

ACHIEVING A HIGH PERFORMING PROVINCIAL HEALTHCARE SYSTEM

MANITOBA HEALTH, SENIORS AND ACTIVE LIVING

2017

ACHIEVING A HIGH PERFORMING PROVINCIAL HEALTHCARE SYSTEM

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Executive Summary

Proposal

Numerous studies of Manitoba's health system have concluded that Manitoba's complex health system governance is an impediment to effective and efficient delivery of health care services across the province. Improved access to quality health care can be achieved while reducing costs through the establishment of a provincial health organization (PHO) that would enable better planning and increased integration of health care services across Manitoba.

The creation of a PHO would allow for centralized and strategic clinical planning and coordination of the services that should be managed province-wide as well as for the development of a provincial health human resources plan. Existing regional health authorities would retain their responsibility for health care delivery and day to day operations and the department of Health, Seniors and Active Living (HSAL) would focus on policy and planning, funding, performance and accountability.

The Case for Change

Thirteen regional health authorities (RHAs) were established in Manitoba in 1996/97 to better manage health care services within geographic areas of the province, and to bring the accountability for health care "closer to home".

By 2012, the number of RHAs had been reduced to five, and along with Diagnostic Services Manitoba (DSM), CancerCare Manitoba (CCMB) and the Addictions Foundation of Manitoba, these became the eight major health service organizations in the province. Each of these organizations does their own clinical planning, standard setting, quality improvement and service delivery in relative isolation of one another.

Government is responsible for overseeing the provincial health care system, yet Manitoba has never developed a provincial clinical services plan, something that is in existence in other jurisdictions and deemed essential to support effective health human resources planning, capital equipment and construction planning, e-health planning, and other functions that are best managed province-wide.

Over time, the RHAs have contributed to better integration and coordination of care within their respective geographic areas, but such a focus is lacking at the provincial level. Patients outside Winnipeg do not receive the full spectrum of health care services from providers located in their local community or RHA. Rather they often travel to larger urban centres for more specialized services. Larger centres in Winnipeg and Brandon rely on health care facilities elsewhere in the province to repatriate patients in a timely manner, thereby ensuring that the Winnipeg and Brandon centers have the capacity to continue to accept new patients.

The various components of Manitoba's health system are interdependent which creates real opportunities for improvements to quality of care and reduce costs. The establishment of a provincial

clinical leadership structure – one that is able to look across the health system to develop and help implement more cost-effective provincial health service delivery models - has been identified in many studies provided to government as a way of realizing such improvements.

In 2013/14, the Provincial Medical Leadership Council (PMLC) launched working groups focused around specific clinical specialty areas. Clinicians from across the province were brought together, often for the first time, in areas such as mental health, palliative care, general surgery, orthopedics and primary care to develop practical recommendations for how to improve the cost-effectiveness of health care in these specialty areas. Their recommendations were well received, but the system struggled to implement them – in part due to the intransigence of the current state.

In 2015/16, Dr. David Peachey was engaged by the province to work with the health system to reflect on the health needs of the population and to develop a provincial clinical and preventive service plan that could address those needs in a clinically sustainable manner. KPMG was similarly retained in 2016 to consider ways of improving the fiscal sustainability of the health system. The authors of these reports (*Provincial Clinical and Preventative Services Planning for Manitoba* – Dr. David Peachey and *Health System Sustainability and Innovation Review* – KPMG) discussed their respective plans and recommendations and consider their reports to be complementary, not duplicative. The authors shared the view of both the challenges and opportunities inherent in the current provincial health system. Dr. Peachey highlighted the essential nature of provincial clinical governance and identified its absence as a significant gap in Manitoba’s current structure. KPMG agreed and identified other components of the system that should be managed or led provincially.

In their work, KPMG identified that “Manitoba’s overall health system and governance model is overly complex for a population of 1.3 million and is sub-optimal in relation to its structural design.” Further, they have identified that many provincial resources are situated in the Winnipeg Regional Health Authority but are not readily available to regional health authorities outside Winnipeg or to Manitoba Health Seniors and Active Living (MHSAL) for provincial needs. In addition, they identify that the department retains several direct service areas (such as Selkirk Mental Health Centre) that should instead be provided by a health organization outside the department whose mandate includes service delivery.

WRHA has been assigned a number of “provincial programs” primarily due to the absence of an entity responsible for province-wide coordination of services. However it is important to note that the WRHA is only responsible, by legislation, for delivering health services in Winnipeg and Churchill. Manitoba’s strong clinical leadership in all major specialties exists within the WRHA; however this expertise is not leveraged to assist other regions (which do not have critical mass of specialists) in planning clinical services, standard setting or recruitment and retention efforts. The WRHA also has expertise in many other areas such as legal, decision support, logistics, etc. that is not leveraged for the benefit of other RHAs in Manitoba.

All major clinical services in Manitoba, whether centrally managed or managed by the RHAs, need to be planned and coordinated provincially. However, Manitoba cannot afford to establish separate corporate entities - like that of Diagnostic Services Manitoba (DSM), which currently exists for provincial lab services and for imaging services outside of Winnipeg and Brandon - for every one of its clinical services.

Manitoba could amend legislation and assign provincial responsibilities to the WRHA however the organization's largely urban focus would likely result in other segments of the health system voicing significant concern about the WRHA "taking over" health care in the province. There could also be a perceived conflict of interest if WRHA were to assume provincial responsibility for clinical planning, standard setting and support for recruitment and retention across the province, as concerns would inevitably surface about the potential for the WRHA to favor its own direct operations in Winnipeg and Churchill.

A preferred option is to use the corporate shell of DSM to establish a PHO that will include provincial clinical leadership and governance and that will be responsible for provincial clinical and preventive services planning, development of cost-effective provincial models of care by specialty, establishing provincial standards of care, supporting recruitment and retention of health professionals throughout the province, advising government on what services to procure from RHAs, and providing governance to a provincial medical staff. Under this model, the RHAs will retain responsibility for health care service deliverables, managing to budget, managing quality, staff engagement and other delivery functions they currently perform. CancerCare Manitoba (CCMB) will continue as a service provider, or could limit its role to provincial planning and standard setting in oncology.

The WRHA will then be resourced in a manner consistent with other RHAs across the province. The PHO will leverage existing resources and expertise in other non-clinical areas for the benefit of all RHAs.

Each RHA in Manitoba has its own medical staff, but the medical staff bylaws that govern the relationship between medical staff and RHAs, are now consistent across the province. The PMLC has established a provincial credentialing process and is moving towards a provincial standards process in association with the College of Physicians and Surgeons of Manitoba (CPSM). Much of the necessary ground work has been laid to establish a truly provincial medical staff and it is envisioned that over time, all physicians, nurse practitioners and midwives in the province, even those not working in RHA facilities, could be included in a provincial medical staff. This could better support physicians, and other independent health providers, allowing them to practice in a manner that best meets the health needs of their patients and all Manitobans.

Under this structure, the PMLC would appoint provincial clinical leads for each of the major specialties, including primary care. These specialty leaders would be responsible for developing safe, patient-centred, cost-effective models of care for their respective specialty areas (using the full scope of practice of health providers), and would be responsible for setting provincial standards and supporting RHAs in the recruitment and retention of medical staff. These specialty leaders would work together, with PMLC, to further develop and sustain a provincial clinical and preventive services plan, using the "Peachy Report" as a starting point. The resulting plan would inform decisions regarding what services should be provided by RHAs and other health provider organizations, and would guide planning in support areas that require a clinical framework to properly plan their services.

The PHO, as envisioned in the preferred option, will also include provincial health human resources functions that are largely in place now, but are administratively housed within the WRHA without a clear mandate in the areas of physician recruitment, health labour relations and workplace safety and health.

The PHO will also include support functions that are better managed provincially such as procurement (contracting, purchasing, and warehousing), decision support, lean management, finance, communications, dietary, laundry, provincial call centre and facilities management.

Vision

The resources of the WRHA and DSM, and certain functions within the Manitoba Health, Seniors and Active Living will be reviewed and reallocated between the PHO and a pared- down WRHA, focused on local Winnipeg service delivery. Certain components of the existing WRHA will be shifted to the PHO so the expertise in the WRHA can be leveraged to better support the entire province. The role of DSM in providing lab and imaging services will be part of the PHO, thus ensuring no net increase in corporate structure and in fact, a decrease in corporate structures over time.

KPMG's preferred option for provincial structure includes:

Regional Health Authorities (RHAs):

- Regional Health Authorities (RHAs) focus on being excellent service deliverers based on an aligned provincial clinical and preventative services plan.
- RHAs divest themselves of some functions that are most effectively and efficiently served in a provincial organization.

Provincial Health Organization (PHO):

- A provincial health organization is needed because certain resources need to be consolidated for optimal provincial use to provide provincial clinical governance and programs and to support provincial planning and commissioning.
- A provincial health organization is created within the existing corporate structure that already exists in Manitoba and through redistributing existing resources that already exist within the provincial health system. (See Section on "Mobilizing a Provincial System" for further detail). The aligned provincial resources will cost less than the existing diffuse structures.

Manitoba Health, Seniors and Active Living (MHSAL):

- The department focuses on Policy and Planning, Funding and Oversight of the provincial health system.
- The department divests itself from delivery of services.
- The department establishes a Transformation Management Office (TMO)

Timelines

The decision to implement provincial clinical governance and create a PHO may be announced in June 2017, with the establishment of a PHO effective April 1, 2018.

A Provincial Health System Lead will be appointed by the Minister of Health, Seniors and Active Living to oversee planning of the PHO and to implement certain components of the PHO that need to be operational before April 1, 2018. In particular, provincial clinical governance and a provincial human resources service will need to be established early on, to ensure the implementation of clinical RHA manage-to-budget initiatives are well coordinated and executed.

A Transformation Management Office (TMO) will be immediately established by the Minister of Health, Seniors and Active Living and the MHSAL Deputy Minister to support the health system redesign.

The Case for Change

The health care system in Manitoba is not sustainable from a quality or cost perspective without change.

Regionalization was introduced in 1996/97 to better integrate care within geographic areas of the province and bring the accountability for health care “closer to home”. Prior to the formation of regional health authorities (RHAs), hospitals and other care facilities competed with each other and did their own independent planning and quality improvement that was not efficient.

Twenty years later, we can look back and see some improvements in health care in Manitoba related to regionalization, but costs have increased at a faster pace than most other jurisdictions in Canada and our outcomes are not proportionally better. Today, the major opportunity to improve the performance of the health system is to plan health services at a provincial level, rather than within individual RHAs. Cost-effective provincial models of clinical care can be developed, for both primary care and specialty services, and delivered in a coordinated manner across the province. Other provinces have moved in this direction, while Manitoba has lagged behind. While Manitoba has the potential to adopt a provincial approach and be successful, it has not leveraged the “Manitoba advantage” to capitalize on its strengths in this area.

Today we have eight major independent health delivery organizations – the five regional health authorities, Diagnostic Services of Manitoba (DSM), CancerCare Manitoba (CCMB) and the Addictions Foundation of Manitoba (AFM). All eight organizations plan health services in relative isolation of one another, and pursue their own quality improvement initiatives. Yet, most Manitobans would assume that our health system is designed to function as an integrated provincial system, since patients journey across the province when seeking care.

In 2012, the medical leadership in Manitoba formed a Provincial Medical Leadership Council (PMLC), reporting to the Deputy Minister. The PMLC includes equal representation from all major health organizations in Manitoba and the registrar of the College of Physicians and Surgeons. The Council began integrating medical staff functions across the province, and also launched a series of working groups focused around particular specialty areas (mental health, general surgery, orthopedics, palliative care, complex continuing care, primary care and diagnostic imaging). The working groups brought clinicians together from across the province to look at practical ways to improve care and improve efficiency. The

results clearly demonstrated that engaging clinicians to focus on a provincial service delivery models for their respective specialties has tremendous opportunity.

Unfortunately, the health system had great difficulty knowing what to do with the PMLC recommendations and how to further work them up and proceed to implementation. This led PMLC to push for the development of a robust provincial clinical services plan that would also address the governance of the health system. While “form follows function”, it was apparent that the siloed “form” was now an impediment to the “function” of improving the health care in our system.

The provision of clinical and preventive services is the core business of Manitoba’s health system, and yet there has never been a specific provincial plan for providing clinical and preventive services. A seamless and integrated approach to patient care is needed to ensure Manitobans from across the province are not negatively impacted by the arbitrary boundaries of regional health authorities. Such a plan is crucial to support sustainability of services and to enable proper human resources planning, facility planning, equipment planning, information technology planning, etc.

Dr. David Peachey was engaged to work with leadership in the health system to develop a provincial clinical and preventive services plan. The health system was reviewed through three separate lenses: data and analytics (quantitative); broad stakeholder consultations (qualitative); and engagement of clinical leaders through specialty clinical working groups (CWGs). The CWGs were very engaged in examining their respective specialty services from a provincial perspective and expressed interest in continuing to work together to jointly plan and oversee the delivery of health services following the completion of Dr. Peachey’s work.

KPMG was retained in 2016 to consider ways of improving the fiscal sustainability and innovation within the health system. KPMG and Dr. Peachey met to discuss their respective plans and recommendations and considered their reports to be complementary, not duplicative. They shared the same views of both the challenges and opportunities inherent in the current provincial health system. Dr. Peachey highlighted that clinical provincial governance was essential and was a significant gap in Manitoba’s current structure. KPMG agreed and went further to identify other major components of the system that should be included in a provincial health services organization.

In their work, KPMG identify that “Manitoba’s overall health system and governance model is overly complex for a population of 1.3 Million and is sub-optimal in relation to its structural design.” Further, they have identified that many provincial resources are situated in the WRHA but are not readily available to RHAs or the health department for provincial needs. In addition, they identify that Manitoba Health, Seniors and Active Living retains several direct service areas that should instead be provided by the service delivery system, such as an RHA or a PHO.

Vision and Target State: A High-Performing Provincial Healthcare System

We need to function as a provincial system and effectively pull ourselves away from the under-performing system we have right now. As Peachey and KPMG have concluded, siloed approaches to planning will not ensure longer term sustainability for our health system – both fiscal sustainability and service sustainability. We believe the provincialization of our health care system remains the number one foundational opportunity for the overall sustainability and protection of Manitoba’s health services.

We need to remain focused on KPMG’s Strategic System Redesign and on Peachey’s “Provincial Clinical and Preventive Service Plan” to help design and implement what our system needs to look like and who needs to be trained to meet the workforce needs of our system – to ensure we can have service sustainability into the future and fiscal sustainability into the future. We also need to ensure the system design enables an approach to provincial clinical governance – to ensure care to Manitobans is provided safely and optimally throughout the province.

Strategic System Realignment

KPMG identifies the requirement for “fundamental strategic system realignment as an enabler to long term sustainability” and notes one of the government’s top priorities must be a strategic system realignment:

“to improve governance, management and service delivery structures by providing structural and policy considerations to Manitoba in the development of a rationalized provide-wide healthcare system structure. This “new target state” structure will supercede the existing current state which is considered fragmented and/or regionalized. The new structure will underpin performance management and compliance by shifting focus to key performance indicators/metrics and system policy, planning oversight, controls, commissioning and delivery roles. In other words, the realignment will seek to align the roles of the Department, the RHAs and other healthcare delivery organizations with that of a high-performing healthcare system.”

KPMG highlights the need for the “... government to reset expectations and operating parameters for all stakeholders so that they operate in an integrated system with limited resources, which is necessary to achieve any meaningful sustainability and efficiency gains.”

In their report, KPMG proposes a preferred provincial structure that has the following outcomes:

- cost improvements and efficiencies in implemented shared services
- clarification of roles and accountabilities
- improved service management capability for province-wide programs
- operating cost improvements from consolidation of management and administration functions

KPMG’s preferred option for provincial structure:

Regional Health Authorities (RHAs):

- Regional health authorities (RHAs) focus on being excellent service deliverers based on an aligned provincial clinical and preventative services plan.
- RHAs divest themselves of some functions that are most effectively and efficiently served in a provincial health organization.

Provincial Health Organization:

- A provincial health organization is needed because certain resources need to be consolidated for optimal provincial use to provide provincial clinical governance and programs and to support provincial planning and commissioning.
- A provincial health organization is created within the existing corporate structure that already exists in Manitoba and through redistributing existing resources that already exist within the provincial health system. (See section on “Mobilizing a Provincial System” for further detail).

Manitoba Health, Seniors and Active Living:

- The department focuses on Policy and Planning, Funding and Oversight of the provincial health system.
- The department divests itself from delivery of services.
- The department establishes a Transformation Management Office (an area that uses the department to support optimal system performance by the RHAs and the PHO).

RHAs – excellence in service delivery to Manitobans

RHAs will focus on excellence in service delivery. RHA boards will hold their organizations to account for their effectiveness and efficiency in service delivery, while controlling scope creep into areas beyond service delivery. Governance of the regional health authorities will be through an independent skill-based Board accountable to the Department, as discussed in the next section.

Regions would have less responsibility for individually planning health services and setting standards – although they will participate in provincial planning and will work within the provincial plan to achieve effective services that meet the needs of Manitobans.

In areas where the resources are currently split between RHAs in a sub-optimal or too-widely-dispersed fashion, regions would be required to divest resources into the provincial health organization for provincial mobilization.

Provincial Health Organization: a provincial approach to serve all Manitobans better

Countless studies have concluded that Manitoba’s structure is an impediment to effective provincial service delivery. In some cases, including the organizational and operational structure of emergency medical services (EMS), studies have found that resources are too widely dispersed across the provincial structures to be effectively used to advance care for all Manitobans (March 2013 Manitoba EMS System Review) In other instances, including the specialist clinical expertise held predominantly within the WRHA, resources are too closely held in one RHA and are not effectively used for the benefit of all Manitobans. The recommendation of both KPMG and Peachey reports is that provincial resources should be housed in a provincial health organization rather than ‘administratively housed’ in one region. The creation of a provincial health organization (PHO) will allow for the transfer of provincial functions from the RHAs and the Department to a provincial service delivery organization, allowing resources to be used provincially.

The envisioned scope of responsibility for this proposed organization includes the following areas and is further elaborated in Appendix A:

- clinical planning and governance
- provincial health human resources, including physician recruitment and retention
- information and communication technology
- emergency medical services
- provincial laboratory services
- provincial diagnostic imaging
- provincial procurement (requirements, purchasing, contracting, logistics)
- clinical engineering
- capital planning

- pharmacy services
- department Service Delivery Realignment
- Health Sciences Centre, including Children’s Hospital
- CancerCare Manitoba
- other components (legal, laundry, food, risk management, communications, finance)

We will need to ensure the governance model reflects a ‘one provincial system’ view. Different jurisdictions across Canada have used different governance models for provincial and superregional health organizations – to varying levels of success. The department proposes that the RHAs and the provincial health organization each have their own independent, skill-based board of directors.

Accountability is gained through a system of reporting and oversight to ensure that organizations achieve established objectives and service delivery targets (for example the Hospital Service Accountability Agreements and Multi-Sector Accountability Agreements established in Ontario). The role of a board in this case is to hold the management accountable for the delivery of a service as defined in the agreements, and to ensure that the organization is run for the benefit of the tax payers / users.

In such arrangement, the role of the board is typically to:

- comply with government rules
- ensure the organization is well-run and meets the performance targets established for it by government in any accountability agreement
- undertake budget negotiations and monitoring performance against budget
- monitor performance against other specific agreed measures such as wait-times, volumes, or delivery of specific services
- appointing and monitoring the performance of the CEO

Corporate Structure of the Provincial Health Organization

A provincial health organization can be formed from within existing corporate structures. This mitigates the need to create a net new organization in a time of fiscal restraint. The resources will be redirected from DSM, the RHAs and the department, and will be leveraged to support the various components of the entire provincial health organization.

Appendix A outlines the proposed sequence to mobilize the provincial health organization.

The Department: refine focus to policy, planning, funding & oversight

KPMG identifies that, like the WRHA, the department needs to refine and refocus its role away from service delivery to policy, planning, funding and oversight – to better hold the service delivery system to account for the provision of health services to Manitobans.

KPMG identify the need for transformation resources in the department to activate the strategic system realignment. They also identify the need to modernize funding approaches that will advance desired behaviours and dis-incent undesirable behaviours.

Transformation Management Office

KPMG recommends the formation of a Transformation Management Office (TMO) within the department to activate the provincial vision. The point of this function is that, while momentum is building for change in Manitoba, there is a need to compress the journey since Ontario, BC and others have been focused on system transformation for the past seven years. KPMG notes this will require fundamental change across all parts of the healthcare system. Finally, KPMG notes it is critical that cost improvements be harvested to ensure that challenging 2017/18 budget directives are met.

The function will be created within the department to implement the ultimate vision – a health system with a single provincial health organization that plans and delivers provincial programs in tandem with health authorities that are focused on delivery and operations. The TMO will drive system performance in the following domains:

- health outcomes and results
- program execution and quality
- innovation
- service integration
- effectively communicating the changes to a broad array of stakeholders

The function will be addressed by redeploying existing resources within the provincial health system and the department, although outside consulting support may be needed to establish specific areas. The TMO is temporary. Once the transformation has been implemented, it will evolve to a performance management function within the department to provide support to the deputy minister and minister.

Modernization of Funding Methods

KPMG identifies that regional alignment can be achieved by the province modernizing its funding approaches.

The establishment of health care services in today's environment is not ideal. As noted earlier, the system is effectively under-planned provincially, resulting in variability in where services are provided and how they are offered. Resources are not planned in a manner that truly meet needs of the population, and the system continues to be funded in a manner leaving ambiguity in deliverables and expectations on service delivery. There is limited oversight of the delivery system in setting expectations, monitoring for performance, and accountability for outcomes, cost, and quality of service.

The department recognizes that modernization of funding models is required to improve the effectiveness and innovation of Manitoba's health system. KPMG has identified this area as 'commissioning' – although the department prefers the broader term of modernizing funding methods. Commissioning is the systematic process of assessing health care needs of a population and putting in place services to address those needs. It begins with the creation of a population-based clinical strategic plan, which sets out where services are fundamentally needed based on health needs and burden of illness of populations. Inequity and addressing the needs of under-served populations is also often part of the analysis, taking into account how to level the playing field in the delivery of services to these groups.

Health system funders then set out a vision of what they want services to look like. This is based on outcomes, what benefits the services will bring to patients, and on known best practice. Based on this vision, the department establishes clear service accountability agreements with organizations to deliver quality services that provide value for money. This involves designing the service specifications, volumes of services, and key performance measures in delivering programs and services. Performance measures are established to monitor the quality and achievement of outcomes, and service delivery organizations are held to account to these measures in the process. The model would serve to contract with delivery organizations and would also enable new and innovative service partnerships in the delivery of care and services (ex: laundry, lab services).

It is proposed that the provincial health organization play a major role in the support, design, and development of a renewed provincial funding (commissioning) function. Working hand-in-hand with the Manitoba Health, Seniors, and Active Living, the PHO and its clinical governance functions would help to design a new provincial funding (commissioning) approach upon which planning, funding, and outcomes would be set. MHSAL would collaborate to build and deploy the performance management framework, leveraging heavily on its regional finance, management services branch, health workforce secretariat, and information management and analytics functions.

The magnitude of the changes at hand with respect to the modernization of the funding methods need not be revolutionary, but rather can be evolutionary in a Manitoba context. Manitoba's largely globally-funded health care system is already positioned to drive technical efficiency in service design and delivery. However, as noted in the Health Sustainability and Innovation Review, efforts will need to be made to fix the fundamentals in performance and accountability in health delivery. Through

accountability agreements, more explicit performance measures will be developed and adopted in an explicit and transparent manner, and consequences will be imposed for systems that do not achieve satisfactory performance.

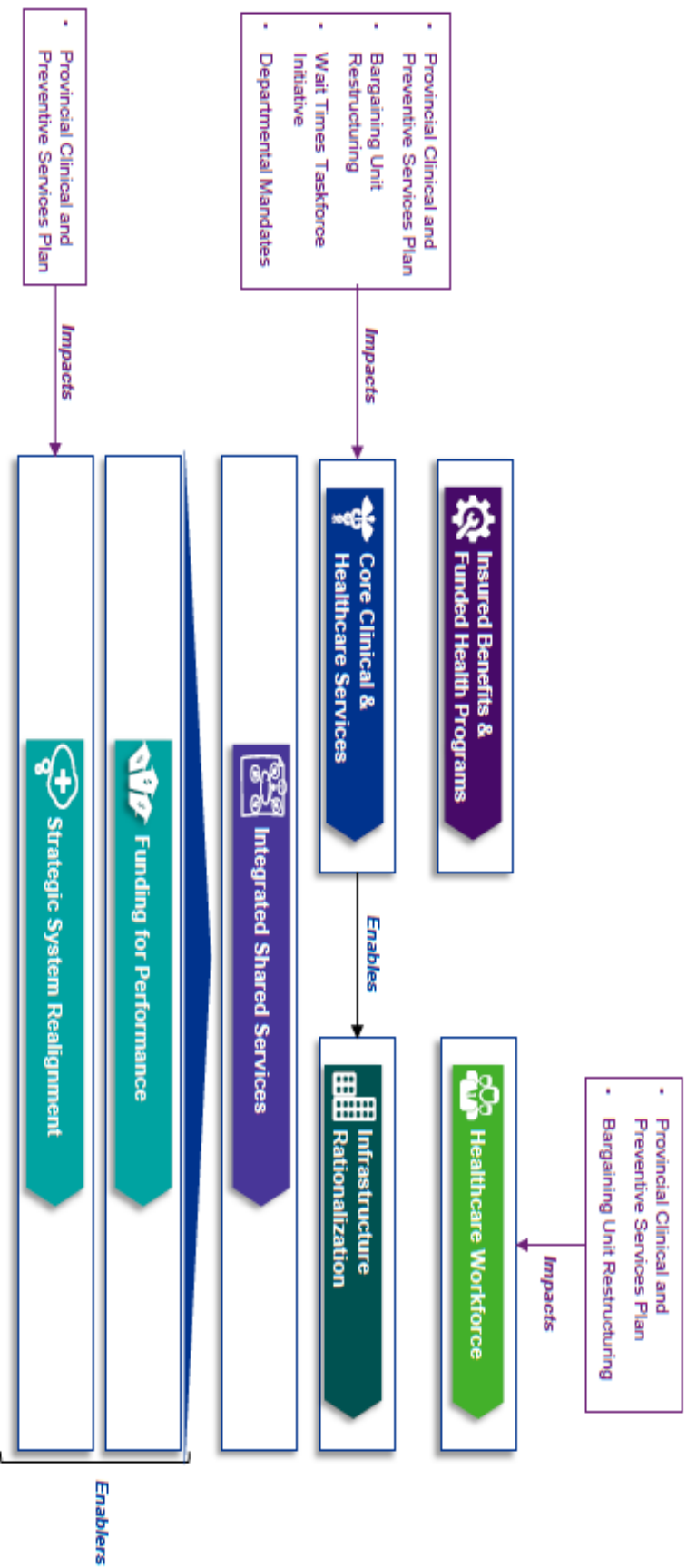
Given the magnitude of the changes at hand, the department does not possess the subject matter expertise to design and develop a formal funding (commissioning) function alone. It is proposed that the services of a consultant be acquired with experience and background in this realm. The consultant would have an understanding of health services delivery and how to integrate policy, planning, finance and analytics functions provincially to be able to best delivery the aforementioned commissioning function.

Financial Impact

While KPMG identified that strategic system realignment is a key enabler of longer term fiscal sustainability, they have also identified financial savings from the alignment and consolidation of diffuse resources into a provincial health organization (KPMG estimated this conservatively at \$5 million in 2018):

Enabling Workstreams & Related Interdependencies

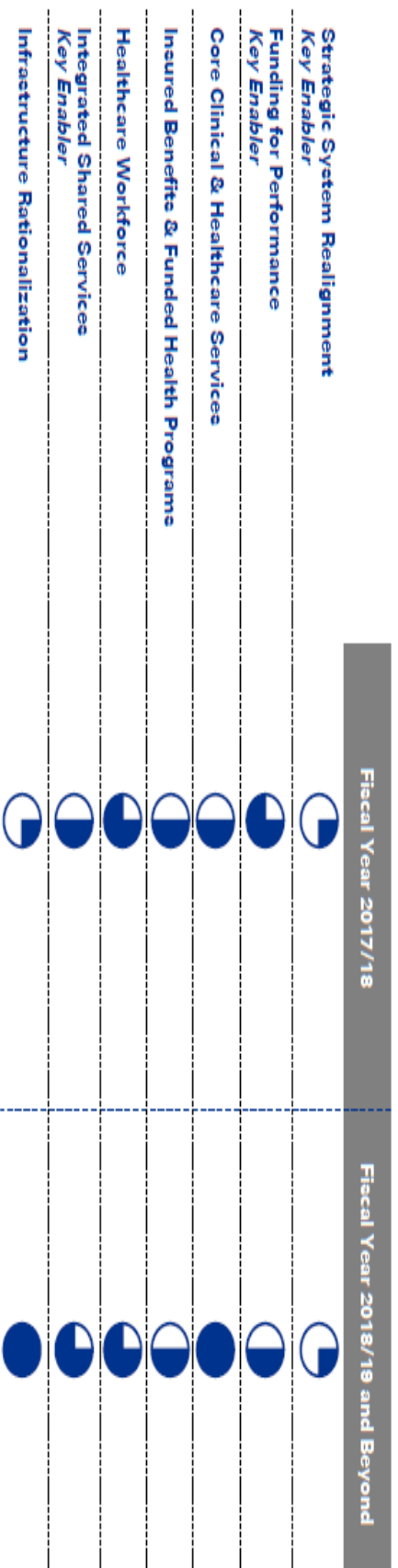
We have identified the key interdependencies and enablers between workstreams and other key policy impacts.



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High-Level Phasing and Benefits Realization

Work on development of the Work Plans has made explicit the challenge of the necessity to deliver short-term cost savings in 2017/18 while in parallel, planning for delivering medium-term transformational opportunities for 2018/19 and beyond.



Potential Cost Savings



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Appendices

Appendix A: Mobilizing the Provincial Health Organization (Proposed Sequencing)

There are two possible options for the creation of the PHO from within existing corporate structures:

1. Corporate Shell of Diagnostic Services of Manitoba

This option proposes using the existing corporate structure of Diagnostic Services of Manitoba (DSM) and repurposing it to become the provincial health organization.

DSM is a not-for-profit corporation with the minister as the sole member and a board that is fully appointed by the minister. There is no specific health legislation related to the DSM corporate structure.

Provincial lab services and provincial diagnostic services will remain within that corporate shell – and will operate as business lines (amongst several others) within the provincial health organization. DSM’s corporate resources, along with other resources redirected from the RHAs, will be leveraged to support the various components of the broader provincial health organization.

KPMG has provided a high level overview of legislative and regulatory change arising from the provincial vision. A revision of The Regional Health Authorities Act will be required to ensure that the narrowed and aligned mandate of RHAs is reflected in the legislation.

2. Restructure DSM and WRHA Concurrently

As an alternative to Option 1, an interim provincial leadership and a transformation management office could be established to assess the resources in DSM and WRHA and consider any changes government envisions making to the Manitoba Health, Seniors and Active Living. Resources would then be identified for inclusion in either the PHO (using the existing corporate shell of DSM), the newly configured and pared down WRHA and within the department.

This has the advantage of essentially combining WRHA and DSM resources under transitional leadership which would then be empowered to split these resources into a PHO and a WRHA that is more focused on primary and secondary care services. This also eliminates the need to negotiate a shift of programs and resources between two separate organizations under two separate leaderships. Past experience suggests that such negotiations would take years to complete and result in changes that would actually increase cost.

As in Option 1, the net number of service delivery organizations would not be more than it is today, and may ultimately be less, but the configuration of services (provincial versus local) would be improved.

Key components of a provincial health organization are as follows:

a. Clinical Planning and Governance

Provincial clinical governance is essential in order to sustain a provincial clinical and preventive services plan and to provide recommendations to government regarding commissioning health services.

“Medical staff” in Manitoba includes all physicians, nurse practitioners, midwives, dentists, physician assistants and medical trainees that require access to an RHA, DSM or CancerCare facility. These organizations are responsible for overseeing the standards of care of these providers when they are working in public facilities, and granting access to resources. They have no jurisdiction over what these providers do in practice in the community.

Health providers in the community who do not require access to a publicly-funded facility are not currently members of the medical staffs. The oversight responsibility for physicians practicing outside of RHAs, DSM or CancerCare facilities rests with the College of Physicians and Surgeons of Manitoba and this oversight and accountability is very limited.

The “medical staff bylaw” is the governance document defining the relationship between medical staff and publicly-funded facilities in Manitoba. In 2012, the PMLC worked with the department to establish a medical staff bylaw that is now consistent across all RHAs, DSM and CancerCare. As well, with the revised medical staff bylaw, the authority for granting appointments and privileges to medical staff has shifted from regional boards to regional chief medical officers. The PMLC established a provincial credentialing process and is working the CPSM to establish provincial standards committees.

In this new clinical governance model, the PMLC could evolve to become the governing body for a single provincial medical staff that will include all physicians, nurse practitioners, midwives, dentists (working in publicly-funded facilities), and physician assistants and medical trainees. The chair of the PMLC will continue to report to the deputy minister (as currently exists).

The clinical governance governing body (ex: the former PMLC with additional multidisciplinary additions) could be responsible for leading efforts to enhance and maintain the Province’s Provincial Clinical and Preventive Services Plan; for advising government on what entities in the province should be commissioned to provide what services (consistent with the provincial plan); for a provincial credentialing process that will make recommendations for appointments and privileges for all “medical staff” in the province (including those working outside of public facilities); for a provincial standards process (in conjunction with the CPSM) that will oversee standards of practice for all medical staff in the province; and for leading physician recruitment and retention efforts across the province. This will ensure that there are consistent standards of practice across the five RHAs, the provincial health organization, other publicly funded organizations and in the community.

The PMLC will appoint provincial specialty leaders who are accountable to PMLC for developing cost-effective provincial models of care for their specialty; overseeing standards of practice for their specialty; and leading recruitment and retention efforts specific to their specialty, across the province. Where

appropriate, these clinical leaders may also be leaders in the relevant departments in the College of Medicine, Faculty of Health Sciences.

Regionalizing medical staff was a key success factor in the early evolution of the RHAs in Manitoba. Likewise, creating a truly provincial medical staff will be the key success factor in developing a truly integrated provincial health care system.

b. Provincial Health Human Resources

Health human resources make up more than 70 per cent of the resources of the health system in Manitoba. Payments to physicians alone account for more than 20 per cent of the provincial health budget (more than \$1 billion annually).

The minister's mandate letter includes responsibility for the following commitments:

- establishing an improved doctor recruitment and retention program with a goal to have the most improved retention rates in our first term
- creating a more collaborative recruitment environment that focuses on a team-based approach
- hiring experts in effective recruitment processes including foreign recruitment of practice-ready doctors
- promoting hometown doctors through education in local communities
- conducting exit interviews with departing doctors to determine their reasons for leaving

In the November 2016 Throne Speech, the government announced a new provincial physician recruitment agency. As the KPMG Health Sustainability Innovation Review (HSIR) was underway, consideration of the structure for this function was included in the scope of the HSIR.

Sustainability of the health system and achieving these commitments requires a provincial approach to health human resources planning, recruitment, medical staff credentialing, contractual models and compensation. Ongoing challenges with distribution and turnover of physicians, nursing and allied health staff in rural and northern Manitoba call for new and innovative provincial approaches to transform models of care, contractual models, compensation, practice supports, professional supports and community supports to optimize health human resources throughout the province.

Currently, the Manitoba Healthcare Providers Network, administratively housed in the Winnipeg Regional Health Authority, consists of functional areas which are provincial in scope:

- provincial medical staff recruitment, credentialing and administration
- provincial health labour relations

Within Manitoba Health, Seniors and Active Living, the Health Workforce Secretariat has three functional areas that are provincial in scope:

- health human resource planning
- contracts and negotiations
- fee-for-service/insured benefits

To be effective, provincial health human resources functions, including planning, recruitment, credentialing, contracting and compensation, must be driven by a provincial clinical services plan led by strong clinical governance.

To enhance the effectiveness of these provincial health human resources functions, it is recommended that the Manitoba Health Providers Network be transferred from the WRHA together with certain resources from the Health Workforce Secretariat, to a new provincial organization with provincial governance aligned with provincial clinical governance.

Streamlining the number of collective agreements and reducing the number of bargaining units in the health system will be improved with the creation of a provincial health organization. It is important to identify what organizational units will be part of the provincial health organization before the proclamation of Bill 29 to optimize the reduction in the number of bargaining units and to minimize disruption arising from the bargaining unit restructuring process. Consultations with health sector bargaining agents are ongoing.

Physician Recruitment and Retention

All provinces, including Manitoba, continue to be challenged by the disproportionate distribution of physician resources and turnover rates of physicians serving rural and remote areas. The provincial clinical and preventive services plan will identify the types of care providers needed in the province, where they will be needed, what models of care they will be participating in, and what specific competencies they will require. This will then inform discussions with the educational institutions regarding what is needed, and inform decisions regarding recruitment and retention strategies.

Developing more collaborative models of care that fully utilize the scopes of practice of providers, transforming contractual models and enhancing professional, personal and community supports will significantly improve access to physician services in rural Manitoba. Recent graduates, both Canadian and internationally-trained, are increasingly seeking group practice models with access to a range of professional and practice supports to maintain and continue to develop competencies over the course of their careers.

Moving towards a provincial medical staff is integral to achieving the transformation necessary to improve retention of physicians throughout Manitoba. Provincial specialty leaders will work with their specialty colleagues, from across the province, to develop networks of specialists that will make those practicing outside of urban centres feel less isolated. Working together, these specialist groups will develop efficient and effective provincial models of care for their respective specialty services. Flexible

care models that enable physicians to work in urban and rural settings, and support continuing professional development opportunities, will better meet the needs of physicians and communities throughout the province.

Recently-established provincial credentialing and standards processes will assure Manitobans of acceptable standards of care, regardless of where they access care in the province. Provincial practice supports, such as Up-To-Date, will be expanded to include a Provincial Emergency Consultation Service (PECS) that will provide essential supports to medical staff throughout the province faced with emergent/urgent clinical situations. This will significantly lessen the anxiety associated with working in more remote areas where certain emergent/urgent patient situations present infrequently.

c. Information and Communication Technology

In 2015, senior leaders in the health system recognized that digital technology would continue to play a critical and ever-increasing role in the delivery of healthcare services, and commissioned a review (ICT Study) of the current state of the information communication technology (ICT) services within the Manitoba healthcare system, including exploration of governance and structure. Stakeholders had recognized that coordinated efforts, integrated planning and a clinical service plan were needed. The fragmented nature of the system is also identified in the Health System Sustainability and Innovation Review, where KPMG reiterated that the health system's overall information communications technology (ICT) delivery and support processes are characterized by a hybrid delivery model with overlapping responsibility.

Since the study, the system has moved to implement the recommendations including strengthening how ICT is governed, operated and planned, implementing a province-wide architecture (building ICT in a standardized way and creating and leveraging technology across the province, including working with BTT to look at mutual opportunities), tackling closer integration and alignment with provincial healthcare system goals, and better focusing, identifying and capturing the value of existing ICT investment and in potential new investment. However, the completion of these recommendations has been hindered by the lack of a clinical services plan, and a fragmented health system that plans, funds and operates ICT in an uncoordinated way. Governance remains fractured, with specific organizations (outside of eHealth and ISB) retaining almost 50 per cent of the province's ICT, including resources, planning and decision-making oriented to local and regional planning. For those Manitobans who access services for the first time, they are surprised by the lack of ICT. For Manitobans that regularly access health care services, particularly across health authority boundaries, they are frustrated by the lack of information their providers have on their condition, tests and previous care. While we have begun to implement province-wide systems, a patchwork of ICT remains, with big gaps outside of Winnipeg generally, in community-based and long-term care services, and in consumers' access to their own healthcare information. Additionally, there are large gaps in data and information that support analysis and performance management of the system.

It is timely to consider a shift to a true provincial ICT in one entity. In Phase 1, eHealth would be transferred from WRHA along with intake and operational capacity from the department to the provincial

health organization. The resources (staff and funding) within the health authorities (RHAs, CCMB and DSM) would also transfer, with staff remaining largely local. All strategic planning and recommendations for investment would be centralized, and aligned to the Provincial Clinical and Preventative Service Plan.

d. Emergency Medical Services (EMS)

An external review of Manitoba's emergency medical services system completed in 2013 (Manitoba EMS System Review) identified that to achieve a more uniform and consistent provincial) program, a provincial EMS organization that will provide program oversight, set performance standards, coordinate and manage all EMS service delivery and provide continuous monitoring of the EMS system is needed. While progress has been made in several areas like movement towards centralized medical oversight, today, Manitobans continue to receive EMS from 20 land license holders with varying service response times, standards and quality, administered by five regions charging an inconsistent cost (albeit to a maximum standardized amount). Basic air ambulance services (those outside of Lifeflight and STARS) could be procured to ensure better pricing and coordination.

It is timely to move toward a provincial approach where operations are integrated, there is centralized accountability and performance is managed. With establishment of a provincial health organization in Phase 1, all EMS services would transfer to be delivered, coordinated and overseen by this organization. In the initial phases, land ambulance services like the remaining community-based services and municipal services like Winnipeg, Thompson and Brandon would be centrally-contracted, along with STARS and basic ambulance services. Billing and collections would be moved centrally, along with the Medical Transportation and Coordination Centre. Centralization of medical oversight would be completed.

Licensing of ambulance providers would continue with the department until such time as a College of Paramedics is established. The timeline for that transition (of licensing from the department to a college) would flow from the May 2017 report on paramedic self-regulation by recognized health care system leader Mr. Reg Toews.

e. Provincial Laboratory Services

Following an effort to contract lab services to the private sector in the late 1990s, a provincial public lab service was established in the early 2000s called DSM. At that time, technologists in smaller communities often did both lab work and radiology work, so DSM also assumed responsibility for diagnostic imaging outside of Brandon and Winnipeg. Today, many of these technologist functions have been separated in smaller communities.

In the new model, DSM will cease to exist as a separate corporate entity and will instead transition to a centrally managed provincial lab service within the provincial health organization.

f. Provincial Diagnostic Imaging

Currently, Diagnostic Imaging Services (radiology) is managed by three organizations: WRHA, Prairie Mountain Health (Brandon) and DSM. The three organizations come together in a Provincial Diagnostic Imaging Council to try and ensure that standards, equipment purchases and other services are coordinated. However, the PMLC has recommended in the past that there be one centrally managed provincial DI service. This would now reside in the provincial health organization.

g. Provincial Procurement

An integrated and coordinated provincial procurement function is also contemplated as part of the provincial health organization's mandate. While there are numerous definitions of procurement, the term is used in this context to include: defining requirements, purchasing, contracting and logistics that includes warehousing and distribution.

In the current state, contracting is largely served by two entities: WRHA Logistics and Regional Health Authorities of Manitoba Purchasing Program (now housed formally under DSM). While progress has been made, there are still key products that remain off-contract, and newer approaches to contracting need to be pursued. Both services function independently with limited coordination and some overlap.

These entities will be merged under the proposed provincial health organization, which would have responsibility for procurement for all Manitoba health authorities / facilities including equipment, supplies, consumables and purchased services. A provincial approach to procurement will serve to create efficiencies and economies and improved coordination in a truly provincial context. This ensures economies of scale provincially in driving best value for contracts.

Importantly, procurement functions will also be beneficially housed alongside clinical governance functions in the PHO. This means that the clinical governance functions responsible for setting the strategic plan and quality standards provincially, would drive the products and services Manitoba has on contract for delivery organizations to use. In this approach, there will be limited ability to deviate or vary off contract (ie utilization of preference items), and commissioning functions will help to ensure that delivery organizations are compliant in their adherence to provincial contracts. Particularly as it relates to medical and surgical devices and supplies, it will be important to have the clinical input (including clinical engineering input) and agreement in the definition of requirements; the PHO would facilitate such requirements being defined at a provincial level.

By focusing broadly on procurement, all supply chain functions will also be considered in a provincial context. Procurement is different than contracting in that it oversees the actual act of *looking up the item in the available supplies catalogue, communicating with the vendor of choice on the procurement, issuing the purchase order to the appropriate proponent and following up with the vendor as required post-purchase*. It is the logical extension of the contracting function in the supply chain once the supplies, consumables, equipment, or services have been appropriately tendered.

In addition to provincial standardization, there will be several other advantages to this provincial approach. On the basis of geography some of the purchasing staff will be centrally consolidated leading to economies of scale in provincial procurement functions. Importantly, having procurement staff outside of delivery organizations will place them at greater arm's length from clinical delivery staff and in a better position to control for and mitigate purchase of off contract and arbitrary clinical preference items.

The purchasing power of a provincial organization can also be expected to provide benefits in pricing negotiations as well as greater flexibility in negotiations with existing Canadian Group Purchasing Organizations (HealthPRO, Medbuy) that have already established products on contract.

There are several health procurement groups already established in Canada; each LHIN in Ontario has established such an organization while some provinces have started to procure some items provincially. The provincial health organization can learn from these organizations as it builds out procurement functionality; provincial procurement will also effectively set the stage for Manitoba to collaborate with other provinces in procurement. For example, opportunities may exist to work with British Columbia on their bulk-buy drug alliance, Saskatchewan on larger and standardized diagnostic equipment orders, Shared Services West (Ontario) on strategic sourcing, Northern Supply Chain (24 hospitals across northern Ontario) on employee benefits arrangements, or Mohawk Shared Services on accounts payable solutions.

There will be challenges. Existing regional staff responsible for procurement often carry a number of other key administrative functions in their day-to-day responsibilities. Thus, a decision to centralize or consolidate the procurement function may not lead to significant extractable resources in support of a provincial system. There will also be systems considerations as the effort will need to be supported by robust procurement software; a single provincial system will be required. Such challenges can be expected to be offset by greatly enhanced purchasing power and standardization. Further the challenges faced in the establishment of other procurement groups in Canada have been well documented; we will benefit from learning from their mistakes.

h. Clinical Engineering

Currently, clinical engineering is dispersed across regions and sites with no provincial alignment. Resources will be better leveraged by consolidating and centrally managing these functions in the provincial health organization.

i. Capital

As with Information and Communications Technology, capital redevelopment and real estate management require better coordination, integrated planning and a clinical service plan. Investments in significant infrastructure like personal care homes, expanded space for CancerCare Manitoba and potential investment in Riverview lack context, system-wide planning and a modern policy framework.

The completion of Peachey's Clinical and Preventive Services Plan provides opportunity to align new investment in major building renovation, new construction or lease holdings to a clinical service plan.

Additionally, there is a lack of consistent asset management and there are significant opportunities to align to a government-wide system that inventories, assesses and methodically plans for renewal or decommissioning of capital infrastructure, providing better risk management and predictability for capital expenditure.

KPMG has set out a work plan to develop a long-term infrastructure strategy in concert with government-wide strategies and standards. Contemporary capital project financing and delivery models across the health system and across government would be pursued to the advantage of Manitoba's tax payer. To ensure consistency in the development and application of new standards, asset management and project delivery a central capacity for the planning, prioritization and support for major project delivery, broad real estate management and high-level asset management would be established. Local facilities maintenance and delivery of projects would remain local with support leveraged from the central capacity that would be housed in the provincial health organization.

j. Pharmacy

Pharmacy services are delivered in numerous settings such as hospitals, personal care homes, cancer clinics and the community, supplying and dispensing a wide range of pharmaceuticals. While regional efforts have served to integrate some pharmacy services, and our public drug plan is collaborating with pan-Canadian partners, there exist several opportunities to administratively streamline our system, and drive better pricing while still ensuring access. A first step is the development of a provincial formulary where a) formulary decisions are evidence-based not preference-based, b) appropriate drug therapies are promoted and inappropriate drug therapies are discouraged, and c) portability and uniformity of the drug benefit is promoted so that Manitobans can expect that if they are started on a drug in hospital it is available as a benefit through Pharmacare in the community. Additionally, contracting and procurement would be centralized under the provincial health organization, supporting local and province-wide supply chain management.

The merit of evolving to a province-wide pharmacy system, similar to Veterans Affairs in the United States, will be explored. This concept entails amalgamating pharmacy services in hospitals and personal care homes with community pharmacy services, and could encompass aspects such as cross-system bulk purchasing, preferred community dispensing (to increase competition and drive down price), and system-wide monitoring of appropriate prescribing and dispensing practice to name a few.

k. Department Service Delivery Realignment

KPMG has identified that achieving role clarity for the department would require that certain programming/services be divested from the department to the Provincial Health Organization. Examples cited by KPMG include:

- emergency management functions such as the Office of Provincial Medical Director, EMS
- Selkirk Mental Health Centre
- the three provincial nursing stations
- public health inspectors

l. Health Sciences Centre

HSC, including Children's Hospital, is responsible for the majority of provincial clinical specialty services, with the exception of cardiac surgery. It is the provincial hospital for several services such as trauma care (with helipad), burn care, tertiary neurosurgery and tertiary pediatric care. As such, it functions as a provincial hospital and should be sited within the provincial health organization.

m. CancerCare Manitoba

In their analysis, KPMG identified that CancerCare Manitoba (CCMB) should be transferred within the Provincial Health Organization. There are two alternatives in this transfer, maintaining the separate legal corporate structure of CCMB, or removing the corporate structure. Either way, the working assumption is that planning, standard setting, and funding functions would be contained in the under the provincial health organization while service delivery would devolve to the regional health authorities. There would be no unique relationship between CCMB and the department.

n. Other Components

Other components will include services such as laundry, food, risk management, legal, communications and other department services that should be devolved to the provincial health organization.