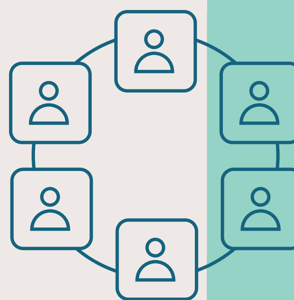
Health Accord
for Newfoundland & Labrador



Our Province. Our Health. Our Future.

A 10-Year Health Transformation

THE BLUEPRINT Implementation Recommendations from the Strategy Committees and Working Groups

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
Health Accord NL. (2022). *Our Province. Our Health. Our Future. A 10-Year Health Transformation: The Blueprint Implementation Recommendations from the Strategy Committees and Working Groups.* https://healthaccordnl.ca/final-reports/.

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Abbreviations

2SLGBTQIA+: Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, and the countless affirmative ways in which people choose to self-identify
AAHP: Association of Allied Health Professional – NL
ACP: Advanced Care Paramedic
ADHD: Attention Deficit Hyperactivity Disorder
BIPOC: Black, Indigenous, and People of Colour
BFI: Baby-Friendly Initiative
CAYAC: Children and Youth in Alternate Care Clinic
CCHPE: Centre for Collaborative Health Professional Education
CEO: Chief Executive Officer
CGA: Comprehensive Geriatric Assessment
CIHI: Canadian Institute for Health Information
CIHR: Canadian Institutes of Health Research
CNA: College of the North Atlantic
CoE: Care of the Elderly
COPD: Chronic Obstructive Pulmonary Disease
CPE: Continuing Professional Education
CRMS: Client Referral and Management System
CSH: Comprehensive School Health
CSSD: Department of Children, Seniors and Social Development
CTAS: Canadian Triage and Acuity Scale
CUPE: Canadian Union of Public Employees
CYCH: Child and Youth Community Health
DIACC: The Digital Identification and Authentication Council of Canada
ECC: Department of Environment and Climate Change
EHR: Electronic Health Record
EMR: Electronic Medical Record
EMR: Emergency Medical Responder
EVT: Endovascular Thrombectomy
FP: Family Physician
FPN: Family Practice Network
FTE: Full Time Equivalent
HCS: Department of Health and Community Services
HIS: Health Information System
HSW: Home Support Worker
ICU: Intensive Care Unit

IPE: Interprofessional Education
IPGS: Department of Immigration, Population Growth and Skills
LHSS: Learning Health and Social System
LPN: Licensed Practical Nurse
MCP: Medical Care Plan
MPA: Department of Municipal and Provincial Affairs
MRP: Most Responsible Provider
NAPE: Newfoundland and Labrador Association of Public and Private Employees
NHS: National Health Service
NLCHI: Newfoundland and Labrador Centre for Health Information
NLHC: NL Housing Corporation
NLMA: Newfoundland and Labrador Medical Association
NORC: Naturally Occurring Retirement Communities
NP: Nurse Practitioner
OCIO: Office of the Chief Information Officer (NL)
PCA: Personal Care Attendant
PCHW: Personal Care Home Worker
PCP: Primary Care Paramedic
PH: Public Health
PHA: Provincial Health Authority
PHR: Personal Health Record
PIP: Practice Improvement Program
PREMs: Patient-Reported Experience Measures
PROMs: Patient-Reported Outcome Measures
QCNL: Quality of Care NL
RHA: Regional Health Authority
RHC: Regional Health Council
RN: Registered Nurse
RNUNL: Registered Nurses' Union NL
RSHN: Regional Social and Health Network
SDH: Social Determinants of Health
UG/PG: Undergraduate/Post-Graduate
WHO: World Health Organization

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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	Re-align 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

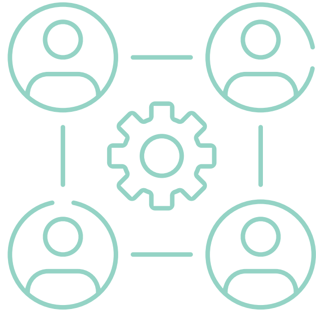
Workforce Readiness Implementation Recommendations		
Call to Action		**Report Cross Reference**
37	Through consultation with stakeholders, create a **Provincial Health and Social Sector Human Resource Plan.**	Action 10.4
38	Create **Workforce Transition Guiding Principles** for all health and social 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



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

Introduction

The framework for Section A of the Blueprint was focused on five major components of the Health Accord (social determinants of health, rebalancing the health system, pathways to facilitate change, governance, and financing). The framework for Section B will focus on the detailed implementation recommendations related to the fifty-seven Calls to Action outlined in the Health Accord NL Report as well as an additional two Calls to Action that were developed as a result of further thought and consideration by committees and working groups.

Each of the six strategy committees (social determinants of health, community care, hospital services, aging population, quality health care, and digital technology) and the four working groups (workforce readiness, education, governance, and finance and intergovernmental affairs) developed their implementation recommendations which contain the Calls to Action, objectives related to each Action, and tactics to advance these objectives. The work of the fourth working group (finance and intergovernmental affairs) was presented in more detail in the two overview summaries at the beginning of Section A.

Please note that the numbering of Calls to Action in Section A and 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.

The Health Accord itself and its Calls to Action are to be taken as one integrated, holistic approach to the transformation of health for Newfoundlanders and Labradorians. The detailed implementation recommendations provide possible ways of and options for the best approach to implementation. There is more flexibility around objectives and tactics, allowing for changes in circumstances, variability among the various regions of the province, and new evidence that is constantly being gathered and analyzed.

However, flexibility around objectives and tactics should not lead to delays in implementation. The case for change, outlined throughout both the Report and the Blueprint, is becoming more compelling as time passes. We have a window of opportunity to act, but that window is narrowing. To do nothing will not mean maintaining the status quo. To do nothing will mean a further deterioration in health, a further weakening of health outcomes, and a further increase in health inequity. We, the people of Newfoundland and Labrador, deserve better.

1. Social Determinants of Health Implementation Recommendations

Social Determinants of Health Committee	
Committee Members	**Secretariat**
Elizabeth Davis (Chair)	Kathleen Mather
Steve Darcy	Maggie O’Toole
John Harnett	Don McDonald
Michelle House	Joining the Social Determinants of Health Committee as members of sub-groups: Mark Griffin, Cynthia King, Renee Ryan, Lisa Baker-Worthman, Joanne Cotter, Terri Jean Murray, Aisling Gogan.
Michelle Kinney	
Pablo Navarro	
Tanya Noseworthy	
Thomas Piggott	
Penelope Rowe	
Bob Williams	
Brenda Wilson	

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

Action 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.

1.1. Facilitate the development of evidence-based research and evaluation programs, including longitudinal studies, on the social determinants of health (SDH), specific to the population of Newfoundland and Labrador.

a. Ensure provincial government support for targeted research for SDH.

b. Focus on SDH research competitions.

c. Appoint a position in the Department of Children, Seniors and Social Development and Community Sector Council to work with community organizations with health and social related mandates to build research capacity.

d. Make funding available for partnership opportunities (e.g., federal government).

e. Be sensitive to cultural bias in SDH research.

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

a. Place a SDH lens on all information systems developed.

b. Differentiate implications for patient/client/resident care and secondary use.

c. See Digital Technology Implementation Recommendations (Actions 34, 35, and 36), Quality Health Care Implementation Recommendations on the NL Council for Health Quality and Performance (Actions 25 and 27), and Governance Implementation Recommendations on Data Governance (Action 24) for further actions, objectives, and implementation steps.

1.3. **Improve access to data for all partners linked with the SDH (e.g., Regional Health Authorities (RHAs), Departments of Health and Community Services (HCS); Children, Seniors and Social Development (CSSD); Finance, Education, and Justice and Public Safety).**

a. See Quality Health Care Implementation Recommendations on the NL Council for Health Quality and Performance (Actions 25 and 27), and Governance Implementation Recommendations on Data Governance (Action 24) for further actions, objectives, and implementation steps.

1.4. **Integrate data on SDH into health policy decision-making and program delivery models as well as social program policy decision-making and delivery.**

a. Develop a jurisdiction specific, modified 'health-in-all-policies' approach across all partners (government, RHAs, community partners).

b. See Governance Implementation Recommendations on proposed Regional Social and Health Networks (RSHNs) in Action 50.

c. Build planning and care delivery related to SDH into Community Teams.

d. See tactics with respect to collecting and linking data in Digital Technology Implementation Recommendations (Actions 34, 35, 36).

1.5. **Ensure effective dissemination models to support improved SDH literacy.**

a. Implement a province-wide Comprehensive School Health (CSH) Framework in a timely manner.

b. See Education Implementation Recommendations related to SDH (Action 47).

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

a. Ensure accessibility to recreation facilities, social activities, and community connections.

b. Create a position in the Department of Municipal and Provincial Affairs (MPA) dedicated to healthy community planning with a focus on opportunities to maximize use of public buildings (e.g., cost of coverage for liability insurance).

c. Encourage municipalities to apply a healthy living lens in their planning for built environments.

d. Allow school gymnasiums to open after hours for community activities.

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

How We Decide – Embedding the Social Determinants of Health

Action 2: Integrate the social determinants of health together with a rebalanced health system into all governance, policy, program, and infrastructure decisions that influence health.

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

a. Develop a public awareness approach on the importance of SDH and on ways in which the province is changing to incorporate SDH to improve health outcomes.

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

a. Establish priority setting and reporting with respect to SDH as a primary role for the RSHNs (Action 50).

b. Strongly encourage a 'health-in-all-policies' approach for businesses.

c. Explore opportunities for businesses to volunteer or provide support for SDH in community groups within their corporate social responsibility activities.

d. Recognize diverse resource levels among businesses to support SDH in planning and decisions (with greater expectations for better resourced businesses).

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

a. Strongly encourage a 'health-in-all-policies' and a healthy communities approach.

b. Create a policy position in MPA to support municipalities.

c. Ensure that municipal leaders in the RSHNs advocate for priority setting for and reporting of the SDH (see Action 28).

2.4. **Ensure that decision-makers across all government sectors and the public sector embed SDH and a rebalanced health system at the**

beginning of policy and program development processes to allow for appropriate integration of these factors in presented alternatives.

a. Develop a jurisdiction-specific, modified 'health-in-all-policies' approach.

b. Include in the mandate for the NL Council for Health Quality and Performance (Action 26) the monitoring of accountability for a SDH approach across all government and public sector groups.

c. Create a government-integrating structure for the 'health-in-all-policies' approach (e.g., integrating councils, guidance for preparation of Cabinet papers).

2.5. Encourage implementation of a 'health-in-all-policies' approach by educational organizations.

a. Take into account a 'health-in-all-policies' approach in the design of buildings, curriculum, and program and service delivery at both K–12 and post-secondary levels.

b. See Education Implementation Recommendations on post secondary curriculum (Action 47).

c. Expand the Education Call to Action referenced above to post-secondary programs outside health faculties and schools (e.g., geography, economics, business).

d. Ensure that educational leaders in the RSHNs advocate for priority setting for and reporting of the SDH.

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

a. Support the development of a strategy to work with the federal government in partnering on initiatives to move Health Accord NL goals forward with respect to SDH.

b. Identify SDH as a priority consideration for government staff serving on Federal, Provincial, Territorial councils/committees.

How We Live – 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 (see Action 8 in the next chapter which adds further depth with a focus on the impact on children and youth).

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

a. Determine the best approach to achieving a basic income for all persons and households living in poverty.

   i. A province-wide, guaranteed basic income, if feasible, is the preferred approach.

   ii. If a gradual approach (beginning with persons with disabilities, seniors, single parent families, households where caregiver has experienced domestic violence) is deemed to be more effective, ensure that there is the understanding that the final goal is to reach all persons and households living in poverty.

b. Offer Newfoundland and Labrador (or possibly the Atlantic Provinces) to the federal government as the location for a basic income pilot for a province-wide program.

3.2. **Simplify the income support and related processes.**

a. Complete the income support simplification process that has already begun.

b. Reintroduce income support rates indexed to inflation.

c. Introduce the NL income supplement and seniors' benefits indexed to inflation.

d. Consider increasing earning exemptions and liquid asset limits for income support clients.

e. Consider an increased low-income tax threshold.

f. Eliminate federal or provincial government clawbacks when new or increased financial supports are provided to avoid diminishing the overall benefit to individuals receiving the financial support.

g. Address barriers for access to MCP for excluded groups with particular attention to migrants (immigrants, refugees, international students, and persons with temporary work permits).

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

a. Conduct thorough and regular data collection on food security and systematic analysis through collaboration between the NL Statistics Agency and Statistics Canada.

b. Prioritize interventions to target food insecurity (e.g., re-invest monies realized from the sugar tax into subsidizing locally produced healthy food), including design, implementation, and evaluation.

c. Commit to food insecurity reduction targets.

d. Assess the impact of policy changes on food insecurity.

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

a. Link the 'housing first' approach with strong eviction prevention program measures formally adopted for those who are experiencing or are at risk of homelessness.

b. Increase the number of NL Housing Corporation (NLHC) social workers to support the increasing numbers and complexity of

persons and families who are experiencing or are at risk of homelessness.

c. Increase collaboration and complementary alignments between organizations and government departments that support responses for individuals experiencing homelessness in order to reduce duplication of effort and maximize the prioritization and allocation of resources to support positive housing outcomes.

   i. Review legislation, regulation, and policies of all involved organizations, in partnership with those organizations, to remove barriers to collaborative outcome-based focuses for clients/patients.

   ii. Redesign models toward a client-centered focus to break down silos created by individual organizational mandates — “not in my mandate.”

   iii. Improve discharge planning from corrections facilities, personal care homes, and the Waterford Hospital.

   iv. Develop governance processes to better inform and set provincial priorities around homelessness.

d. Commit government entities, including RHAs, to work together to increase the level of supportive housing throughout the province in order to decrease the number of people with no other option than extended stays in acute care facilities or emergency shelters.

   i. Decrease costs to the province related to usage of emergency shelters and acute care and placement in correctional facilities for at-risk populations by investing in supportive housing to meet current demands and those anticipated by the downsizing of the Waterford Hospital.

   ii. Have NLHC conduct a cost/benefit analysis across providers to identify gaps and priority areas for funding and policy development.

e. Work with the federal government to improve engagement of the province in planning and accountability mechanisms to ensure the

effectiveness of both provincial and federal funding allocations that relate to homelessness.

f. Implement measures to support housing affordability for the increasing numbers of people in the province without adequate, affordable, and stable housing.

   i. Implement basic incomes for individuals at risk of homelessness.

   ii. Work with private and non-profit partners to increase the supply of affordable housing in the province.

   iii. Expand NLHC social housing stock to meet increasing demands.

   iv. Reinvigorate the prior successful NLHC downpayment assistance program.

   v. Encourage collaboration between the RHAs and NLHC to identify supportive housing needs that will result from downsizing the Waterford Hospital, develop a strategy to address increased needs by region, and begin implementation.

   vi. Develop supports for identified income pressures (e.g., food, utility bills, childcare) for the most under-served populations in the province to decrease the numbers of individuals and families becoming homeless.

   vii. Strengthen tenants' rights through new approaches to tenant protection and rent stabilization.

g. Continue to support measures like the Provincial Home Repair Program that allow individuals to stay in their homes longer.

   i. Continue provincial funding for the Program after the federal funding component ends in 2023–24.

   ii. Modernize the Program to better align with inflationary costs.

   iii. Expand Program eligibility beyond the current thresholds for under-served populations.

iv. Encourage the federal government to re-commit funding envelopes for a modernized version of this Program.

h. Consider both capital and operational expenses when allocating funding related to homelessness.

i. Redesign the funding model within the province to take into consideration the operational costs required to maintain low-income and supportive housing units.

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

a. Adopt a regional approach to transportation for rural communities.

b. Ensure accessibility to public transit for low-income individuals by continuing/implementing a free bus pass program for individuals on income support in areas with public transit (i.e., Corner Brook and St. John's).

c. Seek federal and private forms of funding to enhance transit systems.

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

a. See the Community Care Implementation Recommendations on Community Teams (Action 15) and the Education Implementation Recommendations (Action 37).

b. Encourage social prescribing by practitioners in hospital settings as well as in Community Teams.

c. Encourage community organizations to participate in the social prescribing program.

d. Support efforts to integrate more recreation therapists into hospitals, long-term care, and Community Teams.

3.7. Create Social Navigator positions in Community Teams and develop a data pathway to enable referrals and partnerships.

a. Train Navigators to recognize, record, and intervene in all areas of the SDH.

b. See the Aging Population Implementation Recommendations (Actions 10 and 11), the Community Care Implementation Recommendations on Community Teams (Actions 13, 14, 15, and 20), the Workforce Readiness Implementation Recommendations (Action 40), the Education Implementation Recommendations (Action 47), and the Quality Health Care Implementation Recommendations on SDH indicators (Action 27).

3.8. Attend to living wage and decent work.

a. Recognize the differing living wage rates in different regions of the province and include these considerations in all income or employment policy development/revision exercises.

b. Regularly calculate and publicly report living wage rates by region in the province.

c. Encourage private employers to use the living wage rate for their region as an ethical initiative to support recruitment and retention.

d. Encourage employment supports for a living wage and decent work for migrants.

   i. Encourage the Department of Immigration, Population Growth and Skills (IPGS) and HCS to work closely together in recognizing decent work as an important SDH.

   ii. Provide information and supports to newcomers in the province on the process of getting police record checks and under-served sector checks required for employment or volunteer positions.

   iii. Support employers and community organizations:

      - in the application and interpretation of these checks so they better understand cultural differences that may have an impact on how they are viewed;

- in recognizing foreign police record or under-served sector checks to facilitate employment/involvement of individuals with these documents.

e. Implement labour standards to ensure that, no matter how limited their bargaining power, no worker is offered, accepts, or works under conditions that Canadians would not regard as 'decent' — *Decent work involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives, and equality of opportunity and treatment for all women and men* (International Labour Organization).

f. Explore the relationship between minimum wage and living wage with a move toward the living wage becoming the baseline employment rate for the province.

g. Commit to compensation practices that are free from gender-based discrimination (i.e., equal pay for work of equal value).

3.9. Ensure that the SDH are given priority in the planning for the replacement of Her Majesty's Penitentiary in St. John's with emphasis on rehabilitation, continuity of care, and re-integration.

a. Enhance training for staff to allow for the proper and smooth integration of Eastern Health programs into the Penitentiary.

b. Develop up-to-date assessments and diagnoses at the point of intake to properly inform and enhance individual case plans.

c. Set education and mental health and addictions counselling as a priority in the rehabilitation process, as well as vocational and skills training, with ease of access to community transitional supports.

d. Set a well-staffed Medical Mental Health Unit as a priority with structured intervention units to support incarcerated persons who need special counsel and clinical interventions.

e. Enhance and support the existing drug and mental health court.

f. Supervise non-violent individuals on remand in the community.

g. Support pre-trial initiatives with increasing communication between the prosecution and defense.

h. Ensure continuity of care for chronic health issues and co-morbidities surrounding mental health and addictions for incarcerated persons on their release to the community.

i. Endorse the program for Circles of Support and Accountability (facilitated today by Turnings) for intervention and support post-community release for those who have been marginalized in the wider community due to their own actions or by the actions of the community.

j. Explore a partnership with the College of the North Atlantic to offer diploma trade courses (e.g., carpentry, plumbing, mechanics) in temporary classrooms on the grounds of the institution, and with Memorial University of Newfoundland to offer online courses to incarcerated high school graduates to help them pursue higher education.

Where We Live: Addressing our 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

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

4.2. Provide public information sessions on climate emergency and links with human health.

4.3. Create a policy position in the Department of Environment and Climate Change (ECC) dedicated to climate impacts on health.

4.4. Implement action to reduce the environmental footprint of the health care system.

a. Track the environmental footprint of health care at local, regional, and provincial levels.

b. Incorporate sustainability practices into accreditation standards.

c. Support energy efficient modifications, including transitioning buildings from diesel and fuel oil to electricity, and green building design.

d. Adapt transportation strategies to prioritize a reduction in pollution.

e. Support access to local and sustainably sourced food by purchasing and serving this food within health facilities.

f. Adapt procurement policies to incorporate sustainability as a requirement, where possible.

g. Encourage pension plans' investment in green energy.

4.5. Aggressively implement and build on the actions set out in the government's *Climate Change Action Plan*.

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

a. Minimize the impacts of labour market transitions.

b. Identify and support economic opportunities to support workers in transition.

c. Include workers in discussions that affect their livelihoods.

d. Use research and experience from other jurisdictions to develop this "Just Transition" plan.

4.7. **Support the integration of climate emergency actions across sectors.**

a. Support government's commitment to take a whole-of-government approach to tackling climate change, ensuring that planning will be led by departments and agencies across the provincial government (including the Departments of Fisheries, Forestry and Agriculture; Finance; Industry, Energy and Technology; and Transportation and Infrastructure) in collaboration with other partners from the public and private sectors.

b. Ensure that there is public reporting on the outcomes of the climate action plan.

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

a. Update the provincial "Turn Back the Tide" website to directly link the climate emergency to health.

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

4.10. **Recognize environmental sustainability, including sustainable food systems, as a dimension of health care quality as defined with measures developed by the NL Council for Health Quality and Performance.**

How We Relate: One Inclusive Society

Action 5: Take immediate action to create a provincial Pathway for Inclusion, shaping an inclusive health system within an inclusive society.

5.1. 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.

a. Develop an engagement policy that includes a process to identify and action meaningful methods of knowledge collection and transfer for groups experiencing health inequities.

b. Ensure that groups experiencing health inequities are included as members on patient/client/resident councils and Community Advisory Councils, and any other councils/boards/networks where decisions are made about services that impact them.

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

a. Formalize and communicate a zero-tolerance policy on racism and exclusion, including the following elements:

i. Develop robust data sets to effectively measure the extent of racism occurring in the province.

ii. Encourage and support organizations throughout the province in the public and private sectors in developing and implementing formal organization specific action plans to eliminate racism and exclusion with:

- defined actions;
- result-based indicators;
- accountability measures;
- mandated public reporting requirements.

5.3. **Recognize that inclusion is more than ending exclusion. Implement an effective inclusion lens for new and existing policies, programs and environments that are developed and implemented with the full participation of excluded groups.**

a. Include a review of policies, programs, and services to ensure that they are welcoming and supportive of migrants (i.e., immigrants, refugees, temporary workers, and international students) and their needs related to the SDH.

5.4. **Actively address racism and all forms of exclusion in the provincial health system through the implementation of informed and comprehensive plans of action.**

a. Increase cultural humility and awareness through contact-based education and training on the value of diversity to the provincial health system (see the Evidence Archive at www.healthaccordnl.ca for existing resources such as the Sexual Orientation Gender Identity Nursing Toolkit).

b. Make a system-wide commitment to addressing exclusion and racism that incorporates the role of appreciative inquiry and encourages the identification of exclusionary behaviours/practices.

c. Strengthen recruitment, appointment, and retention activities to increase diversity at the board, management, and front-line levels in the health system.

d. Implement data collection processes, safe complaints processes, and targeted surveys to provide accurate ways of defining exclusion in the system with a means to ensure that this information is provided in a protected manner to senior levels of the organization and the NL Council for Health Quality and Performance.

e. Name a person/team responsible for health equity at local, regional, and provincial levels with a mandated requirement to address issues of health inequity in meaningful ways that support an equitable Learning Health and Social System.

f. Implement the previously developed "Indigenous Health Framework."

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

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

5.7. **Develop and implement a health equity lens (e.g., PROGRESS PLUS) in partnership with specific population groups, for required application to existing and new policies, programs, and environments.**

a. Require each organization/facility within the system to carry out an assessment of racism and exclusion and develop a responsive "Equity Culture" program including, but not limited to:

i. Critical mass at employee, management, and board levels;

ii. Training and awareness;

iii. Employee "speak-up" culture;

iv. Declaration of equity values with defined staff/employee behavioural expectations;

v. Standards of care;

vi. Bystander reporting requirements;

vii. Culturally group appropriate dedicated spaces within facilities;

viii. Health equity standards for accreditation;

ix. Accountability structures with clear performance expectations and an executive and board lead for equity;

x. A commitment to continuous improvement;

xi. Public reporting requirements.

Invest in Our Future – Early Childhood and Youth

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

Action 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).

6.1. **Implement a Prevention and Early Intervention Plan focusing on fostering resilience in children and families (see Community Care Implementation Recommendations, Actions 15.2 and 15.5).**

6.2. **Invest in universal access to early childhood education, prioritizing children in under-served families.**

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

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

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

6.6. **Implement a renewed governance structure for Healthy Students Healthy Schools to facilitate the use of the CSH framework in schools (this would be the joint work of the Departments of Education and HCS).**

a. See Implementation Recommendations on Community Teams (Actions 13, 14, 15), Digital Technology (Actions 34, 35, 36), and Data Governance (Action 51).

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

Integrated Models of Care for Children and Youth at Risk

Action 7: 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.

7.1. **Ensure the implementation of one model of integrated Child and Youth Community Health (CYCH) Services (including families) across home, school, and community in the province with central intake and access and a streamlined organizational structure.**

7.2. **Implement an interprofessional province-wide program to provide health support to children and youth in care, modeled on the Children and Youth in Alternate Care (CAYAC) Clinic.**

7.3. **Endorse the immediate implementation of the recommendations set out in the December 2021 report by the Office of the Child and Youth Advocate entitled: "A Special Kind of Care" which relates to children with complex health needs or disabilites in staffed residential care.**

7.4. **Address the barriers between the health system and the education system in providing support for school-age children who have complex health needs.**

a. See the joint document from the Privacy Commissioner and Child and Youth Advocate, *Yes! You Can! Dispelling the Myths about Sharing Information Relating to Children and Youth Who Receive Government Services*, released in December 2021.

7.5. **Initiate and commit to a longitudinal cohort study starting at birth, to look at health outcomes over time, with protected funding.**

a. One noteworthy example of such a study: Since the early 1970s, Alan Sroufe, Byron Egeland, Elizabeth Carlson, Andrew Collins, and others have been following a large cohort of children from the sixth month of the mother's pregnancy through to the present in "The Minnesota Study of Risk and Adaptation from Birth to Adulthood." This study provides a coherent picture of the complexity of development from birth to adulthood with a focus on pathways leading from the child, the caregiving environment, and the social milieu to abuse or neglect.

Liveable and Predictable Basic Income for Families

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.

This Action echoes Action 3 but adds more depth with respect to children and youth.

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

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

8.3. **Ensure that these policies and actions are targeted toward and effective for those families with greater poverty: single parent households, households with three or more children, migrants, Indigenous children, and children up to two years of age.**

8.4. **Ensure that youth who have left the family home but are living in poverty are engaged in any policy and program development, and, ultimately, ensure that new services are targeted toward and effective for this population.**

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

2. The Aging Population Implementation Recommendations

Aging Population Committee	
Committee Members	**Secretariat**
Joan Marie Aylward (Chair)	Robert Wilson
Kim Babb	Henry Kielley
Suzanne Brake	Nicole Gill
Kelli O'Brien	
Roger Butler	
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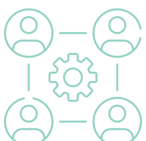


A Comprehensive Provincial Frail Elderly Program

Action 9: Develop and implement a formal Provincial Frail Elderly Program to address the critical need of our population.

9.1. Implementation of a comprehensive Provincial Frail Elderly Program that is incorporated across the continuum of care and is designed as a provincial geriatric care service model.

a. Program components should include:

i. a move from an institutional-based model of care to a person-centered, home-first approach to care with a focus on choice, wellness, and maximizing quality of life;

ii. trained navigators for the aging population and their families;

iii. a defined process at the community level using a healthy aging lens for the identification of elderly living with or at risk of frailty;

iv. community-level application of the Resident Assessment Instrument — Home Care (RAI-HC) and other complementary assessments (e.g., the Comprehensive Geriatric Assessment — CGA). The results of the assessments should be included in the electronic health records. Referral networks and the provision of related support services will be developed;

v. standardized care pathways based on comprehensive assessments for persons living with frailty across the continuum;

vi. community level rapid response teams to address early symptoms of frailty (including but not limited to paramedics, social workers, community health nurses, and other allied health professionals);

vii. options for dementia care (specialized dementia care spaces) in other areas of the continuum (e.g., personal care homes or Western Health's protective community residences). With appropriate physical and psycho-social design, these spaces would delay or prevent premature placement in long-term care when access to daily nursing care is not required;

viii. regional networks that include Community Teams with knowledge and information-sharing capacity for care of older persons regardless of the care setting;

ix. certified senior-friendly emergency departments across the province, included as part of the accreditation process, with a team approach to the provision of acute care services, respite care, restorative care, long-term care, and end-of-life care for the older adult as chosen and needed;

- criteria include staffing, education, policies and protocols, guidelines and procedures, quality improvement, outcomes measures, equipment and supplies, and physical environment (https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/geriatrics/geri_ed_guidelines_final.pdf, https://geriatric-ed.com/)

x. a dedicated provincial focus to addressing polypharmacy in the seniors' population so that all patients over age 65 taking five or more medications are automatically triggered for pharmacy review assessment (e.g., Beers Criteria);

xi. Frail Elderly Units in Central Health and Western Health, and a similar approach for Labrador, with a focus on assessment, rehabilitation, respite care, and restoration;

xii. a permanent provincial tertiary care team and Frail Elderly Unit in St. John's to care for complex frailty cases referred by the regional networks;

xiii. clear public outcome/performance reporting on quality of care (using a seniors' lens) for all frailty programs (e.g., by

regional and provincial health authorities, NL Council for Health Quality and Performance);

xiv. a new division of geriatric medicine within the Faculty of Medicine at Memorial University with an academic unit focused on research and education of frail elderly persons.

b. Implementation steps required to establish a comprehensive Provincial Frail Elderly Program include the following:

   i. Establish the administrative structure and strategy necessary to implement a Provincial Frail Elderly Program (e.g., program director, administration, resources, and connections to all related clinical areas);

   ii. Educate family physicians, nurse practitioners, nurses, physiotherapists, occupational therapists, and other allied health professionals directly involved in care of older persons;

   iii. Increase education for other health providers on the impacts of aging and the care for older adults;

   iv. Establish faculty appointments for geriatricians actively involved in clinical training;

   v. Explore options to develop a Community Team model in long-term care facilities to ensure adequate provision of allied health services in these facilities;

   vi. Develop community-based Frailty Referral Networks as Community Teams are established and practitioners are trained;

   vii. Implement steps required to certify all emergency departments across the province, beginning with the renovation at the Health Sciences Centre, as senior-friendly, starting with interim identification tool of seniors at risk (https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/geriatrics/geri_ed_guidelines_final.pdf, https://geriatric-ed.com/complete-checklist/);

viii. Implement standardized care pathways for persons with frailty;

ix. Create Frail Elderly Units by repurposing beds currently being used by those receiving alternate level of care;

x. Create Centres of Excellence on Aging that encompass the continuum of care in western, central, and eastern regions of the province and a program for Labrador;

xi. Designate rehabilitation and restorative beds for the three regional Centres of Excellence on Aging (30 rehabilitation beds and 35 restorative beds in total), and add the additional staffing required to provide appropriate care;

xii. Identify innovative options to support individuals with dementia in other areas of the continuum as part of broader dementia care action plans at the provincial and federal level;

xiii. Transition and broaden the existing Home Dementia Program into the Frail Elderly Program;

xiv. Adopt a "Senior-Friendly Care Framework" for all hospitals across the province.

9.2. Ensure that long-term care facilities are integrated into the comprehensive Provincial Frail Elderly Program.

a. Deliver comprehensive person-centered, equitable care focused on maximizing function and independence in long-term care.

i. Create standardized care pathways based on comprehensive assessments for persons living with frailty.

ii. Identify innovative options to support individuals with dementia as part of broader dementia care action plans at the provincial and federal level.

iii. Increase understanding of mental health issues for older persons.

iv. Address polypharmacy so that all patients over age 65 taking five or more medications are automatically triggered for pharmacy review assessment.

v. Adopt a policy on nutrition in care facilities that is person-centered (including culturally related choices).

vi. Increase hours of nursing care for long-term care to four hours per day to align with advancements in other jurisdictions post pandemic.

    i. Build advanced foot care coverage into increased nursing/practical nursing hours.

vii. Keep spouses/partners together as they age in place regardless of level of care required with location determined by the highest level of care required.

viii. Adopt an age-friendly caring approach and create a culture of equity and inclusion as a principle of care with special attention to health equity issues for seniors (e.g., multi-cultural considerations, seniors who identify as Indigenous, 2SLGBTQIA+, physical or intellectual disability status).

ix. Strengthen the role of resident and family councils in service delivery decisions related to enhancing residents' quality of life.

x. Encourage all residents of long-term care facilities to have an Advanced Health Care Directive (AHCD) on file.

b. Develop a Community Team model in long-term care facilities.

    i. Ensure access to comprehensive care including medical, health, and social services and therapies provided by a team including physicians, mental health caregivers, palliative resources, physiotherapists, occupational therapists, speech-language pathologists, recreation therapists, dietitians, pharmacists, pastoral caregivers, psychologists, and social workers.

    ii. Maintain adequate levels of properly oriented dietary, laundry and housekeeping staff, recognizing their roles in creating a quality environment.

iii. Ensure that residents in nursing homes have access to services such as podiatry, dental, hearing, and vision care.

c. Build connections for long-term care facilities across the integrated continuum of care.

   i. Ensure timely communication of clinically relevant information and treatment protocols to residents, family, and care providers in long-term care facilities (i.e., full circle of care as prescribed under Personal Health Information Act).

   ii. At the Community Team level, clinical navigators assist with and facilitate the transition of care from emergency or in-patient settings or rehabilitation facilities to long-term care facilities.

d. Ensure a well-prepared, empowered, and appropriately compensated work force.

   i. Build and support resilience of the long-term care workforce.

   ii. Listen to the voices of the providers at the point of direct care.

   iii. Embed senior/geriatric care into the physician and nurse practitioner curriculum.

   iv. Expand education for social workers, occupational therapists, physiotherapists, pharmacists, behaviour therapists, speech-language pathologists, clinical navigators, recreation therapists, pastoral/spiritual care workers, and other trained allied health professionals in care of older persons.

   v. Assess and take action to address the culture and workload conditions that are negatively impacting recruitment and retention in long-term care facilities.

   vi. Follow national standards for staffing and staffing mix in long-term care facilities.

   vii. Ensure continuing education for both the unregulated and regulated direct care workforce in long-term care facilities.

e. Ensure that long-term care facilities are engaged in the Learning Health and Social System.

   i. Include long-term care facilities within the newly imagined health information and virtual care system.

   ii. Ensure data collection needed to effectively manage and support long-term care facilities and their staff, including resident quality of care, resident quality of life, resident and family experiences, and quality of work-life for staff.

   iii. Build research around health and health equity for older persons, including a focus on areas such as Community Team models of care in long-term care facilities, polypharmacy, a culture of inclusion as a principle of care, and innovative approaches to dementia-inclusive care facilities.

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

a. Develop a team of 10–12 geriatricians located across regions of the province (1–2 in Labrador-Grenfell Health, Western Health, and Central Health; 6–8 in Eastern Health), based on:

   i. Recruiting each year one geriatrician (a Fellow of the Royal College of Physicians and Surgeons of Canada) for the next 10 years;

   ii. Establishing a temporary Return in Service Agreement with another university (e.g., Dalhousie University) for the education of geriatricians until the capacity to graduate geriatricians is increased in Newfoundland and Labrador.

b. Educate 30 family physicians in CoE and 60 geriatric-educated nurse practitioners who will be distributed across regional centres and Community Teams.

c. Increase training posts for 12 months in Memorial University's Family Physician CoE program — each 12-month post will be used for one 12-month residency, two six-month training posts for

family physicians, two nurse practitioners, or a combination of these professionals depending on availability of the practitioners to take on training.

d. For the immediate future, utilize education programs in other jurisdictions that will assist the province in building capacity (e.g., Nurses Improving Care for Health System Elders program implemented in Nova Scotia).

e. Embed senior/geriatric care in the physician and nurse practitioner curriculum.

f. Expand education for social workers, occupational therapists, physiotherapists, pharmacists, behaviour therapists, speech-language pathologists, recreation therapists, pastoral/spiritual care workers, and other allied health professionals in care of the elderly as deemed appropriate for the population served.

g. Ensure CoE educated allied health professionals on Community Teams or available regionally through a referral process.

h. Provide continuing education for CoE trained practitioners.

i. Ensure a sustainable workforce of adequately educated and compensated home support workers.

j. Avail of resources available at the community level including acknowledging family and caregivers in the community.

k. Educate social navigators and clinical navigators assigned to Community Teams on care of older persons.

l. Adopt an interdisciplinary team-based, person-centered approach to care focused on maximizing function and independence in long-term care.

    - https://rnao.ca/sites/rnao-ca/files/FINAL_Web_Version_0.pdf

m. Assess and take action to address the culture and workload conditions that are negatively impacting recruitment and retention in long-term care homes.

9.4. Because of the critical need for the Provincial Frail Elderly Program, implementation plans should be started immediately.

a. Develop and implement the strategic framework for the Provincial Frail Elderly Program at the provincial level with the input from geriatricians and clinical leaders in related programs.

b. Advance program development opportunities related to the care of the frail adults (e.g., Home Dementia Program), occurring in the Regional Health Authorities in 2022–2023.

c. Incorporate in any renovations or new builds related to emergency departments the requirements of a certified "senior-friendly emergency department." This should be set as provincial policy and all developments tracked to ensure compliance.

d. Include development of the Frail Elderly Program in the strategic directions of government as communicated by the Minister of HCS in preparation for the 2023–26 strategic planning cycle.

e. Increase recruitment and retention of geriatricians, enhance education of other practitioners, and increase the number and availability of home support workers in care of older adults.

f. Ensure that the proposed Senior Executive (Health Accord) (see Action 56) facilitates the start of the Provincial Frail Elderly Program and initiatives the development of an ongoing Seniors' Secretariat function in the province.

g. Establish a restorative care unit at the Miller Centre for patients with potential for optimization and on a pathway to return to the community.

An Integrated Continuum of Care

Action 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.

10.1. **In the community, shift the focus on care for seniors to a model built on a philosophy of well-being that includes both intrinsic factors (e.g., physical, mental, social health) and extrinsic factors (e.g., optimal functioning).**

a. Increase the provision of targeted health literacy initiatives and services to promote healthy behaviours and increase the resilience of vulnerable seniors' populations with an emphasis on well-being.

b. Improve the early identification of mental health decline in seniors.

c. Ensure that older people with mild to moderate mental health conditions are able to access mental health services in their communities.

10.2. **Enhance the availability of home support which includes support for those who need help in the instrumental activities of daily living (e.g., shopping, housekeeping, care of the home, food preparation, and transportation) by addressing barriers to access.**

a. Recruit and retain more home support workers (HSWs) in the province. Include incentives (e.g., the addition of health benefits and mileage reimbursement).

b. Expand care options available to clients to allow them to age in place (e.g., help with food and the activities of daily living).

c. Link home support providers, community organizations, Community Teams, and the client to proactively identify support needed to allow clients to stay at home longer.

d. Support families and other existing or potential caregivers in the community to address care gaps at the community level which may be identified by a community organization (e.g., SeniorsNL).

e. Create new and innovative linkages with personal care homes to provide episodic care for persons in the community (e.g., adult day programs).

10.3. Implement resources required for early assessment and detection of frailty.

a. Educate primary health care providers and Community Teams on early recognition of frailty using frailty assessments.

b. Adopt the RAI-HC as a standardized frailty screening tool for all Community Teams across the province.

c. Apply policies to ensure that Community Teams actively and consistently conduct frailty assessments on potentially frail patients/clients.

d. Dedicate resources to proactively assess patients presenting to acute care facilities (e.g., senior-friendly emergency departments, prevention of alternate level of care).

10.4. Ensure the sharing of care plans and assessments among practitioners and Community Teams to reduce duplication of effort.

a. Adoption and use of one comprehensive assessment tool (RAI-HC) which contributes to the Comprehensive Geriatric Assessment (CGA) for implementation/care planning.

b. Adoption of policies and procedures for all health providers within the circle of care to have access to patient/client/resident information (e.g., RAI-HC, CGA).

10.5. **Implement virtual care tools to increase access to services, particularly for seniors who have transportation barriers.**

a. Identify opportunities and priorities (e.g., Home Dementia Program, Frail Elderly Program) to expand virtual care offerings to seniors.

b. Identify and develop platforms required (e.g., video technology, remote monitoring).

c. Provide appropriate technology for patient/client consultation to practitioners and patients/clients.

d. Promote use of technology to monitor chronic conditions.

e. Provide appropriate education for seniors in the utilization of technology.

10.6. **Integrate into Community Teams allied health professionals educated in caring for older adults.**

a. Identify and collect data necessary to develop a staffing model for allied health care professionals educated in the care of older adults.

b. Ensure that the appropriate number of CoE educated health professionals is incorporated into the Community Teams. For some professionals this may be defined by provincial programming (e.g., rehabilitation).

c. Formalize a consultation and referral process for CoE educated professionals.

d. Create continuing education opportunities for allied health care professionals to care for older adults.

e. Ensure patient/client/resident information is shared across Community Teams (including RAI-HC and CGA).

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

a. Implement services and resources (including new technologies) to allow persons to receive rehabilitation, restorative care, respite care, and end-of-life care options at home or in the community.

b. Develop a Provincial Rehabilitation Program that includes frailty, with provincial pathways, complete oversight, and capabilities to measure outcomes.

c. Where necessary, ensure adequate number of rehabilitation and restorative beds and related practitioners in facilities, to facilitate transition back to community or home.

10.8. Ensure the availability of longer-term residential options when care at home or individualized community care is no longer an option.

a. Such options must be designed in accordance with the principle of the fundamental link between quality of care and quality of life and with the support of interprofessional teams.

b. Immediately implement a provincial policy and allocate any resources necessary to keep spouses/partners together as they change care levels. This policy could be similar to the Life Partners and Long-Term Care Act in Nova Scotia.

10.9. Ensure the availability of longer-term residential options including affordable housing, supportive housing, retirement residences (e.g., Naturally Occurring Retirement Communities — NORC), congregate living, personal care homes, and long-term care facilities.

a. Identify residential priority needs for seniors in both urban and rural areas in Newfoundland and Labrador based on identified needs at the regional level — link with the Seniors' Secretariat and community groups.

b. Implement support measures required to prevent homelessness in vulnerable seniors' populations (e.g., older women, Indigenous people, and other under-served groups).

c. Increase support for the Provincial Home Repair Program to allow seniors needing home repairs to stay in their homes longer.

d. Use priorities to guide residential investment and development opportunities (e.g., development of new housing/complexes for those with disability to age in place).

e. Leverage already existing housing options and facilities and provide appropriate supports to make them better suited as residential options for seniors (e.g., NORC).

f. Identify opportunities to conduct pilot projects on innovative community service options (e.g., nursing homes without walls).

g. Adopt legislation and polices to ensure the people of the province have the ability to live in a place of their choosing with supports matched to their care needs.

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

a. Provide education on person-centered and family-centered care for health care professionals.

b. Redefine care for older adults toward wellness and maintaining function.

c. Realign resources and policies to ensure a person-centered and family-centered approach is put in place.

10.11. Establish certified senior-friendly emergency departments.

a. Ensure appropriately educated staff and staff mix on site.

b. Require ongoing and mandatory education for health care professionals in the emergency departments.

c. Implement appropriate policies, protocols, and procedures.

d. Ensure that quality improvement and quarterly performance outcome measures and benchmarks are in place. Measures should examine structure, process, and outcomes including the volume of

persons older than 65 years, the number of older adults with repeat emergency department visits, and the number of older adults requiring admission and readmissions.

e. Ensure that appropriate equipment/supplies are on site in the emergency department.

f. Ensure that the appropriate senior-friendly environment is created.

g. Include senior-friendly provisions in the design of new builds and/or renovations.

Note — All of the above would be required components of an accreditation certification for senior-friendly emergency departments.

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

a. Implement appropriate policies, protocols, and procedures with strengthened information sharing among care providers, families, and caregivers.

b. Ensure an appropriate and supported change management approach to move forward policy implementation.

10.13. Ensure early acute care discharge planning that includes the person and their family, and the supports necessary for the transition back to community (or the personal care home or long-term care facility).

a. Ensure families, Community Teams, and relevant community organizations or facilities are included in the early discharge planning.

b. Ensure supports and equipment are provided at discharge or are available at the community level.

c. Provide adequate monitoring, particularly in first days and weeks post-discharge, to mitigate risk of deterioration.

d. Ensure monitoring of quality measures to evaluate quality of transition from hospital to home including wait time between the request for community support and the first visit on discharge.

10.14. Ensure appropriate communications between care providers (acute and community) on details of patient/client/resident treatment and status.

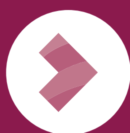
a. Ensure timely communication of clinically relevant information and treatment protocols to patients/clients/residents, family, and all out-patient care providers including nursing homes (i.e., the full circle of care as prescribed under the Personal Health Information Act).

10.15. Ensure that care providers are supported by an inclusive and integrated health information and virtual care system from the moment individuals are admitted to health care facilities.

10.16. Support transitions through levels of care and care settings with clinical navigators.

a. At the Community Team level, establish clinical navigator positions with dedicated responsibility to support transitions of care for older people through effective coordination and communication of the care pathway (see Action 14.1).

Addressing Ageism and Building Age-Friendly Communities



Action 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.

11.1. Develop an age-friendly public media campaign with a specific focus on awareness and prevention of ageism, the benefit of age-friendly communities, and the significant social and economic contributions of seniors.

a. Adopt the definition of Ageism included in the Global report on ageism published by the World Health Organization (WHO) — ageism refers to the stereotypes (how we think), the prejudice (how we feel), and the discrimination (how we act) towards others or oneself people based on age.

b. Review previous age-friendly campaigns in the province, and revitalize, where possible, relevant components.

c. Identify priority messaging not covered in previous campaigns for promotional development through engagement with seniors' organizations and community representatives.

d. Leverage media templates provided by the WHO or other jurisdictions in the development of material.

e. Commission campaign work which includes:

   i. identifying the negative impacts of ageism;

   ii. hearing testimonials from individuals with lived experience; valuing seniors and the contributions they make to society;

   iii. promoting intergenerational activities within communities and schools;

   iv. identifying age-friendly communities and organizations to allow for recognition of municipal and organizational efforts.

f. Adopt the United Nations Decade of Healthy Aging Framework to guide implementation processes and use in public awareness materials.

g. Educate those involved in the health and social systems on ageism as a significant influence on health, and on social and health care delivery.

h. Work with stakeholders such as community groups and municipalities to develop a framework for promotion of age-friendly communities and roll-out of media campaign.

11.2. Ensure a non-ageist culture of caring approach in health care through promotion, policy, education, communication, and inclusion (through a seniors' lens).

a. Require health and community sector employees who care for older persons to assess the impacts of ageism in their work environments using an inclusion lens as a guide. This should be a priority with actions and performance measures.

b. Require employees to complete education on the negative impacts of ageism and the ways to ensure an age-friendly care approach (e.g., WHO resource: https://cdn.who.int/media/docs/default-source/campaigns-and-initiatives/global-campaign-to-combat-ageism/global-campaign-to-combat-ageism---toolkit---en.pdf).

c. Strengthen the capability of the health workforce to understand the range of health literacy needs of older people.

d. Require all health care professionals and workers to achieve specific competencies regarding non-ageist culture.

e. Adopt an age-friendly caring approach as a principle of care with special attention to health equity issues for seniors (e.g., multi-cultural considerations, seniors who identify as Indigenous, 2SLGBTQIA+).

f. Recognize positive changes in language and behaviours that demonstrate an age-friendly caring approach.

g. Identify and communicate a complaints or reporting process for individuals or caregivers to bring forward concerns on ageism and quality of care with a link to the role of the Seniors' Advocate.

h. Require leadership teams to review and take action on concerns and complaints.

i. Educate clients, professionals, students, and the public on the principle of autonomy for all ages.

j. Ensure the appropriate education of frontline practitioners and students in aging-related matters, with particular attention to multi-dimensional and multi-systemic factors, and frailty.

k. Craft communication regarding services and programs to reinforce and support a non-ageist culture.

11.3. Optimize the use of electronic portals to support Community Teams and others to share best practices and lessons learned in becoming age-friendly.

a. The Seniors' Secretariat and the Department of Health and Community Services (HCS) should work with the Office of the Chief Information Officer (OCIO) to develop an age-friendly information portal.

b. Engage competent experts on an age-friendly philosophy and best practices to support resource development.

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

a. Implement a public process to identify individuals or groups across the province interested in becoming age-friendly champions in their community, and develop a registry and networking process for the group.

b. Implement a call through Municipalities Newfoundland and Labrador to identify municipal workers/elected officials interested in becoming age-friendly champions.

c. Develop a train-the-trainer module for utilization of a seniors' lens and other resources for municipal and community champions.

d. Establish competencies to qualify as an "Age-Friendly Assessor."

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

a. Provide education through Municipalities Newfoundland and Labrador to designated municipal/community representatives to increase knowledge on age-friendly communities.

b. Develop and distribute an Age-Friendly Newfoundland and Labrador Communities Program (Vision) to promote a lifespan approach to healthy aging and planning for changing demographics.

c. Develop a user-friendly lens that can be used as an assessment tool at the municipal/community level.

d. Provide education on the use of an age-friendly lens in planning activities.

e. Work with municipalities and communities to adopt "Age-Friendly Municipality" as a value or principle of service.

f. Work toward all local service districts and municipalities having a dedicated age-friendly policy/process.

g. Engage Wellness Coalitions and Newfoundland and Labrador as supports and champions for this work.

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

a. Work with the registry of Age-Friendly Champions to identify current challenges in the completion of assessments.

b. Engage champions to identify steps necessary to overcome the main challenges.

c. Provide training and support to municipalities and communities to complete assessments and apply for funding (provincial and federal) available to support age-friendly communities.

d. Dedicate resources at the community level to assist communities in writing proposals for federal and provincial funding opportunities.

e. Establish categories of age-friendly initiatives (e.g., recreation, social, transportation) and support applications across categories.

11.7. Apply universal design principles for developing age-friendly communities.

a. Fully engage older persons in the development of regulations under the Province's Accessibility Act.

b. Require municipalities to adopt universal design principles for new builds and renovations.

c. Ensure that governments at all levels capitalize on levers available to improve accessibility to public facilities.

d. Ensure that the provincial government, municipalities, and the private sector take into account the needs and potential limitations of older persons when designing buildings, walkways, transportation systems, and other aspects of the built environment.

e. Provide education resources for those involved in various levels of planning.

11.8. Increase government investment and support for age-friendly communities.

a. Through the Seniors' Secretariat, identify opportunities to increase budget funding for age-friendly communities with the goal of keeping older persons healthier and able to live independently.

b. Through the Seniors' Secretariat, look for opportunities to better leverage federal funding to increase the attractiveness of funding allotments supporting age-friendly communities.

c. Have the provincial government schedule support programs to allow applicants to apply for both provincial and federal funding (e.g., New Horizons).

d. Through the Seniors' Secretariat, implement a data collection process to measure the benefits and value of age-friendly investments.

e. Increase government investment in age-friendly activities through projects that move beyond initial assessments.

f. Provide government funding to community organizations to support and manage age-friendly activities.

g. Provide dedicated resources to work at the community level to support the development of age-friendly communities.

h. Through the Seniors' Secretariat, Department of Municipal and Provincial Affairs (MPA), Newfoundland and Labrador Housing Corporation (NLHC), and HCS, work with communities to strengthen their work on age-friendly communities.

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

a. Provincial government review policies and funding programs for municipalities, communities, and community-based organizations to identify opportunities to align with and support age-friendly practices (e.g., apply an age-friendly lens).

b. Provincial government review broader policy and funding programs to identify opportunities to align with age-friendly practices (e.g., developing criteria for environmental assessment and assignment of crown lands).

c. Provincial government apply an age-friendly lens in the development of new policies and funding programs.

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

a. Invite input from volunteer groups, community service groups, faith groups, and individuals regarding skills and competences that should be enhanced to help them in their work as they support older people in their communities.

b. Through the Seniors' Secretariat, work with municipalities and community-based organizations to identify development opportunities for volunteers who support older persons including recruitment, screening, training, support, and recognition.

c. Through the Seniors' Secretariat, establish a comprehensive working group to identify/create resources to support volunteers.

    i. The working group would partner in the delivery of supportive resources with volunteer groups and families (e.g., train-the-trainer, 50+ organizations, Community Sector Council NL).

d. Acknowledge that much care and support is offered in neighbourliness, where people do not consider themselves volunteers.

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

a. Through the Seniors' Secretariat, work with MPA to establish a Minister's or Premier's award/accreditation for communities becoming more age-friendly.

b. Develop criteria to be used in the award process.

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

a. Through the Seniors' Secretariat, work with municipalities and communities to:

    i. develop materials that can be used to engage local businesses in supporting age-friendly communities (e.g., opportunities for fundraising, volunteering, applying universal design principles, donations);

    ii. establish a forum to share information with local businesses about the opportunities.

b. Seek opportunities for innovative and entrepreneurial partnerships to develop and improve on the pillars of age-friendly communities.

c. Provide resources for RHAs and municipalities to promote local business engagement in age-friendly initiatives.

d. Provide resources for businesses to become informed on an age-friendly philosophy and matters to be considered in planning.

e. Certify and acknowledge businesses who are in compliance through planning, retrofit, or assessment.

11.13. Encourage provincial departments, communities, and municipalities to take immediate action to support seniors.

a. Address institutionalized ageism to remove barriers prohibiting older people from engaging fully in provincial, civic, and economic activities as part of the community.

b. Provide more opportunities for seniors to be involved in the community through civic and social activities such as volunteer work, mentoring, and continued education.

c. Identify and implement intergenerational activities that will support mutual understanding and cooperation among different generations.

d. Review tax rules to support seniors staying in the workforce and engaging in healthy living activities.

e. Work across government and social sector entities (community-based) to improve access to services, develop new initiatives that address the social determinants of health (SDH), and coordinate assistance for vulnerable seniors.

f. Develop a referral system for older people at risk of social or economic isolation to receive appropriate supports through their contact with Community Teams, social housing, SeniorsNL and other public and community services.

g. Implement initiatives designed to recognize and appreciate the heterogeneity of older adults (e.g., health status, genetic makeup, stress levels, careers, social engagement, geographic location).

h. Change the way in which communications occur including both the language of content and images used (balanced imagery showing healthy seniors, not just frailty).

i. Within government, develop a Seniors' Secretariat that includes the positions currently within the Seniors and Aging Division of the

Department of Children, Seniors and Social Development (CSSD) and additional positions (leadership and policy) necessary to:

i. develop and expedite government strategies, policies, and programs to support positive outcomes for seniors;

ii. ensure that the impact of legislation, policies, and programs are brought to the attention of the Minister Responsible for Seniors, Cabinet and Cabinet Committees, and departments;

iii. monitor and review programs and other activities of government departments and agencies with a seniors' lens to ensure compliance with government policy and strategic directions supporting seniors;

iv. liaise with provincial government departments and agencies, the Seniors' Advocate, other governments, advisory councils, and seniors organizations throughout the province on issues affecting seniors;

v. ensure collaboration across government departments, agencies, and community organizations to address institutional ageism and legislative and policy gaps.

j. Establish an annual 'Seniors' Summit' 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.

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.

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

a. Increase the number of positions in HCS from the current three staff dedicated to seniors, and provide enhanced executive support to advance major change initiatives. This may include dedicated teams focused on specific topics.

b. Strengthen the powers and duties of the Seniors' Advocate to mirror those of the Child and Youth Advocate with a view to incorporating the updated requirements identified in the new national standards of long-term care for seniors.

c. Engage the Office of the Seniors' Advocate to develop, through consultation, a statement of rights and responsibilities for care and services with seniors.

d. Complete a jurisdictional scan on progressive legislative options that support an integrated continuum of care (i.e., person-centered care throughout the full spectrum of health services).

e. Provide provincial government commitment and approval to develop legislation.

f. Engage with seniors, care providers, and groups representing older adults in the province to identify specific challenges and opportunities in Newfoundland and Labrador.

g. Build legislation to position the province as a leader in the rights and care of older persons.

h. Strengthen role of the Seniors' Advocate in monitoring and reporting on the quality of health care for seniors.

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

a. HCS prioritize the finalization and implementation of Personal Care Home Regulations with a specific focus on quality of care, appropriate

staffing models, educational standards, care delivered based on assessed need, innovative use of options, and geographic coverage across the province.

b. HCS develop new regulations for home care that include a person-centered, managed-care approach with a focus on education standards for home care workers, care delivery based on assessed need, service level agreements, managed and supported shift structures, accountability, and geographical coverage.

c. Regulate work hours and supports for home care workers with short shifts and multiple places of work (e.g., bus card access, decreased taxi fares, and a gas mileage subsidy).

d. Include necessary legislative and regulatory requirements to ensure person-centered and quality long-term care.

e. Include necessary legislative and regulatory requirements to support accessibility, quality, and affordability of supportive housing for seniors to allow them to age in place.

f. Ensure that there are feedback loops, including public reporting, through which care providers can learn from outcomes and patient experience, and plan for service and workforce improvements.

g. Include a requirement to keep spouses/partners together as they age in place regardless of the level of care required with the location to be determined by the highest level of care required.

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

a. Establish new core competency profiles based on best practices, supportive of collaborative, person-centered practices that represent the foundational competencies required to work as a HSW or personal care home worker (PCHW) in Newfoundland and Labrador. This would ensure that workers have the skills they need to safely deliver care (e.g., reduce injuries).

b. Review and revise provincial qualifications for PCHWs and HSWs.

c. Develop and implement provincial policies and procedures for new educational qualifications.

d. Recognize current staff and support grandfathering/upgrading as necessary for transition.

e. Increase hours of nursing care for long-term care to four hours per day to align with advancements in other jurisdictions post pandemic.

f. Adopt a policy for a moratorium on the building of new large structure, institutional-based, long-term care facilities.

g. Update and ensure alignment with operational standards to strengthen the role of resident and family councils in service delivery decisions related to enhancing residents' quality of life (e.g., frequency of meetings, requirement for minutes, and transparency of process).

h. Adopt a policy on nutrition in care facilities that is person-centered, including culturally related choices, with ensured access to options included in the Canada Food Guide.

i. Develop criteria and strategy for the prior approval of new personal care homes based on regional or geographic needs using a seniors' lens.

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

Identify and work with current residential providers to explore expanded service options such as respite care, rehabilitation, and personal daily living supports for those needing extra assistance (e.g., bathing, meals, social events) but able to stay in their homes. Evaluate the New Brunswick model tested locally in a pilot project.

12.5. Broaden vaccination, pharmaceutical, dental, vision, foot care, and hearing coverage for older adults.

a. Develop a program to increase shingles and pneumonia vaccines for those 65 years of age and older.

b. Look to analyses already completed in other jurisdictions that demonstrate the cost-benefit analysis to guide increased funding decisions at the provincial level.

c. Identify the means to incorporate and ensure that advanced foot care coverage is included at the community level and in institutional care settings as a required care component.

d. Build advanced foot care coverage into increased nursing/practical nursing hours (4.0 hours/resident/day) in long-term care facilities.

e. Explore options to offer preventative dental coverage to seniors who do not have insurance coverage.

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

a. Work with the federal government to implement new national standards for long-term care.

b. Work with the federal government to address gaps in equipment and services (e.g., equipment, medications, foot care, dentistry) for individuals residing in long-term care.

12.7. Fully implement a provincial Home First policy in a coordinated manner with Community Teams.

a. Implement policy recommendations made in the Provincial Home Support Review (2016).

b. Require implementation of the Home First Policy especially for seniors assessed as having higher rehabilitation potential upon presentation to an acute care facility.

c. Develop clear discharge plans in partnership with the local Community Team(s).

d. Develop and deliver education to related practitioners that clarifies their roles and responsibilities related to the Home First Policy.

e. Allocate funding by RHAs and provide other supports necessary for implementation of the policy.

f. Measure performance of the Home First Policy with respect to desired outcomes.

12.8. **Fully implement a policy for the completion of AHCD defined by the province's Advance Health Care Directives Act, 1995.**

a. Encourage all seniors and persons with chronic illness to have an AHCD on file with their Community Team and available for presentation in personal care homes, acute care centres, and long-term care facilitates as appropriate.

b. Eventually, move to require all patients/clients/residents to have an AHCD on file in their Community Team and in any supported living arrangement.

c. Educate health care professionals to assist with preparation of AHCD.

d. Educate the public about the benefits of AHCD and shared decision-making.

e. Fully implement and promote a policy for AHCD.

f. Ensure that the AHCD is included in the electronic health record and can be easily accessed by care providers.

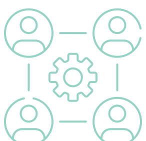
12.9. **Include a lifespan approach in legislation, program, and policy development.**

a. Establish an age-friendly policy framework with education materials for government agencies and community groups.

b. Develop and implement an age-friendly standard to be required in all government agencies and government-funded community groups.

3. Community Care Implementation Recommendations

Community Care Committee	
Committee Members	**Secretariat**
Shanda Slipp (Chair)	Cheryl Etchegary
Carmel Casey	Monica Bull
Heather Hanrahan	Cynthia Clarke
Ada John	
Michael Jong	
John Norman	
Judy O'Keefe	
Lynn Power	
Nicole Stockley	



Community Teams

Action 13: Connect every resident of Newfoundland and Labrador to a Community Team, providing a central touchpoint of access and a continuum of care.

13.1. Create approximately 35 Community Teams in Newfoundland and Labrador that will provide patient/client-centered, longitudinal, comprehensive community care within the scope of the care providers.

a. Teams are accountable to and operationalized by Regional Health Authorities (RHAs) — see 13.3 for a description of how the Community Teams will affiliate with the existing primary care structure.

b. New and expanded teams will be established first in areas of greatest need (e.g., high numbers of unattached patients/clients, provider instability or turnover).

c. Teams will be co-designed with Family Practice Networks (FPNs) where available, building on the principles of the College of Family Physicians of Canada Medical Home model (which have been adapted for a Newfoundland and Labrador context in the Health Home model). The patient/client and family are at the center of care.

   i. Governance of the Community Teams, including affiliation agreements, will require development with a provincial approach (recognizing regional needs and differences). Leadership teams should include front-line providers and representation from community primary care practices.

d. Up-front government investment will be required to quickly establish new Community Teams and to re-organize current primary health care providers and community services into Teams.

e. Maps of the regions showing the potential locations of Community Teams are included in Section A, Rebalancing the Health System: Community Teams.

13.2. The base size and composition of a Community Team will depend on the needs of the local population and local availability of providers.

a. As a minimum, each Community Team will consist of family physicians, nurse practitioners, nurses, social workers, social navigators, clinical navigators, public health nurses, pharmacists, and administrative and clerical support.

b. Where needed and feasible, enhanced services of allied health professionals will be added from various RHA community programs including Community Support, Community Mental Health and Addictions, Community Care, and Public Health or from private practices. These may include occupational therapists, physiotherapists, mental health providers including psychologists, elder care workers, midwives, chiropractors, among others, joining together to form Community Teams, while removing the silos of our current system.

c. Patients/clients will access the most appropriate provider at the most appropriate time.

   i. Patients/clients and families will have direct access to all Community Team members without the need for referrals (e.g., if the patient/client had questions about their medications, they would be booked directly with the Team pharmacist; patients/clients requiring review of their diabetes might be initially assessed by the nurse specializing in chronic disease with support from the dietitian and pharmacist).

   ii. The decision of the most appropriate provider would be based on patient/client needs, availability of team members, and the scope of practice for each Community Team member.

   iii. When a patient/client accesses Team members, relevant information is shared among the Team and the most responsible provider (MRP) (see below) for long-term planning of the patient's or client's care.

d. Effective Teams recognize that leadership is shared, that patients/clients are known to all team members, and that patients/clients are participating partners in their own care. The measure of a Team's success is the patient's or client's recognition that, when they see one member of the Team, they are seeing the whole Team.

e. Virtual connection will be used to enable team-based care where co-location is impossible.

f. The support of episodic, non-continuous care services (such as 811 HealthLine and "walk-in" clinics) should be continually re-evaluated as more patients/clients are connected to accessible, continuous, team-based community care and are educated on how and when to access the most appropriate care. In situations where episodic, non-continuous care services persist, formal written communication back to the patient's or client's Community Team is required.

g. Experience and learnings derived from the four new collaborative teams currently being developed and implemented as well as ongoing surveillance of best practices in other jurisdictions will help inform decisions around provider numbers required.

13.3. Build on the existing structure of community primary care practices in the province, recognizing the excellent work and deep longitudinal relationships in primary care between family physicians, nurse practitioners, and their patients/clients.

a. Primary care practices will be affiliated with Community Teams.

   i. Pathways with affiliation agreements must be created to incentivize and promote team-based care for existing private practice clinics and integrate them into the Team structure, while respecting the vital role these practices play in the primary care system.

   ii. Allied health providers from the Teams will collaborate with primary care clinics on a determined rotation basis — in person and virtually.

   iii. Affiliation agreements with the RHA-led Teams would include expectations for allied health support, electronic medical record (EMR) and data sharing, governance/leadership, advanced access and after-hours coverage, use of virtual care, quality management, and evaluation. A provincial approach will ensure consistency across regions but must respect regional needs and differences.

iv. Affiliation agreements will support the stability and integrity of the primary care practices.

v. Family physicians will be supported to transition to an appropriate payment model which facilitates team-based care and collaboration (e.g., blended capitation).

vi. Family physicians and providers within primary care practices will be free to determine their own practice arrangements, be they employer/employee, contractor/independent professional, or practice partners.

vii. The Family Practice Network structure can facilitate the change management process required for moving toward team-based care.

viii. The accountability of providers in a primary care practice will continue to be to their own practice arrangement/agreement, to their professional standards, and to their patients/clients with affiliation agreements addressing accountability to the broader Community Team.

b. Allied health providers may be RHA-employed or engaged through service contracts (e.g., a community pharmacist or privately operating physiotherapist or chiropractor).

c. Roles and responsibilities of all team members must be clearly defined (see the Workforce Readiness Implementation Recommendations).

i. Expectations including accountability and reporting structures must be clearly defined.

d. Some providers employed within RHAs will be merged into Community Teams, inclusive of their current work, as deemed possible by RHAs.

i. This will require a refocusing and philosophical reprioritization of community care needs.

ii. Special attention must be taken not to create gaps in acute care or in existing community roles.

13.4. **Roster patients/clients to a Community Team and to a family physician or nurse practitioner within the Team who will be responsible for coordinating and leading comprehensive patient/client care as the most responsible provider.**

a. Rostering to the Team enables the primary providers to commit to the patient/client that they will provide a basket of services on a continuous basis, and the patient/client to commit to the provider that they will seek primary care only from that Team.

b. Rostering will enable tracking of patient/client numbers and needs, as well as recognize the current relationships that exist between patient/client and primary care provider, which should be 'grandfathered in.'

c. Ideally, the patient/client is rostered to a Community Team and to a primary practitioner within the Team in their geographic catchment area (when pre-existing relationships do not exist).

d. Where pre-existing relationships exist, these will be respected and as such may continue. It is possible these relationships may exist between a patient/client and a provider who is outside of the catchment area. Over time, as teams grow and access to community care is enhanced, patients/clients may choose to transition and roster to the Community Team and health care provider in their catchment area.

e. Patients/clients should still have choice in their Team and for their MRP as part of this patient/client-centered model of care.

f. Contingencies and planning must exist for provider coverage in cases of vacations, illnesses, retirement, or resignation of the MRP.

13.5. **Provide care to a population base of 7,000–8,000 and upwards, with special arrangements (including linkages with larger Teams) for smaller or more isolated communities.**

a. Depending on team size, a provider mix within the Community Team may comprise:

   i. As a rough guide — 1,250–1,500 patients per 1.0 full time

equivalent (FTE) family physician (FP), an additional 800 patients per 1.0 FTE nurse practitioner (NP), and an additional 300–500 patients per 1.0 registered nurse (RN). Thus, each group of one FP, one NP, and one RN would roster 2,350–2,800 patients/clients.

ii. FTEs must be taken into account, recognizing that many providers may have continued responsibilities outside of clinic time (e.g., emergency department coverage, hospital work, academic responsibilities).

iii. Evidence in the literature is lacking for additional patient/client capacity with the addition of other health providers to the team. As above, learnings derived from the four new collaborative teams as well as ongoing surveillance of best practices in other jurisdictions will help inform decisions around provider numbers required and ability to roster and care for additional numbers of patients.

b. Smaller catchment communities would have smaller Community Teams with allied health support from larger teams. Community Teams with small catchment populations (e.g., 2,000–2,500 patients/clients) may include two FPs, one NP, one social worker, one shared social or clinical navigator, and one shared pharmacist. Allied health providers (e.g., physiotherapy, occupational therapy, mental health support) from the nearby Teams with bigger catchment populations would be aligned to support the smaller teams, both with visiting support and virtually.

c. Networks of several teams will exist across regions and support each other.

13.6. Establish a provincial health and social workforce planning strategy including coordinated recruitment and retention of community care providers.

a. See Workforce Readiness Implementation Recommendations.

b. Community health care providers should be appropriately remunerated and incentivized, while care is taken not to create unintended gaps in the acute care/hospital system.

13.7. Connect Community Teams with patients/clients, families, schools, and community organizations outside of RHAs.

a. Utilize a web-based platform for building Community Teams, allowing groups and organizations outside the current health system structure (such as schools and community organizations) to connect with Teams.

b. Design governance structures which involve community advisory groups and community partners, allowing Teams to be built from the ground up, and responsive to local needs.

c. Develop an integrated approach to patient/client engagement within the new Community Team structure.

13.8. Support enhanced access (including advanced access, and after-hours and weekend access) for community care (which may be a shared responsibility between multiple teams and affiliated primary care clinics).

a. Enable advanced access, including same-day scheduling where appropriate, and timely access to the most appropriate provider.

b. Health centres will be serviced by providers within the Community Team and supported by an integrated ambulance system.

c. The model of enhanced access and urgent care coverage will depend on a patient's or client's distance to the nearest community hospital, size of the catchment population, availability of providers, and access to a virtual emergency department (see Section A, Summary 12, A Rebalanced Health System: Health Centres).

13.9. Develop strategies for employment of members of the Community Teams, affiliation agreements with community primary care clinics, and service contracts with privately funded providers.

a. Ensure that remuneration strategies for FPs within Community Teams support the underlying principles of best practices for team-based care and this Call to Action. A blended capitation payment model is the preferred payment method for FPs in Community Teams that aligns with these principles.

b. Develop service contracts with private providers such as pharmacists, chiropractors, and physiotherapists, especially in smaller communities.

   i. Each professional body or association will be engaged in developing contracts and service agreements.

c. Develop transition agreements and ensure careful planning to mitigate unintended consequences of changes in health care facilities.

13.10. Ensure that Community Teams participate actively in the Learning Health and Social System and are included in the overall evaluation framework for the Health Accord.

a. The Community Team is committed to improvement in quality and will evolve mechanisms to analyze data, translate knowledge to their providers, and optimize appropriate use of health care resources, including both underutilization of effective interventions, and over-utilization of unnecessary interventions.

Coordination of Care

Action 14: Improve coordination of care across the health and social systems by enhancing communication and system navigation.

14.1. Establish a social navigator and a clinical navigator attached to every Community Team.

a. Social navigators (who are social workers or providers from a related social science discipline) should be part of interprofessional community care teams, where they work alongside other health

care staff to identify patients with social issues affecting their health and connect them with needed resources.

i. Examples of potential points of contact where social determinants of health (SDH) needs are identified:

   - A non-clinical team member interacts with a patient during the health care visit (e.g., administrative support person learns that a patient need assistance with transportation).

   - A clinical staff member identifies a patient 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 FP learns a patient has a disability which could qualify for a tax credit application, a pharmacist learns a patient could qualify for additional insurance coverage for medications, a home support worker identifies patient would benefit from more home supports).

   - A patient 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. For example, the latter scenario might include patients who have frequent emergency department visits or who require unanticipated early readmission to hospital.

ii. 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.

b. Clinical navigators, also part of the interprofessional Community Teams, will ensure the continuum of care for the patient cared for by the Community Team across all health care services accessed by the patient such as acute care (in-patient and emergency), rehabilitation, long-term care, and community support services, with particular focus on under-served populations including frail elderly persons.

i. The clinical navigator should identify all health care services accessed by patients/clients cared for by the Community Team such as acute care (in-patient and emergency), rehabilitative and continuing care services. An integrated health information and virtual care system across all levels of care will be essential to accurate and timely identification of such interactions.

ii. The clinical navigator should ensure that all relevant clinical information is shared with the service being accessed and communicate as necessary with the relevant providers. Integrated electronic patient information will be essential in this regard.

iii. Critical points of transition such as admission, transfer, and discharge will require particular attention to ensure seamless and continuous care for the patient/client.

iv. Common problems should relate to appropriate medication use, social and family supports, and ensuring access to levels of care appropriate to each patient/client.

c. Social navigators would normally have a bachelor or graduate degree in social work or a related social science discipline. Clinical navigators would be nurses, either registered nurses or licensed practical nurses, with experience in community nursing, acute care, or geriatric care.

d. Social navigators and clinical navigators should be educated in several areas of competence including motivational interviewing, trauma-informed care, and mental health first aid. The navigators should be knowledgeable about the range of resources available and ensure that appropriate referral and subsequent follow-up takes place.

e. A centralized and accessible source of information should be established for navigators, providers, individuals, and family caregivers that clearly specifies available supports, programs, and resources.

14.2. **Establish touchpoint access for patients/clients and families to connect them with Community Teams and to direct them to the right care at the right time with the right provider.**

a. Clinical navigators should assist in directing as appropriate.

b. EMR and technology solutions should allow direct patient/client booking and access where appropriate.

c. Existing tools such as Patient Connect NL and Bridge the gApp should be utilized.

d. The 811 HealthLine and 211 (a telephone and online directory that helps connect Newfoundlanders and Labradorians to critical community-based supports) should have access to local Community Team composition and be able to direct patients/clients directly to the right provider.

e. Interventions by all providers in the system should be available in the electronic health record and accessible to both the patient/client and the Community Team.

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

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

a. The Family Practice Renewal Program and FPNs can play a valuable role in this coordination and delivery (see Education Implementation Recommendations)

b. See Action 45 for more detail on education in team-based care delivered interprofessionally.

14.5. **Support the digital infrastructure needed to enable effective communication and sharing of patient/client information as necessary (see Digital Technology Implementation Recommendations).**

a. Ensure Community Teams are using a well-supported electronic medical/health record (EMR/EHR), which is connected to the health information and virtual care system, and the Community-based Client Referral and Management System (CRMS).

b. Ensure that data-sharing and information flow is electronic and seamless.

c. Ensure that information from care provided by 811 HealthLine providers is shared with Community Teams and primary care providers.

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

e. Ensure that patients/clients are active participants in their care, using digital tools such as remote patient monitoring and chronic disease management tools.

14.6. **Connect home care and home support services for residents of all ages and abilities to Community Teams to enable collaboration.**

a. Home support workers should be active team members in their patient's/client's care.

b. Education around team-based care should extend to home support workers.

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

a. Connect the school system and Community Teams, with information shared back and forth as appropriate.

14.8. **Pay special attention to the care gaps for children with complex medical and social needs, including children in alternate care.**

a. Community Teams should assure wrap-around care for children with complex medical and social needs, with support from specialty clinics as required.

b. Ensure the implementation of the integrated 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 (see Social Determinants of Health Implementation Recommendations, Action 6).

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

Action 15: Place greater emphasis on health promotion and well-being, the social determinants of health, and chronic disease management.

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

a. See Social Determinants of Health Implementation Recommendations.

b. Equip Community Teams with knowledge of existing programs and services via 211 so they can work with patients/clients to find the right programs and services.

c. Connect Community Teams to community-based organizations to optimize knowledge of the programs and services that are available for patients/clients.

d. Explore the addition of kinesiologists, recreation specialists, and/or recreation therapy workers to Community Teams to facilitate linkages to healthy living, exercise programs, and leisure and recreation opportunities that support health and well-being.

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

a. Implement and support the Comprehensive School Health (CSH) Framework of the Pan-Canadian Joint Consortium for School Health.

b. See Social Determinants of Health Implementation Recommendations.

15.3. Work closely with the proposed Provincial Frail Elderly Program and regional Centres for Excellence on Aging, drawing on their expertise of the lived experience of aging in the community (see Aging Population Implementation Recommendations, Actions 9, 10, 11).

a. Place priority on the prevention and appropriate management of frailty, including education of providers and community interventions.

b. Implement resources required for early assessment and detection of frailty, including the education of members of Community Teams on use of frailty assessments.

c. Identify opportunities and priorities (e.g., Home Dementia Program, Frail Elderly Program) to expand virtual care offerings to seniors.

d. Work closely with acute care hospitals in early discharge planning and in implementing the Home First Policy, to better coordinate care across the continuum.

e. Support the completion of Advance Health Care Directives by all patients/clients rostered with Community Teams.

f. Be a resource for municipalities and community-based organizations in the development of age-friendly communities.

15.4. **Enable team members to work to their full scope of practice to include preventative care and chronic disease management.**

a. Conduct an analysis of perceived scope barriers for all providers, and plan strategically to address them, under regulatory body guidance.

15.5. **Integrate Public Health (PH) into Community Teams.**

a. Community Teams should have knowledge of the diversity of roles and availability of/access to relevant PH workforce for their community (e.g., community developers, inspectors, cultural knowledge keepers, epidemiologists).

b. Discussions should be ongoing between providers to determine the right person-right time approach in roles where current overlap or gaps might be identified (e.g., immunization programs), providing an integrated approach.

c. All community needs assessments should include PH components (e.g., tobacco control, water quality, sanitization, food safety, motor safety, use of car seats, and air pollution), and other relevant environmental factors that impact health.

d. Relevant PH staff should have access and means to share relevant data to inform and receive information to ensure maximum contribution to the Community Teams (e.g., child health programs and children in care service providers).

e. Monitoring and surveillance of PH issues (e.g., communicable disease, substance use) with feedback to Community Team level should be supported.

f. Removal of barriers to treatment for substance use disorders should occur.

g. Local availability of community-based PH services (e.g., breast feeding support) should be collected, kept current, and widely known to groups such as social navigators and clinical navigators within Community Teams, community family medicine clinics, and 811 HealthLine.

h. Intersectoral research should be supported and relevant information included from PH experts such as national collaborating centres for PH, as they serve as knowledge hubs for PH (e.g., communicable disease control, healthy living, emergency preparedness).

i. Funding models, based upon community needs data, should incorporate PH workforce and other resources.

j. PH should have prominence in the overarching governance model.

k. All stakeholders need to know, participate in, review, and integrate relevant elements in and stemming from the Public Health Protection and Promotion Act (e.g., five-year review plan).

15.6. Optimize community level partnerships with wellness coalitions, community advisory committees, family resource centres, municipal partners, and patient/client-led self-help groups.

a. Community Teams should have knowledge of and connection to these groups and their programs and services to inform patients/clients when the information is relevant to their care.

b. Ensure that these groups are included in the 811 HealthLine resource database and 211, as well on the web-based platform that will be used to identify team members and connect teams.

15.7. Expand and strengthen prevention programs.

a. Programs such as BETTER, INSPIRE/COPD-outreach, Janeway Lifestyle Program, and Strongest Families parenting program, among others, should be leveraged and expanded.

  i. The BETTER Program is an evidence-based approach to chronic disease prevention and screening, focusing on cancer, diabetes, cardiovascular disease and their associated lifestyle factors. BETTER practitioners embedded in Community Teams have been shown to improve chronic disease prevention and cancer screening.

  ii. INSPIRE/COPD-outreach clinics are currently being piloted to improve Chronic Obstructive Pulmonary Disease (COPD) care

in the community. Early evidence has shown a significant reduction in emergency department visits and hospitalizations.

   iii. The Janeway Lifestyle program has a detailed psycho-educational curriculum for children, youth and families on healthy active living with a virtual delivery option to see patients/clients province-wide. The team can also work directly with the Community Teams to provide education, guidance, and programming.

b. The funding of these prevention programs should be within the overall budgets for Community Teams.

c. Preventative programs delivered within Community Teams may increase the capacity of Teams to roster and care for more patients/clients, but this would have to be carefully studied and tracked.

15.8. Expand preventative dental care with special attention to schools and long-term care settings (see Actions 9.2 and 12.5).

a. Integrate oral health assessments in community care assessments, Comprehensive Geriatric Assessments, and chronic disease management.

   i. Explore the attachment of dental hygienists and dentists to Community Teams, targeting under-served populations, to provide necessary preventative dental care and dental treatment services.

   ii. Support education of providers in oral hygiene for long-term care settings.

b. Integrate oral health education into Healthy Students Healthy Schools Programming.

   i. Enable a dental hygienist-driven model for oral health education, preventative dental care in schools, including various fluoride applications and assessments for dental sealants.

c. Collect oral health information to support planning, implementation, and evaluation of dental care programming.

15.9. Consider additional roles of the pharmacist within Community Teams.

a. Include comprehensive medication management of chronic disease, focus on underutilization and overutilization of medications, medication reconciliation at transitions of care (e.g., hospital discharge), caring for under-served populations, deprescribing, monitoring drug therapies, and patient-focused medication counselling.

b. In collaborative activities, include facilitating medication access, coordinating with community pharmacists, and engaging in research/quality improvement/education initiatives.

c. Determine the number of pharmacists according to roles and responsibilities, sustainability of the model (salaried pharmacists or private pharmacists), the size of the catchment area, and the fiscal envelope of the province.

15.10. Consider additional roles of the nurse practitioner and registered nurse within Community Teams.

a. Include Community Team health promotion, disease prevention and management, coordination, education, direct patient care, health assessments; collaboration with other community services such as public health, home care, community groups; oversight and contributions to team operations and quality improvement (e.g., infection control, emergency preparedness); coordination of health promotion activities in the community; coordination of specialty clinics; education; and research activities.

15.11. In developing the role of social and clinical navigators, consider how best to address the following roles and responsibilities within the Community Team:

a. Help patients effectively and efficiently use the health care system by educating and connecting patients/clients to resources and support services, provide care facilitation and coordination, assist with appointment scheduling and other logistical support (e.g., transportation, health insurance), assist with health literacy, provide patient/clients education and psychosocial support, and link patients/clients and families to resources and services.

b. See Social Determinants of Health Implementation Recommendations for other considerations for the role of the navigator with respect to the SDH (Action 3), the Aging Population Implementation Recommendations (Actions 10 and 11), the Workforce Readiness Implementation Recommendations (Action 40), the Education Implementation Recommendations (Action 47), and Quality Health Care Implementation Recommendations on SDH indicators (Action 27).

4. Hospital Services Implementation Recommendations

Hospital Services Committee	
Committee Members	**Secretariat**
Sean Connors (Chair)	Karen Dickson
Larry Alteen	Annette Bridgeman
Greg Browne	Pat Hepditch
David Carroll	
Tina Edmonds	
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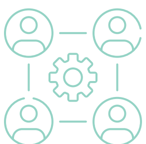


Health Centres

Action 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.

16.1. **Provide equitable access within an urgent care model based on distance from a hospital emergency department, size of the catchment population, use of the emergency department at the health centre, and availability of providers.**

a. Implement a modernized and provincially organized emergency health service so that patients requiring emergency care are provided easy access via ambulance with highly skilled paramedics. The paramedics will provide emergency care at the first point of contact with the patient and during transport to the closest urgent care centre in a health centre or emergency department in a hospital, as appropriate.

b. Realign current emergency departments in health centres to match the needs of the population. Health centres in close proximity to hospitals (60–90 minutes) would provide extended hours (12-hour) urgent care, while health centres located at a greater distance or limited by geography would provide a model of 24-hour urgent care appropriate for the population.

16.2. **Ensure that health centres distant from a hospital develop 24-hour collaborative care models linked with virtual care and hospital emergency departments.**

a. Implement Community Teams providing access for patients in the catchment area to primary care and urgent care services. This would include facilitation of access to hospital emergency departments for health issues that are emergent in nature. Collaborative care models could include a mix of family physicians, nurse practitioners, and advanced care paramedics.

b. Locate acute in-patient beds only in locations with a 24-hour service and sufficient volume of patients.

c. Access to long-term care beds in the current locations will remain, as this care should be as close to the community as possible.

16.3. **Create appropriate linkages to higher levels of care.**

a. Deploy virtual services to enable rural urgent care and other services to be supported by highly trained providers following local referral patterns, at regional hospitals, or at a provincial centre.

b. The requirement for health centres to have in-patient/holding beds will be based on 24-hour services being provided in the facility, current utilization of acute care beds, and sustainability of staffing. This will require a process for escalation of care, including for providers at hospitals to accept patients requiring in-patient care from providers at health centres.

16.4. **Align the number of beds with optimal occupancy of 85%, and follow appropriate bed management for length of stay and alternate level of care.**

A Planned Hospital System

Action 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.

17.1. Organize the hospital system into three levels of care delivery:

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

2. **Regional Hospitals**
   These hospitals provide a full spectrum of services up to and including secondary acute and ambulatory/out-patient specialty services primarily by generalist specialists (e.g., general surgeons, general internal medicine specialists, obstetricians, psychiatrists) with family physicians and some visiting subspecialists, as well as appropriate nursing and allied health professionals. They provide care for emergencies 24 hour a day for the local population, with escalation of care when required. They need Centres of Excellence on Aging which also provide consultation support in geriatric care for community hospitals and Community Teams.

3. **Tertiary Hub**
   The tertiary hub provides a full spectrum of services up to and including tertiary acute and ambulatory/out-patient subspecialty services primarily by subspecialists with specialists and family physicians, as well as appropriate nursing and allied health professionals. It has capacity to manage complex trauma and provide a full range of time-critical emergency medical services.

a. Community hospitals are located in Carbonear, Clarenville, Burin, Stephenville, St. Anthony, Happy Valley-Goose Bay, and Labrador City.

b. Regional hospitals are located in St. John’s (with tertiary and secondary services across two sites), Gander/Grand Falls-Windsor (one centre across two sites), and Corner Brook.

c. The tertiary hub is located in St. John's.

17.2. Ensure standardization of hospital services.

a. Ensure development, implementation, and evaluation of provincial acute care standards.

17.3. Implement best practices for care provision (e.g., senior-friendly emergency departments, provincial stroke care program, cancer care, cardiac care).

a. Research best practice for each content area.

b. Develop and implement plan for change based on best practice and current state.

c. Link with accreditation and participate actively in a Learning Health and Social System (LHSS).

d. Collaborate with Community Teams.

e. Utilize technology to enhance adherence to patient care standards.

f. See Action 9 on the comprehensive Provincial Frail Elderly Program.

17.4. Ensure baby-friendly obstetrics units.

a. Achieve Baby-Friendly Initiative (BFI) designation through the implementation of the 10 steps required to become BFI designated across the continuum of care with added focus on facilities providing maternal/newborn care (Source: Breastfeeding Committee for Canada, 2021).

b. Measure and monitor BFI indicators across the continuum of care.

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

a. Implement staffing/service level alignment as identified in acute care standards to be developed.

b. Ensure practitioners are working to their full scope of practice.

17.6. Establish procedures for the transfer and return of patients to the referring hospital.

a. Develop and implement procedures and best practices based on transfer and repatriation policies developed/enhanced for acute care standards.

b. Implement, monitor, and evaluate the practices/procedures.

c. Establish clinical efficiency and system flow as a provincial standard for performance.

17.7. Develop a Centre of Excellence on Aging in the regional hospitals in Central Health and Western Health with a geriatrics team, a stroke care unit, restorative care, a focus on reducing alternate level of care use, and partnerships with other health facilities and Community Teams in the region.

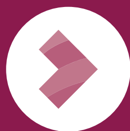
17.8. Ensure that appropriate wait time objectives are established, monitored, and pursued as a key part of the reorganization of hospital services.

a. Link with accreditation and participate actively in a LHSS.

b. Establish centralized referral processes.

c. Link with provincial standard for performance for clinical efficiency and system flow.

Location of Services



Action 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.

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

a. Realign services and programs over time as need and opportunities arise, due to attrition, recruitment, and sustainability to ensure safe and high quality services.

b. Continue general surgery in St. John's, Carbonear, Clarenville, Gander, Grand Falls-Windsor, and Corner Brook.

   i. Because of the small number of in-patient surgeries, plan how in-patient surgery and day surgery/procedures in Burin and Stephenville should be delivered for the people of the catchment area (particularly in the event of provider loss).

   ii. Develop a model of surgery services in the three geographically isolated hospitals of Labrador-Grenfell Health that provides access to urgent surgery and lower complexity procedures and is sustainable.

c. Continue obstetrics services in St. John's, Clarenville, one unit in Central Health (because rotation of services across two sites is unsustainable), Corner Brook, Labrador City, Happy Valley-Goose Bay.

   i. Evaluate the need for obstetrics in Carbonear because currently the majority of births from the Carbonear catchment area occur in St. John's.

ii. In view of the decreasing number of births in Burin, plan how obstetrics services can be sustained as they are vulnerable to provider loss.

iii. The current model of maternity services in St. Anthony is unsustainable due to the small number of births (the number of births in 2020/21 was 40).

iv. Provincially, midwifery/family medicine maternity services should be developed in sustainable locations, based on criteria including volume, proximity to obstetrical backup, and needs of the local population.

v. Ensure enhanced services for travel and accommodation at obstetrics locations for patients and their families who have to travel significant distance.

vi. Ensure travelling obstetrics services and local primary care to provide local prenatal and postnatal care.

d. Locate intensive care units (ICU) programs in the three regional hospitals: St. John's, Central Health, and Corner Brook.

i. Designate current ICU beds as special care beds/unit in community hospitals because they do not have the specialized human resources commensurate with the provision of ICU care.

e. Continue orthopedics in St. John's, Gander, and Corner Brook. The low number of in-patient orthopedic procedures in St. Anthony is a concern.

f. Ensure the sustainable location of other core services (e.g., radiology, anesthesiology, psychiatry, pediatrics, internal medicine, ophthalmology, and pathology).

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

a. Utilize virtual care.

b. Enhance collaboration between facilities, including travelling clinics, establishing a provincial model of services.

c. Provide relevant training and simulation.

d. Ensure streamlined processes for referrals and consultations.

e. Improve processes such as central intake and waitlist management.

f. Utilize community care providers when appropriate.

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

a. Utilize Community Teams, ensuring providers work to their full scope of practice.

b. Define levels of care for services at each health facility, and ensure appropriate staffing and resources.

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

a. Increase numbers of medical specialists in key locations with a requirement at the time of hiring to provide regularly scheduled travelling and virtual clinics to facilities with sufficient patient volume.

b. Develop a model of remuneration to appropriately compensate for travel costs and time.

18.5. Align the number of acute care beds in facilities across the province with a target occupancy of 85%, length of stay near the comparable Canadian average, and decreased use of alternate level of care beds.

a. Align bed numbers as utilization of hospital acute care beds changes due to transformation of the health care system (particularly by

Community Teams and the Centres of Excellence on Aging), and by improvements in discharge processes.

b. Ensure that best practices and acute care standards are implemented, monitored, and evaluated, linked to the provincial standard for performance for clinical efficiency and system flow and the LHSS.

c. Ensure the appropriateness of admissions to hospital, including addressing processes in community care and emergency care.

d. Continuously adjust acute care beds as necessary to match the needs of the current and future populations.

18.6. Before services are re-aligned, make needed investments in the establishment of Community Teams, improved emergency transportation, and enhanced information systems, including virtual care.

a. Ensure timelines and short-term and long-term strategies are identified and appropriate investments are made to obtain enhanced efficiencies and improved services/care.

18.7. Ensure the community is engaged in the process to provide a sustainable health system.

a. Prioritize patient and public engagement in processes and decision-making groups.

b. Continue public and community engagement throughout the 10-year Health Accord.

c. Educate the public on high quality health care to establish opportunities for true partnerships between members of the public and the health system.

Janeway Hospital Services

Action 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).

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

a. Match the services of the Janeway to the needs of the current population.

   i. Incorporate obstetrics in-patient services to fully utilize available resources in the Janeway.

   ii. Examine the need/utility for a step-down unit to provide care to babies who no longer require NICU care.

b. Identify solutions for wait times, including appropriate skill mix (generalist vs. specialist), appropriateness of services, and wait list management.

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

a. Develop a provincial program for children and youth at risk to ensure equitable access to services.

   i. Develop integrated care teams for children and youth incorporating acute care clinicians with Community Teams

province-wide, with an approach informed by experiences from other jurisdictions.

b. Expand the Children and Youth in Alternative Care (CAYAC) Clinic to provide services provincially for children in out-of-home care.

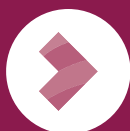
19.3. Design a seamless transition from youth to adult care.

a. Ensure integration with the Community Team that will maintain consistency in relevant care providers across the transition from youth to adult care.

b. Ensure the transfer of information across care providers.

c. Implement planned/designed transfers.

Keeping Care Close to Home



Action 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.

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

a. Create a new model of care for vulnerable older adults across the continuum that involves Community Teams working at their optimal level, embeds geriatric services across the continuum, maximizes advanced care planning, maximizes communication between hospital-based care, Community Teams, and long-term care; supports aging at home, encourages provision of care close

to home (not in acute care hospitals), and provides innovative models of home support delivery where human resources are matched to demand.

b. Develop provincial standards of care for patients receiving alternate level of care, incorporating geriatric care experts.

c. Embed person-centered and family-centered care across the continuum to ensure optimal functioning of this new model, including engaging patient partners to support enhancement of care of older adults and solutions to current challenges.

d. Link health and social services to provide comprehensive care.

20.2. Develop robust, standardized admission, discharge, and transfer planning processes in hospital.

a. Ensure appropriate utilization of hospital resources.

b. Ensure excellent and streamlined entrance points into the system. Central intake with a single point of contact with navigation ensures that client's needs are matched with the appropriate service.

c. Implement relevant acute care standards as they are developed.

d. Link with provincial standard for performance for clinical efficiency and system flow.

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

a. Link with teams providing care to frail elderly persons, certified senior-friendly emergency departments, and social navigators and clinical navigators in Community Teams to provide services to complex patients/clients linking acute care with community care.

b. Ensure education for current care providers and facilitators about care of frail older persons.

c. Enhance processes for advanced care planning prior to admission to acute care.

20.4. **Develop the appropriate linkages to Community Teams and community hospitals to provide accessible and enhanced community/primary care (e.g., chronic disease management, mental health supports).**

a. Improve policy and practices impacting access (e.g., ambulatory care services and home hemodialysis).

b. Enhance access to Pharmacare and dental care and continuity between acute care and community care.

c. Ensure community/primary care is accessible, reducing the need to travel to hospitals to receive service, including non-emergency visits to the emergency department.

d. Implement alternate scheduling models, self-scheduling models, and walk-in clinics for primary care providers.

e. Implement an integrated health record, incorporating community and acute care.

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

a. Increase numbers of medical specialists in key locations with a requirement at time of hiring to provide regularly scheduled travelling and virtual clinics to facilities with sufficient patient volume rather than requiring all patients to travel to specialists.

b. Ensure adequate remuneration for travelling specialist care, including travel time.

20.6. **Enhance emergency departments with appropriate skill mix and best practices.**

a. Reduce inappropriate admissions from the emergency department.

b. Implement senior-friendly emergency departments.

c. Ensure that Canadian Triage and Acuity Scale (CTAS) scoring and guidelines are in place, including review of data quality.

d. Ensure appropriate and high quality mental health services in emergency departments and community to respectfully meet the needs of clients.

e. Provide access to Sexual Assault Nurse Examiners in all the hospitals of the province.

f. Eliminate paper-based processes with enhanced digital health solutions.

g. Continually assess patient/client demand and presentations to ensure that skill mix aligns with need.

Setting the Standard for Provincial Acute Care Services

Action 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.

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

a. A people-centered and family-centered philosophy;

b. Care provision by interdisciplinary teams across the continuum;

c. A framework and classification system to define acute care services, including:

   i. Definitions of a standardized measurement of an acute care bed.

   ii. Definitions of a community, regional, and tertiary hospital.

iii. Levels of service and care model delivery standardization.

21.2. Develop a proposed structure for acute care standards:

a. A provincial structure responsible for oversight of provincial acute care standards;

b. Human Resources;

c. Delivery of quality acute care services;

   i. Models of care for major services including emergency care, obstetrics, medicine, inpatient surgery inpatient, and critical care admissions.

   ii. Levels of care for hospital services (including required resources, staffing, and transfer/repatriation criteria to higher/lower levels of care).

d. An optimal model for access and patient flow.

   i. In-patient services.

   ii. Out-patient services.

e. Clinical Care Standards.

   i. Patient care pathways.

   ii. Clinical information systems.

f. Acute care performance metrics.

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

a. System stakeholder engagement is required to develop provincial standards and programming that is based on the best available

information regarding effectiveness and/or best practice, balanced by the perspective of patients/clients, clinicians, researchers, administrators, and educators.

b. Each standard must include process and outcome measures to monitor performance and impact on relevant health outcomes, to be utilized for continuous quality improvement.

21.4. Develop bed management processes across Regional Health Authorities (RHAs) to ensure clinical efficiencies across regions and to ensure equitable access.

a. Ensure that admission, discharge, repatriation processes, and best practices are effective, implemented, and evaluated across sites within and across regions.

b. Link with the provincial standard for performance for clinical efficiency and system flow.

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

a. Ensure monitoring and continuous quality improvement.

b. Require the development of quality improvement plans.

c. Participate actively in the LHSS.

Digital Technology Requirements for Hospital Services

Action 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.

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

a. Incorporate social determinants of health (SDH) to integrate relevant information from outside the traditional health care system.

b. Implement a fully integrated provincial health information and virtual care system with integrated reporting.

c. Ensure that providers have access to the right information when they need it, thus increasing awareness of clients'/patients' involvement with other parts of the health care system (community, acute, long-term care, private providers), as well as social systems.

d. Ensure all advancements in digital technology maintain privacy, security, equity, and inclusion.

e. Allow measurement of value-based outcomes.

f. Eliminate paper-based processes (e.g., fax machines) as enhanced digital health solutions are implemented.

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

a. Enhance virtual care with a provincial model of specialty care based in regional hospitals.

b. Expand virtual care methods to provide options for the most appropriate means of communication for the patient/client (video, phone, etc.).

c. Ensure appropriate infrastructure and remuneration to facilitate high quality virtual care.

d. Establish a provincial structure for virtual care.

e. Integrate the electronic paramedicine care record.

f. Implement the central dispatch for the provincial air and road ambulance system.

g. Implement the virtual emergency system.

h. Enhance and expand remote patient monitoring services.

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

a. Develop a patient portal with features such as appointment scheduling and the ability to add verifiable information to their own records while ensuring accuracy, in such a way that best facilitates knowledge for patients/clients/residents and providers.

b. Include features and information access for patients/clients/residents that best meets their needs.

c. Develop education and support resources for the public to facilitate use of patient tools and the patient portal.

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

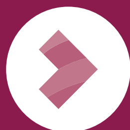
a. Implement electronic clinical practice guidelines, order sets, and other care standards.

b. Ensure the ability to measure and evaluate patient outcomes to enforce care standards.

c. Ensure the ability to evaluate system measures, such as access and efficiency.

d. Participate actively in the LHSS.

Provincial Integrated Air and Road Ambulance System



Action 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).

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

a. Engage expertise to modernize and integrate the system up-front to enable other system change.

b. Establish an integrated ambulance system as a foundational component to other system change.

c. Implement performance-based contracting with required quality standards tied to the contractor's remuneration.

23.2. Support training, recruitment, and retention within the road ambulance system that would have a solid skill mix of advanced care paramedics (ACPs) and primary care paramedics (PCPs).

a. Expand the number of ACPs to 250–300 and PCPs to 600–650 over a 10-year period.

b. Discontinue training of emergency medical responders (EMRs).

c. Provide a training option to current EMRs to upgrade to PCPs, and as opportunity arises, reassign EMRs to a non-emergency transportation system.

d. Ensure an appropriate remuneration and system structure to support skill mix.

e. Deploy advanced care paramedicine to function as a mobile health care system, allowing patients to begin receiving emergency care in their homes while facilitating rapid access to hospital emergency services.

23.3. Create one central medical dispatch system for the whole province.

a. Expand the current dispatch centre, including relevant technology, for the air and road ambulance located in the Miller Centre, to provide services for the entire province.

b. Ensure triage capacity.

c. Locate ambulances utilizing dynamic deployment.

23.4. Establish one provincial air ambulance system that would include bases in St. John's and Happy Valley-Goose Bay, medevac services for Labrador, helicopter services which fly 24 hours a day, seven days a week, and one-off out of province flights.

a. Establish a 24-hour dedicated medical flight team availability to align with aircraft based in Happy Valley-Goose Bay.

b. Provide a helicopter service that can operate 24 hours per day.

c. Ensure that medevac services in Labrador-Grenfell Health are integrated as part of the provincial air ambulance service.

d. Determine the relative role of private and government air services, and provide long-term service agreements.

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

a. Transition EMRs who do not choose to upgrade to PCPs to the non-emergency transport system as the numbers of PCPs and ACPs in the ambulance system increase.

b. Implement a separate non-emergency transportation system in locations where it is supported by the volume of emergency and non-emergency transportation.

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

a. Expand province-wide an electronic patient care record that is integrated with institutional and community electronic systems.

b. Establish a single management provider for the integrated road and air ambulance system.

c. Determine the relative role of private vs. public operations of the ground ambulance system.

23.7. Develop a virtual emergency system with physicians and nurse practitioners to improve access to emergency care in more rural settings.

a. Provide virtual emergency consultation to local providers.

b. Complete further analysis to determine if one provincial virtual emergency department or a number of regional virtual emergency departments would provide the best service solution for the people of the province. While it is acknowledged that regional virtual emergency services (in which clinical care is provided virtually from the most appropriate catchment emergency department) can provide important local contextual knowledge and potentially reduce care transitions, one provincial virtual emergency service may be more efficient and ensure that consistent service and emergency care is offered province-wide throughout the journey from home to the emergency department.

c. Provide a provincial emergency service for coordination of clinical efficiency and movement between regions, particularly in the facilitation of the transfer of the patient to an available bed.

23.8. Provide public oversight of the integrated ambulance system.

a. Ensure the new Emergency Health and Paramedicine Services Act is reflective of the Health Accord NL ambulance plan and is comprehensive and up-to-date.

b. Write legislation, regulation, standards, and policies as required.

23.9. Link community paramedics and advanced care paramedics with Community Teams.

a. Establish formal roles and responsibilities for community paramedics within Community Teams.

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

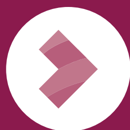
c. Include advanced care paramedics in the collaborative urgent care models at health centres (see Action 59.9).

d. Implement or expand programs based on a review of best practices.

5. Quality Health Care Implementation Recommendations

Quality Health Care Committee	
Committee Members	**Secretariat**
Patrick Parfrey (Chair)	Susan Stuckless
Kris Aubrey-Bassler	John McGrath
Jared Butler	Donna Roche
Antionette Cabot	
John Jeddore	
Debbie Kelly	
Tanya Noseworthy	
Ed Randell	
Melissa Skanes	

A Learning Health and Social System



Action 24: Foster a culture of quality and establish a comprehensive, effective, and sustainable Learning Health and Social System.

24.1. **Foster a culture of quality improvement among all administrators, providers, stakeholders, and patients/clients/residents.**

24.2. **Expand on existing work in the Regional Health Authorities (RHAs), Quality of Care NL (QCNL), Newfoundland and Labrador Centre for Health Information (NLCHI), and the educational institutions to form an integrated, coordinated, and effective Learning Health and Social System (LHSS) that will facilitate improvement in the health of the population, and more effective and efficient systems.**

24.3. **Assign responsibility for the LHSS to the NL Council for Health Quality and Performance to support LHSS activities across the province and to advocate for a LHSS with stakeholders, frontline staff, and the public.**

24.4. **Develop standard tools for socio-demographic data collection which focuses on measurement of social system performance, social factors related to health of individuals, and social determinants of health related to communities and population groups.**

To attain the preceding four objectives the following steps are recommended.

a. Create a network of partners that can align leadership and program initiatives towards creating a culture of learning for better health outcomes. These partners should include the Departments of

Health and Community Services (HCS) and Children, Seniors and Social Development (CSSD), the Provincial Health Authority (PHA), Regional Health Councils (RHCs), QCNL, and NLCHI.

b. The LHSS should be formally initiated in year one and supported in its evolution over the next four years.

c. The network should be comprised of stakeholders within the health and social systems responsible for the implementation of change strategies and the identification of opportunities to align with the Health Accord in implementing a 'health-in-all-policies' approach. These should include:

    i. institutions and facilities;
    ii. clinical and social programs;
    iii. community organizations;
    iv. private business;
    v. members of the public;
    vi. educational and learning institutions;
    vii. municipalities;
    viii. not-for-profits;
    ix. regulators;
    x. professional associations;
    xi. unions;
    xii. others that have influence over the health and social systems.

d. LHSS core values will be consistent with person focus, privacy, inclusion, transparency, accessibility, adaptability, co-operative participatory leadership, scientific integrity, and provision of value (improved health outcomes relative to the cost).

e. A LHSS for the province needs to incorporate the following:

    i. A way to identify issues, problems or gaps: creation of a bridge across patients/providers/decision-makers and researchers.

    ii. Managed data/information to understand the issues identified.

    iii. Systems to embed learning cycles (research included) in care processes.

    iv. Data and analytics to understand what is working (or not) and why.

v. Dissemination mechanisms to scale best practices.

vi. A supportive culture because this has benefits for all.

f. Patient/client and public engagement are key:

i. to ensure person-centeredness from the design onward;

ii. to enhance health literacy in the population;

iii. to inform consumers of care;

iv. to provide data to inform best practices;

v. to collaborate in evidence generation and dissemination;

vi. to advocate for best care and outcomes;

vii. to provide feedback that will help systems adapt.

g. Key components of the LHSS include:

i. bidirectional feedback loops — data collection embedded in care delivery, and care changed in response to evidence;

ii. a partnership between research and clinical operations;

iii. a robust data infrastructure;

iv. analytic capacities to make use of clinical and SDH data;

v. a means to integrate new knowledge into care delivery.

h. Digital health infrastructure should be modernized and expanded to include records for virtually all health system/patient interactions in a format that is readily amenable to analysis and comparison. This will ensure that patient/client/resident visits, outcomes, and costs can be analyzed, assigned to the appropriate team or program and compared both across and within jurisdictions.

i. The LHSS should include rigorous mechanisms to identify and prioritize health system efficiency and effectiveness questions,

design and conduct data syntheses and research to answer those questions, and incorporate the results into system change.

j. Digital tools should be developed to:

    i. Describe the characteristics and the health and social needs of the populations cared for by each clinician and clinical team.

    ii. Facilitate the identification of patients/clients/residents with unmet health or social needs.

    iii. Facilitate bidirectional communication to inform patients/clients/residents of critical health system news, remind them of upcoming appointments, and facilitate the collection and comparison of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs).

    iv. Make evidence and data readily available at the point of care to inform clinical decision-making.

   The LHSS does not automatically follow when digital tools are made available. A culture of continuous quality improvement and comfort and capacity for change must be built among all health system stakeholders, including patients/clients/residents.

k. The health system and providers should be encouraged to adopt a single electronic medical/health record that is accessible by all health providers to decrease duplication and enhance the coordination between providers and within care teams.

Accountability for Improved Health Outcomes

Action 25: Improve accountability structures within the health and social systems to focus on achievement of better health outcomes.

25.1. **Implement a comprehensive accountability framework to improve health outcomes for the province inclusive of both health and social sectors and the structural changes recommended by Health Accord NL.**

a. Focus on improving health outcomes in the already extensive accountability structures within the facilities of the RHAs.

b. Create an accountability structure within Community Teams with a focus on health outcomes and appropriate use of health care interventions.

c. Develop an accountability framework for SDH within the health system, especially as it relates to inclusion, the environmental impact of the health system, the linkages between the health and education systems, the continuum of care for frail elderly persons, and interventions to improve well-being.

d. Link the lessons arising from the Learning Health and Social System with the accountability structures.

25.2 **Amend the Regional Health Authorities Act, the Public Health Act, the Protection and Promotion Act, the Health and Community Services Act, the Emergency Health and Paramedicine Services Act, and any related regulations to include specific requirements for accountability that cross all levels of health organizations — board, CEO, executive, management, and front line.**

25.3. **Review existing accountability mechanisms to determine whether and how they should be improved.**

a. In view of the overlap that occurs in the RHAs with processes for safety, utilization, and quality, determine an optimal accountability structure that can improve health outcomes.

25.4. **Develop an evaluation agenda to measure system performance including metrics for appropriate medication use across the health system (to inform interventions on overutilization and underutilization), access to comprehensive primary care, adverse events, wait times for critical procedures and services, and backlogs of surgeries.**

a. Active participation in the LHSS requires linkages with Quality of Care NL, NLCHI, and the proposed NL Council for Health Quality and Performance. The accountability for responding to this evaluation agenda rests with the health and social delivery systems.

25.5. **Engage with community organizations and municipalities to adopt and evaluate a 'health-in-all-policies' approach.**

25.6. **Establish a program for monitoring wait times, and report publicly on how our system is achieving appropriate standards.**

a. Support transparency as a core value through annual reporting by the NL Council on Health Quality and Performance (i) to the House of Assembly and the public on overall measures of quality and performance and on specific areas of concern, (ii) to hospitals, long-term care facilities, and Community Teams on more specific measures, and (iii) to providers on appropriateness of use of health care interventions.

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.

26.1. **Create an organization, protected by legislation and arms-length from government, which provides information and advice, in an iterative process, to improve quality and performance of institutions and providers in the health and social systems. This should evolve from structures already created to provide clinical interpretation and knowledge translation of data and to improve quality in the province.**

a. The NL Council for Health Quality and Performance (The Council) would be led by a Board of no more than nine members with a small office responsible for initiatives related to reporting on the quality and performance of the health and social systems, supporting the LHSS, and evaluating implementation of Health Accord NL.

b. The Board should be comprised of evaluation, research and clinical leaders, community leaders, and public representatives.

c. The staff should be led by a CEO and include program managers for the LHSS and for the evaluation plan. The staff would work closely with QCNL, NLCHI, the LHSS, and the team selected to implement the evaluation plan.

d. The CEO should report annually to the House of Assembly, supported by the Chair of the Board of The Council.

    i. Determine a framework and general key performance metrics for reporting to the House of Assembly including mechanisms for consistent and transparent communications and public engagement, including public reporting.

    ii. More specific measures will be necessary for reporting to the health and social system, including to institutions and providers.

e. Start The Council as an interim structure in year one and complete legislation in year two. The legislation should include a clause to ensure data requests are fulfilled within a specified time period.

26.2. The Council should be formally connected to QCNL and NLCHI who can provide research, evaluation, data management, and knowledge translation expertise for the health and social systems.

a. QCNL should be responsible for the following:

    i. Development of an approach to quality of care and performance in partnership with hospitals, long-term care facilities, Community Teams, individual providers and the social system.

ii. Development of an approach to quality of care and performance in the private sector, such as ambulance operations, home care and personal care homes.

iii. Providing advice to the delivery system on possible interventions that ensure actual practice is best practice, using evidence-based guidelines in health care, including recommendations from Choosing Wisely Canada.

iv. Creation of measures of the social determinants of health (SDH) at both the community and individual level. QCNL should lead the development of new metrics, measures, and indicators for the social determinants of health, as well as facilitating the development and implementation of data collection tools and training to ensure appropriate tracking and quality that will enable use at community, regional and provincial levels.

b. In addition to current staffing in QCNL, four additional full-time equivalent (FTE) positions are required to lead and complete research and evaluation associated with the SDH and economic analysis (to be added in year one).

c. The Council should enable current work on health system quality under QCNL and others to be expanded, coordinated, and continued. QCNL can provide leadership in coordinating clinical and social leads responsible for evaluation and research design, developing evaluation and research questions and concepts to ensure efforts are in line with The Council. Social and clinical leads should be supported by a staff of project managers, researchers, analysts, and communications professionals to deliver expertise in knowledge translation, economic analysis, implementation, patient engagement, and social metrics.

d. NLCHI should be responsible for providing effective and efficient access to data, collaborating and providing resources to enable the research and evaluation agenda, and prioritizing the mobilization of available technologies to support the Health Accord agenda.

e. Memorandums of understanding between The Council, QCNL, and NLCHI should be put in place to ensure prioritization of The Council's mandate and to ensure existing resources are leveraged without duplication of effort.

f. NLCHI and QCNL should work with the Family Practice Renewal Program and Memorial University's Office of Professional and Educational Development to develop feedback processes to improve care in Community Teams.

g. The formal partnership between The Council, QCNL and NLCHI can leverage Canadian Institutes of Health Research (CIHR) and provincial government funding currently in place for QCNL, while also leveraging the skills and expertise already established within QCNL. CIHR funding ends in 2025/26 after which increased sustained direct funding from the provincial government for QCNL will be necessary.

Long-Term Evaluation Plan

Action 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.

27.1. **Identify the leaders and groups needed to evaluate each component of the five-year Health Accord plan that evolves over the ten-year horizon for the plan.**

27.2. **Determine in 2022 the metrics needed and the data sources necessary so that baseline data are available prior to implementation of the plan.**

27.3. **Ensure the evaluation plan focuses on quality, inclusion, and integration.**

27.4. **Assign responsibility for the implementation of the evaluation plan to The Council.**

a. Develop a long-term evaluation plan for the Health Accord to enable baseline evidence to be defined in year one, and evaluations to be presented in the public in years three, five, eight, and ten.

b. Identify leaders and groups for the evaluation of the impact of actions recommended by Health Accord NL for:

   i. The SDH in the following areas (i) poverty including homelessness and food insecurity, and (ii) inclusion.

   ii. Childhood, including childhood development, school health, and groups at risk.

   iii. Aging, including age-friendly communities and the continuum of care for the frail elderly in the community.

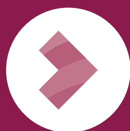
   iv. The effectiveness of community care, particularly in relation to access; provision of urgent care; ability to meet the needs of high-risk groups; prevention of disease, frailty and hospitalization; and appropriate use of health care resources.

   v. Performance of hospital services particularly in relation to improvement of access; better patient outcomes; and sustainability and integration of services.

   vi. Improvement in workforce readiness, particularly in reducing vacancies; improving workplace satisfaction and work-life balance; providing more interprofessional education; and improving cultures of compassion, inclusion, quality, and integration.

   vii. Health and social system value as determined by better health outcomes relative to the cost.

Measuring and Tracking Indicators of the Social Determinants of Health in Newfoundland and Labrador



Action 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.

28.1. **Implement new and co-ordinate existing measures of SDH in Newfoundland and Labrador at community, regional, and provincial levels.**

a. QCNL in partnership with NLCHI should be responsible to The Council for achieving the following objectives.

b. QCNL should collaborate with other groups to ensure the expertise in the province on the SDH is included.

c. Through use of focus groups in selected high priority areas of social care, develop metrics that facilitate ongoing evaluation of and interventions in social care programs.

d. As Community Teams evolve, introduce methods of data collection on SDH, derived from research, that will then be used in the care of patients/clients and the evaluation of programs to improve care.

28.2. **Integrate trained social navigators into Community Teams to assess, document, and address SDH at the point of care in the community.**

28.3. **Ensure that all indicators of the SDH are accessible for both patient/client/resident care and secondary uses.**

28.4. **Develop a data governance structure framework to ensure the collection, quality, coordination, transparency, and analysis of SDH indicators.**

28.5. **Ensure that all indicators of SDH are accessible for care delivery, tracking, and evaluation in a linked and safe manner.**

28.6. **Commit to making indicators of SDH accessible and publicly available.**

28.7. **Expand the provincial Climate Data information Portal to include a climate emergency "Report Card" to annually report publicly on the success of preventative actions taken throughout the province with respect to the impacts of climate change on public health and progress toward defined provincial outcomes.**

Improving Appropriateness of Medication Use

Action 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.

29.1. **Prioritize the addition of pharmacists to Community Teams who focus on underutilization and overutilization of medications with models to be determined by roles and responsibilities, sustainability of the model, and the fiscal envelope of the province (see Action 13).**

a. Within Community Teams, establish the role of pharmacists in improving appropriateness of medication use and continuity of care in the community and long-term care.

b. Build upon Choosing Wisely Canada recommendations for medication use to create a Community Team collaborative approach to appropriate prescribing and de-prescribing

c. Define evaluation metrics to consistently monitor medication use, and provide regular reports to Community Teams as a means of continuous quality improvement.

d. Determine the number of pharmacists needed per 1,000 population by the number of new Teams started, amount of money provided to initiate Teams, evaluation of initiatives to insert pharmacists into Teams, and engagement with pharmacists concerning roles and responsibilities.

e. Initially, add six pharmacists to the 12–16 Community Teams envisaged in years one and two.

f. Determine how private community pharmacists can engage effectively with Community Teams.

Pathology and Laboratory Medicine

Action 30: Establish pathology and laboratory medicine as a provincial networked service based on hub-and-spoke modelling.

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

a. A provincial management structure;

b. A laboratory test formulary which provides an up-to-date and searchable registry of orderable laboratory tests and laboratory test information;

c. A modernized specimen transport system;

d. Centralization of core routine community services to three hub sites for the regions;

e. Continuation of core routine in-patient services to the other eight hospitals;

f. Dissemination of point of care technologies to rural and remote sites.

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

a. Improved pathology and laboratory medicine services require concurrent organizational and technological change.

b. Implementation of the new administrative structure with province-wide scope should occur immediately.

c. Realign managerial, medical, and scientific oversight and accountability based on a province-wide scope within a new administrative structure.

d. Organizational changes to support a hub-and-spoke service model should occur over a one-to-two-year timeframe concurrently with implementation of the new administrative structure.

e. All technology change should be completed within a three-to-four-year timeframe, initiated by adoption of automated high throughput technologies for three hub sites; right-sized technologies meeting clinical program needs for other large hospitals; and small rapid point of care testing technologies at health centres.

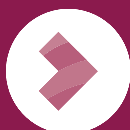
f. Complete detailed site level planning after implementing the new administrative structure, testing menu revisions, and completing final on-site test assignments at the health centres.

The operation of the provincial laboratory test formulary should move under the new administrative structure for laboratories province-wide. As the main decision-making body on site-level test

availability, it should address appropriate test utilization in collaboration with other initiatives.

g. A province-wide point of care testing program should oversee operations and future decision-making concerning use of point of care testing technologies.

Improvements in Provincial Programs for Cancer, Cardiac Care and Stroke



Action 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.

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

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

a. Redesign diagnostic cardiology services for improved community/ ambulatory access with a target of 50% out-patient activity.

b. Centralize patient intake with nurse practitioners (NP)-led rapid access clinics, including for heart failure. Such clinics should allow NPs to work at the full scope of their practice.

c. Improve coordination of services within the program and with the emergency departments and critical care units of the province.

d. Focus on virtual care at home, with Community Teams, other hospitals and emergency departments, together with use of eConsult, and remote patient monitoring.

e. Provide a more coordinated hub-and-spoke model for rapid and comprehensive management of an individual's cardiac health, no matter where they live in the province.

f. Focus on continuous quality improvement including better access to cardiac surgery, fewer days in hospital waiting for cardiac interventions, and better health outcomes.

g. Use data, including APPROACH and MyCCath, for visual management, integrated performance monitoring, and integrated workplace management.

h. Collaborate with key partners to expand/implement proven models of cardiac rehabilitation, including virtual connection with individuals and Community Teams.

i. Engage in innovation and research including precision medicine, translational genomics, and value-based care delivery.

31.3. **Start a Provincial Stroke Care Program that follows quality standards for value-based care as part of a Learning Health and Social System.**

31.4. **Provide better stroke care across the continuum of care from initiation of stroke to reintegration in the community.**

a. Increase thrombolysis rates in eligible ischemic stroke patients to greater than 20% by improving the recognition of stroke symptoms and the need to go to the emergency department, by using more streamlined code stroke protocols (with a goal of door to needle for tPA time of 30 minutes), and by use of accurate electronic methods to monitor processes.

b. Improve secondary stroke prevention by appropriate and timely referral for carotid artery testing in patients with transient ischemic attacks in the area of the brain supplied by the carotid artery.

c. Initiate endovascular thrombectomy (EVT) immediately in Eastern Health and, subsequently, in the other regions.

d. Improve stroke care through the provision of stroke care units and stroke rehabilitation services in Central Health and Western Health.

e. Integrate with Community Teams to provide appropriate interprofessional care when the patient returns to the community.

f. Create an effective quality improvement program that can transform stroke care outcomes in the province, including an integrated information management system.

g. Obtain stroke distinction status for the Provincial Stroke Care Program with Accreditation Canada.

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

a. Provide genomic and clinical expertise in the Centre for Translational Genomics to apply germline and somatic genetic information to improve outcomes in high-risk families and in patients with disease.

b. Implement/improve screening programs for groups at high risk of lung cancer, breast cancer, colon cancer and cervical cancer, and in under-screened groups.

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

a. Improve access to (i) stereotactic body radiation therapy and radiosurgery, (ii) cancer services in Western Health, and (iii) support for patients with hematologic malignancies.

b. Engage in clinical trials, and use program specific data to improve access, appropriateness of care, and efficiency.

c. Provide ongoing support for the cancer survivors.

31.7. In the three provincial programs, enhance a culture of quality through use of program specific data with a focus on improving health outcomes. Develop an information management system to measure performance and outcomes across the stroke care continuum.

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

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

31.10. Engage with air carriers to determine the feasibility of scheduled flights from Labrador and the west coast of the Island to bring patients to St. John's for tertiary services, particularly for cardiac care and cancer care.

New Health Care Programs

Action 32: Create an Occupational Health Clinic with linkages to the Community Teams.

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

a. Immediately conduct a feasibility study on implementing a comprehensive occupational health clinic, including linkages to Community Teams.

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

Action 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).

33.1. Make policy decisions around the location of midwifery services, integration with obstetrics units, and funding for these services.

a. Develop policy through engagement with RHAs, obstetrics units, midwives, family physicians, and mothers.

33.2. Improve access to sexual health clinics outside the St. John's region and partner with Community Teams and schools.

a. Provide provincial sexual health services in St. John's, in the rural Eastern Health region, and in the regions of Central Health, Western Health, and Labrador-Grenfell Health with outreach to communities through visiting clinics and virtual care.

b. Develop a partnership between the clinics and Community Teams to improve sexual health, including the education of physicians.

c. Develop a partnership with schools, including the training of sex educators.

33.3. Provide access to Sexual Assault Nurse Examiners in all regions of the province.

a. Provide a provincial program for the assessment and treatment of those who have experienced sexual assault.

b. Make Sexual Assault Nurse Examiners with appropriate training available to all hospitals in the province, with examiners present in all regions.

33.4. Expand publicly funded dental services, and develop a preventative approach to oral health (see Actions 9.2, 12.5, and 15.8).

a. Expand comprehensive dental care coincident with investments made by the federal government.

b. Develop a community-based approach to oral health and wellness with special attention to children and schools, to older adults, and to residents of long-term care facilities.

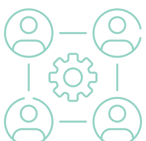
c. Create a partnership between Community Teams and oral health professionals to strengthen oral health in the community.

33.5. Determine the feasibility of hospice care in the province starting with the St. John's region.

a. Evaluate the approach to hospice care currently being undertaken in Grand Falls-Windsor.

6. Digital Technology Implementation Recommendations

Digital Technology Committee	
Committee Members	**Secretariat**
Paul Preston (Chair)	Owen Parfrey
Brendan Barrett	Andrea McKenna
Randy Giffen	Gillian Sweeney
Heather Hanrahan	
Ron Johnson	
Chandra Kavanagh	
Niki Legge	
Josh Quinton	
Blair White	



Calls to Action and recommendation approaches have been provided by the strategy committees and working groups concerning health information and virtual care.

See Action 1, Social Determinants of Health Implementation Recommendations
See Action 10.5, Aging Population Implementation Recommendations
See Action 14, Community Care Implementation Recommendations
See Action 22, Hospital Services Implementation Recommendations
See Action 24, Quality Health Care Implementation Recommendations
See Actions 48.7, 51 and 55, Governance Implementation Recommendations

Modernization of Foundational Information Technology Systems

Action 34: Modernize foundational information technology systems.

34.1. Modernize the health information and virtual care system to meet the requirements outlined in the Health Accord Calls to Action and detailed in these implementation recommendations.

a. Finalize the government request for proposal to detail requirements of the Health Accord recommendations and select the successful vendor to implement modernizing the health information and virtual care system. Select the successful proponent based on their capacity to meet the requirements and associated pricing.

b. Select a vendor to implement the new health information system (HIS) aligned with the Health Accord's strategy. Vendors who can align solutions across sectors inclusive of acute care, long-term care, community, and the social sector will be favoured.

c. Plan change management and solution implementation for HIS modernization.

d. Plan a phased approach, prioritizing systems based upon the implementation timelines of the Health Accord Calls to Action. The implementation details will be synchronized with all other Calls to Action.

e. Design the HIS to capture data in an analyzable format to underpin a Learning Health and Social System (LHSS) strategy with long-term implementation objectives.

f. As part of the LHSS, create metrics that measure access, coordination, and efficiency, and use these measurements to guide change and technology.

g. Establish plans to ensure that the NL Council for Health Quality and Performance has access to data required for the implementation of their workplan.

h. Establish plans to strongly encourage innovation and appropriate third party access to data and systems (supporting local technology, innovation capacity, and economic development).

i. Begin integration and connection of systems that were previously difficult or impossible, particularly connections between community care, long-term care, hospitals, and social care.

j. Establish a plan in partnership with the Office of Chief Information Officer (OCIO) to replace the MCP billing system, given it is over 30 years old and currently operates on mainframe technology. It is understood that there are different options available to replace this system, and each option will need to be explored and evaluated. The Department of Health and Community Services (HCS) has identified this as a requirement for Health Accord efficiencies to be found.

k. Continue the work presently underway within the NL Centre for Health Information (NLCHI), working in partnership with the OCIO, to implement a Newfoundland and Labrador digital identity framework. Work is ongoing within the federal government on this initiative. This work will assist patients/clients/residents and members of the public in having digital access to the health care system as a whole, including their own health record.

34.2. **Upgrade enterprise-wide management systems to allow for effective management of the health system (e.g., finance, human resources, supply chain, and procurement), including access to data for bench-marking, performance management, transparency of performance, and better support for decision-making and accountability.**

a. Plan a single, centralized, integrated, and consistent administrative information system that facilitates administration of a single Provincial Health Authority (PHA) with Regional Health Councils (RHCs) within the health system. Ensure that analytics, reporting, benchmarking, and other data capabilities exist.

34.3. **Implement e-technology processes to enable interventions to improve quality and outcomes.**

a. Determine the best e-decision support tools and associated clinical processes to improve quality and outcomes.

b. Implement and integrate the above outlined health information and virtual care system with the community-based technology and long-term care technology to enable Community Teams and long-term care teams to order, refer, and schedule electronically.

c. Implement new capabilities that drive efficiency and integration such as e-ordering, e-referral, and e-scheduling.

34.4. **Ensure that systems are inclusive of everyone in Newfoundland and Labrador, particularly minority and at-risk groups, and enable appropriate data collection for measurement and evaluation.**

a. Use a change management plan for technology adoption, education strategy, staff training, and communication and execution of plan.

b. Capture the necessary data needed to evaluate the gaps. Implement change based on this evaluation. Data collection to lead change is a critical component of the LHSS.

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

a. Investigate where the gaps are in the system, plan how to address them, and engage the groups affected. Ensure that the system can capture SDH data on individuals and allow for integration with other sources of SDH data.

b. Implement the appropriate technology to meet the requirement of a LHSS.

c. Establish data governance and data sharing agreements required for the flow of SDH data to support change.

34.6. **Create one integrated Personal Health Record (PHR) that will empower patients/clients/residents and practitioners to better manage health. Place personal health information in direct access to the patient/client/resident through an integrated patient portal.**

a. Plan the data and services that should be available to patients/clients/residents (e.g., scheduling, access to test results, access to education resources) which have been clinically validated in PHR. Address the issues of when/where certain outcomes become available. As the HIS modernizes, more data will become available to patients/clients/residents and practitioners.

b. Implement the appropriate technology to meet the requirement of (a) above.

c. Manage improvement in digital literacy through education for providers and patients/clients/residents.

34.7. **Support innovation and local technology industry expertise as well as innovation and continuous improvement in the health and social systems.**

a. Facilitate a LHSS and transparent reporting to the public, institutions, and providers.

Virtual Care Technologies

Action 35: Adopt and leverage virtual care technologies.

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

a. Create a Provincial Virtual Care Strategy (e.g., define care pathways, short-medium-long-term milestones). Define and implement a strategy to support adoption of virtual care pathways, where appropriate, over a 10-year period with milestones.

b. Create a Virtual Emergency Department Strategy with one virtual emergency system, supported by appropriate digital technology tools.

c. Plan communications with Community Teams, hospitals, and other providers to ensure patients/clients/residents and stakeholders understand options and benefits of different modalities.

35.2. Empower and connect people through digital access to their own personal health information through a direct access patient/client portal, enabling patient/client self-reporting and monitoring, and supporting more preventative and proactive care via electronic alert reminders for services such as screening and remote monitoring.

a. Define a strategy and implementation plan to roll out the PHR. Clearly define the services, test results, scheduling, etc. that are available via the patient/client portal. The first version should strive to make simple, yet high-value transaction services available in the record, such as scheduling, appointment reminders, and blood test results. Grow the list over time.

b. Provide digital literacy initiatives to support patient/client and provider adoption of the PHR, delivered through technology resources tied to each care team.

35.3. Make every home a part of the health system.

a. Develop strategy and a communications plan to shift the mindset of the health system, extending health into every home with appropriate technology and education/training tools (e.g., PHR, remote patient monitoring tools, other virtual care tools, digital literacy support).

b. Provide technical support to Community Teams and other care pathways to support practitioners and patients/clients in the provision of care to individuals within their own homes.

35.4. Standardize and support key technologies, such as telephone for simple appointments with family physicians, a richer visual conferencing software for more involved appointments, and extension of existing remote patient monitoring, virtual emergency department, and other programs into new areas as the virtual care system matures.

a. Define the technologies that will be used and standardized along the virtual care continuum.

b. Roll out an adoption campaign to the general public and providers in partnership with Community Teams and other virtual care practitioners.

35.5. Collect SDH data and patient/client/resident-reported health measures through the capacity of virtual care to allow for point of care information collection (including social factors) that can be analyzed to support effective policies and interventions.

a. Use virtual care and PHR tools for self-reported information (alignment with every-day clinical standards is required). Waivers can be presented to patients/providers, seeking consent where needed.

b. Build capability to leverage captured and self-reported SDH data through analytics, research, and automated tools.

Use of E-technology for Improved Outcomes

Action 36: Develop a Provincial Digital Technology Strategy and Policy to guide e-technology development and implementation.

36.1. **Establish a Provincial Digital Strategy Committee.**

36.2. **Establish a policy determining when third party applications or custom-built applications are required.**

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

a. Develop and strategize which solutions take priority.

b. Implement the services.

c. Start with Community Teams to further utilize pharmacy e-prescribe technology being offered by Canada Health Infoway. The foundational work has already been completed with implementation underway in other parts of Canada. This has identified the initial concerns and problems to be addressed as implementation continues.

d. Continue adding to and building a robust digital service for the province.

36.4. **Implement a modernized and integrated health information and virtual care system that encompasses the full continuum of care.**

a. Build integration processes and technology that make the user experience seamless (e.g., use one login that provides access to approved services instead of multiple logins, avoid disparate systems and non-integrated systems).

b. Ensure that access to the virtual emergency system and appointments are made available across the province.

c. Ensure appropriate and transparent reporting. This should be planned in collaboration with a LHSS strategy with long-term implementation objectives.

36.5. Adopt "integrated by design" as a principle for future health technology investments.

a. Establish guiding principles that define the need for integration. Use an open and scalable infrastructure (use cloud or other scalable systems where possible). While custom build may suit individual hospitals, it is not scalable over the full provincial system and over time. Instead, consider user group engagement when customization options exist for cloud/scalable solutions.

36.6. Develop strategies to address broadband connectivity across the province.

a. Work with the federal government and the provincial government to set timelines for digital integration that are aligned with broadband expansion throughout the province.

36.7. Develop strategies to address digital literacy issues in the province.

36.8. Ensure that support teams are trained to help patients/clients and practitioners with integration.

a. Provide computer literacy initiatives in community centres. For example, those without access to smartphones or other tablet/computer technology need support in the community to leverage such tools.

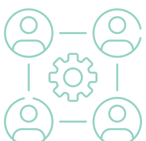
b. Work with Community Teams to fully understand opportunities for virtual care.

36.9. **Publish and display data on time for consultation, procedures, and referrals. Share details openly with the public, always respecting privacy and confidentiality, so that improvements can be made over time.**

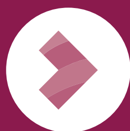
36.10. **Maintain an innovation pathway for local entrepreneurs to address identified opportunities for improvements in e-technology. This means assigning a mandate for innovation to an appropriate organization, sharing information openly, and measuring progress.**

7. Workforce Readiness Implementation Recommendations

Workforce Readiness Working Group
Working Group Members
Louise Jones (Chair)
Antionette Cabot
Adam Churchill
Vernon Curran
Debbie Forward
Vanessa Mercer-Oldford
Gordon Piercey
Dennis Rashleigh
Heidi Staeben-Simmons
Heather Hanrahan (Secretariat)



A Provincial Health and Social Sector Human Resource Plan



Action 37: Through consultation with stakeholders, create a Provincial Health and Social Sector Human Resource Plan.

37.1. The first component of the Plan is centred on human resources.

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

b. 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.

c. Create a strategic recruitment plan to ensure that health care providers are in place.

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

e. 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.

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

37.2. **The second component of the Plan is centered on education (see Actions 45, 46, and 47).**

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

b. 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.

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

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

37.3. **Ensure that the Human Resource Plan being created by the Department of Health and Community Services (HCS) encompasses the ten human resource and education objectives listed above.**

a. The following steps are recommended:

    i. Create a small secretariat to support the creation of the Provincial Plan.

    ii. Create a provincial steering committee representative of stakeholders in the health and social system inclusive of government, employers, and employee representative groups.

    iii. Complete broad stakeholder engagement, compile evidence and stakeholder engagement feedback, create a draft plan with actions and objectives, seek feedback, and finalize plan within 15 months.

b. Given the seriousness of the current situation, actions and initiatives should not be delayed pending the completion of the plan.

c. It is essential that stakeholders work together to ensure that the human resource plan for the health and social systems, which is so urgently needed in our province, is implemented in a focused, collaborative, and timely manner.

Workforce Transition Guiding Principles

Action 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).

Where employees or physicians are represented by unions/associations, a high-level principle-based document inclusive of guiding principles would be created jointly with employee or physician representation, including NAPE, CUPE, RNUNL, AAHP, NLMA, and others. Further, union-specific transition agreements may in turn need to be negotiated with each employee or physician representative group.

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

38.1. **Provide an environment that is fertile for health and social system change while at the same time ensuring that employees and physicians have protection and security as they are impacted by this immense change process.**

38.2. **Develop the needed workforce transition agreements following the key principles jointly developed by the employee or physician representative bodies, employers, and government. Include the following principles taken from the National Health Service (NHS) England Framework for Integrated Care Boards:**

a. People-centered approach — account taken of the needs of patients, residents, clients and families and the impact on employees or physicians; a supportive approach with those impacted by change; stability of employment where possible; a standard approach to change for all employee and physician groups where possible; and a skills-based approach that maximizes existing skills and retraining where necessary.

b. Compassion and inclusion — openness and transparency of process and actions, actions to increase the diversity of the new workforce and particularly the leadership, and supportive change management.

c. Minimal disruption — policy as simple as possible, collaboration to avoid unnecessary duplication of effort, employment stability throughout the transition period, and minimal uncertainty.

38.3. Facilitate the transfer of staff and physicians to new programs or services being relocated, balancing the need to keep skills within the service and the place of residence of the affected person.

a. To create an environment conducive to change and with the greatest opportunity for success, employees should be treated as the most valuable resource. A number of tenets will be required in a workforce transition guiding principles document:

   i. Negotiation with all employee groups who are impacted by change and encouragement of best human resources practices throughout the transition.

   ii. Guiding principles that have been jointly negotiated with their union/association including HCS; Regional Health Authorities (RHAs), NAPE, CUPE, RNUNL, AAHP, NLMA, and potentially others depending on the scope of work.

   iii. Inclusion of a statement regarding employment commitment such as the following from the NHS documents: “The employee will receive employment commitment to continuity of terms and conditions to enable all affected employees to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainly during the transition.”

iv. Principles that enable this change process while providing protection and security to employees.

v. Change implemented in a way that demonstrates the importance and value of people and their well-being and enables the delivery of organizational priorities.

b. Further union-specific transition agreements for those who are affected by the rebalancing of the system may need to be negotiated with each employee representative group and be inclusive of the following topics:

i. Commitments for retraining and job security.

ii. Guidelines to protect staff with respect to the following options:

- Staff moving with the job they currently hold to another employer/entity;
- Staff maintaining salary and benefits;
- Staff having access to future jobs and/or benefits.

Scope of Practice

Action 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.

39.1. **Ensure that all health and social system providers in Newfoundland and Labrador are working to their highest level of education and/or training and understand the potential contribution of every member of the team.**

a. Review legislation and regulation of regulated professionals to determine if change is required. This review should be informed by a jurisdictional scan.

b. Work with regulators, employers, and government to enhance scope of practice within legislation and regulations for health professionals where appropriate such as:

   i. Registered nurses including prescribing, airway management, and expanded scope of remote nursing.

   ii. Pharmacists with increased scope of practice consistent with other Canadian jurisdictions including providing virtual pharmacy, ordering laboratory tests, and prescribing for chronic disease management.

   iii. Pharmacy technicians with expanded scope of practice comparable to other Canadian jurisdictions.

39.2. **Work with the appropriate professional colleges to review legislation and regulation of regulated professions to address specific Calls to Action and the significant change resulting from the reimagined health and social systems.**

39.3. **Because some of the scope of practice change can be accomplished by change in employer policy versus the need to have legislative change, review provincial workforce policy and practice to clarify and enhance scope and, for provider teams, to understand the potential contribution of every member of the team including, but not limited to:**

a. Primary care paramedics (PCPs) and advanced care paramedics (ACPs) to provide full scope of services inclusive of community paramedicine services.

b. Nurse practitioners (NPs) enabled to admit and discharge to and from in-patient facilities, to provide all primary care within their scope of practice, and to provide on-call services as required.

c. Licensed practical nurses (LPNs) practicing to their current scope across all areas of service provision.

d. Respiratory therapists to practice as anesthesia assistants where required.

e. Pharmacy technicians to practice to their current scope. Given that this is a newly regulated profession in Newfoundland and Labrador, further work needs to be done to ensure that they practice to their full scope.

39.4. **Implement a Provincial Education Strategy for team members to understand one another's role and scope (see Action 45).**

39.5. **Define the provincial scopes of practice for unregulated providers (such as personal care attendants, home care workers, and therapy assistants), including clarity of practice, competency development, and regulation for unregulated groups. Provide support for them to practice at their highest level of their education.**

39.6. **Complete a systematic review to determine when a generalist approach to the provision of care could be implemented (e.g., family physicians, general surgeons, general practitioner surgeons, and general practitioner anesthetists, all working to full scope).**

a. Review situations where the scope of practice of certain professionals has been narrowing in recent years (e.g., new graduate general surgeons are not trained to the same broad scope as previous graduates).

b. Work with regulatory colleges and educational institutions to enable the health professional to work to an enhanced scope of practice, based upon the needs of the community where the health professional will practice.

39.7. **Create strong interprofessional collaborative practice with each professional group, respecting and understanding each other's scope of practice.**

Recruitment of Health and Social System Providers

Action 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.

40.1. **Identify the current and future demand for each category of health care provider, the current and future supply of these same provider groups based on existing patterns of entry and exit from the workforce, and the gap between supply and demand for each provider group now and for at least ten years into the future. Update the data annually.**

a. Support the establishment of a Provincial Recruitment and Retention Office within the health system as announced by government in January 2022:

   i. use a provincial approach for recruitment for hard-to-fill positions;

   ii. employ dedicated resources to provide real time information on employment opportunities to potential applicants and to link students with potential employers;

   iii. conduct recruitment fairs within Newfoundland and Labrador and participate in national and international recruitment events in collaboration with the Department of Immigration Population Growth and Skills (IPGS);

   iv. use dedicated recruiters for rural and northern communities who can create linkages with the relevant community.

b. Assess the current state of supply and retention of health providers inclusive of current vacancy and turnover data.

40.2. Develop a Recruitment and Retention Plan for addressing each provider gap, using strategies of marketing, incentives and compensation, succession planning, and rural focus.

a. Start a marketing campaign to attract potential recruits:

   i. attendance of health organizations at national and international recruitment fairs;

   ii. focus on Newfoundlanders and Labradorians who are health providers working elsewhere, encouraging them to return to Newfoundland and Labrador;

   iii. development of an employee referral program with financial incentives;

   iv. utilization of modern and emerging recruitment channels and tactics through technology, including social media platforms, artificial intelligence, augmented reality, and virtual reality.

b. Enhance and promote existing employment incentives to attract potential recruits:

   i. sponsorship for individuals to complete education with bursaries, enhanced bursaries, and signing bonus incentives;

   ii. deferred salary and deferred salary-in-reverse programs for training for all occupations;

   iii. mentorship programs for persons recently hired as well as for those aspiring to progress in their careers;

   iv. new employee program aimed at retaining persons recently hired including onboarding, mentorship, and support particularly prior to the start of independent practice;

   v. transparent and flexible incentives inclusive of relocation expenses and competitive with other Canadian jurisdictions.

c. Develop and implement effective succession planning strategies. These need to better prepare employees to take on new roles and improve knowledge transfer and retention. This should be performed

regardless of planned vacancy. Highest risk areas should be identified, and plans put in place so that there is protection for planned and unplanned vacancies. When vacancies are expected, such as the case with expected retirement of solo practitioners, increase the staff complement to support the transition to a new provider and continuity of patient care.

d. Deploy proven strategies such as those contained in *Making it Work: A Framework for Remote Rural Workforce Stability* (Strasser et al, 2018, Northern Periphery and Arctic Programme 2014–2020; European Union). Key considerations include an understanding of the commonalities of rural and remote locations, the reality that providers who stay for short periods of time limit the quality and cultural relevance of the services, an understanding of the type of person who will stay in a rural location and of the investment in training of people from rural and remote areas, and the need for community engagement.

40.3. Deploy strategies to stabilize the current workforce inclusive of:

a. developing an Immigration Strategy;

b. working in partnership with local and community stakeholders;

c. creating a "Grow Your Own" recruitment and retention strategy in partnership with the Department of Education, Memorial University and the College of North Atlantic;

d. encouraging urban and rural high school students to pursue health careers.

40.4. Develop an Immigration Strategy.

a. Establish an Immigration Recruitment Division with immigration expertise within the Provincial Recruitment Office.

b. Collaborate and use resources available from the Department of Immigration, Population Growth and Skills (IPGS) identifying shared immigration priorities.

c. Clarify and understand provincial immigration pathways and workforce-related funding.

d. Utilize a provincial approach for international recruitment, and potentially work with the private sector companies who have skills in the immigration process.

e. Focus on international students currently being educated in Canada.

f. Identify potential career pathways for internationally-educated providers and support them through to their intended career destination. This may include hiring of internationally-educated health providers into alternate health care positions until they receive appropriate credentials.

g. Collaborate with IPGS, and potentially implement dedicated positions to assist and support internationally-educated health professionals through complex immigration and foreign qualification recognition processes.

h. Support internationally-educated professionals in their settlement and integration in Newfoundland and Labrador.

i. Work with regulators regarding processes (such as bridging programs to obtain licensure) to facilitate a smooth and expedient transition to Newfoundland and Labrador workplaces.

40.5. **Work in partnership with local communities and stakeholders to:**

a. strengthen and stabilize the workforce to build relationships with post-secondary education institutions, including public, private, and out-of-province;

b. develop strategies to engage community advisory committees in recruitment and retention, including onboarding with community involvement;

c. implement strategies to engage organizations and associations representing individuals from diverse backgrounds and excluded groups;

d. create partnerships with employees and stakeholders such as unions and associations to create positive work environments.

40.6. Encourage urban and rural high school students to pursue health careers to:

a. support youth volunteerism in health and social sectors;

b. offer summer employment for high school and post-secondary students;

c. offer formal programs for high school students such as MedQuest;

d. develop a "Grow Your Own" recruitment and retention strategy by working with high school students to enter health-related professions and by encouraging students from rural areas of the province to return home following post-secondary education;

e. explore pathway programming in high school toward health and social occupations;

f. create programs introducing Indigenous high school students to health careers, and encourage and support high school completion.

40.7. Stabilize all segments of the current workforce, and create strategies to achieve Health Accord objectives.

a. Stabilize nursing supply — NP, registered nurse (RN), LPN, and personal care attendant (PCA). While Newfoundland and Labrador has committed to increase RN, LPN and PCA seats, there is a need for additional NP seats to fill vacancies and new positions. Develop strategies that encourage students from rural and remote communities to complete these programs and return to rural and remote work locations.

   i. Invest in the recruitment of recent health graduates with attractive job offerings that can ensure the province retains local students and graduates. For example, Nova Scotia has started to offer nursing students jobs at the end of their first year of nursing school, and all graduates are offered a job upon graduation.

ii. Participate in programs such as that recently announced by the Canadian Association of Schools of Nursing to better support new graduate nurses and help the "integration of nursing graduates into the workforce who are competent, emotionally resilient, and retainable."

iii. Have a broad Nursing Practice Education Strategy that focuses on fostering positive relationships between students and employers across all points of the education continuum, and on improving the linkages between education and employment.

b. Stabilize physician supply — Build on the planning day held by the Memorial University's Faculty of Medicine in June 2021 and the subsequent report produced, *Rural Newfoundland & Labrador Physician Recruitment and Retention Plan*, July 2021. This report made ten key recommendations to stabilize the physician workforce including, "the development of the province-wide physician Human Resource Workforce Plan outlining clearly the current need (types of physicians required and locations) and projected future provincial needs."

c. Stabilize with multi-pronged strategies all health and social system vacancies inclusive of nurses, physicians, allied health professionals, and other positions.

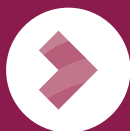
40.8. Evaluate the strategies to make sure they are addressing deficits between demand and supply.

a. Develop and monitor a set of key indicators to evaluate the strategy to inform improvements.

40.9. Address the needs of the reimagined health system for increased numbers of providers such as geriatricians, advanced care paramedics, nurse practitioners, rural generalist family physicians, allied health professionals, early childhood educators, and home care workers.

a. Create targeted strategies for each of these providers in keeping with specific Health Accord Calls to Action.

Strategies to Engage, Stabilize and Retain the Current and Future Workforce



Action 41: Create strategies that will engage, stabilize, and retain the current and future health and social system work-force. Ensure strategies support inclusion of under-represented groups and quality of care in the provision of service.

41.1. **Develop a change management plan for implementation of the actions, particularly in relation to the development of Community Teams (including integration of pharmacists), changing roles of health facilities, integration with the broader social and extended health system, and stronger team development.**

41.2. **Support collaboration, integration, and change across sectors including RHAs, multiple government departments, private health care, the education sector, regulatory colleges, municipalities, and the non-profit health and social system.**

a. Create a unit dedicated to change management within the Provincial Health Authority (PHA) to take the lead on transformational change within the health system. The unit would adopt a “best practice” change management methodology system-wide. See Actions 52 to 55 for further detail on the structure for change management related to the implementation of the Health Accord Calls to Action.

b. This plan should include proven principles of change management:

  i. use an evidence-informed approach to change;

  ii. engage employees in the creation of the change management plan;

iii. identify the sponsors and champions of change management;

iv. provide transparency and open communication regarding the change to the general public and all stakeholders;

v. provide training and support as required;

vi. create an implementation roadmap;

vii. invite participation and feedback;

viii. monitor and measure progress and adjust approach to change as required.

c. Implement change management strategies with greater use of innovative methodologies for virtual care and improvement in quality of care.

d. Implement change management strategies that will bring tertiary care services closer to the patient by deploying virtual care options, having specialists visit community and regional hospitals, and supporting travel cost for patients.

e. Ensure that policies will support change in the practice of providers.

41.3. **Use current RHA staff engagement survey feedback, and, where necessary, complete further research to understand low engagement within the current workforce. Use this information to develop action-specific initiatives with the goal of enhancing employee and physician engagement.**

41.4. **Use workplace data to create strategies to enhance physical and psychological safety of employees and physicians.**

a. Consider the impact of COVID-19 on the current workforce, including mental health impacts.

b. Use acuity-based staffing to ensure that workforce allocation matches workload demands and patient safety.

c. Implement the National Standard of Canada on Psychological Health and Safety in the Workplace.

d. Continue to focus on innovation, diversity and inclusion, and a psychologically healthy workforce.

e. Ensure physical safety for staff and reduction of workplace injuries.

41.5. Focus on needs of the public in workforce design and allocation.

a. Ensure an interprofessional team mix in Community Teams and in long-term care, and integration of Community Teams and school health.

b. Ensure staff have the skills and knowledge to carry out their work. Conduct ongoing review and evaluation of staff duties and adapt as required to the needs of the population (e.g., enhancing existing roles, creating new ones, or phasing out unwarranted positions).

c. Ensure the right people are in the right job with the right skills and the knowledge to succeed. Be nimble enough to integrate new roles as new needs arise in order to sustain the workforce.

41.6. Implement strategies that aim to increase workforce retention inclusive of creating a workforce that is committed to the organization and/or remaining in Newfoundland and Labrador.

a. Administer and analyze employee experience surveys, act on recommendations, and communicate action to the workforce so they will understand that their voices matter.

b. Engage with employees to better understand workplace culture. Enhanced focus on employee retention includes a need to understand the cause of internal turnover.

    i. Deploy succession planning techniques mentoring employees for future roles; anticipate vacancies and hiring in advance to ensure no gaps in service, particularly for solo or hard-to-recruit positions.

ii. Discuss generational differences in the workforce that result in people having differing approaches to life (e.g., desire to have multiple roles in order to experience diversity in their work).

iii. Seek to better understand the employee's desire to work in a casual or temporary position rather than have full-time permanent employment.

iv. Adapt to changes in the workforce and the preferences of the workforce.

v. Implement recognition and reward programs that employees value.

vi. Implement a span of control for managers at a level that enables strong team development, employee support, and performance feedback.

vii. Adopt a long-term view of human resource planning and policy changes, and consider implications for the wider workforce beyond roles directly involved in the policy.

viii. Ensure that an appropriate complement of supports is available in the workplace (e.g., clerks on a nursing unit, replacing absent staff to keep core staffing).

ix. Offer opportunities for professional development that could potentially lead to a higher position and/or greater commitment to and engagement in the organization.

x. Engage with the wider community with respect to inclusion of health care workers, providing attractive amenities in the community that can help provide work-life balance.

xi. Utilize the Integrated Capacity Management System currently used by the RHAs to ensure that the allocation of resources is balanced and aligned with demand. Develop and monitor a set of key indicators to evaluate the actions to inform improvements.

xii. Implement change management strategies for Health Accord implementation inclusive of greater use of quality care and digital care methodologies.

xiii. Develop a corporate social responsibility strategy.

An Environment that Values Leadership and Management

Action 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.

42.1. **Cultivate a climate where individuals with leadership potential aspire to manage and lead.**

42.2. **Create organizations where good management and leadership techniques are applied, including succession planning and mentorship programs.**

a. Deploy succession planning programs to identify and form future leaders.

b. Mentor those with potential for management, new managers, and those with potential for senior positions.

c. Offer these programs both in-person and virtually.

42.3. **Support management to achieve full potential with a review of their span of control including the number of employees, the number of services/disciplines, and the geographical location of services.**

a. Implement change resulting from a span of control review.

b. Evaluate the impact of change over time.

42.4. Provide best-in-class leadership development in all areas of management competency for current leaders and those with potential to move to management and leadership positions.

a. Adopt the LEADS in a Caring Environment Framework (**L**ead self, **E**ngage others, **A**chieve results, **D**evelop coalitions, and **S**ystems transformation).

b. Create an interprofessional provincial leadership program appropriate to all providers

c. Offer programs in management essentials (e.g., budgeting, staff scheduling, giving staff feedback).

d. Provide sponsorship for university management and leadership education.

e. Provide support to managers to integrate strong leadership practices in their day-to-day work.

Strategies and Evidence to Support Human Resource Planning

Action 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 this evidence and data in strategy development.

43.1. **Create strong health and social system human resource planning led by the Departments of HCS, and Children, Seniors and Social Development (CSSD).**

43.2. **Create systems and processes to capture robust, comprehensive, and timely data and evidence regarding the social sector and private sector health workforce to create strategic workforce plans.**

43.3. **Collaborate with key partners such as employers, regulatory bodies, professional associations, unions, and others in workforce planning activities.**

43.4. **Solicit input from stakeholders and under-represented groups in the health and social system workforce.**

43.5. **Ensure workforce planning considerations are part of all future health and social system strategic planning.**

43.6. **Partner with stakeholders and researchers to document areas for improvement, evidence collection, and key policy questions requiring investigation.**

43.7. **Identify key research areas and support research by academics, consultants or within organizations to inform this work.**

43.8. **Work nationally, building on what is currently available from the Canadian Institute for Health Information (CIHI), to develop a health and social system comprehensive human resource database that can be used for comparison and strategy by:**

a. regular collection and reporting on key data elements regarding these workforces;

b. regular input from stakeholders and under-represented groups in the health and social system workforce;

c. workforce planning as a part of all future health and social system strategic planning;

d. workforce projections models for priority occupations;

e. evaluation of Newfoundland and Labrador health and social system human resource practices and monitoring of trends in other jurisdictions;

f. use of data trends for decision-making and course corrections;

g. collaboration with stakeholders and researchers to determine key policy positions, areas for improvement, and evidence collection;

h. identification of key research areas and research collaborators.

8. Education Implementation Recommendations

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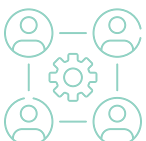

Principles for Health Provider Education

Action 44: Develop and apply clear guiding principles in all education development and delivery initiatives.

44.1. **Develop and apply principles aligned with the following as educators renew, refine, and implement educational programming:**

a. Collaboration to enable health professionals to work in interprofessional teams that promote and advocate for the health of the individual and the community.

b. Recognition of the role of the patient/client/resident, acknowledge patient/client/resident autonomy, and ensure that the patient/client/resident is an active member of the care team. Should the patient/client/resident not be competent, the family member, caregiver, or designated substitute decision-maker must be included to bring the patient/client/resident's perspective.

c. Recognition of the patient/client/resident as a critical focus of public engagement, and the patient/client/resident as a participant in the educational program.

d. Assurance that curriculum and clinical experiences are developed through inclusive and equitable lenses.

e. Inclusion of change management principles, and provision of contextual approaches to all health care providers.

f. Integration of quality assessment and improvement practices in every aspect of care.

g. Provision of clear, comprehensive programming on care for Indigenous peoples which includes the concepts of cultural safety/humility, anti-racism, equity, and inclusion.

h. Active inclusion of community perspectives into curriculum planning.

i. Creation of a focus on continuous improvement in a Learning Health and Social System (LHSS).

j. Recognition that health provider care requires a life-long learning process including adaptation to change both in what is delivered and how it is delivered.

k. Preparation of learners with the requirements associated with a Learning Health and Social System (e.g., on-boarding, transitioning through practice).

l. Development of creative ways to engage with health care education institutions outside of the province whose graduates come to work in the province so that learners can experience some of their education and have clinical mentors in Newfoundland and Labrador.

44.2. Implement this objective in collaboration with the Council on Higher Education, Schools (the College of the North Atlantic, nursing schools, and private colleges), and faculties within Memorial University.

a. Develop a principles document with distribution to all provincial health-related education programs, health authorities, and licensing bodies to formally guide education development/revision activities.

b. Require application of the principles document in all health-related education development and revision activities.

c. Report annually to the Minister of Health and Community Services (HCS) and the Council on Higher Education (or alternate mechanism) on the application of principles.

Notes:

1. *The Public Post-Secondary Education Review document "All Hands on Deck: Responding to the Challenges of the 21st Century by Leveraging Public Post-Secondary Education" recommended abolishing the Council on Higher Education and establishing an alternative mechanism to facilitate and ensure focused attention*

on collaboration between Memorial University and the College North Atlantic and other stakeholders in the post-secondary education system.

2. *The Council on Higher Education is one possible governance mechanism that can receive progress reports and be accountable to government. Any new mechanism as recommended by the Public Post-Secondary Education Review Document, "All Hands on Deck" or a renewed and expanded Council should bring together all the institutions responsible for health professional education and provide oversight and promote the development of collaborative interprofessional education in the province. The body must be accountable to government.*

3. *There is a key assumption that a comprehensive Health Human Resource Plan is in place to support Education Implementation Recommendations, and the development of health care provider education should be linked to the provincial Health Human Resources Plan.*

Learners Learning Together – A 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.

45.1. **Provide health care education to teams in their practice environments through a province-wide distributed model incorporating digital technology, where appropriate.**

a. Implement this objective in collaboration with certifying colleges and regulators, schools (the College of the North Atlantic, nursing

schools, and private colleges), Memorial University faculties, Provincial Health Authority (PHA), Regional Health Councils (RHCs), and the Centre for Collaborative Health Professional Education (CCHPE).

b. Design educational content for team-based, multidisciplinary Undergraduate/Post-Graduate (UG/PG) and in-practice learners.

c. Develop interprofessional modules for change management, digital technology, and interdisciplinary team development, using the Family Practice Renewal Program's Practice Improvement Program (PIP) model.

d. Integrate digital technology to expand (geographically and content-related) educational delivery activities for both student and continuing education learners

e. Pilot team-based learning in both community and hospital-based practice environments.

f. Ensure all practice environments encourage and support team-based clinical education opportunities for practitioners at all learning levels (pre-graduation and post-graduation).

g. Recognize continuing education credits for team-based learning activities.

45.2. Create collaborative governance among faculties and schools to oversee interprofessional team learning.

a. Implement this objective in collaboration with the provincial government, Memorial University, College of the North Atlantic, and the Council on Higher Education.

b. Expand and revise the role of the Council on Higher Education (or alternative mechanism) to include a Steering Committee on interprofessional health care education which links the health faculties of Memorial University, the School of Health Sciences at the College of the North Atlantic, and the private colleges.

c. Integrate the Minister and Deputy Minister of HCS into the reporting structure of the revised Council on Higher Education (or alternative

mechanism), and include patient/client representation and diversity of public membership.

d. Within Memorial University, strengthen the Council of Health Sciences Deans by including all faculties of health, social, science and humanities to oversee health care professionals learning together and to ensure the development of both basic and clinical interprofessional educational programs

e. Develop specific terms of reference for the oversight body to define the collaborative development and delivery of interprofessional, team-based learning, and the coordination of educational development and delivery activities required by the various health-related educational providers.

f. Identify formal working group(s) for the oversight body made up of representatives from current provider groups or related committees (CCHPE, Health Education Planning Committee, Family Practice Renewal Program). Include in all working groups, patient/client/resident members and consultation opportunities with Indigenous peoples, 2SLGBTQIA+, community members, and racially diverse members of the community to reflect current regional and urban populations.

g. Expand or revise and fund the CCHPE to formally include all faculties involved in health care education to develop a true interprofessional learning environment across the continuum of education from classroom to clinical practice.

45.3. Co-create curriculum, and employ integrated clinical placements.

a. Implement this objective in collaboration with Memorial University, CCHPE, and College of the North Atlantic.

b. The expanded Memorial University's CCHPE (including the schools of nursing) in collaboration with College of the North Atlantic (and private schools) will:

   i. survey health education providers to identify priority areas for collaborative curriculum development and related curriculum update schedules;

ii. survey learners and recent graduates to identify recommended areas for co-creation and delivery of curriculum;

iii. identify stakeholders and partners to be included in the curriculum development process based on learning principles, including patient/client/resident and inclusion representatives;

iv. identify three to five co-creation priorities as a pilot initiative, and begin the development of an integrated delivery process;

v. apply lessons from the pilot initiative to all related on-going development and delivery activities.

45.4. Facilitate the integration of interprofessional clinical placements across the province for all faculties and schools through a central coordination and management system.

a. Implement this objective in collaboration with HCS, the PHA, Provincial Clinical Placement Program, Memorial University, and College of the North Atlantic.

b. Identify, review, and recognize the roles of all employees throughout the province currently involved in clinical placement activities (faculties, schools, RHAs).

c. Develop a central coordination and management system that supports integration of clinical placements, maximizes allocated resources, and minimizes/removes current barriers associated with finding clinical preceptors.

d. Create a position to manage the Provincial Clinical Placement Program.

e. Begin a standardization program for preceptor recognition and provide a stipend for being a preceptor. Cover costs for participation of patients/clients/residents and persons with lived experience in Interprofessional Education (IPE) activities.

f. Integrate HSPNet, Comp Keeper, and other technologies that support integrated clinical placements.

45.5. Engage all relevant partners, including Black, Indigenous and People of Colour (BIPOC), and other marginalized voices in curriculum development and delivery activities.

a. Implement this objective in collaboration with schools, faculties, PHA, and RHCs.

b. Identify partners to be included in the curriculum development delivery process based on learning principles, including patient/client/resident and inclusion representatives.

c. Identify and provide the supports required for partner participation, including different means of knowledge sharing.

d. Include partners as equal participants in development and delivery activities.

45.6. Clearly define the expected competencies of the "formal" education process for each professional group, recognizing overlapping roles (e.g., the entry-level practitioner, the generalist, and the specialist).

a. Implement this objective in collaboration with CCHPE, faculties, schools, post-graduate and Continuing Professional Development.

b. Expand CCHPE to coordinate the definition of the roles for all professional and provider groups.

c. Create clear expectations (outcome objectives) for entry into practice, for generalists entering specific provincial contexts, and for specialists in the new structure.

45.7. Provide collaborative continuing professional education responsive to specific and changing community health care needs.

a. Implement this objective in collaboration with Memorial University's Faculty of Medicine, the College of the North Atlantic, CCHPE, PHA, RHCs, and Regional Social and Health Networks (RSHNs).

b. Expand and redevelop CME.MD seminars to involve all health care professional/provider groups under the Memorial University-College

of the North Atlantic collaborative governance. Involve patients/clients/residents and individuals from the Indigenous and BPOC communities.

Note: Expand the model for the continuing interprofessional education of the Family Practice Renewal Program's Practice Improvement Program which provides a mix of online learning opportunities, group learning, and mentorship programs, and ensure the consistent inclusion of the all health care professions.

c. Identify community health care priorities through data gathering (e.g., community health needs assessment, Community Team data, team-member surveys, analysis of adherence to follow-up, NL Centre for Health Information, and NL Council on Health Quality and Performance).

d. Identify priority Continuing Professional Education (CPE) needs, and communicate these needs to the health education oversight body.

e. Develop and deliver team-identified or system-identified collaborative CPE responsive to identified needs.

45.8. **Review and revise the current governance structure and funding arrangements for interprofessional education within Memorial University's health-related faculties and schools (the College of the North Atlantic, nursing schools, and private colleges).**

45.9. **Promote a more focused approach to collaborative governance of the health sciences faculties and schools at Memorial University to include nursing, pharmacy, medicine, social work, and kinesiology.**

45.10. **Provide education and practice-based education for generalists within the province.**

a. Implement this objective in collaboration with PHA, RHCs, faculties, and schools.

b. Define specific Newfoundland and Labrador practice contexts.

c. Adopt an acceptable definition of generalist which recognizes the breadth of knowledge and skills needed for specific contexts and locations.

d. Determine at which level (UG/PG or in-practice) these areas of knowledge and skills need to be acquired.

e. Develop role-specific education for recruitment and retention of generalist primary care providers and for generalist-specialist care providers.

45.11. Where not provided in-province, establish needed specialty and subspecialty education through inter-provincial agreements with local input, and clinical placements with supported educational programs and mentorship in the province.

a. Implement this objective in collaboration with HCS, faculties, schools, the PHA, and RHCs.

b. Review interprovincial agreements to determine the current opportunities to experience provincial clinical placements and mentorship.

c. Identify options (e.g., contracts, agreements) to work with out-of-province providers to support curriculum development and delivery that is collaborative and team-based.

d. Identify and either modify or create opportunities to support local students undertaking out-of-province educational programs to complete clinical placements in a team-based clinical environment in the province.

e. Develop mentor/supervisor expertise in the province.

Updated Curriculum Content

Action 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.

46.1. **Ensure that health care provider curricula prepare the graduate to become an entry level practitioner with competencies, skills, and confidence to provide a defined scope of practice focused on the patient/client/resident:**

a. Demonstration of knowledge of the social determinants of health (SDH), the health impacts on different populations, and the ability to influence these impacts.

b. Demonstration of knowledge of public health, its function in communities, and collaboration as health care providers.

c. Demonstration of knowledge and competences in age-related health factors including multi-dimensional care, frailty, mental health, aging, and dementia.

d. Active participation in quality programming including quality assessment and the practice of continuous quality improvement at the individual, team, and community levels.

e. Active strengthening of the approach to inclusion and equity.

46.2. **Implement this objective in collaboration with schools, faculties, the PHA, RHCs, and the provincial government.**

a. All Memorial University faculties and schools and College of the North Atlantic curriculum committees undertake a review to identify both current didactic and clinical-based interprofessional and team-based education in their curricula.

b. Identify overlap, and create and expand opportunities within existing education and continuing education programs and offerings to increase applied skills related to priority topics identified above.

c. Report additional learning needs and potential opportunities to the oversight body to identify opportunities for support and prioritization among faculties and schools.

d. Identify stakeholders and partners to be included in the curriculum development process based on learning principles, always including patient/client/resident and inclusion representatives.

e. Develop an inclusive and collaborative curriculum development and delivery plan with timelines and supports (e.g., per diems) for partner participation.

f. Identify immediate-term, medium-term, long-term, and ongoing offerings considering all available modalities (e.g., visiting lecture, virtual learning, simulation, core curriculum updates, topic-focused intensive course development).

g. Identify and secure resources required.

h. Begin implementation of educational programming with priority focus on inclusion, aging and frailty, and the SDH.

i. Prepare practitioners with specific focus on:

    i. developing the individual's ability to provide culturally appropriate and relevant Indigenous health care with humility;

    ii. developing the ability to integrate anti-racism practices;

    iii. developing the ability to integrate anti-oppression practices (e.g., 2SLGBTQIA+, BIPOC, disabled persons, multicultural communities).

Preparing the People of the Province

Action 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.

47.1. **Provide resources and education for patients/clients/residents, families, and other caregivers to effectively undertake electronic communication and to access practitioners and necessary records.**

a. Implement this objective in collaboration with PHA, RHCs, RSHNs, schools, faculties, and CCHPE.

b. Establish regional-based groups which include representatives of community programs, the Community Team(s), health centres, and regional hospital.

c. Develop a diverse patient/client/resident advisory core team which can prioritize educational needs and participate on formal committee structures at the local level.

This could be an expansion into the community of the RHA patient/client/resident advisory committees with an education program for these committees.

d. Undertake a needs assessment of the local community that includes the patients/clients/residents, the public, and the professional practitioners.

e. Define the learning needs and the educational opportunities.

f. Practitioners provide instruction/information to patients/clients/residents and caregivers to prepare them to avail of digital opportunities related to access (e.g., booking appointments, virtual appointments), and information resources (e.g., test results, system supports).

47.2. Develop patient/client/resident participation networks to enable participation at the system level.

a. Implement this objective in collaboration with PHA, RHCs, CCHPE, and RSHNs.

b. Create a digital-based membership network.

c. Identify existing patient/client/resident engagement and participation activities occurring within the region.

d. Expand existing patient/client/resident lists and/or develop new patient/client/resident registries for those willing to participate in learning development and delivery activities.

e. Develop participation networks and programs to ensure active and consistent patient/client/resident participation in practitioner learning activities.

47.3. Enhance knowledge among community leaders to recognize, demonstrate, and encourage:

a. the benefits of interprofessional teams and their role in a sustainable health care model;

b. the benefits of community-based care and Community Teams;

c. the measures of quality care and their role in continuous improvement activities;

d. the preparation for current and future technologies and their role in care;

e. the preparation for changing environments and their impact on health;

f. the individual and community level actions that can improve health status;

g. the continuing role of public health;

h. the role of SDH, especially inclusion, on health outcomes;

i. the role of a holistic approach to health and health care (e.g., social prescribing);

j. the benefits of inclusive and age-friendly communities.

47.4. Implement this objective in collaboration with PHA, RHCs, RSHNs, and CCHPE.

47.5. Identify community leaders and residents who are interested in learning about current and emerging health and social system changes in their region and who are willing to participate in an advisory group that is sustainable over time. Some minimal funding and the commitment to include broader representation than just community leaders should be provided.

a. Formally recruit the community champions into a regularly scheduled information-sharing forum at the regional level.

b. Engage and encourage community champion participation in community level information sharing opportunities (e.g., town halls, municipal events, 50+ events, health-related information sessions).

c. Connect community champions with social navigators and clinical navigators in Community Teams, Regional Social and Health Networks, local government, and community organizations to support information sharing.

9. Governance Implementation Recommendations

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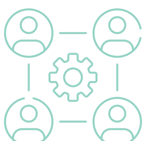

The Governance Committee Recommendations call for:

i. a reimagined governance structure for the health system (a Provincial Health Authority — PHA — and Regional Health Councils — RHCs)

ii. a new structure at the regional level that does not govern but connects and integrates by bringing together all the entities in a region which influence the health of the people of that region (Regional Social and Health Networks — RSHNs)

iii. a holistic and integrative Provincial Data Governance model to guide the use of data to improve our health and social systems in a transparent, ethical, and accountable manner.

iv. a transitional structure to immediately initiate the implementation of the Health Accord Calls to Action pending the legislation and policy decisions needed to create the permanent structures. Included in the transitional structure are:

- a one-year transitional PHA and CEO;
- a three-year Senior Executive (Health Accord) position in the Cabinet Secretariat;
- the Premier's Advisory Council on Health which is the connection between the Health Accord Task Force and the implementation team;
- a transitional NL Council for Health Quality and Performance.

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.

This Call to Action involves the development of a single PHA to which the Minister of Health and Community Services (HCS) has delegated responsibility and accountability for provincial programs and standards of care in the provincial health system. For these areas of focus, a single Authority will improve the effectiveness and efficiency of services that can be standardized (e.g., stroke care) and services that can be better integrated (e.g., ambulance services, health information systems).

48.1. Delegation of responsibility and accountability by the Minister of HCS.

a. Appoint a Board with competency requirements designed to reflect the responsibilities and accountabilities associated with provincial health service delivery.

b. Provide education and orientation activities for Board members to ensure they clearly understand their roles and responsibilities, including the importance of the social determinants of health.

48.2. Initial actions by the Board in accepting responsibility and accountability for the direct provision of provincial health services.

a. Develop an outcome-based strategic plan that reflects the responsibilities.

b. Develop a framework for connecting the social determinants of health (the social, environmental, and economic conditions that have an impact on health) with the health system at the provincial level.

c. Appoint and set expectations, mutually agreed upon goals, and standards of performance for the CEO.

d. Appoint the members of the RHCs (see 48.5).

e. Establish a unit dedicated to change management and linked with the guiding team (see Action 52.3) to take the lead on transformational change within the Regional Health Councils.

48.3. Ensure full consideration of the impacts of the social determinants of health (SDH) in public health and health system services — directed by the Board and operationalized by the CEO.

a. Delineate the intersection of services between the health and social sectors that impact health — identifying roles and ensuring that connections and referral networks are established.

b. Recognize that regional variations exist with respect to the SDH and ensure that integration efforts are responsive to the needs in each region.

c. Develop a plan for integrating the SDH into service delivery with deliverables and timelines.

d. Develop outcome measures for the system that include the SDH, recognizing the role of other partners.

e. As a committed partner in the Learning Health and Social System (LHSS), adopt a continuous improvement philosophy for the integration of the SDH, with regular enhancements to policies and delivery models as best practices and evidence become available.

48.4. Develop and maintain standards of care for provincial programs of care delivery — directed by the Board and operationalized by the CEO.

a. Set expectations for inclusion in the processes used to develop standards of care (e.g., ensure that patient/client/resident representatives and persons with lived experience are involved in the development process).

b. Develop standards of care to improve the quality of health service delivery with appropriate quality assurance mechanisms.

c. Require transparency in performance reporting on how well provincial standards are being met while ensuring that information in the reports is provided in language that is precise and as readily understandable by the public as possible.

d. Require the development of a complaints process for patients/clients/residents who are not satisfied with the care delivered or received — including a process for staff to use in addressing complaints.

e. Require the creation of a safe environment (psychological and physical) and development of a process to allow practitioners and

others in the system (employees, volunteers, etc.) to report a concern with respect to the delivery of standards of care, the administration of the system, or the quality of the system.

48.5. **Delegate responsibility and authority to the RHCs for health service delivery in their respective regions (see Action 49).**

a. Finalize the number of regions most appropriate for the rebalanced health system.

b. Appoint the members of the RHCs with competency requirements designed to reflect the responsibilities and accountabilities associated with regional health service delivery (the appointment process will be finalized during the transitional year).

c. Provide education and orientation activities for RHC members to ensure they clearly understand their roles and responsibilities.

d. Approve policies and a strategic plan created by the RHCs for their respective regions.

    i. Strategic plans should be developed taking into consideration the strategic directions of the PHA and the evidence-based needs of the region.

e. Clearly delineate the reporting structure for the Regional Administrator as it relates to the RHC and the CEO of the PHA.

48.6. **Create and have oversight of the integrated air and road ambulance system (see Action 23) — directed by the Board and operationalized by the CEO.**

a. Create a new integrated air and road ambulance system with clear program parameters (e.g., employee structure, management structure) and an implementation strategy to move from the model currently in place in the province to the new model.

b. Develop policies and performance measures for the system, and monitor performance as a normal part of practice.

c. Ensure regular and transparent reporting to the public on the performance of the new system using language that is precise and as readily understandable by the public as possible.

48.7. Modernize and manage the province's health information and virtual care system (see Action 51) — directed by the Board and operationalized by the CEO.

a. Establish protocols to enhance data collection and accessibility that maximize the use of health information and data as an important resource in care, as important to support secondary uses, and as critical to information connections across systems.

   i. Enable the sharing of information across practitioners in the circle of care.

   ii. Ensure appropriate accessibility of data for research, policy, evidence informed decision-making, management, evaluation, and innovation.

   iii. In collaboration with social systems, government agencies and departments:

      - establish linkages for information systems across health and social systems (i.e., ensure that information systems can interface with each other);

      - develop a framework for collecting and sharing social information with groups outside the formal health system that have an impact on health.

b. Develop policies and performance measures for the new health information and virtual care system with a specific focus on modernization and integration to improve the efficiency and effectiveness of care.

c. Set rules for the expanded use of virtual care with specific attention to the measures necessary to protect the practitioners and patients/clients/residents using the technology:

i. required initiatives to increase digital literacy;

ii. the provision of devices and internet access necessary to expand virtual care offerings (i.e., availability and affordability);

iii. the acknowledgement that not all communities have access to adequate broadband;

iv. the need for different types of protections for different types of virtual care.

d. Maximize the role and value of a modern health information and virtual care system in planning for a sustainable health care system for the province.

e. Set expectations for the continued development of virtual care including a virtual emergency system and virtual specialist appointments to improve access and reduce waitlists for care.

f. Identify the person or position that has responsibility for the oversight of the data governance framework within the Provincial Health Authority.

48.8. Oversee accountability for health outcomes through monitoring and reporting on quality, safety, and performance — directed by the Board and operationalized by the CEO.

a. Set the strategic goals for the provincial health system with defined outcomes and performance measures.

b. Partner with others in the development of the LHSS.

c. Develop and report to the public annually on a provincial health report card in collaboration with the NL Council on Health Quality and Performance that is based on outcomes and does the following:

i. demonstrates integration of the SDH;

ii. identifies the outcomes that the PHA will meet with the help of partners in other sectors (e.g., private practitioners, family physicians, education system, justice system);

iii. clearly reports the changes that have been made using language that is understandable by the public.

d. Ensure that the performance contract of the CEO specifically requires the achievement of outcomes identified by the Board as provided for in the province's *Transparency and Accountability Act*.

48.9. Increase province-wide efficiencies within the health system by ensuring the sharing of resources through a clear division of responsibilities, improved communications, and enhanced collaborations — directed by the Board and operationalized by the CEO.

a. Define the principles that will be used by the PHA to guide decision-making (e.g., fairness, inclusion, quality).

b. Set provincial policies for programs and resources that will be delivered at the provincial level.

c. Formally develop provincial level partnerships to increase collaboration with other sectors that affect health (e.g., social, justice, education).

d. Clearly delineate resources, responsibilities, and accountabilities for the delivery of regional services by the RHCs.

e. Define the processes that will be used to communicate and collaborate with Regional Social and Health Networks (RSHNs).

48.10. Ensure a provincial, progressive, and persistent strategy for recruitment and retention, finance, and other support areas — directed by the Board and operationalized by the CEO.

a. Determine the employment structure for the new health system including the number of employers, in consultation with unions and other stakeholders.

b. Set the principles, standards and expected results for the management of shared services.

c. Adopt a continuous improvement philosophy for shared services as an ongoing strategy.

d. Set up committees that include representation from the RHCs to effectively monitor and guide the performance of shared services.

48.11. Find the most effective and efficient approach to procurement for the province's health system, building on the work that Central Health has done in its role as the lead for the provincial supply chain — directed by the Board and operationalized by the CEO.

a. Identify and create opportunities to support local procurement.

b. Identify and create opportunities for strategic procurement initiatives that encourage innovation (e.g., first purchaser initiatives).

c. Identify and create opportunities to support sustainability and other social benefits (e.g., inclusive employment practices, social enterprise).

48.12. Partner with others in building a LHSS and engage with post-secondary educational institutions to ensure a common vision and direction regarding the education of highly qualified personnel, applied research, and shared resources as well as the development of an academic health sciences network — directed by the Board and operationalized by the CEO.

a. Formalize a partnership with post-secondary institutions for collaboration in the following areas:

i. establishing academic and health system oversight of interprofessional education;

ii. facilitating effective recruitment strategies;

iii. supporting the work of the NL Council on Health Quality and Performance.

48.13. Partner with Indigenous communities to ensure appropriate response for all areas of health system delivery which are provided for the members of Indigenous communities.

a. Set expectations for the inclusion of Indigenous persons/perspectives in all decision-making activities of the board and executive team for all areas of health system delivery that are provided for the members of Indigenous communities.

48.14. Be directly linked to the regional entities which influence health and health outcomes in their regions.

a. Include Regional Administrators from the RHCs within the executive team of the PHA.

b. Ensure regional representation on the Board of the PHA.

c. Develop a formal connection between the convenor and field catalyst positions for the RSHNs (see Action 50) and the provincial position dedicated to partnerships.

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.

The RCHs should be the regional entities to which the PHA will delegate responsibility and accountability for health services at the regional level. They should be responsible for the regional hospital, community hospitals, health centres, Community Teams, and long-term care facilities in the region and will work closely with the people of the region to ensure that the services provided

are aligned with the needs in their region. This should include the integration of the SDH into regional care models. The members of the RHCs should be appointed by the PHA (see 48.2 and 48.5).

49.1. As RHCs, assume responsibility for the direct provision of health services at the regional level.

a. Develop policies and a strategic plan at a regional level that reflect the expected responsibilities.

   i. Strategic plans should be developed taking into consideration the strategic goals of the Provincial Health Authority and the evidence-based needs of the region.

   ii. The PHA will give final approval to the strategic plan for the region.

b. Jointly with the provincial CEO, appoint the Regional Administrator.

49.2. Facilitate the effective and coordinated 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.

a. Set expectations, mutually agreed upon goals, and standards of performance for the Regional Administrator.

b. Identify the number and locations of Community Teams for their region (see Action 59).

c. Oversee the establishment of the principles and standards for the delivery of programs at the regional level aligned with provincial direction.

d. Ensure that the Regional Administrator:

   i. integrates change management principles for staff as they move through program and service transitions;

   ii. identifies needs-based regional priorities for health care programs;

iii. puts in place reporting structures necessary to ensure coordination among all care providers in the region;

iv. identifies the strategy and shared service considerations (e.g., human resources, procurement) necessary to effectively deliver programs at the regional level;

v. establishes performance measures pertinent to the region to monitor program performance.

49.3. Include formal and informal structures for working with Indigenous partners.

a. Identify formal collaboration processes with Indigenous partners at all levels of decision-making (e.g., RHC, Regional Administrator, and local program areas).

b. Set the expectation for Indigenous considerations in all decision-making processes.

c. Ensure that the Regional Administrator sets expectations for an inclusive culture in regional health programs including cultural humility, awareness, and safety (see related information in the objective below and in Action 5).

d. Ensure that the Regional Administrator begins implementation of objectives identified in the Provincial Indigenous Health Framework as appropriate for their region.

49.4. Focus on inclusion and public engagement to ensure continued high quality of care to all residents of the province, regardless of race, income, age, gender, ethnic identity, place of residence, ability, etc. — directed by the RHC and operationalized by the Regional Administrator.

a. Formally adopt an inclusion lens in decision-making processes.

b. Adopt health equity as a principle in the delivery of service, with defined performance measures.

c. Provide contact-based training on inclusion and health equity for the Council and for staff members, physicians, and volunteers.

d. Ensure that the Regional Administrator identifies formalized and inclusive engagement structures with patients/clients/residents in the region to gather input on a regular basis.

e. Publicly report on inclusion and health equity activities and performance with reports written in language that is precise and as readily understandable as possible.

f. Participate in the implementation of the Province's Pathway to Inclusion (see Action 5).

49.5. Include formal and informal structures for partnering with patients/clients/residents and with members of the public.

a. Under the direction of the Regional Administrator, identify formalized collaboration/partnership processes with patients/clients/residents and members of the public in the region, including:

   i. clearly stated roles and responsibilities;

   ii. measures to ensure that there are incentives for people to participate and no barriers to their participation (e.g., internet access, daycare, transportation, stipends, costs);

   iii. identified ways for the information collected to be included in the decision-making functions of the organization.

b. Build on and strengthen the work of the existing Community Advisory Committees in each region.

c. Build on and strengthen the work of the existing Wellness Coalitions in each region.

d. Ensure that the health-specific experience of the existing Community Advisory Committees and Wellness Coalitions helps inform the more broad-based RSHNs (see Action 50).

49.6. Partner with community organizations to reach under-served populations and other groups that have proven challenging to reach through traditional health care pathways.

a. Acknowledge and support various approaches for knowledge sharing and information gathering (e.g., focus groups, surveys, one-on-one meetings).

b. Provide safe and respectful environments for under-served populations to come forward with information or concerns, recognizing that the information may come via different pathways for different groups.

c. Provide supports to ensure that members of under-served populations are able to participate in engagement opportunities.

49.7. Be accountable for health outcomes through monitoring and reporting on quality, safety, and performance — directed by the RHC and operationalized by the Regional Administrator.

a. Identify and monitor regionally pertinent and responsive, measures of quality, safety, and performance.

b. Identify and address data gaps in the region.

c. Include performance monitoring as a regular agenda item of the RHC.

d. Develop and report publicly on a regional health report card based on health outcomes in collaboration with the NL Council on Health Quality and Performance.

   i. The report card should clearly demonstrate integration of the social determinants of health.

   ii. The report card should clearly identify the outcomes that they will meet with the help of partners in other sectors.

   iii. Reports should be written using language that is precise and as readily understandable as possible.

e. Ensure that the performance contract of the Regional Administrator specifically requires the achievement of outcomes identified by the RHC.

f. Participate actively in the LHSS.

49.8. **Reduce the silos among the publicly funded and privately funded health care providers while maintaining the autonomy of organizations involved.**

a. Include in the expectations of the Regional Administrator responsibility for representation of the health system in the RSHNs (see Action 50).

b. Develop service agreements with privately funded care providers in the region who are integral to the achievement of improved health outcomes for the region.

49.9. **Be directly linked with the PHA.**

a. Report on a regular basis to the PHA including information collected through engagement and partnership activities at the regional level.

b. Support the Regional Administrator in the role as a member of the executive team of the PHA.

c. Communicate regularly with the regional representative(s) on the board of the PHA.

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 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).

The formalized RSHN is a new structure, building upon promising practices that have occurred informally in some areas around the province. They will be a critical force in addressing the many silos that are negatively affecting the province's ability to best serve our residents. The RSHNs should formally bring together partners across the many sectors whose mandates affect the overall health of people in their region (e.g., health, justice, education, housing, Indigenous communities, municipalities, community sector). This should provide a regular opportunity for the members of the RSHN to identify gaps in service, to develop priorities for action, and to consider areas where their mandates overlap or could be better aligned to better serve individuals (e.g., health, justice, education, community organizations and housing working together to address a youth homelessness issue). As priorities change, so, too, should the partners that make up the RSHN.

These RSHNs are essential in ensuring that we can make the culture shift from believing and acting as if the health system has the greatest influence on health, health outcomes, and health equity to understanding that social determinants of health have the greatest influence, and acting based on that new understanding.

50.1. Establish a RSHN in each designated health region.

a. The Senior Executive (Health Accord) position within government (see Action 56.1) works with the Premier's Advisory Council on Health to facilitate the identification of a recommended structure and terms of reference for the RSHNs.

b. The Senior Executive (Health Accord) position, in consultation with key departments and the Advisory Council on Health, facilitates the implementation of the RSHNs in each region, including:

    i. the process for the identification of members for the RSHN, including patient/client/resident representatives, persons with lived experience, and representatives from community groups;

    ii. the expected process for holding engagement meetings with existing networking groups (e.g., Community Advisory Committees of the RHAs, municipalities) to help identify priorities for the region;

    iii. completion of the human resource and budget work required to designate convenor and field catalyst positions for each

region as supports to the RSHNs (note that there may be more than one RSHN per region);

iv. responsibilities for Cabinet or Ministers to jointly set overall direction for the RSHNs;

v. processes by which the challenges and opportunities identified by the RSHNs are communicated and, where appropriate, addressed at the regional, provincial, or government level;

vi. legislative and/or regulatory requirements necessary to convene the group, define roles and responsibilities, cover liability or indemnification arrangements, and identify operational practices for the RSHNs;

vii. promotion of the RSHNs as an important tool in supporting better health outcomes and strengthening health equity for people of the province.

c. The Premier formally welcomes the identified members to participate in the RSHNs.

50.2. Identify the partners in each RSHN, encouraging the participation of partners who are unique to an individual region as well as those who are common among regions.

a. Members of the RSHNs common across the regions should include the senior leaders in the region in the health system, the education system, the justice system, municipalities, NL Housing Corporation, and social services programs.

b. The initial group will identify at the outset additional individuals/groups which are unique to the region and should be included in the RSHN. This should include the appropriate numbers from community organizations.

c. The field catalyst will facilitate the representation from community organizations in the region.

d. RSHNs should have a process in place to select additional members based on changing regional priorities.

e. Participation arrangements should be meaningful with all partners viewed as equal at the RSHN table. People's participation will be supported (including financial compensation for costs incurred to participate) to ensure inclusive engagement.

f. Methods of participation may vary for individuals or smaller organizations specific to the region who may not wish to be regular members of the RSHN.

g. The convenor should have the responsibility for bringing the members of the RSHN together, for facilitating the meeting times, for maintaining minutes of the meeting, and for ensuring that decisions made at the meetings are implemented.

50.3. Encourage and facilitate the culture shift to acknowledge the link between social determinants of health and health outcomes and health equity.

a. Ensure that the culture shift is clearly defined in the terms of reference and roles and responsibilities of the RSHNs.

b. Ensure that orientation materials, agendas, and priority setting processes of the RSHNs are based on a SDH perspective.

50.4. Provide a forum for dialogue and collaboration among the various partners in the communities in the regions.

a. Ensure that the terms of reference for the RSHNs include expectations related to dialogue, collaboration, and reporting back to participants for accountability.

b. Ensure that the legislation and/or regulations that set up the RSHNs clearly identify dialogue and collaboration as a main objective.

c. Annually set priorities for collaboration projects based on identified needs within the region.

d. Implement a person-centered versus a system-centered view to service delivery.

e. Place emphasis on collaboration activities that will result in a material impact to the client or population with a goal of prevention versus activities that only provide temporary fixes.

f. Ensure a comprehensive view when identifying care providers, volunteers, or services at the community level that may be available to assist in achieving better health outcomes.

g. Focus agendas on regional priorities where collaboration among the partners will better serve clients and improve outcomes beyond that which any partner can achieve independently.

h. Include a process to bring in other health or social representatives for input when additional information or expertise is required.

i. Put in place appropriate confidentiality and information protection processes to facilitate open and safe dialogue among the partners.

j. Ensure that there are opportunities for RSHNs to regularly communicate with each other to share best practices and identify opportunities.

k. Ensure there are opportunities for RSHNs to engage with the RHA's Community Advisory Councils and Wellness Coalitions in the region.

l. Put in place a process for members of the RSHNs to communicate back to their respective organizations and relevant Ministers about barriers or gaps in service that prevent collaboration towards improved outcomes.

50.5. Ensure accountability for connections among and across these partners.

a. Ensure that the legislation and/or regulations that set up the RSHNs include the requirement for groups at the regional level to work together, within their combined mandates, to improve the health outcomes of people of the region with transparency in the prioritization and other processes of the RSHNs.

b. Include language in the legislation and/or regulations for the RSHNs to consider all resources available to support the achievement of better outcomes, including clear consideration of the wider resources

available in the community and non-profit sectors which have the capacity to draw resources from beyond the public sector.

c. Ensure that the legislation and/or regulations to set up the RSHNs include clear accountability requirements for carrying out their mandate.

50.6. Provide resources to support these new RSHNs.

a. Identify and put in place two positions per RSHN:

   i. a convenor to bring together and support the work of the RSHN;

   ii. a field catalyst who connects the community sector groups, engages them in conversations, and works with them to determine the best approach for their participation in the RSHN.

b. Post positions for extended periods (e.g., three to five years) to support effective recruitment and retention of qualified candidates.

c. The terms of reference developed for the RSHNs should include the role of the convenor and field catalyst positions, supports for participation, and operational budget processes for each region.

d. The Senior Executive (Health Accord) position in government develops a process that RSHNs can use to propose a project requiring approval or funding which is not available through the individual member organizations.

e. The Senior Executive (Health Accord) position identifies the review and approval process to be used when an RSHN submits an application.

50.7. Ensure that the leaders of the various groups in the regions are the members of the RSHNs.

a. The legislation and/or regulations that set up the RSHNs include a definition of the members who will be expected to participate, specifying those in leadership roles who have authority to make

decisions at the regional level.

b. For community organizations, a leader for one organization may be asked to represent other groups with similar mandates in the region.

50.8. Initiate the creation of the RSHNs within year one of the implementation of the Health Accord.

a. Given the lack of precedents for these RSHNs, the Senior Executive (Health Accord) will be the initial catalyst within government for the immediate implementation of the RSHNs and will provide oversight of their progress over the first two years.

b. Responsibility for convening the RSHNs lies with the respective convenors.

c. The legislation and/or regulations to formalize the RSHNs will be developed in year three, based on the progress over the first two years.

d. This legislation will identify the government entity to which the RSHNs are accountable and the provincial structure for the formal connections among RSHNs.

Provincial Data Governance Model

Action 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.

51.1. **Oversee the development of an integrated data governance model to improve the health and social systems of the province including the requirements necessary to:**

a. define what is meant by health information and SDH information;

b. protect personal health information and SDH information;

c. define limitations of the right of access of health care providers to personal health information without consent;

d. define parameters of the use of personal health information and SDH information for management purposes to improve services or quality of care;

e. protect the integrity of the data;

f. prevent inappropriate exploitation of data by third party providers;

g. carefully manage secondary use protocols, attending to privacy and ethics concerns.

51.2. **Ensure that the person whose health information is being used has the right to:**

a. request correction of the data;

b. have access to the list of providers who accessed the data;

c. refuse consent for research use.

51.3. **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.**

a. Align public policy and legislation to address data custodianship — who owns health and SDH data and how and when the data can be used.

b. Determine which data sources on SDH currently exist, how they are collected and governed with a view to determining how these

can be linked and used to support health care decision-making and policy-making.

c. Identify any gaps in data on health or SDH that need to be filled and develop a strategy to do so.

d. Determine who is responsible for the integration of health and SDH data, assigning responsibility for governing and strategy in this area.

e. Recognizing the lack of SDH indicators within the existing health and social systems, ensure the collection, quality, co-ordination, transparency, and analysis of SDH indicators.

f. Establish any required data governance and data sharing agreements required for the flow of SDH information.

g. Prioritize principles of sharing information to improve health and SDH.

51.4. **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.**

51.5. **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.**

51.6. **Promote the goals and accomplishments of data governance and nurture a data-driven culture.**

a. Begin to align data standards and quality throughout the province.

b. Maintain consistency as data systems become more integrated.

c. Demonstrate transparency through displaying quality of care data (such as wait times in emergency departments) on display screens and online.

51.7. **Ensure that data governance includes the use of data for research to better inform strategy and priorities.**

51.8. **Establish the infrastructure and technology with a "privacy by design" lens.**

a. Align solutions related to the provincial strategy with a focus on connection and integration.

b. Set up and maintain the processes and policies.

51.9. **Understand data governance as an ongoing and iterative process, responsive to changing circumstances and enabling leaders to re-balance priorities.**

a. Review the lessons learned from the COVID-19 pandemic and from the cyberattack in late 2021.

b. Maintain a close link with the development of the federal government's Pan-Canadian Health Data Strategy with its focus on strengthening health data foundations through:

   i. modernizing health data collection, sharing and interoperability;

   ii. streamlining and updating the approach to privacy and access for the digital age;

   iii. clarifying accountability, sovereignty, and health data governance to bring meaningful change in the way governments share health data.

51.10. **Ensure that each organization has a data governance framework consistent with the provincial policy.**

a. Identify the person or position that has responsibility in the organization for the oversight of the data governance framework.

b. Identify the persons or positions that have both the authority and the responsibility for handling and safeguarding specific types of data.

c. Outline the sanctions for misuse of personal health and SDH information.

51.11. Support the government's efforts to develop a digital identity program for the people of the province (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).

a. Ensure that the digital identity program is person-centered, convenient, secure, privacy-preserving, verifiable, in the person's control, and voluntary.

b. Recognize that trust is the foundation of a digital ID strategy and establish that trust by building a common set of principles, rules, and standards for all participants within the digital ID ecosystem and establishing trust anchors by incorporating traditionally trusted organizations such as banks or utility providers.

c. Maintain a close connection with the The Digital Identification and Authentication Council of Canada (DIACC), a non-profit coalition of public and private sector leaders committed to developing a Canadian framework for digital identification and authentication, and its Pan Canadian Trust Framework (a publicly available set of tools, requirements, and criteria used to verify information assurance of digital solutions, services, and networks).

51.12. Promote data governance as a resource for improving health outcomes and health equity.

Change Management

Action 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).

52.1. **Build a change management approach based on five key elements:**

a. Focus on health, not simply health care, with attention to social, economic, and environmental factors that have the biggest effect on health.

b. Rebalance the health system.

c. Find the leadership and the energy to undertake substantial change.

d. Listen to the voices of the people for whom the health and social systems exist, and continue to integrate the learnings from their lived experience with evidence and innovations.

e. Provide an environment that is fertile for health and social system change while at the same time ensuring that employees and physicians have protection and security.

52.2. **Adapt the principles of change management as outlined in Action 41.2.b. to create the change management strategy.**

52.3. **Establish the change management strategy.**

a. Provide leadership in initiating the strategy through a team comprised of the Deputy Minister of Health and Community Services, the Deputy Minister of Children, Seniors and Social Development, the interim CEO of the Provincial Health Authority, and the Senior Executive (Health Accord), all of whom are expected to have strong and demonstrated change management skills.

b. Establish a change management guiding team with a full-time director and a representative team of no more than ten 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, Memorial University, College of the North Atlantic, major unions, and professional associations linked with the health and social systems.

   i. Define the roles of the guiding team in providing support for leaders, developing processes that are flexible in diverse sectors, ensuring attention to the components noted above, and identifying obstacles that are preventing progress.

   ii. Ensure that the members of the guiding teams are educated in current change management philosophy and practice and utilize data and knowledge translation methods to enable clear communication of change pathways, goals, objectives, and timelines.

   iii. Provide additional support for the team through policy leads from other key government departments (e.g., Education, Justice, Environment and Climate Change, Municipalities, Finance).

   iv. Create ongoing formal and innovative relationships between the guiding team and each of the above groups.

   v. Have the guiding team 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.

vi. Establish a unit within the Provincial Health Authority dedicated to change management and linked with the guiding team to take the lead on transformational change within the Regional Health Councils.

Actions 53, 54 and 55 illustrate the complexity, scope, and diversity of the need for change management in realizing the vision and the objectives of Health Accord NL. They highlight the Health Accord's focus on public engagement, integration and ending silos, a Learning Health and Social System, and wiser use of digital technology. The three examples are not meant to be comprehensive but are intended only to show the essential need for change management in every aspect of the transformation needed to improve health and health outcomes in Newfoundland and Labrador.

Change Management and Connections Between Social Determinants of Health and the Health System

Action 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.

53.1. **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.**

53.2. **Ensure a common understanding across the leadership structures of government departments, the health system, social systems, and the Regional Health Councils about the scope of factors which influence health, health outcomes, and health equity.**

a. Develop expectations of leaders in taking responsibility and ensuring accountability for integration across all their organizations for their roles in health.

b. Provide resources to support these roles and responsibilities.

53.3. **Develop a change management plan for the implementation of the actions to engage, stabilize, and retain the current and future health and social system workforce, particularly in relation to the changing roles of health facilities, integration with the broader social and extended health system, and stronger team development.**

53.4. **Use change management in the development and application of clear guiding principles in all provider education development and delivery initiatives.**

53.5. **Implement change management strategies that will bring tertiary care services closer to the patient by using virtual care options, having specialists visit community and regional hospitals, and supporting travel cost for patients.**

53.6. **Develop ongoing evaluation processes to ensure that integration is happening and to adapt when new learning leads to new directions.**

Change Management and Community Teams

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, and frail elderly persons (the wording of this Action has been revised since the release of The Report).

54.1. Develop and invest in a change management plan at both provincial and regional levels, in the short-term and the long-term, to assure the development and maintenance of effective and responsive interprofessional teams.

54.2. Develop and execute a public engagement plan to initiate and maintain Community Teams and their integration with communities and other services that influence health.

54.3. Develop and execute a plan to integrate the Community Teams with health centres, long-term care facilities, and hospitals.

54.4. Develop and maintain a process to assure that current unmet needs are met (e.g., children in need, persons with disabilities, persons with mental illness and addictions, and frail elderly persons).

54.5. Integrate within pathways for education for Community Team members (in their practice environments) elements of team-based care, digital technology, quality improvement, and change management.

54.6. Engage with the Family Practice Renewal Program and the Family Practice Network structure to help facilitate the change management process required for moving toward team-based care.

54.7. Develop and use metrics in relation to inclusion, quality of care, and integration that facilitate improvement.

54.8. See Action 13.3 for more detail.

Change Management and Digital Technology

Action 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.

55.1. **Plan change management and solution implementation for the modernization of the health information and virtual care system.**

a. Invest adequately in change management and training at each phase of implementation to ensure effective virtual care and integrated provision of information to providers and institutions.

b. Develop and execute change management plans that integrate a wide range of providers, systems, and institutions.

55.2. **Use a change management plan for technology adoption, education strategy, staff training, and communication and execution of plans.**

55.3. **Develop and implement a plan to enhance digital literacy among the public, meeting the needs of those who do not have these skills.**

55.4. **See Action 36 for more detail.**

Transitional Governance Structure

Action 56: Establish a transitional governance structure to begin preparations for the implementation of Health Accord NL.

56.1. Appoint a Senior Executive (Health Accord) in Cabinet Secretariat. This position would be in place for two to three years with a mandate to oversee the beginning of the implementation of the Health Accord's Calls to Action with the authority to lay out the framework to support the full transition imagined in the Health Accord.

a. The Senior Executive (Health Accord) would be supported by a Council of Deputy Ministers from the many departments directly connected to this Accord implementation process.

b. The Senior Executive (Health Accord) would provide advice on the shift in focus to social determinants of health and initiate the development of the Regional Social and Health Networks.

c. The Senior Executive (Health Accord) would provide policy advice on key initial implementation steps (e.g., integrated air and road ambulance system, new health information systems, development of Community Teams, the NL Council for Health Quality and Performance, and sustainability of health services), and would participate in engagement with the federal government. Other duties of the Senior Executive (Health Accord) position include the following:

    i. convene groups necessary to begin implementation of the Accord;

    ii. translate the recommendations into a work plan with defined timelines and responsibilities;

    iii. initiate the work required to facilitate government actions related to budgeting, human resources, legislation, regulation, appointments, etc.;

    iv. support implementation of actions across departments in collaboration with the relevant Deputy Ministers;

    v. work closely with the transitional CEO of the PHA to support the transition in the health care system;

    vi. meet regularly with the Premier's Advisory Council on Health (see 56.2) to ensure alignment between the tenets of the Accord and the implementation steps underway;

vii. work with the NL Council on Health Quality and Performance and Quality of Care NL to develop evaluation and progress reports on the implementation process;

viii. update the relevant Ministers, the Premier, and Cabinet on progress;

ix. update the members of caucus of the three political parties on progress;

x. help design a permanent structure within government for ongoing oversight of the Health Accord.

56.2. Establish an Advisory Council on Health which reports to the Premier and is supported by the Senior Executive (Health Accord).

a. Appoint members from the Health Accord's Task Force, strategy committees, or working groups to ensure continuity with the strategic visioning process undertaken by the Health Accord.

   i. Include representation from all regions of the province as well as Indigenous communities.

   ii. Include persons with skill sets related to locally-based community engagement and collaboration.

b. Hold special responsibility for ensuring the creation of RSHNs, given this unique approach to collaboration related to the social determinants of health.

c. Meet quarterly to monitor progress and identify successes and challenges on implementation to bring to the attention of the Premier.

d. Advise the Premier on matters of intent or alignment related to the Accord visioning process.

56.3. **Appoint a transitional PHA and a transitional CEO.**

a. This transitional structure would be in place for one year with a mandate to set the groundwork for the implementation of the rebalanced health system.

b. 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.

c. 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.

d. The transitional Board and CEO would work closely with the existing RHAs and their CEOs who would continue their existing responsibilities during the transitional year. The RHAs would begin preparatory steps for the establishment of Community Teams and improvement of sustainability in health services.

e. 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 and the new approach to health information systems. The Board and CEO would be expected to use modern change management approaches to address the complexity inherent in rebalancing the health system.

f. There should be a comprehensive pre-selection and post-appointment orientation on the intent and philosophy of the Health Accord for the members of the transitional board.

g. The transitional Board and CEO would also begin preparatory steps for the establishment of Community Teams (including overall geographic catchment areas for the Teams, determination of first Teams to be set up, affiliation agreements with community family practices, and employment arrangements for team members).

56.4. **Put in place a transitional Council in anticipation of the legislated NL Council for Health Quality and Performance.**

a. This transitional Council would connect with Quality of Care NL and would have the following responsibilities:

   i. report on baseline indicators to the public, providers, institutions, and governance structures;

   ii. initiate the evaluation plan;

   iii. support and advocate for the culture shift necessary to implement a LHSS.

56.5. **Determine how best to incorporate the SDH with the health care structure by working closely with community organizations at the provincial and regional levels.**

56.6. **Develop processes to resolve health system issues related to the number of regions, the number of employers, and the appointment of the CEO and Regional Administrators.**

a. Include engagement with the people who will be most affected by these decisions.

56.7. **Create the RSHNs in the first year of the implementation of the Health Accord with the understanding that there will be a two-year to three-year period to allow them to evolve and find the best structure to enable them to carry out their mandate.**

a. Ensure continuous learning and developmental evaluation of the RSHNs to prepare for their enshrinement in legislation in year three.

10. Finance and Intergovernmental Affairs Implementation Recommendations

Finance and Intergovernmental Affairs Working Group
Working Group Members
Patrick Parfrey (Chair)
Cathy Duke
Lynn Gambin
Patricia A. Hearn
Ken Hicks
John Kattenbusch
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Josh Quinton
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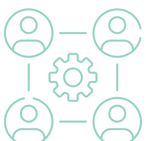
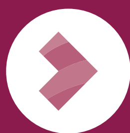


The conclusions of this working group are contained in Section A, Summary 1, Health Accord NL: Overall Implementation and Summary 2, Health Accord NL: Financial Implications and Interdependence with the Federal Government. The working group was responsible for the investments and savings estimates included in all 29 Summaries.

Financial Implications



Action 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 strengthening of health equity needed for a thriving and prosperous province.

The five-year plan is summarized in the Health Accord NL: Timelines for Implementation of Major Actions (Figure 4 in Section A, pages 30–40).

57.1. **Place the Health Accord Report and implementation recommendations at the center of decision-making so that spending decisions necessitated by the fiscal state of the province are consistent with the Health Accord.**

57.2. **Use the funding estimates over time and the potential for new sources of funding for Community Teams, an integrated air and road ambulance system, and a modern health information and virtual care system to determine the speed at which change can occur. The funding estimates are provided in Section A, Summary 2, Health Accord NL: Financial Implications and Interdependence with the Federal Government.**

a. Provide up-front new funding in the health system to achieve downstream efficiencies.

b. Determine the role of public vs. private funding for the road and air ambulance systems.

c. Determine policies for the timelines to provide an integrated health information and virtual care system.

57.3. **Identify efficiencies that can be achieved in the short-term and medium-term in the health system, to support changes that can occur within the fiscal envelop of the province.**

a. Plan reallocation of funding to needed services based on the feasibility of introducing collaborative urgent care models; alignment of beds with occupancy rate and reduction in length of stay and alternate level of care rates; provision of sustainable specialty services; and reduction in the use of low value interventions.

57.4. **Use the new health system governance structure, the NL Council for Health Quality and Performance, and a Learning Health and Social System to support an effective approach to improved use of health resources, which includes reduction in overutilization of unnecessary interventions and increased utilization of necessary interventions.**

57.5. **Use the new structure and initiatives on recruitment and retention to decrease vacancies and the use of locums, increase workplace satisfaction, and decrease workplace injuries and the need for sick leave.**

a. Develop sustainable specialty services and Community Teams with the objective of reducing the use of locums and reducing the use of health providers from the private agencies.

b. Provide a healthier workplace that enhances workplace satisfaction and organizational commitment.

Engagement with Federal Government

Action 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.

See Section A, Summary 2, Health Accord NL: Financial Implications and Interdependence with the Federal Government

58.1. Use the research and strategic initiatives provided by Health Accord NL, together with intergovernmental experience and knowledge of funding provided by various departments of the provincial government, to apply to the federal government for consolidated targeted funding over several years for the priorities identified by Health Accord NL.

a. Extend content of the strategic plan to areas in which there is overlap between the priorities expressed by the Prime Minister in his mandate letters to his ministers in December 2021 and in the Supply-and-Confidence Agreement made between the Liberal Party of Canada and the National Democratic Party in March 2022.

b. Advocate for an increase in the Canada Health Transfer to the provinces.

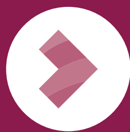
c. Advocate for consideration of the percent of the population who are seniors and the percent who live in rural communities as additional criteria for the Canada Health Transfer.

d. Support up-front funding for later efficiencies for some policies (e.g., air and road ambulance system, health information and virtual care system), but insist on long-term continuing funding for other

policies (e.g., Canada Mental Health Transfer, Community Teams, long-term care).

e. Develop a strategic plan specifically for federal funding related to the Social Determinants of Health.

Actions That Can Start in the Short Term



Action 59: Begin action immediately on initiatives needed to rebalance the community, long-term care, and hospital system.

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

a. Build on knowledge obtained from the initiation of collaborative teams funded in 2021 and 2022.

b. Empower RHAs to plan Community Teams in collaboration with health providers and communities in the relevant region, using the human resources currently available and additional new providers to create a fully functional Team.

c. Fund Community Teams who meet the needs of the area and who best offer an integrated, functional, interprofessional team.

59.2. **Initiate programs to improve the health of children at risk. Ensure that the first set of Community Teams to be implemented includes attention to better interprofessional care for children in care and children with complex health needs.**

a. Build on the lessons learned from the Eastern Health CAYAC (Children and Youth in Alternate Care) clinic.

b. Create linkages between CAYAC clinics and Community Teams.

59.3. **Engage with communities on how integration of Community Teams, health centres, community hospitals, regional hospitals, and tertiary care outreach would occur in their regions.**

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

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

a. Transfer Women's Health in-patient care from the Health Sciences Centre to the Janeway Hospital.

b. Repurpose beds/budget in hospitals with occupancy rates less than 85% to needed services in the region.

c. Create an agreed-upon continuing approach (involving senior administrators and physicians) to reducing prolonged length of stay in medicine beds and high alternate level of stay rates in health centres and hospitals.

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

a. Integrate geriatricians/family physicians trained in care of elderly persons into the process of reduction of ALC rates.

b. Implement interventions to provide the services lacking for patients who are receiving ALC.

59.7. **Initiate a formal Frail Elderly Program with interprofessional geriatric teams in regional hospitals with outreach to community hospitals and Community Teams.**

a. See the Aging Population Implementation Recommendations (Action 9).

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

a. Government decide policies with advice from HCS in collaboration with the Interim CEO and Board of PHA and Senior Executive (Health Accord).

b. Identify the managers of the new system.

c. Create a single provincial central dispatch.

d. Increase training places for Advanced Care Paramedics and Primary Care Paramedics.

e. Start a provincial virtual emergency system.

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

a. Determine which health centres will provide 12-hour or 24-hour urgent/same day care.

b. Determine the mix of family physicians, nurse practitioners, and advanced care paramedics for each health centre that provides collaborative urgent care.

59.10. **Initiate immediate planning and investment in a modern, integrated, provincial health information and virtual care system, and give priority to improvements in virtual care.**

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

a. See the Workforce Readiness Implementation Recommendations (Action 37).

Conclusion

The Blueprint is summarized in Section A (Summaries of Implementation Recommendations) and is given in more detail in Section B (Implementation Recommendations from Strategy Committees and Working Groups). It is urgent to begin the implementation of The Blueprint immediately. The transitional structure outlined in Section B (Action 56) ensures that the initiation of the implementation recommendations can happen within the next few months. A summary of the Timelines for Implementation of Major Actions outlined in Section A is presented in a poster format for easy reference.

The compelling case for change shows that the health of the people of Newfoundland and Labrador is not good enough, whether we compare our health with that of the people of other Canadian provinces or we compare health among groups within our province. We can choose to change this unacceptable reality; we must choose to do so. The vision of Health Accord NL remains central: improved health and health outcomes of Newfoundlanders and Labradorians through acceptance of and interventions in social determinants of health and a higher quality health system that balances community, hospital, and long-term care services. The danger is that we will default to implementing the second part of this vision related to the health system while continuing to ignore the first half related to the social determinants of health. To do so will not achieve the improvements needed in our health. The Health Accord and its Calls to Action must be taken as one integrated, holistic approach.

From the beginning of the implementation, engagement with people and communities will be critical if we are to bring about the culture change needed to improve health, health outcomes, and health equity. One important element of this ongoing engagement will be a developmental evaluation process to ensure that the process is iterative and engages with all those who have a vested interest in improved health outcomes for the people of the province. This evaluation process will ensure sensitivity to changing realities within the province and to new evidence which would require adjustments or amendments to the recommendations contained in Section B. It will also assess the beneficial outcomes achieved during implementation, will determine the potential impact of any major social changes on specific Calls to Action, will assess unintended negative consequences, and will maintain accountability to the people of the province.

The final component of the work of the Health Accord is the Evidence Archive which has informed the vision, objectives, Calls to Action, and implementation recommendations. Included in the Evidence Archive are 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. That Evidence Archive is now publicly available online and is easily accessible. It is hoped that the Evidence Archive will grow over time as the Health Accord recommendations are implemented.

To support continued public engagement with the implementation of the Health Accord, thirteen short videos have been created and are available on healthaccordnl.ca and on YouTube.

The title of each of the Health Accord's documents in its final report is *Our province. Our health. Our future. A 10-Year Health Transformation.* The compelling case has been outlined. The evidence has been gathered and analyzed. The public engagement has taken place. The vision has been imagined. The Calls to Action have been named. The implementation recommendations have been developed. We must work together with conviction, energy, and persistence to ensure that the transformation happens. Our province, our health, and our future depend on our commitment to do so. We can choose to become a healthier province. Let us make that choice together.

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.

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Acknowledgement
Creative Design and Communications by Perfect Day:
John Devereaux, Heather Bonia, Duncan Major, Vanessa Iddon, Olivia Wong

Health Accord
for Newfoundland & Labrador

Our province. Our health. Our future.

A 10-Year Health Transformation

THE BLUEPRINT
Implementation Recommendations
from Strategy Committees
and Working Groups