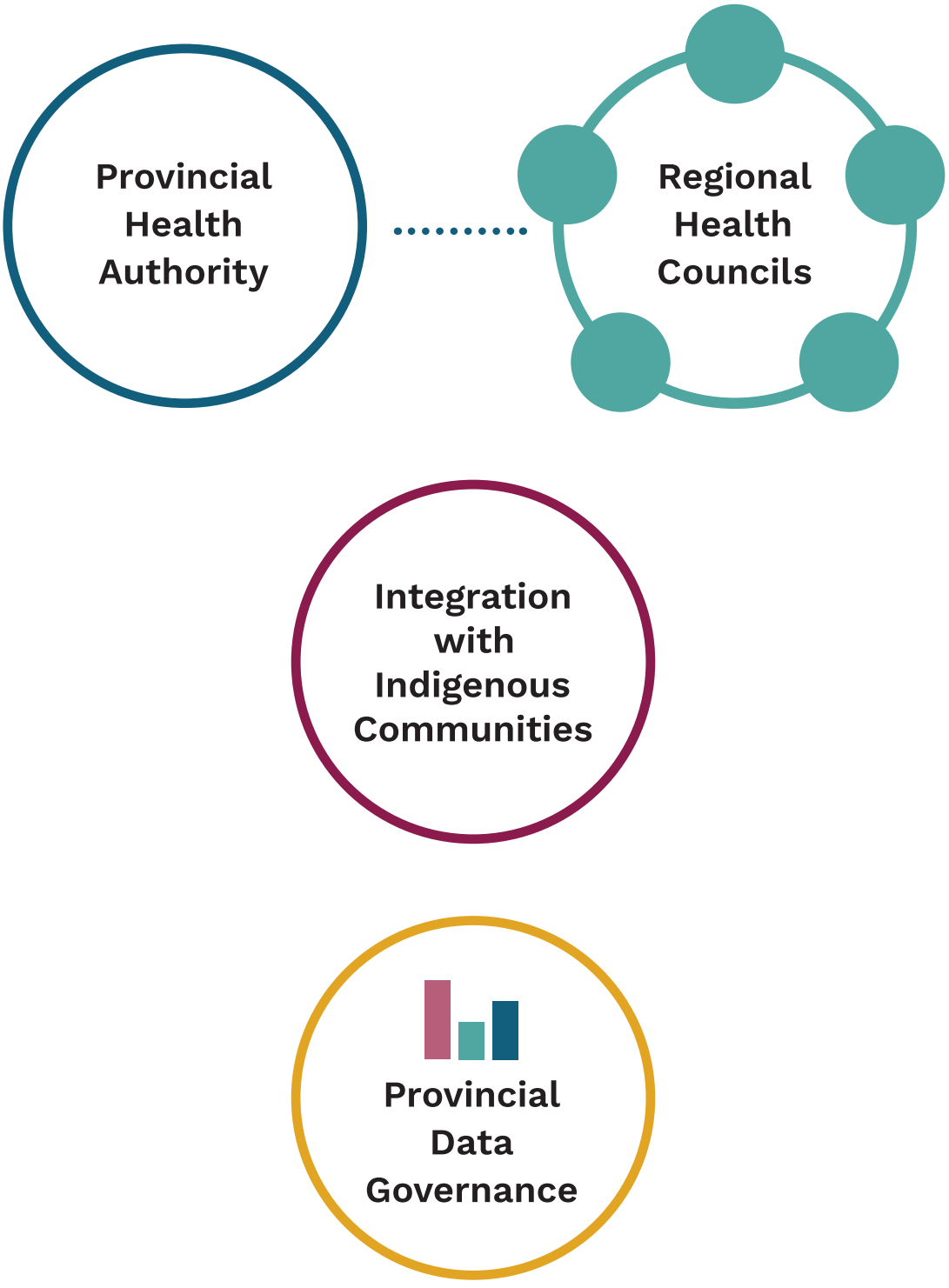
Cross-References

Calls to Action: 47, 53, 54, 55

Section A:
- Governance: Transitional Structures

Section B:
- Governance Implementation Recommendations
- Workplace Readiness Implementation Recommendations
- Social Determinants of Health Implementation Recommendations
- Digital Technology Implementation Recommendations
- Community Care Implementation Recommendations
- Education Implementation Recommendations

V. Governance



26. Governance: An Approach to the Health System

Introduction

The present governance structure in Newfoundland and Labrador includes five governing Boards who have been delegated authority from the Minister of Health and Community Services (HCS) to govern and manage the province's health system: four Regional Health Authorities (RHAs) and the NL Centre for Health Information (NLCHI). The governing boards are challenged to maintain the balance between standardization of programs and services necessary for the small population in the province and sensitivity to diverse needs of people across our complex geography.

Rationale

There are challenges with the existing governance model for Newfoundland and Labrador's health system. There is a lack of clarity concerning accountability between the Minister of HCS and the RHAs. Government has announced that the free-standing Board for the NLCHI will be restructured, but there is as yet no final decision on what that will mean. Many health practitioners and health-related community sector organizations are not included in existing governance structures. While good efforts are being made through Community Advisory Councils and Wellness Coalitions for better linkages with the public and within communities, more work is needed to include the voice of lived experience in decision-making and direction-setting. Diverse funding arrangements exist for community-based organizations which provide direct health care with no certainty of annual budgets, multi-year commitments, or accountability frameworks.

Recent crises including the COVID-19 pandemic and the cyberattack illustrate the lack of standardization among the RHAs with respect to policy or information system protocols. As is so with all jurisdictions in Canada, Newfoundland and Labrador needs to develop standards to address how data is structured, governed, and secured with attention to mediating conflict between privacy and access required for care delivery.

Responsibility

Within our public health system, the responsibility for the overall governance of the system belongs with the provincial government. The Minister of HCS has the mandate to carry out this responsibility under the Health and Community Services Act (2018), the Regional Health Authorities Act, and the Public Health Protection and Promotion Act (2020).

Policy

There is need for a provincial level structure that will have responsibility, authority, and accountability for the overall health system and for those programs and services that can be best standardized, integrated, and delivered provincially. At the same time, the geography of Newfoundland and Labrador with many small communities in rural and remote areas leads to variations in health outcomes and challenges the goal of health equity. A high level of sensitivity is needed to ensure an appropriate response to the diversity of health issues which result from these variations. Stakeholders have clearly emphasized the need for regional structures if we are to best serve our residents and avoid the less-efficient, one-size-fits-all approach that typically occurs in a centralized model.

Structure

The Provincial Health Authority (PHA) will provide province-wide planning, integration, and oversight of the health system and deliver province-wide programs including the ambulance system, the health information and virtual care system, and the Learning Health and Social System (LHSS) (Table 18). For this PHA, there should be a government-appointed board of trustees and a

Chief Executive Officer (CEO) with a senior executive team. The competency-based Board of the PHA should have membership from all regions of the province.

Table 18. Major responsibilities of the Provincial Health Authority

Provincial Health Authority
▶ Consideration of social determinants of health (SDH) in health system
▶ Framework for connecting SDH with health system at provincial level
▶ Standards of care for provincial programs of care delivery
▶ Delegated responsibility and authority to the Regional Health Councils for health service delivery
▶ Change management strategies
▶ Oversight of integrated air and road ambulance system
▶ Province's health information and virtual care system
▶ Accountability for health outcomes
▶ Province-wide efficiencies within the health system
▶ Provincial progressive strategy for recruitment/retention, finance, etc.
▶ Employment structure for the rebalanced health system
▶ Effective, efficient approach to procurement for the health system
▶ Partnerships in building a Learning Health and Social System
▶ Engagement with post-secondary educational institutions with respect to vision and direction
▶ Partnerships with Indigenous communities
▶ Provincial level partnerships with other sectors that affect health

Regional Health Councils (RHCs) should have the level of authority needed to address the organization and quality of health care delivery at the regional level, be sensitive to local and regional variations, facilitate engagement with patients/clients/residents and with members of the public (including youth) to ensure that the health system is responsive to the identified health needs of the people

of the region, and link with other groups and organizations which have an impact on the health of the people of the region (Table 19).

Table 19. Major responsibilities of the Regional Health Councils

Regional Health Councils
▶ Responsibility for direct provision of health services at regional level
▶ Delivery of programs through community teams, health centres, mental health programs, community hospitals, regional hospitals, and publicly funded long-term care facilities in the region
▶ Change management strategies
▶ Identification of number and locations of Community Teams for the region
▶ Standards for program delivery aligned with provincial direction
▶ Inclusive culture and an inclusion lens in health program delivery
▶ Formal and informal structures for working with Indigenous partners
▶ Inclusion and public engagement to ensure continued high-quality care
▶ Formal/informal structures for partnering with patients/clients/residents and with members of the public
▶ Partnerships with community organizations to reach vulnerable populations
▶ Accountability for health outcomes through monitoring and reporting
▶ Reduction in silos among publicly funded and privately funded health care providers
▶ Integration with the Provincial Health Authority
▶ Participation on behalf of the health system in Regional Social and Health Networks
▶ Health equity as a principle in service delivery with outcomes measured
▶ Active participation in the Learning Health and Social System

The RHCs would be led by PHA-appointed Boards with Regional Administrators. The Regional Administrators should be members of the provincial senior executive team led by the CEO of the PHA. The PHA should delegate authority to the RHCs for the organization and quality of health care delivery at the regional level.

Investments

The actual operational investments of one PHA and up to five RHCs will likely be little different from the investments of operating the present five governing Boards. Additional investments at the provincial level should include annual amounts of $0.02M to support participation of Indigenous communities and $0.1M for a position to support partnerships at the provincial level. At the five regions, new investments should include a total of $0.1M for partnerships with Indigenous communities, $0.25M for partnerships with regional community organizations, and $0.5M for increased financial support for Regional Wellness Coalitions. There is a further recommendation for expanding the coverage of expenses for board members to include areas such as childcare and eldercare and per diem amounts to allow the inclusion of members whose expenses are not covered by an organization which can support such expenses. The total annual investment is $1.1M per year.

As noted in Summary 22, Pathways to Facilitate Change: A Modern Health Information and Virtual Care System, the PHA and one provincial digital system will enable efficiencies in back office functions in years four to seven of $5.5M to $22M annually (estimates based on previous studies for 2015; these estimates may be conservative as wage increases since that time have not been considered). There are other areas which are difficult to quantify but will likely produce additional savings, particularly for people, processes, and technology.

Benefits

This new governance structure should ensure consistent quality of care throughout the province, development and maintenance of standards for provincial programs of care delivery, integration of the air and road ambulance system, modernization of the province's health information and virtual care system, province-wide efficiencies in recruitment and retention activities as well as financial systems and procurement, enhanced partnerships with Indigenous communities, regionally-based delivery of health services

(Community Teams, health centres, mental health programs, community and regional hospitals, and publicly funded long-term care facilities), inclusion and public engagement, partnering with patients/clients/residents in their care, strengthened accountability for health outcomes, and reduced silos between publicly funded and privately funded health care providers.

Implementation

The implementation plan for the new governance structure must begin immediately but will need one year's preparation led by a transitional structure (PHA Board and CEO).

Among the issues to be addressed during that one year's preparation are:

- the determination of the number of regions
- delineation of roles and responsibilities between HCS and the provincial and regional structures
- the delineation of roles and responsibilities between the PHA and the RHCs
- the decision about one provincial employer or multiple regional employers
- the appointment process for the Boards of the PHA and RHCs
- the appointment process for the provincial CEO and Regional Administrators

Cross-References

Calls to Action: 48, 49

Section A:
- Pathways to Facilitate Change: Regional Social and Health Networks
- Governance: Integration with Indigenous Communities
- Governance: Transitional Structures

Section B:
- Governance Implementation Recommendations

27. Governance: Integration with Indigenous Communities

Introduction

There are five large Indigenous communities in Newfoundland and Labrador (Fig 35):

1. The Inuit of Nunatsiavut (north coast of Labrador) with approximately 7,200 members. The land claim and self-governing Nunatsiavut Government were established in 2005. Nunatsiavut is part of Inuit Nunagat, the Inuit homelands across all of Canada. The traditional language is Inuttitut.

2. The Innu Nation of Nitassinan in two communities: Natuashish and Sheshatshiu, which have a combined population of approximately 2,500 people. The traditional language is Innu-aimun.

3. The Southern Inuit of NunatuKavut (south coast of Labrador) with approximately 6,000 members represented by the NunatuKavut Community Council. The Canadian federal government announced the beginning of land claim negotiations in August 2018. The traditional language is Inuttitut.

4. The Miawpukek Mi'kmaq First Nation situated in the southern central area of Newfoundland. Around 950 members live on reserve at Conne River and about 2,000 members live off reserve. Their traditional language is Mi'kmaq.

5. The Qalipu Mi'kmaq First Nation in southern and western Newfoundland with about 24,000 members in 67 different communities, as well as members who live outside these communities. Their traditional language is Mi'kmaq.

There are also several other Mi'kmaq communities who live in independent bands on the west coast of Newfoundland.

Fig 35. The geographic location of Indigenous communities in Newfoundland and Labrador (provided by First Light, St. John's Friendship Centre)

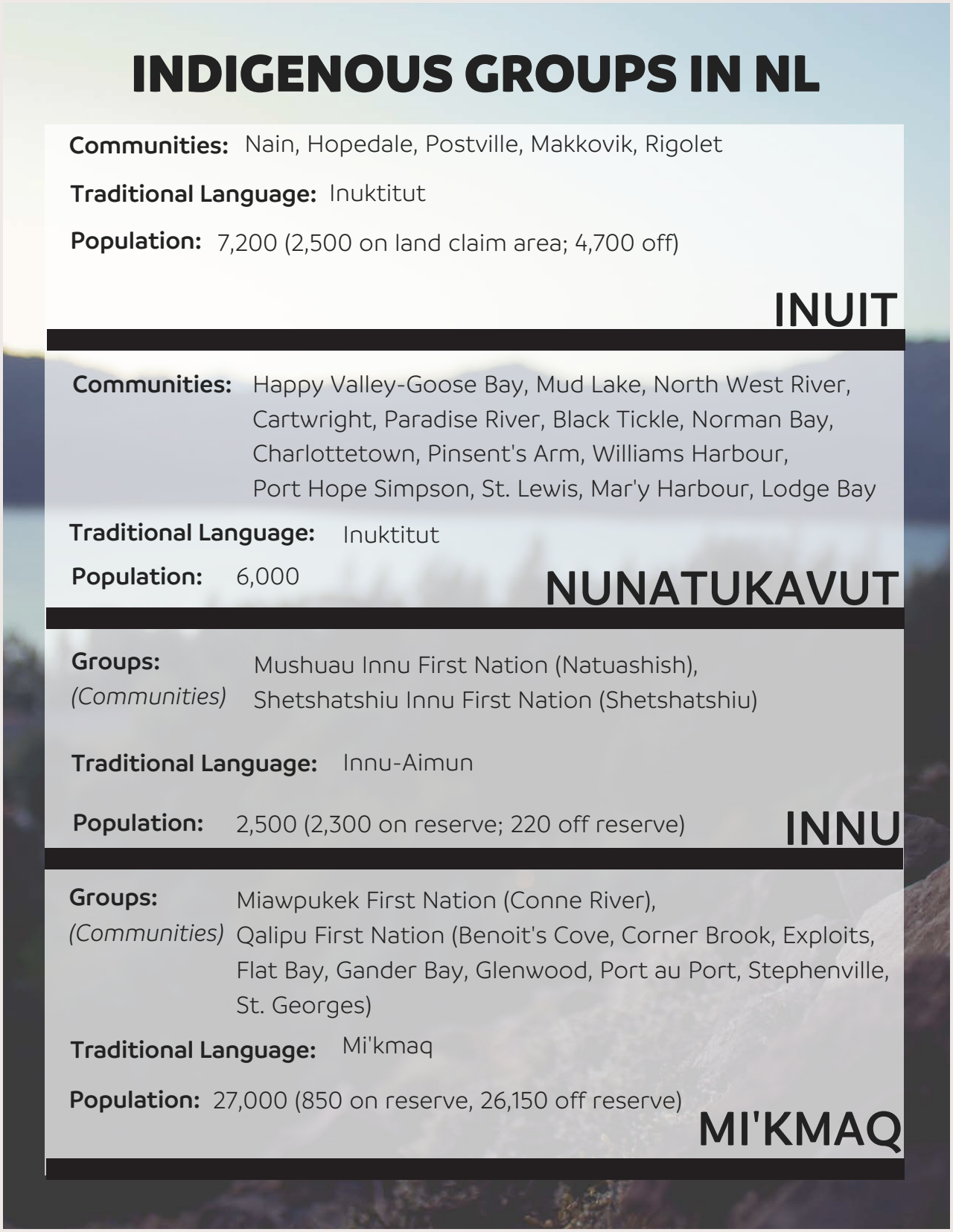


Fig 35. The geographic location of Indigenous communities in Newfoundland and Labrador (provided by First Light, St. John's Friendship Centre)

Members of Indigenous communities were present on the Health Accord Task Force as well as strategy committees and working groups. A special town hall was held with the members of the Qalipu Mi'kmaq First Nation. One of the Co-Chairs gave an interview with OK (OKâlaKatiget Society) Radio which provides communications with the Inuit of the North Coast and Lake Melville region of Labrador. Regular meetings were held with the leadership of the Indigenous communities.

In his mandate letter to the federal Minister of Health in December 2021, Prime Minister Trudeau included the following direction: "In support of the Indigenous Early Learning and Child Care system, continue to invest in Aboriginal Head Start in Urban and Northern Communities Program." In that same letter, the Prime Minister also supported another basic tenet underlying the work of Health Accord NL and Indigenous communities when he said that the Minister must "collaborate with various communities, and actively seek out and incorporate in your work, the diverse views of Canadians. This includes women, Indigenous Peoples, Black and racialized Canadians, newcomers, faith-based communities, persons with disabilities, LGBTQ2 Canadians, and in both official languages."

Rationale

There continues to be a gap in life expectancy of more than ten years between Indigenous people and non-Indigenous people in Canada, also likely to be the case in Newfoundland and Labrador. A disproportionate number of Indigenous children are in care in our province. In her 2019 report, the Child and Youth Advocate found that 34% of children in care are Indigenous.

Indigenous communities have differing degrees of self-government and, therefore, differing degrees of authority over their primary health and social systems. All communities rely on the provincial government for secondary and tertiary health services.

Indigenous communities bring wisdom to the vision of improved health, health outcomes, and health equity, most especially in their close connection with the land and in their understanding of the importance of the health of the community as well as the health of individuals in the community.

Therefore, it is important that there be a strong partnership between the government of Newfoundland and Labrador and the governing councils of the various Indigenous communities — to ensure improved health and health equity for members of the communities and for the shared wisdom about improved health for everyone in Newfoundland and Labrador.

Responsibility

Responsibility lies with leadership from the provincial government and with leadership from the varied Indigenous communities.

Policy

In addressing the health inequity experienced by the members of Indigenous communities in Newfoundland and Labrador, Health Accord NL reiterates the need to listen to the voices of Indigenous people and communities. An important resource in listening to the lived experience of Indigenous peoples comes from the Truth and Reconciliation Commission's Ten Principles for Reconciliation and 94 Calls to Action that speak to all sectors of Canadian society.

The guiding principles for the Recommendations include "the health of Indigenous people," "health inequity," and "collaboration," all important in developing any Calls to Action which relate to members of Indigenous communities. Attention is paid to social exclusion and anti-racism as well as intergenerational trauma linked with the residential school system and the near erasure of recognition of the Qalipu First Nation. Racism and all forms of exclusion limit access to social supports, including health care treatment, and negatively affect the health and wellness of Indigenous peoples as well as other excluded groups.

The pathway to inclusion, therefore, must include responsive means of engagement, knowledge collection, knowledge transfer, and participation for groups experiencing health inequities in a "meeting people where they are" approach — "Nothing about us without us." This must be evident throughout

the province. It must also focus on a culture of equity and inclusion within health organizations demonstrated through the values, language, and behaviours of people working in the system and affirmed by the reported experience of patients, clients, and residents.

Areas linked with the health system which must pay particular attention to members of Indigenous communities especially those who live in remote areas include the integrated air and road ambulance system, care for older persons, the recruitment and retention of health professionals, and comprehensive curriculum review related to concepts of cultural safety/humility, anti-racism, equity, and inclusion.

Structure

Once the new governance structures are approved, the Provincial Health Authority (PHA) and the recommended Regional Health Councils (RHCs) should create formal partnerships with Indigenous communities at the provincial level and within the regions. The Boards should include in their membership representatives of Indigenous communities. The Regional Social and Health Networks (RSHNs) should also include the leadership of Indigenous communities in their respective regions.

Indigenous communities should be represented as members of The Premier's Advisory Council on Health (see Summary 29, Governance: Transitional Structures).

Investments

Specific investments related to the policy and structural changes above are contained in the investments already identified for each area throughout the implementation recommendations.

Implementation

From the beginning of the implementation of the Health Accord, the unique presence of Indigenous people in Newfoundland and Labrador and their relationship with the provincial government must be acknowledged and included in all planning and implementation steps in response to the Calls to Action.

Cross-References

Calls to Action: 1, 3, 5, 7, 8, 12, 23, 31, 40, 44, 45, 48, 49, 56

Section A:
- Rebalancing the Health System: Air and Road Ambulance Services
- Governance: Transitional Structures

Section B:
- Social Determinants of Health Implementation Recommendations
- Aging Population Implementation Recommendations
- Hospital Services Implementation Recommendations
- Workforce Readiness Implementation Recommendations
- Education Implementation Recommendations
- Governance Implementation Recommendations

28. Governance: Provincial Data Governance Model

Introduction

Digital technology is advancing at a rapid pace. The internet and the means to access it (such as tablets and smartphones), social media platforms, and messaging apps have become integral to the lives of people globally. Data governance ensures instant communication and information availability and storage, has educational benefits, creates social connectivity, allows remote working and work collaboration, and enables health care delivery, management, and research.

In our health and social systems, data is an important, valuable public asset that is required to deliver health care, make informed policy decisions, monitor health and social system performance, enable research and innovation, and empower citizens with access to their own health information.

However, today's digital technology and information systems are provider-centric, and our legislation is designed based on custodians who determine access to patient information. There is an urgent need to shift from a provider-centric model to a person-centric model and modernize our legislation to enable appropriate data access and sharing. Data must be accessible to the person about whom the information exists. Provider teams must have access to all pertinent patient information and community/population-level data through digital technology solutions to enable shared information for patient/client/resident care. Access is needed for uses beyond direct care, such as research, innovation, and health and social system performance measuring and monitoring.

A robust data governance framework is essential to protect the privacy of Newfoundlanders and Labradorians while using the benefits of this technology. A resource to support this framework is a Digital ID that allows people to verify themselves online securely and to protect personal information. Digital identity is an electronic representation of a person, personal information used exclusively by that person to verify themselves online securely in order to receive valued services and to carry out transactions with trust and confidence.

Source: The United Nations (https://unite.un.org/blog/the-importance-of-data-governance)

Fig 36. Key elements of data governance

Rationale

Data governance is everything done to ensure that data — for both internal and external uses — is secure, private, accurate, complete, available, trustworthy, and usable. It includes the actions people must take, the processes they must follow, and the technology that supports the entire data life cycle. Data governance means setting internal standards or policies that apply to how data is gathered, stored, manipulated, accessed, and deleted. Elements include privacy, data ethics, security, information management, data architecture, data modeling and design, data storage and operations, data integration and interoperability,

documents and content, reference and master data management, data warehousing, meta-data, and data quality.

Data governance provides data management practices with the necessary foundation, strategy, and structure needed to ensure that data is managed as an asset and an invaluable resource.

The Health Accord has identified the need to:

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

ii. improve access to data for all partners linked with the social determinants of health (e.g., Regional Health Authorities, Departments of Health and Community Services; Children, Seniors and Social Development; Finance, Education, and Justice and Public Safety);

iii. implement a renewed governance structure for Healthy Students Healthy Schools (HSHS) to facilitate the use of the CSH framework in schools (a joint endeavour of the Departments of Health and Community Services and Education);

iv. identify, document, address, and track indicators of social determinants of health in Newfoundland and Labrador, in an ethically transparent and publicly accessible manner, at the point of care in the health system and at community, regional and provincial levels.

These actions cannot be ethically and effectively implemented without a transparent and provincial data governance model.

Responsibility

A data governance model requires a holistic approach where all those who have a vested interest in the data participate in the practice and focus on learning and improving data over time. It is well-understood that unconscious bias and social cultural norms can cause people to reinforce exclusion and biases in collecting, analyzing, using, and sharing data. The voices of vulnerable and marginalized groups must be present and heard when data governance structures and processes are being developed and implemented.

Policy related to data governance should be developed by the provincial government in a collaborative approach with the federal, other provincial and territorial governments. The Health Accord proposes that the Provincial Health Authority be delegated responsibility to modernize and manage the province's health information including its management systems and virtual care technology (see Action 48). The PHA must work closely with the appropriate government departments and offices to help create and implement the data governance model and framework.

Policy

Elements of policy development related to data governance include the following:

i. Oversee the development of an integrated data governance model to improve the health and social systems of the province.

ii. Ensure that the privacy of the person whose health information is being used is protected and that the person has control over the use of the data.

iii. Align public policy and legislation to address data custodianship — who owns health and SDH data and how and when the data can be used.

iv. Create a provincial data strategy, organizational structure, and processes that align with health and social system priorities, including linkages with the social determinants of health.

v. Ensure that data governance clearly supports the priorities and strategies of those who need the data, serves the needs of users throughout the data life cycle, and balances apparent conflicts between data privacy and care delivery.

vi. Engage all those who are representatives of the stakeholders (owners, producers, users, or beneficiaries of the data) in shaping the data governance process with special attention to the inclusion of persons who are from marginalized or at-risk groups in the society.

vii. Understand data governance as an ongoing and iterative process, responsive to changing circumstances and enabling leaders to re-balance priorities.

viii. Ensure that each organization has a data governance framework consistent with the provincial policy.

ix. Support the government's efforts to develop a digital identity program for the people of the province.

x. Promote data governance as a resource for improving health outcomes and health equity.

Structure

It may be necessary to amend the Access to Information and Protection of Privacy Act (ATIPPA) as well as other Acts related to governance in general to allow for new approaches to data governance. Government, through its Office of the Chief Information Officer and the Office of the Information and Privacy Commissioner, holds ultimate responsibility for oversight of information protection and digital technology.

Any organization which has access to personal information should have governance frameworks based on the provincial template with roles and responsibilities of users of data, rules for access to data, management of data breaches, training requirements, etc. Awareness of the ongoing and iterative growth of digital technology must be built into the Provincial Data Governance Model.

Ongoing collaboration with the federal government, other provincial governments and territorial governments is essential to ensure a pan-Canadian approach to this fundamental element in our lives.

Investments

The investments needed to develop the Provincial Data Governance Model are included within investments related to the modernization of the province's health information and virtual care system (see Actions 34, 36).

Benefits

Appropriate data governance ensures the balance between the privacy of the person whose information is being gathered and used and the user of the information (e.g., health care providers, managers, researchers, policy makers). It allows the benefits of digital technology (as outlined above in Actions 34, 35, 36) to be realized to improve the health and social systems of Newfoundland and Labrador. It gives the people of the province a strong voice in shaping policy and practice related to the collection, quality, coordination, transparency, and analysis of personal and population data for the purpose of strengthening health, health outcomes, and health equity in the province.

Implementation

Good work on data governance has been initiated by the Newfoundland and Labrador Centre for Health Information and by the Office of the Chief Information Officer. This work must be expedited in anticipation of the redevelopment of the health information and virtual care system as proposed by Health Accord NL.

Cross-References

Calls to Action: 34, 35, 36

Section A:
- Pathways to Facilitate Change: A Modern Health Information and Virtual Care System

Section B:
- Digital Technology Implementation Recommendations

29. Governance: Transitional Structures

Introduction

It is urgent that the transformation envisioned by Health Accord NL begin as soon as possible. Since creating legislation and establishing governing structures needs appropriate time and careful attention, it is recommended that a transitional structure be established to prepare for the more permanent structure. The transitional structure must ensure that the transition focuses on the importance of attention to social determinants of health (SDH) and on the preparation for the rebalancing of the health system.

Rationale

The transitional structure would have three components: an appointed Senior Executive (Health Accord), a transitional Provincial Health Authority (PHA) and Chief Executive Officer (CEO), and a transitional NL Council for Health Quality and Performance. It is also recommended that an Advisory Council on Health be established to ensure continuity with the Health Accord process and ongoing engagement with the people of the province. All would work closely together to begin the implementation process and to ensure the ongoing engagement with the public in these first steps.

The existing Regional Health Authorities (RHAs) would continue with their mandates during the transitional year. The RHAs would begin preparatory steps for the establishment of Community Teams and improvement of sustainability in health services.

The development of the Regional Social and Health Networks (RSHNs) should also be initiated in this transitional period, led by the Senior Executive (Health Accord) and the Advisory Council on Health.

Responsibility

Government has recently appointed the interim CEO of the PHA. The appointment of a transitional Board for the PHA has not yet been announced. The Premier and Cabinet are encouraged to appoint the Senior Executive (Health Accord) position within the Cabinet Secretariat as well as the Premier's Advisory Council on Health. The Senior Executive (Health Accord), working with the Premier's Advisory Council on Health, would facilitate the initiation of the RSHNs.

Policy

The Senior Executive (Health Accord) would be in place for three years with a mandate to oversee the beginning of the implementation of the Health Accord's Calls to Action with the authority to lay out the framework to support the full transition imagined in the Health Accord. The Senior Executive (Health Accord) would provide advice on the shift in focus to the SDH and initiate the development of the integrating RSHNs, provide policy advice on key initial implementation steps (e.g., integrated air and road ambulance system, new health information and virtual care systems, development of Community Teams, the NL Council for Health Quality and Performance, sustainability of health services where there are low numbers of patients and challenges in recruitment of health professionals), and participate in engagement with the federal government.

An Advisory Council on Health would be established with members from the Health Accord's Task Force to ensure continuity with the strategic visioning process undertaken by the Health Accord. The Advisory Council should include representation from all regions of the province as well as from Indigenous communities.

The transitional PHA and CEO for the health system would be in place for one year with a mandate to set the groundwork for the implementation of the rebalanced health system. Acknowledging the instability this may cause already stressed staff, managers, and physicians, it is essential that the transitional CEO have strong and demonstrated change management skills.

The transitional Board and CEO would work closely with the Senior Executive (Health Accord) in the preparation for actions needing immediate attention including the integration of the air and road ambulance system, the new approach to a health information and virtual care systems, and the development

of the Learning Health and Social System (LHSS). The Board and CEO would be expected to use modern change management approaches to address the complexity inherent in rebalancing the health system.

A transitional NL Council for Health Quality and Performance would be created in anticipation of the legislated Council. This transitional Council would connect directly with Quality of Care NL; identify baseline indicators for reporting to the public, providers, institutions and governance structures; initiate the evaluation plan, and support and advocate for the culture shift to a LHSS.

Structure

The Senior Executive (Health Accord) would be supported by a committee of Deputy Ministers from the many departments directly connected to this Accord implementation process.

The Advisory Council on Health would report to the Premier with support from the Senior Executive (Health Accord).

In accordance with current governance best practice, the Board of the transitional PHA would be competency-based with predetermined competencies, inclusive of geographic and Indigenous representation.

Table 20. Transitional structures prior to the formalization of permanent health and social governance structures

Transitional Structures
Interim Provincial Health Authority Board and CEO
Regional Health Authorities (existing)
Senior Executive (Health Accord) in Cabinet Secretariat
Premier's Advisory Council on Health
Interim NL Council for Health Quality and Performance

Investments

The estimated investments for the transitional PHA Board and CEO, the Senior Executive (Health Accord) supported by a policy advisor, the Advisory Council on Health would be $0.9M for year one and $0.3M for years two and three. The cost of the transitional NL Council for Health Quality and Performance is noted in Summary 21, Pathways to Facilitate Change: NL Council for Health Quality and Performance.

Benefits

This transitional structure ensures that the momentum gained in the creation of the Health Accord will not be lost while the appropriate legislation is developed for the permanent structures, and while further engagement is undertaken about specific implementation steps.

Implementation

Implementation of the transitional structures would be within four months of the submission of The Recommendations to the Premier and Minister of Health and Community Services.

Cross-References

Calls to Action: 56

Section A:
- Pathways to Facilitate Change: NL Council for Health Quality and Performance

Section B:
- Governance Implementation Recommendations
- Quality Health Care Implementation Recommendations

Section A: Conclusion

Section A calls attention to the major focuses of the Health Accord: the social determinants of health, a rebalanced health system, pathways to facilitate change, governance, financing, and timelines. This framework for the implementation plan for completion within five years will be useful for engagement in finalizing the process for implementation, for decision-making related to policy and procedure, and for evaluation to start as soon as the implementation begins.

A graphic overview of the Health Accord NL: Timelines for Implementation of Major Actions can be found on pages 30–40 of this Blueprint. It is also presented separately in a poster format for ease of reference for accountability.

The four case studies woven through the twenty-nine summaries have shown the importance of responding to Health Accord NL's Calls to Action for improved health and health outcomes for individual Newfoundlanders and Labradorians. Whether we look through the lens of the personal lives of people as these case studies do or the health of the population as the summaries do, the overarching call to action is clear: the intersection of attention to social, economic, and environmental conditions with the rebalancing of our health and social systems is essential if we are to achieve our vision of better health and health outcomes as well as improved health equity for the people of the province.

We know what needs to be done. We now have an overview of realistic and financially accountable ways to do what needs to be done. The last summary of Section A describes a transitional structure which allows us to begin the journey of implementation immediately. Section B, Implementation Recommendations from the Strategy Committees and Working Groups, is a separate document which gives more detail and further options about ways of ensuring that this journey takes us to a healthier Newfoundland and Labrador. The time has come to start a new journey together, confident that we can choose to improve health for ourselves and for all those who will come after us in this place which we call home.

Appendix A

Introduction to Section B: Implementation Recommendations from the Strategy Committees and Working Groups

Health Accord
for Newfoundland & Labrador

Our Province. Our Health. Our Future.
A 10-Year Health Transformation:
THE BLUEPRINT

Recommendations presented as part of the implementation ideas for the Health Accord NL Calls to Action are outlined in two Sections.

Section A provides a set of summaries for the major action areas, briefly outlining the rationale, responsibility, policy, structure, benefits, investment, and implementation timeline for each one.

Section B provides more details on how each action may be implemented.

The ideas outlined in Section B represent the work of each of the six strategy committees and four working groups of the Health Accord NL Task Force. Throughout the period of time in which Health Accord work has been ongoing, over 100 members of committees and working groups from all over the province brought a wealth of knowledge and lived experience that has contributed to idea generation in the hopes that practical, sustainable, and positive change may occur. Engaging with experts, health and social system stakeholders, and the public, committees and working groups have scoured research and evaluation findings, articles, jurisdictional scans, and many other bodies of knowledge to become well informed on the most pertinent ideas to bring forward. Those ideas are captured in Section B of the Blueprint: Implementation Recommendations from the Strategy Committees and Working Groups.

The ideas presented in Section B are not meant to be prescriptive or all encompassing. They are not meant to outline the only way forward, but simply a way forward that is rooted in a strong foundation of knowledge, research, and evidence.

One of the guiding principles of our work is accountability for reasonableness. This means that we all must understand that our realities of today will not be our realities of tomorrow. Things are always changing. Therefore, we must be constantly adapting as we work together to find our way.

It is our hope that, as the recommendations are implemented, we will find the balance between our confidence about the pathways presented and the need to be nimble and pragmatic in our problem solving.

Section B of the Blueprint: Implementation Recommendations from the Strategy Committees and Working Groups may be found online at www.healthaccordnl.ca/final-reports/

Appendix B

Introduction to the Evidence Archive

Health Accord
for Newfoundland & Labrador

Our Province. Our Health. Our Future.
A 10-Year Health Transformation:
THE BLUEPRINT

Since the inception of Health Accord NL, transparency has remained a guiding principle for all work. As such, we are pleased to provide a repository of all the evidence which informed the work of Health Accord NL: summaries of the evaluations of the health and social systems in the province, input from the six-part public engagement series, expert testimony, formal presentations by stakeholders, reports, and Canadian and international research findings.

The Evidence Archive is easily accessible and searchable by various topics and interests. The Archive has been developed so that it may grow over time as work continues to serve as a health and social system resource for decision-makers, the public, and everyone who has an interest in transforming health or sees themselves at the center of change.

The archive may be found online at healthaccordnl.ca/the-evidence/

Appendix C

Required New or Revised Legislation and Regulation Resulting from Health Accord NL

Health Accord
for Newfoundland & Labrador

Our Province. Our Health. Our Future.
A 10-Year Health Transformation:
THE BLUEPRINT

Relevant Call to Action	Potential Legislative Impact
Life with Economic Security	
Action 3: Ensure that Newfoundlanders and Labradorians have a liveable and predictable basic income to support their health and well-being, integrated with provincial programming to improve food security and housing security.	Provision of basic income would require new or amended legislation. Simplified income support process may require an amendment to the Income and Employment Support Act. Attention to living wage and decent work would require amendments to the Labour Standards Act. Barriers to MCP may require an amendment to the Medical Care and Hospital Insurance Act.
Climate Emergency	
Action 4: Take an aggressive and proactive approach to addressing the climate emergency through increased awareness, focused planning, aligned resources, and effective accountability mechanisms.	This may require amendments to any acts impacting Fisheries; Forestry; Agriculture; Energy and Technology; Transportation and Infrastructure; Municipalities; and Environment. There is no immediate need for amendments identified.
Pathway to Inclusion	
Action 5: Take immediate action to create a provincial Pathway for Inclusion, shaping an inclusive health system within an inclusive society.	This may require an amendment to the Human Rights Act, 2010. There is no immediate need for amendments identified.
Integrated Models of Care for Children and Youth at Risk	
Action 7: Develop one model of community health services for children and youth with complex health needs and a more integrated approach to respond to health needs of children and youth in care.	This may require amendment to the Children, Youth and Families Act. There is no immediate need for amendments identified.

Continued on next page

Relevant Call to Action	Potential Legislative Impact
Progressive Aged Care Legislation, Regulation, and Policy	
Action 12: Develop and implement provincial legislation, regulation, and policy required to provide appropriate, quality, and accessible care and protection for older persons in Newfoundland and Labrador.	New legislation will be required to provide appropriate, quality, and accessible care and protection for older persons inclusive of enshrining the rights of older adults and establishing an accountability structure for an integrated, transparent, and coordinated approach to quality care. A new legislative framework (Act and regulations) for home care, supportive housing for seniors, personal care homes and long-term care facilities will be required. Amendment of the Seniors Advocate Act will be needed to mirror the powers of the Child and Youth Advocate. There may be need to update the Advance Health Care Directives Act.
National Pharmacare	
Action 29: Establish a pharmacist-supported model to improve appropriateness of medication use and continuity of care in the community, long-term care and in hospitals. Support the creation of a National Pharmacare Program.	A National Pharmacare Program may require amendment to federal legislation including the Canada Health Act and potentially the creation of a new federal Pharmacare Act. At the provincial level, amendments may be needed to the Pharmaceutical Services Act, and the Pharmacy Act, 2012.
Occupational Health Clinic	
Action 32: Create an Occupational Health Clinic with linkages to the Community Teams.	There may be a need to amend the Workplace Health, Safety and Compensation Act.

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Relevant Call to Action	Potential Legislative Impact
Provincial Integrated Air and Road Ambulance System	
Action 23: Design one provincial, modern, integrated air and road ambulance system with a central medical dispatch.	There is a need to review the new Emergency Health and Paramedicine Services Act to ensure that it is reflective of the Health Accord NL ambulance plan and is comprehensive and up to date. New regulations, standards, and policies will be required.
Scope of Practice	
Action 39: Create a health and social system environment that enables all providers to work to the highest scope of practice within their education and/or training.	There are 17 acts regulating health professionals in Newfoundland and Labrador. In specific cases, legislation for health professionals and corresponding regulation will need to be modernized to support these changing scopes. There will need to be a review of legislation and regulation of regulated professionals to determine if changes are required.
Collaborative Education Development and Delivery Model	
Action 45: Develop and deliver education and continuing education programs that use an integrated, inclusive, and collaborative care model where practitioners learn and practice together. This requires integration across curricula and across programs throughout the learning experience.	Legislative amendments may be required to the Council on Higher Education Act, the Memorial University Act, the College Act, and the Private Training Institutions Act.

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Relevant Call to Action	Potential Legislative Impact
Provincial Health Authority	
Action 48: Create a Provincial Health Authority to provide province-wide planning, integration, and oversight of the health system and to deliver province-wide programs such as the ambulance system and information systems.	New legislation will be required to create a Provincial Health Authority. There may also need to be amendments to the Health and Community Services Act, and the Public Health Protection and Promotion Act. The Regional Health Authorities Act will likely be replaced. The Independent Appointments Commission Act will need to be amended to permit the appointment of the permanent CEO of the Provincial Health Authority outside the Independent Appointments Commission.
Regional Health Councils	
Action 49: Create Regional Health Councils that (i) have the level of authority needed to address the organization and quality of health care delivery at the regional level, (ii) are sensitive to local and regional variations, and (iii) facilitate engagement with patients/clients/residents and with members of the public (including youth) to ensure that the health system is responsive to the identified health needs of the people of the region.	New legislation will be required to create the Regional Health Council. The Regional Health Authorities Act will likely be replaced.
Regional Social and Health Networks	
Action 50: Establish a Regional Social and Health Network in each region of the province which is responsible for the integration of the services of various organizations that influence health and health outcomes (e.g., health systems, social programs, municipalities, schools, police, recreational programs, arts and cultural programs, community sector non-profit and voluntary groups, and private sector businesses).	New legislation will be required to create the Regional Social and Health Networks.

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Relevant Call to Action	Potential Legislative Impact
NL Council for Health Quality and Performance	
Action 26: Establish the NL Council for Health Quality and Performance to improve health and social systems, which fully incorporates principles of diversity, inclusion, and integration.	New legislation will be required to establish the NL Council for Health Quality and Performance.
Accountability for Improved Health Outcomes	
Action 25: Improve accountability structures within the health and social systems to focus on achievement of better health outcomes.	There may need to be amendments to the Transparency and Accountability Act, the Public Health Protection and Promotion Act, the Patient Safety Act, the Health and Community Services Act, the Emergency Health and Paramedicine Services Act, and any related regulations to include requirements for accountability that cross all levels of health organizations — board, CEO, executive, management, and front line.
Provincial Data Governance Model	
Action 51: Develop a holistic and integrated Provincial Data Governance Model which includes a strategy that defines a vision for how data will be used to improve the health and social systems of Newfoundland and Labrador in a transparent and accountable manner.	Amendments may be required to the Personal Health Information Act and the Access to Information and Protection of Privacy Act, 2015.

Appendix D

Health Accord NL Terms of Reference

Health Accord
for Newfoundland & Labrador

Our Province. Our Health. Our Future.
A 10-Year Health Transformation:
THE BLUEPRINT

Appendix D: Health Accord NL Terms of Reference

Purpose:

Health Accord NL, the provincial Task Force on health (the Task Force), is responsible for developing a 10-Year Health Accord for Newfoundland and Labrador that comprises actions and recommendations in strategic areas of health and health care to be implemented throughout the life of the Health Accord.

Mandate:

The Task Force has the mandate to:

- Work with the Minister of the Department of Health and Community Services to assist in the delivery of the Task Force mandate.
- Work with the Task Force strategic committees and working groups to review work plans, provide strategic direction, ensure connection and continuity, and build consensus amongst stakeholders for actions and recommendations.
- Work to implement strategies to ensure opportunities for two-way engagement and communication with all stakeholders, particularly the public, including opportunities to provide feedback to and connect with representatives on the Task Force, committees, and working groups.
- Work with key informants, Indigenous communities, and the community sector to garner advice and counsel as needed, as well as to build consensus for actions and recommendations.

Membership:

Task Force Members:

- Co-Chairs, Task Force (2 positions)
- Chair, Social Determinants of Health Committee*
- Chair, Community Care Committee
- Chair, Hospital Services Committee
- Chair, Aging Population Committee
- Chair, Quality of Care Committee*
- Chair, Digital Technology Committee
- Chief Executive Officers, Regional Health Authority (4 positions)
- Chief Executive Officer, NL Centre for Health Information
- Deputy Minister, Health and Community Services
- Executive Director, NL Medical Association
- President, Registered Nurses Union of Newfoundland and Labrador
- Executive Director, Association of Allied Health Professionals
- President, Newfoundland and Labrador Association of Public and Private Employees
- President, Canadian Union of Public Employees
- Dean, Faculty of Medicine, Memorial University
- Community Members (3 positions)
- Member from Indigenous Communities
- Member Appointed by Liberal Party
- Member Appointed by Progressive Conservative Party
- Member Appointed by New Democratic Party
- Engagement Advisor (1 position)
- Chair, Workforce Readiness Working Group
- Chair, Education Working Group
- Chair, Governance Working Group*
- Chair, Finance and Intergovernmental Affairs Working Group*
- Other representatives as invited or required by the Task Force

* The Co-Chairs chaired two committees and two working groups.

Secretariat:

- Operations Manager
- Senior Policy Advisor – Health
- Senior Policy Advisor – Interdepartmental
- Clinical Epidemiology Advisor
- Implementation Advisor
- Communications Advisor
- Other representatives as invited or required by the Task Force

Rules Of Procedure:

Meetings:

- The Task Force will meet monthly.
- The Secretariat will support the Task Force and will distribute a draft agenda with relevant documents for the meeting no later than five days before an agreed meeting date.
- The Task Force will strive to work by consensus in drafting its advice and recommendations.
- A record of each meeting will be kept and will be circulated to The Task Force after each meeting.

Accountability:

- The Task Force is accountable to the Premier and the Minister of Health and Community Services.

Members:

- Attend meetings on a regular basis.
- Review all necessary meeting material and be prepared to speak to the items on the agenda.

Review:

These terms of reference will be reviewed as needed.

Appendix E

Health Accord NL Membership: Task Force, Strategy Committees, and Working Groups

Health Accord
for Newfoundland & Labrador

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Membership: Task Force, Strategy Committees, Working Groups

Health Accord NL Task Force Members

Task Force	
Task Force Co-Chair **Committee Chair: Quality Health Care** **Working Group Chair: Finance**	**Patrick Parfrey** *(Clinical Lead, Quality of Care NL; John Lewis Paton Distinguished University Professor)*
Task Force Co-Chair **Committee Chair: Social Determinants of Health** **Working Group Chair: Governance**	**Elizabeth Davis**
Committee Chair: Community Care	**Shanda Slipp** *(Family Physician, Western Health)*
Committee Chair: Aging Population	**Joan Marie Aylward** *(Community Champion; Former Provincial Politician; Former NLNU President; Former Executive Director of St. Patrick's Mercy Home)*
Committee Chair: Digital Technology	**Paul Preston** *(Former CEO, techNL)*
Committee Chair: Hospital Services	**Sean Connors** *(Associate Professor of Medicine – Cardiology; Clinical Chief of Cardiac Care Program, Eastern Health)*
Working Group Chair: Workforce Readiness	**Louise Jones** *(Former CEO, NL Council of Health Professionals; Former Regional Health Authority CEO)*
Working Group Chair: Education	**Ian Bowmer** *(Past President, Royal College of Physicians and Surgeons of Canada; Professor Emeritus and former Dean, Faculty of Medicine, Memorial University)*

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Eastern Health	**David Diamond** *(CEO)*
Central Health	**Andrée Robichaud** *(CEO)*
Western Health	**Michelle House** *(Interim CEO)*
Labrador-Grenfell Health	**Heather Brown** *(CEO)*
NL Centre for Health Information	**Steve Clark** *(Former CEO as of February, 2022)*
Department of Health & Community Services, Government of NL	**Karen Stone** *(Former Deputy Minister as of December, 2021)*
Department of Health & Community Services, Government of NL	**Andrea McKenna** *(Deputy Minister as of December, 2021)*
Newfoundland & Labrador Medical Association	**Robert Thompson** *(Executive Director)*
Registered Nurses' Union NL	**Yvette Coffey** *(President)*
Association of Allied Health Professionals	**Pamela Toope** *(Executive Director)*
NL Association of Public and Private Employees	**Jerry Earle** *(President), Member until September, 2021*
Canadian Union of Public Employees NL	**Sherry Hillier** *(President), Member until December, 2021*
Faculty of Medicine, Memorial University	**Margaret Steele** *(Dean of Medicine, Memorial University; Chair Elect, Association of Faculties of Medicine of Canada)*
Community Member	**Bud Davidge**
Community Member	**Linda Oldford**
Community Member	**Michael O'Keefe**
Indigenous Community Member	**Anthony Andersen** *(Nunatsiavut Government, Minister of Finance)*

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Task Force Member appointed by Liberal Party of NL	**Jeff Marshall** *(Chiropractor)*
Task Force Member appointed by NL New Democratic Party	**Joshua Smee** *(CEO, Food First NL)*
Task Force Member appointed by Progressive Conservative Party of NL	**Ross Wiseman** *(Former Provincial Cabinet Minister & Health System Manager; appointed October 2021)*
Engagement Advisor	**Stephen Tomblin** *(Retired Professor of Political Science, Memorial University)*
Support	
Operations Manager	**Lynn Taylor** *(Manager, Quality of Care NL)*
Senior Policy Advisor – Health	**Heather Hanrahan** *(Assistant Deputy Minister, Government of NL)*
Senior Policy Advisory – Interdepartmental	**Tanya Noseworthy** *(Assistant Deputy Minister, Government of NL)*
Clinical Epidemiologist	**John Harnett** *(Retired Professor of Medicine, Memorial University)*
Implementation Advisor	**Cassie Chisholm** *(Director, Cardiac & Critical Care, Eastern Health)*
Communications Advisor	**Melissa Ennis** *(Communications Lead, Quality of Care NL)*

Health Accord NL Task Force Committee Members

Social Determinants of Health*	
Chair	**Elizabeth Davis**
Community Leader	**Penelope Rowe** *(CEO, Community Sector Council NL)*
Health Professional	**Steve Darcy** *(Family Physician, Eastern Health)*

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Regional Health Authority Leader	**Michelle House** *(Interim CEO, Western Health)*
Content Experts	**Thomas Piggott** *(Former Medical Officer of Health, Labrador-Grenfell Health)*
	Brenda Wilson *(Professor & Associate Dean, Community Health & Humanities, Faculty of Medicine, Memorial University)*
	Pablo Navarro *(Senior Research Officer, NL Centre for Applied Health Research)*
	Bob Williams *(Retired Physician; Former RHA Executive; Former Deputy Minister, Health & Community Services)*
	John Harnett *(Clinical Epidemiologist; Retired Professor of Medicine, Memorial University)*
	Michelle Kinney *(Deputy Minister, Health and Social Development, Nunatsiavut Government)*
	Tanya Noseworthy *(Assistant Deputy Minister, Government of NL)*
Support – Social Determinants of Health	
Secretariat *(Quality of Care NL)*	**Kathleen Mather** *(Knowledge Translation Lead)*
Senior Policy Advisor *(Government of NL)*	**Maggie O'Toole** *(Director of Policy, Planning, and Evaluation (A), Health & Community Services)*
Digital Technology Support *(NL Centre for Health Information)*	**Don MacDonald** *(Vice President, Data & Information Services)*

*Also joining the Social Determinants of Health Committee on various sub-groups: Mark Griffin, Director of Quality Management and Training, Children, Seniors and Social Development; Cynthia King, Director, Income Support, Immigration, Population Growth and Skills; Renee Ryan, Director, Policy, Planning and Information Management, Children, Seniors and Social Development; Lisa Baker-Worthman, Program Consultant, Health and Community Services; Joanne Cotter, Provincial Director, Children & Youth, Children, Seniors and Social Development; Terri Jean Murray, Director, Disability Policy Office, Children, Seniors and Social Development; Aisling Gogan, Assistant Deputy Minister, Children, Seniors and Social Development

Community Care	
Chair	**Shanda Slipp** *(Family Physician, Western Health)*
Community Leader	**John Norman** *(Mayor, Bonavista)*
Health Professional	**Lynn Power** *(Executive Director, College of Registered Nurses NL)*
Regional Health Authority Leader	**Judy O'Keefe** *(Vice President, Clinical Services, Eastern Health)*
Content Experts	**Nicole Stockley** *(Family Physician, Eastern Health; Director of External Engagement, NL College of Family Physicians)*
	Ada John *(Director, Conne River Health and Social Services)*
	Michael Jong *(Retired Family Physician; Former RHA Executive, Labrador-Grenfell Health)*
	Carmel Casey *(Family Physician, Central Health)*
	Heather Hanrahan *(Assistant Deputy Minister, Government of NL)*
Support – Community Care	
Secretariat *(Quality of Care NL)*	**Cheryl Etchegary** *(Health Policy Analyst)*
Senior Policy Advisor *(Government of NL)*	**Monica Bull** *(Senior Manager, Primary Health Care, Health & Community Services)*
Digital Technology Support *(NL Centre for Health Information)*	**Cynthia Clarke** *(Director, eHealth)*

Hospital Services	
Chair	**Sean Connors** *(Associate Professor of Medicine – Cardiology; Clinical Chief of Cardiac Care Program, Eastern Health)*
Community Leader	**Dorothy Senior** *(Patient Partner)*
Health Professional	**Greg Browne** *(Clinical Chief of Surgery, Eastern Health; Chief of Staff, Eastern Health)*
Regional Health Authority Leader	**Gabe Woollam** *(Vice President, Medical Services, Diagnostics & Pharmacy, Labrador-Grenfell Health)*
Content Experts	**Tina Edmonds** *(VP People, Quality and Safety (Acting), Western Health)*
	David Carroll *(Interim VP Medical Services, Central Health)*
	Larry Alteen *(Retired Family Physician; Former RHA Executive, Eastern Health & Central Health; Former Medical Consultant, Health & Community Services)*
	Jeannine Herritt *(Director, Regional Medicine Program, Eastern Health)*
	Heather Hanrahan *(Assistant Deputy Minister, Government of NL)*
Support – Hospital Services	
Secretariat *(Quality of Care NL)*	**Karen Dickson** *(Health Policy Analyst)*
Senior Policy Advisor *(Government of NL)*	**Annette Bridgeman** *(Director, Regional Services, Health & Community Services)*
Digital Technology Support *(NL Centre for Health Information)*	**Pat Hepditch** *(VP, Solutions & Infrastructure)*

Aging Population	
Chair	**Joan Marie Aylward** *(Community Champion; Former Provincial Politician; Former NLNU President; Former ED, St. Patrick's Mercy Home)*
Community Leader	**Rick Singleton** *(Ethicist & Theologian)*
Health Professional	**Kim Babb** *(Geriatrician, Eastern Health)*
Regional Health Authority Leader	**Kelli O'Brien** *(President & CEO, St. Joseph's Care Group, Thunder Bay, ON; Former VP People, Quality and Safety, Western Health)*
Content Experts	**Roger Butler** *(Family Physician, Geriatric Researcher, Eastern Health)*
	Suzanne Brake *(Former Provincial Seniors' Advocate)*
	Sharron Callahan *(Chair, NL Seniors & Pensioners Coalition; President, CARP NL; Chair, Seniors Advisory Committee, St. John's)*
	Nancy Healey-Dove *(Nurse Practitioner, Central Health)*
	Tanya Noseworthy *(Assistant Deputy Minister, Government of NL)*
Support – Aging Population	
Secretariat *(Quality of Care NL)*	**Robert Wilson** *(Research Associate)*
Senior Policy Advisor *(Government of NL)*	**Henry Kielley** *(Director, Seniors & Aging and Adult Protection, Children, Seniors & Social Development)*
Digital Technology Support *(NL Centre for Health Information)*	**Nicole Gill** *(Director, Evaluation & Performance Improvement)*

Quality Health Care	
Chair	**Patrick Parfrey** *(Clinical Lead, Quality of Care NL; John Lewis Paton Distinguished University Professor)*
Community Leader	**John Jeddore** *(Medical Resident)*
Health Professional	**Melissa Skanes** *(Chief of Interventional Radiology, Eastern Health; Clinical Assistant Professor of Radiology, Memorial University)*
Regional Health Authority Leader	**Antionette Cabot** *(Vice President, Clinical Services, Labrador-Grenfell Health)*
Content Experts	**Ed Randell** *(Clinical Chief Laboratory Medicine, Eastern Health; Professor, Division of Laboratory Medicine, Faculty of Medicine, Memorial University)*
	Debbie Kelly *(Professor & Special Advisor of Practice Innovation, School of Pharmacy, Memorial University)*
	Jared Butler *(Family & Sports Medicine Physician; Shalloway FPN; Medical Director Primary Care, Central Health)*
	Kris Aubrey-Bassler *(Family Physician; Director, Primary Healthcare Research Unit, Memorial University)*
	Tanya Noseworthy *(Assistant Deputy Minister, Government of NL)*
Support – Quality Health Care	
Secretariat *(Quality of Care NL)*	**Susan Stuckless** *(Research Associate)*
Senior Policy Advisor *(Government of NL)*	**John McGrath** *(Assistant Deputy Minister, Corporate Services, Health & Community Services)*
Digital Technology Support *(NL Centre for Health Information)*	**Donna Roche** *(Director, Analytics & Data Access)*

Digital Technology	
Chair	**Paul Preston** *(Former CEO, techNL)*
Community Leader	**Josh Quinton** *(Investment Advisor, CIBC Wood Gundy & Board Director)*
Health Professional	**Brendan Barrett** *(Nephrologist, Eastern Health; Professor of Medicine, Memorial University)*
Regional Health Authority Leader	**Ron Johnson** *(Vice President, Innovation and Rural Health, Eastern Health)*
Content Experts	**Randy Giffen** *(National Innovation Team, IBM Canada; Retired Family Physician)*
	Blair White *(Former Vice President, Corporate Services, NL Centre for Health Information)*
	Chandra Kavanagh *(Director, Bounce Health Innovation)*
	Niki Legge *(Director, Mental Health & Addictions, Health & Community Services)*
	Heather Hanrahan *(Assistant Deputy Minister, Government of NL)*
Support – Digital Technology	
Secretariat *(Quality of Care NL)*	**Owen Parfrey** *(Project Coordinator)*
Senior Policy Advisor *(Government of NL)*	**Andrea McKenna** *(Deputy Minister, Health & Community Services)*
Digital Technology Support *(NL Centre for Health Information)*	**Gillian Sweeney** *(Former Vice President, Clinical Information Programs & Change Leadership)*

Health Accord NL Task Force Working Group Members

Workforce Readiness
Louise Jones (Chair) *(Former CEO, NL Council of Health Professionals; Former Regional Health Authority CEO)*
Antoinette Cabot *(Vice President, Clinical Services, Labrador-Grenfell Health)*
Vanessa Mercer-Oldford *(Assistant Deputy Minister, Regional Services (A), Health and Community Services)*
Dennis Rashleigh *(Vice President Clinical-Medical Services, Rural and Primary Health Care, Western Health)*
Vernon Curran *(Associate Dean of Educational Development, Office of Professional & Educational Development, Faculty of Medicine, Memorial University)*
Heidi Staeben–Simmons *(Associate Vice President, Public Affairs, College of the North Atlantic)*
Debbie Forward *(Former President, Registered Nurses' Union NL)*
Gordon Piercey *(President, Association of Allied Health Professionals NL)*
Adam Churchill *(Senior Manager, Health Workforce Planning, Health and Community Services)*
Heather Hanrahan (Secretariat) *(Assistant Deputy Minister, Government of NL)*
Finance & Intergovernmental Affairs
Patrick Parfrey (Chair) *(Health Accord NL Co-Chair)*
Patricia A. Hearn *(Deputy Minister, Intergovernmental Affairs)*
John Kattenbusch *(Vice President, Corporate Services and Provincial Shared Services Supply Chain, Central Health)*
John McGrath *(Assistant Deputy Minister, Corporate Services, Health & Community Services)*
Ken Hicks *(Director, Economics, Department of Finance)*

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Lynn Gambin
(Associate Professor, Department of Economics, Memorial University)

Josh Quinton
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James Rourke
(Professor emeritus & former Dean of Medicine, Memorial University)

Cathy Duke
(CEO, Destination St. John's)

Heather Hanrahan (Secretariat)
(Assistant Deputy Minister, Government of NL)

Education

Ian Bowmer (Chair)
(Past President, Royal College of Physicians and Surgeons of Canada; Professor Emeritus & former Dean of Medicine, Memorial University)

Collette Smith
(Vice President, Clinical Services and Human Resources, Chief Nursing Officer, Eastern Health)

Laura Chu
(Adult Neurology PGY5, Memorial University; Past President, Professional Association of Residents of Newfoundland and Labrador)

Andrew Hunt
(Assistant Dean, Distributed Medical Education, Faculty of Medicine, Memorial University)

Irene O'Brien
(Dean of Health Sciences, College of the North Atlantic)

Linda Inkpen
(Former Registrar, College of Physicians & Surgeons of NL)

Leah Healey
(Research and Education Specialist, Registered Nurses' Union NL)

Peggy Colbourne
(Director, Western Regional School of Nursing)

Paul Banahene Adjei
(Interim Dean, School of Social Work, Memorial University)

Amy Hudson
(Governance and Strategic Planning Lead & Co-lead Negotiator, Recognition of Indigenous Rights and Self Determination, NunatuKavut)

Tanya Noseworthy (Secretariat)
(Assistant Deputy Minister, Government of NL)

Governance
Elizabeth Davis (Chair) *(Health Accord NL Co-Chair)*
Victor Young *(Former Chair & CEO, NL Hydro and Fishery Products International; Former Chair, Royal Commission of NL's Place in Canada)*
Michael Clair *(Consultant, Retired Public Servant and University Administrator)*
Louise Bradley *(Former President & CEO, Mental Health Commission of Canada; Board Member, The Gathering Place)*
Brad Graham *(Vice President, Institute on Governance; Senior Fellow at Munk School of Global Affairs and Public Policy)*
Penelope Rowe *(CEO, Community Sector Council NL)*
Kris Aubrey-Bassler *(Family Physician; Director, Primary Healthcare Research Unit, Memorial University)*
Aisling Gogan *(Assistant Deputy Minister, Children, Seniors and Social Development)*
Don MacDonald *(Vice President, Data & Information Services, NLCHI)*
Maggie O'Toole *(Director of Policy, Planning, and Evaluation (A), Health & Community Services)*
Kathleen Mather *(Secretariat, Social Determinants of Health Committee; Knowledge Translation Lead, Quality of Care NL)*
Tanya Noseworthy (Secretariat) *(Assistant Deputy Minister, Government of NL)*

Online Access to Health Accord NL Documents

The Interim Report, The Report, The Summary (in multiple languages), The Blueprint (Section A: Summaries of implementation Recommendation and Section B: Implementation Recommendations from the Strategy committees and working Groups), a Poster showing the summary of Timelines for Implementation of Major Actions, a series of short videos summarizing key elements of the Health Accord, and The Evidence Archive can be found online at healthaccordnl.ca/final-reports.

Contact

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Notes

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Health Accord
for Newfoundland & Labrador

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THE BLUEPRINT
Summaries of Implementation Recommendations