PARTNERING TO CREATE THE SAFEST HEALTHCARE SYSTEM

THE HIROC CONNECTION

... KEEPING SUBSCRIBERS CONNECTED

ISSUE #32
WINTER 2013

HEALTHCARE **INNOVATOR:**

ACCREDITATION CANADA'S WENDY NICKLIN

NURSE **PRACTITIONERS:**

FULFILLING A CRUCIAL ROLE IN THE HEALTHCARE SYSTEM

CLAIMS DEFENCE **INITIATIVE**

ADDRESSES RISING COSTS

IN THIS **ISSUE** OF THE **HIROC CONNECTION**

3 HIROC AND BLG NAMED ACC VALUE CHAMPIONS

4 NURSE PRACTITIONERS: FULFILLING A CRUCIAL ROLE IN THE HEALTHCARE SYSTEM

6 CLAIMS CORNER: 10 THINGS YOU MIGHT NOT KNOW
Marnie MacPhee, Nancy McCurdy, Agnese Alati
SENIOR CLAIMS EXAMINERS

7 HIROC'S CLAIMS DEFENCE INITIATIVE

8 STAFF FIND A VOICE THROUGH IMPROVEMENT BOARDS

9 TRANSFORMING PATIENT CARE THROUGH COLLABORATION

10 HEALTHCARE INNOVATOR
Philip De Souza
COMMUNICATIONS SPECIALIST, HIROC

12 CENTRAL CCAC WINS CANADIAN INNOVATION BEST PRACTICE AWARD

13 ASK A LAWYER: A PRIMER ON CLASS ACTIONS
Jonathan Gutman
GENERAL COUNSEL

14 LIABILITY RISK REDUCED

15 MIDWIVES MAINTAIN PRIMARY CARE

16 HIROC 'PROPERTY CHAMPIONS'

17 DEDICATED TO PROPERTY LOSS PREVENTION

18 ROLLOUT OF RAC TO NON-ACUTE SECTORS

19 SAVE THE DATE: HIROC's ANNUAL GENERAL MEETING AND RISK MANAGEMENT CONFERENCE

19 CUT THE CLUTTER WITH RISK WATCH

20 WELCOMING NEW SUBSCRIBERS

PHOTO ON COVER: From small steps taken by Willi Kirenko, Director, Quality and Interprofessional Practice in 2001, has grown a thriving NP practice at Chatham-Kent Health Alliance. From left: Curtis Smith, Nurse Practitioner; Natalie Koegler, RPN; and Delynne Teetzel, Nurse Practitioner. Photo by Ellen Gardner.

QUESTIONS? CONTACT HIROC

TORONTO
4711 Yonge Street, Suite 1600
Toronto, Ontario
M2N 6K8

Tel: 416.733.2773
Fax: 416.733.2438

TOLL FREE TORONTO:
Tel: 1.800.465.7357
Fax: 1.800.668.6277

WESTERN REGION
875 Gateway Road, Suite 9
Winnipeg, Manitoba
R2K 3L1

Tel: 204.943.4125
Fax: 204.949.0250

TOLL FREE WINNIPEG:
Tel: 1.800.442.7751

SUBMIT TO THE HIROC CONNECTION

We welcome submissions to The HIROC Connection. Please contact:

Ellen Gardner or
Philip De Souza
Communications & Marketing
egardner@hiroc.com
pdesouza@hiroc.com

Please visit our website; **hiroc.com** to see back issues of The HIROC Connection. HIROC subscribers can click on SUBSCRIBER LOGIN and then go to publications. If you have misplaced your password, email: **inquiries@hiroc.com**

WELCOME TO THE FIRST HIROC POP-UP!

For exactly one hour between sessions at this year's Canadian Home Care Summit in Gatineau, Quebec, the HIROC pop-up was the "go to destination" in the exhibit hall. While they munched on yummy snacks, delegates learned about HIROC and had fun photos taken of themselves with their conference friends and fellow delegates. The buzz around HIROC was enhanced by the Canadian Home Care Association's Executive Director, Nadine Henningsen and CHCA President John Schram, who were both huge "guest" ambassadors for HIROC. ■

The 2013 ACC Value Champion award was presented at the ACC Annual Meeting in Los Angeles in October. (From left:) Richard Stock, Catalyst Consulting who did an in-depth analysis of four years of litigation matters; Mike Boyce, VP, Claims, HIROC; Veta T. Richardson, President and CEO of ACC; and John Morris, National Practice Group Leader for the Health Law Group of Borden Ladner Gervais LLP. (Photo by Scott Dressel-Martin, Dressel-Martin MediaWorks, Inc.)

HIROC AND BLG NAMED **ACC VALUE CHAMPIONS** WELL-DESERVED RECOGNITION FOR LONG-TERM CLIENT/FIRM ARRANGEMENT

The unique and longstanding partnership between Borden Ladner Gervais LLP and HIROC was this year recognized with one of the highest honours you can receive in the law world. The Association of Corporate Counsel *(ACC)* named BLG and HIROC as 2013 ACC Value Champions for "delivering substantial value to their client organizations by cutting spending, improving predictability and achieving better legal outcomes."

This innovative arrangement came about largely through the efforts of John Morris, National Practice Group Leader for the Health Law Group of BLG and HIROC's VP, Claims Mike Boyce.

The award is recognition of HIROC and BLG's somewhat daring decision to adopt an unconventional, untried and quite innovative fee and service arrangement.

"We took a different approach to medical malpractice in Canada," says Mike. "We wanted expertise rather than an area of geographic concentration and we offered steady, ongoing work, which allowed us to attract the best and brightest defense counsel."

The current arrangement consists of a base fee combined with a performance fee, which is determined by process management, responsiveness, predictable costs and results. "In today's terms, the most progressive arrangements are those that are based on billing for service rather than hours," says John. "We can't predict every matter, but we do have a sense of what is a reasonable fee. In HIROC's case, the volume makes it easier to predict."

Both partners acknowledge that their close working relationship over 25 years made this arrangement possible. "We have built a strong foundation of trust, based on a desire to see each other's business succeed," says Mike. "BLG has always been incredibly efficient at having the right level of lawyer do the work and the strategic use of paralegals. We saw the new agreement as an inducement to be even more efficient, and as a learning experience."

HIROC and BLG are the only Canadian organizations to be recognized as 2013 ACC Value Champions. "This approach makes the point that alternative value arrangements deliver predictability to the client, which is important for all corporations and their budgeting," said one of the award judges. "It also diminishes the notion that the only reason clients pursue alternative value arrangements is to reduce costs."

"We have always considered ourselves partners with HIROC," said John, "driven by respect, good faith and the desire to see each other do well. We are delighted that we were able to arrive at an arrangement that not only made sense to our business, but most importantly, meets the needs of our client, HIROC." ■

Willi Kirenko, Director, Quality and Interprofessional Practice at Chatham-Kent Health Alliance (left) with Delynne Teetzel, NP at Chatham-Kent.

NURSE PRACTITIONERS: FULFILLING A CRUCIAL ROLE IN THE HEALTHCARE SYSTEM

LOIS HALES, SENIOR HEALTHCARE RISK MANAGEMENT SPECIALIST, HIROC
ELLEN GARDNER, MANAGER, MARKETING AND COMMUNICATIONS, HIROC

It would surprise many people that for more than 50 years, Nurse Practitioners have been providing a vast array of services in acute, chronic and community settings.

There are currently over 3,000 NPs in Canada working in three, soon to be four specialties: Primary Health Care, Adults, Pediatrics and Anesthesia. Every provincial and territorial government has passed legislation enabling NPs to provide advanced care in a variety of settings.

Yet, despite their crucial role in healthcare delivery, the path to acceptance for NPs has not been smooth or easy. Prior to July 1, 2011, specific acts of care provided by the Nurse Practitioner were only possible through doctors' orders *(medical directives)*. But, growing recognition of their essential role and persistent lobbying by RNAO and the Nurse Practitioners' Association of Ontario *(NPAO)* finally prompted the necessary legislative adjustments. Changes to Regulation 965 of the Public Hospitals Act, 1990, in 2011 and subsequent amendments in July 2012, position Ontario as the first jurisdiction in Canada to legally authorize Nurse Practitioners to admit, treat, transfer and discharge hospital in-patients.

"I JUST THOUGHT IT WAS A GOOD IDEA"

Well before these changes were implemented, many NPs were making waves in their own hospitals and community healthcare clinics. One of those pioneers is Willi Kirenko, Director, Quality and Interprofessional Practice at Chatham-Kent Health Alliance. There was no grand plan in her moves to maximize the NP role, just an urgent need.

"I thought it was a good idea back in 1998 when there were not enough doctors to staff two emerg departments," she says from her tidy, windowless office in the basement at Chatham-Kent.

Willi had herself just been accepted into the NP program and a couple of years later, in 2001, with the blessing of her forward-thinking CEO, they applied for funding to bring one NP into the emergency department. "It was the beginning of a new model of care for our hospital," she recalls.

"It was a wonderful day!" says Chatham-Kent NP Delynne Teetzel speaking about the changes to the legislation enabling NPs to conduct their role in a more direct, efficient manner. A former emerg nurse who was 'gently coaxed' into becoming a NP by Willi in 2009, Delynne says the NPs perform a vital function as the supply of primary care physicians diminishes and the population changes. "In emerg, we speed up the flow by seeing the lower acuity patients faster and routing the sicker ones back sooner."

What patients notice and appreciate about NPs is the follow-up protocol. "We always call to see how they're doing and make sure the treatment worked," says Delynne. "They love that phone call!"

THE FIRST NP-LED MODEL OF CARE IN ONTARIO

Lakeridge Health in Whitby, one of the largest community hospitals in Ontario, is a good example of what can happen when the barriers come down. Michelle Acorn, Lead Nurse Practitioner and former Advance Practice Professional Practice Leader at Lakeridge Health, has been a NP for over 14 years and for many of those years, she worked under severe restrictions.

She remembers a time when NPs could only deliver care with medical directives when working on in-patient care units. "Our practice wasn't even recognized," she says.

Michelle used various platforms to push for change, most notably as president of NPAO. With her years of experience, she was a natural for co-chairing a provincial expert panel charged with developing the NP hospital toolkit to assist with NP implementation and evaluation in hospitals.

"It's been invigorating to help create and sustain the first NP-led model of hospital care in the province," she says. Once working within a "shared care" model that listed a physician and NP on the admission and discharge orders, Michelle's name now stands apart as the most responsible practitioner *(MRP)* on everything from ordering medications and tests in each patient chart to the whiteboards hanging at each bedside for communication.

The bridge to successful integration of NPs, at Lakeridge and elsewhere, is built through strong collegial relationships. "It's not just about NPs," says Michelle, "but a fully dedicated interprofessional team collaborating to provide safe and efficient quality patient care."

A HUGE QUALITY AND SAFETY FACTOR

"There is a huge quality and safety factor to what we do," confirms Delynne at Chatham-Kent. "We know every interruption increases the likelihood of errors. NPs work with the other care providers to improve the flow within the system and this significantly reduces the number of interruptions."

The powers now granted to Nurse Practitioners are a seismic leap from what they once were, but the lobbyists like Michelle and NPAO are advocating for even more regulatory amendments. These would remove restrictions on ordering x-rays such as CTs, performing point-of-care lab tests, applying forms of energy such as a defibrillator, and enabling NPs to prescribe narcotics and controlled drugs.

Today the best judges of the flourishing role of NPs are the patients who, whether they know it or not, interact with NPs every day. In a recent patient satisfaction survey at Chatham-Kent, there were six references to the "excellent care" they're receiving from Nurse Practitioners. "We know it's the right care for the right mix of patients at the right time," says Willi. "What we hear from patients who have been waiting to see a physician, 'Can't I see a NP?'" says Delynne. "We provide speedy and excellent whole person care." ■

"We know it's the right care for the right mix of patients at the right time," says Willi Kirenko.

Lead Nurse Practitioner at Lakeridge Health Michelle Acorn (right) with student Nurse Practitioner Keeli Stith-Jarrett and patient Joe Burgess."It's been invigorating to help create and sustain the first NP-led model of hospital care in the province," says Michelle. (photo by Kathleen Rose, Communications Department, Lakeridge Health)

Senior Claims Examiners at HIROC (from left): Marnie MacPhee, Nancy McCurdy, Agnese Alati.

CLAIMS CORNER:
10 THINGS YOU MIGHT NOT KNOW ABOUT THE HIROC CLAIMS DEPARTMENT

1. KNOWLEDGEABLE TEAM
The HIROC Claims team is made up of 11 examiners, a manager and a vice president. When you add it up, our team has over 225 combined years of experience in insurance claims matters! The group meets regularly to discuss complex matters and review developing trends in the area of medical malpractice law.

2. ROUND ROBIN PROCESS
Every claim that is reported to HIROC is viewed by each one of our experienced examiners. Our claims Round Robin process gives each of the examiners an opportunity to share his/her knowledge and provide input about each individual claim. An added benefit of the Round Robin process is that each of us learns about exposures we may not have seen previously.

3. A LOT OF CLAIMS
Twenty-five years is a long time to be processing claims – so, do we even know how many we've done? Since HIROC's inception over 25 years ago, we have handled 23,784 claims. Currently we take in about 1,300 new claims annually.

4. LEGAL TEAM
In addition to our team of examiners, HIROC has its very own in-house legal team consisting of three full-time lawyers who handle defence matters on behalf of our subscribers. Having a legal team on-site means that subscribers and examiners have convenient access to timely, expert legal advice.

5. BLG – OUR PARTNERSHIP AND AWARD WINNING AGREEMENT
Together with the HIROC family, Mike Boyce, VP, Claims, has cultivated a productive and now internationally recognized relationship with our extended family, Borden Ladner Gervais *(BLG)*. In 2011, BLG and HIROC established a six-year, values-based partnership that increases the predictability of legal fees while rewarding law firm performance.

This innovative arrangement was recently recognized with the 2013 Values Champion award by the Association of Corporate Counsel *(ACC)*. The principal authors of the partnership, Mike Boyce and John Morris, partner at BLG, are modest about the achievement. "I am proudest of the fact that the award recognizes that we managed to do something great by partnering with others – BLG in this case – to generate savings that we can put back into Canadian healthcare," said Mike.

6. WE WILL GO THE DISTANCE WITH OUR SUBSCRIBERS
Fortunately, most claims are resolved through a negotiated settlement or a dismissal with or without costs. There are times though, when matters cannot be resolved and a trial is necessary. Two of HIROC's claim files proceeded through trial to judgment in the past year. It's important for our subscribers to know that when a resolution cannot be reached, HIROC will support them throughout the trial.

7. LIFESPAN OF CLAIMS
Claims remain open and active for an average of 2.3 years. Obstetrical claims average an even longer period at 3.1 years, primarily owing to the length of time it takes to develop expert opinions on some complicated causation issues. Different limitation periods in various jurisdictions, application of the discoverability rule, and the potential delay in actual reporting following an incident are just some of the factors that can increase the lifespan of a file. Historically, files with settlement values in excess of $1 million remain open two to three times longer at an average life of seven years!

8. SETTLEMENT VALUES
Based upon the 3,843 liability files in which indemnity payments have been made, the average settlement value is $19,000.93. With obstetrical claims, of which 168 settled since HIROC's inception, the average settlement value is $92,442.65. Obviously, these matters consume a lot of time and energy by those involved, including our subscribers, their staff and our legal and claims experts.

9. AN EXPENSIVE PROCESS
Legal costs are the biggest component of the expenses we incur in responding to claims. The average legal expense on non-obstetrical claims, where expenses have been incurred, is $9,127.28. Given that obstetrical claims generate far higher loss payments, it's not surprising that legal fees in such cases are also higher at an average of $14,847.55. The sooner claims are reported to HIROC, the sooner we can set to work investigating and resolving claims. The shorter lifespan of a claim will naturally lead to lower expenses and more timely settlements.

10. THE TYPE OF CLAIMS WE HANDLE
The vast majority of our claims relate to allegations of medical malpractice, but we also handle claims involving injuries to visitors at our subscriber premises. These may involve persons being trapped in an elevator; being struck by an electronic parking gate; or simply slipping and falling on a substance left on the floor. A number of our subscribers have also purchased property insurance through our brokerage department. The claims that we handle for these subscribers include buildings damaged by fire or flood; theft from the office or employee vehicles; or equipment that has been vandalized. Rest assured that your claims team is ready for any new claim that comes our way and we are here to provide you with the best service possible! ■

CLAIMS DEFENCE INITIATIVE
ADDRESSES RISING DEFENCE COSTS

In 2011, HIROC began looking at options to mitigate the impact of rising legal defence costs for large subscribers. A leading cause of this increase is taxes, particularly in Ontario. For every dollar of Ontario legal fees, HIROC has to remit 24 cents in tax *(8% Ontario Retail Sales Tax, 13% HST and 3% Premium Tax)*. As a reciprocal, HIROC is not able to claim any HST rebates or input tax credits. After a two-year trial of the program, this fall the HIROC board formally approved the expansion of the Claims Defence Initiative.

HOW IT WORKS
When a subscriber signs on with the program, HIROC amends the insurance policy making it responsible only for indemnity costs *(amounts paid to claimants)*, with the subscriber agreeing to be responsible for defence costs relating to the claims covered by the policy. HIROC then reduces its premium to reflect the reduced costs to HIROC.

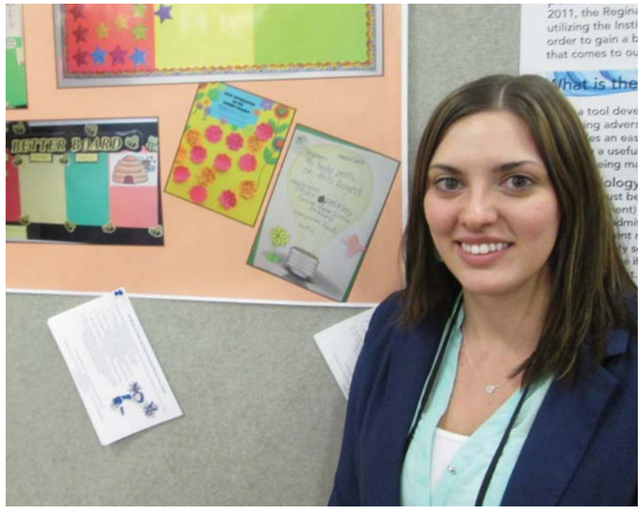
Under the terms of the arrangement, the subscriber appoints HIROC Management Limited *("HML")* as its irrevocable agent to manage claims defence costs in accordance with an Agency Agreement. The agent, on behalf of the subscriber, sets up a claims defence account where the participating subscriber deposits an actuarially-determined amount every year. HML, as agent, manages the account, pays invoices for claims defence costs from the account and prepares quarterly statements detailing the claims defence costs paid, thus enabling the participating subscriber to claim HST rebates.

Each participant also receives a year-end actuarial report prepared by an independent actuary who reviews their claims experience and calculates their actuarial liability for future costs. *(It should be noted that the subscriber does take on additional risk by assuming responsibility for these costs, and a detailed cost-benefit analysis is certainly required.)*

"For now, the program is geared primarily to Ontario subscribers since Ontario is the most heavily taxed province and the program yields a much higher potential return for Ontario subscribers," says says Greg King, VP, Finance at HIROC. HIROC is, however, looking at defence costs for subscribers in other provinces with a view to an expanded roll-out in a year or two.

HIROC is hoping to add at least ten more subscribers in 2014. "Those who participate can expect an 18% reduction in claims defence costs which represents a 5% decrease in overall liability insurance costs," says Greg. "The program is the first of its kind in this area," Greg concludes, "and we know it will deliver what subscribers have been asking for, significant savings on their legal and defence costs and on their overall premiums."

If you'd like more information about the Claims Defence Initiative, please contact Greg King at gking@hiroc.com or 416.730.3045. ■



Nike Rodine, RN and Clinical Improvement Facilitator. Her own project overload became the impetus for for implementing Improvement Boards.

STAFF FIND A VOICE THROUGH IMPROVEMENT BOARDS AT SUN COUNTRY, ALL PROBLEMS DESERVE A PLACE ON THE BOARD

PHILIP DE SOUZA
COMMUNICATIONS AND MARKETING SPECIALIST, HIROC

Niki Rodine, RN and Clinical Improvement Facilitator at Sun Country Health Region beams with pride when asked how Improvement Boards make a difference in healthcare. “It’s great to see a relatively simple idea transform communication between staff and supervisors/managers on issues that are important to frontline staff,” she says.

Niki was introduced to the Improvement Board concept when she attended a presentation by the Saskatchewan Surgical Initiative in November 2011. “I came back with a passion to spread this great idea,” she said.

Niki’s own project overload actually became the impetus for implementing the boards. “I was finding it really difficult to keep track of my projects and ideas,” she says. “I felt like a hamster spinning on a wheel not really seeing any changes or progress.” She got busy and created an Improvement Board in her office with sticky notes of all her ideas and projects. From that starting point, she would move all these sticky notes across the board as she completed items. “It really helped me and my manager actually see how much I had on the go,” she describes. “It also gave me a great sense of accomplishment when I was able to move something into the completed area!”

Her passion for improvement was kicked up a notch from there. “I wanted to get all our staff to speak up about the issues they come in contact with on a daily basis and hear their ideas on how to solve those issues,” she says.

With Improvement Boards, frontline employees now have a voice. “Improvement Boards make improvement visual,” says Niki. “They help all parties remain accountable and they move things along in an efficient manner that maintains staff interest.”

The boards have produced not just buy-in, but solid results. Niki highlights how the Improvement Boards have been instrumental in getting over 100 staff ideas implemented. “In most cases, they were often simple things that managers didn’t realize were a cramp in the daily activities of staff,” she says.

Sun Country can now boast of having an improvement-focused culture. “Staff knows that complaining goes nowhere,” says Niki. “Now they see the power of using their voice to make improvements. This is definitely a move in the right direction.”

The next step for the Improvement Boards is to continue to implement them in all facilities, track progress and follow up with staff to see how they feel about the whole process.

“There are no big problems; just a lot of little problems,” Niki quips, quoting Henry Ford. Her experience with Improvement Boards is proof that when you break down the problems, change is possible. ■

TRANSFORMING PATIENT CARE THROUGH COLLABORATION NO PLANS WITHOUT THE PATIENT PERSPECTIVE AT FIVE HILLS

PHILIP DE SOUZA
COMMUNICATIONS AND MARKETING SPECIALIST, HIROC

Have you ever said, “If only someone asked for my opinion, things would be different in healthcare?” Well, that’s exactly what happened to Rick Farrant, a 67-year old from Moose Jaw, Saskatchewan and a recent patient in the Five Hills Health Region.

After a brief stay in hospital, Rick received an interesting phone call from Bernie Doepker, Director of Community Engagement at the Moose Jaw Union Hospital. “I was asked to participate in a design workshop as a patient representative,” he said. “I was amazed that someone actually wanted patient input.”

The phone call was only the beginning of a series of surprises for Rick. When he arrived at the workshop, Rick was amazed to see board members, directors, the CEO, and other professional people waiting for him and the other invited guests. “I thought I was going to some fancy Tupperware party!” he says, “I wondered, what am I doing here with these people?”

Rick Farrant with HIROC’s Susan Bowen: “It’s just amazing to know that I have made a difference in our healthcare.”

He quickly began plotting a getaway strategy. But what happened that day in the warehouse made Rick glad his getaway strategy was never put into action. “They were actually listening to us,” he says. “They weren’t telling me what to say, rather, they were asking questions and were eager to hear what I felt would work in a hospital.”

Planning was underway for a new facility in the region and the hospital was determined to do things differently. Rick describes going to the first meeting in a giant warehouse, a location chosen so they had room to build mock-ups of the various rooms, departments, and operating theatres to scale. Together, the patient/family representatives, healthcare providers, and architects would collaborate to map out the flows of patients, providers, and supplies.

ACTING ON PATIENT INPUT

What the hospital heard from patients and other stakeholders gave them pause and prompted them to re-evaluate the ways things were traditionally done. While brainstorming the design of the mental health unit, the group saw initial renderings that had patients having to walk through the entire unit to see reception. “From a patient perspective, that didn’t make sense to me,” says Rick. “We suggested that they move reception to the front and then have the patient moved directly into a treatment room so they wouldn’t have to be moved from room to room.” This change was included in the final design.

“I believe that the path that Saskatchewan healthcare is taking is the right path to providing the best service and healthcare to everyone in our province,” says Bernie Doepker. “Collaborating with our patients/family members is a must for this journey.”

“It’s just amazing to know that I have made difference in our healthcare,” Rick proclaims with pride, but more importantly he notes, “And all the more amazing to know that this is a place where patients come first!” ■

"We need to keep collaborating with like-minded organizations such as yours." HIROC's Philip De Souza and Joanna Noble with Accreditation Canada President and CEO, Wendy Nicklin (third from left) and Monica Lovas, Education Services Administrator at Accreditation Canada.

HEALTHCARE INNOVATOR: MUCH TO CELEBRATE AND MUCH TO DO WHEN IT COMES TO CREATING A SAFER HEALTHCARE SYSTEM

AN INTERVIEW WITH ACCREDITATION CANADA'S WENDY NICKLIN
PHILIP DE SOUZA
COMMUNICATIONS AND MARKETING SPECIALIST, HIROC

Healthcare leaders need to identify some core standardized indicators, with targets, of health and quality outcomes.

It's a glorious, sunny August weekend in the Nation's capital and more than 500 Accreditation Canada surveyors *(known as "Ambassadors of Quality")* have gathered at the Westin Hotel Convention Centre. They come together every three years to celebrate achievements, receive updates on the accreditation program, develop new skills and build on best practices.

HIROC was fortunate to pry Wendy Nicklin, Accreditation Canada's President and CEO, away from her peers to find out what's next for her and her team.

Q: WHAT ARE SOME OF ACCREDITATION CANADA'S KEY ACHIEVEMENTS?

A: Research-based best practices are absolutely critical to ensuring a safer system. We convened the Patient Safety Advisory Committee with the goal of identifying the top five or six best research-based practices to mitigate risk. After a few gruelling brainstorming sessions, they selected 21 best practices from a list of 100.

The first 21 Required Organizational Practices *(ROPs)* were released in 2005. There was some pushback from healthcare leaders who said it was unrealistic to expect them to comply with such an extensive list. The team worked with key partner organizations *(CPSI and HIROC)* to ensure alignment of language, direction and commitment.

In the end, the introduction of the ROPs was a success and – based on feedback – we have continued to improve the clarity of 'evidence of compliance'. New ROPs for different healthcare sectors *(e.g. homecare, long term care)* have been developed and an ROP lifecycle is now in place that removes ROPs from the list when compliance is high.

The Qmentum accreditation program is built on eight dimensions of quality, and of those, two are focused on patient safety and worklife. We knew we needed standards for healthcare providers and their work environment; a work environment where staff feel safe and know their decisions are respected has a strong impact on healthcare provider satisfaction and quality of care.

Q: SINCE QMENTUM WAS ROLLED OUT, WHERE IS ACCREDITATION CANADA SEEING THE GREATEST AREAS OF IMPROVEMENT?

A: Improvements are happening throughout the continuum of care and we're encouraged by widespread acceptance of the need for a culture change. Quality and safety are everyone's responsibility. We can longer say, "Oh, safety, that's not my business." From CEOs to frontline care providers, we all must strive for improved collaboration and a mutual focus. While challenges remain, it is gratifying to see all the improvements that are happening and celebrate those successes.

Q: WHERE DO THE GREATEST CHALLENGES REMAIN?

A: When you look at Canada, there are really 14 very different healthcare systems – jurisdictional and national. While we are all committed to population health and improving quality of care, there are varying agendas.

First, there is need for a 'vision' of health and healthcare for Canadians. As a country, what are our goals? Second, healthcare leaders with a national perspective need to identify some core standardized indicators, with targets, of health and quality healthcare outcomes. Individual jurisdictions could then build on those indicators with their own geared to regional issues and priorities.

The Council of Federations is a good platform with the potential to move in this direction.

I was recently in China speaking at a conference with other colleagues, including Dr. Mike Durbin from the UK. After hearing about the framework being used in the NHS *(National Health System)* in the UK, I thought to myself, why not here?

Q: HOW CAN WE MAKE THIS VISION A REALITY?

A: Well, first we need to keep collaborating with like-minded organizations such as yours. HIROC does a fantastic job helping its subscribers identify trends, implement strategies and offer solutions to improve patient safety. Other national organizations like CPSI, CIHI, CFHI, Accreditation Canada and the Health Quality Councils are also adapt at partnering.

It's essential that we don't reinvent the wheel. We need to build on the knowledge, expertise and wisdom of our colleagues.

Look at airline pilots. They work for different airlines that are competing for passengers, however they never keep valuable information to themselves. Safety and transparency come first. If there is a particular airport with a tricky landing, they will radio the pilots who are coming in behind them on final approach and share what they know.

Q: WHY IS THIS SURVEYOR CONFERENCE SO IMPORTANT?

A: Our surveyors give their time and expertise to Accreditation Canada – participating on surveys, advisory committees and in other ways. All this while working full-time in healthcare. This conference is our opportunity to give back to them. They network, listen to experts like Jeffrey Braithwaite *(see below)* and learn about updates to the Qmentum program and future directions of Accreditation Canada. For us, we benefit from hearing their feedback on what is working or not working, and new trends they're seeing in the field.

Q: DURING JEFFREY BRAITHWAITE'S KEYNOTE, HE SAID THE FOLLOWING, "WENDY IS A LEGEND OUTSIDE OF CANADA". WHAT DO YOU THINK ABOUT THAT?

A: It was very thoughtful of Jeffrey to say that and very humbling. My primary goal is to contribute to improving the quality of healthcare within Canada. Accreditation Canada is 55 years old, the second oldest health services accreditation program in the world. This depth and breadth of experience is valued worldwide.

While we will continue to improve the program and strengthen its value and relevance within Canada, it is often only when you are outside of your own country that you realize we are doing great things here and should be proud of what has been accomplished!

***Note:** Professor Jeffrey Braithwaite is the professor and Foundation Director of the Australian Institute of Health Innovation, and professor and Director of the Centre for Clinical Governance Research in Health, both based in the Faculty of Medicine at the University of New South Wales.* ■

HIROC Board Member and Chief Executive Officer of the Central CCAC Cathy Szabo (centre), together with colleagues Mary Burello-Cordovan (left) and Yvonne Ashford, accepting the 2013 Canadian Innovation Best Practice Award from the National Research Corporation.

CENTRAL CCAC WINS CANADIAN INNOVATION BEST PRACTICE AWARD

MMSS REDUCES MEDICATION ERRORS AND KEEPS PEOPLE SAFER, HEALTHIER

HEATHER DOYLE

In our quest to create the safest healthcare system, it's always thrilling to see our subscribers being recognized for furthering that goal.

In September, the Central Community Care Access Centre *(CCAC)* was awarded the 2013 Canadian Innovation Best Practice Award from the National Research Corporation for its Medical Management Support Services *(MMSS)* Leading Practice. HIROC Board Member and Chief Executive Officer of the CCAC Cathy Szabo accepted the award on the organization's behalf.

The Innovation Best Practice Award is an annual award presented to a Canadian organization that best demonstrates an innovative service that results in significant improvements in patient-centred care and health outcomes. "With more people leaving the hospital sooner and living in the community with complex medical conditions, delivering safe, quality care at home is more important than ever," says Cathy Szabo, CEO of the Central CCAC. "We thank the NRC for acknowledging these successes." In 2008, the Central CCAC partnered with the Institute for Safe Medication Practices *(ISMP)*, Mackenzie Health, and the other hospitals in the Central region to develop Medication Management Support Services *(MMSS)*. A key goal of Medication Management Support Services *(MMSS)* is to improve the safety of patients as they transition through the health system.

SITTING DOWN WITH PEOPLE IN THEIR HOME ENVIRONMENT

MMSS targets adult patients with complex medical conditions such as those with more than one chronic condition or taking more than three prescription medications. A few days after that patient is discharged from the hospital, a pharmacist visits his or her home to conduct in-depth medication reconciliation.

This simple step is the key to the service's success. "The beauty of this approach is that it teaches people about proper medication use and then lets them self-manage," says Cathy. "This reduces the chances of improper medication use causing their symptoms to worsen or their health to decline."

The pharmacist double-checks dosages and make sure the packaging is suitable and can be opened without difficulty. It's not unusual to find two medications doing the same thing and one can be eliminated. The pharmacist also communicates with the patient's family doctor about their medications.

It's no surprise that this personalized approach is keeping people safer and healthier. Of the 1,679 people receiving MMSS in 2012-2013, 67 per cent reported fewer visits to the emergency department; 62 per cent reported a decrease in falls; and 55 per cent reported less pain. MMSS is also delivering cost savings. It saves the Ontario Drug Benefit program approximately $55 per patient for a total of $325,000 in savings so far.

The Medication Management Support Service is now a core part of the CCAC's integrated approach to healthcare. "Our organization is committed to patient-centred care and patient safety," says Cathy. "Patients come to us expecting to get the best possible care. This helps us deliver." ■

ASK A LAWYER

A PRIMER ON CLASS ACTIONS: WHAT ARE THEY & WHY ARE THEY SIGNIFICANT?

JONATHAN GUTMAN
GENERAL COUNSEL, HIROC

Q: WHAT EXACTLY IS A CLASS ACTION? WHY ARE THEY SIGNIFICANT? WHAT KINDS OF CLAIMS ARE BROUGHT THIS WAY?

A: A class action is a lawsuit in which a plaintiff *(called a representative plaintiff)* starts a proceeding on behalf of itself and a larger group of plaintiffs alleging a common cause of action against one or more defendants. Before a lawsuit can proceed as a class action, the class must be certified by a court; not just any lawsuit will qualify.

Generally speaking, for a class to be certified, the court must be satisfied that there is an identifiable class of people, whose claims raise common issues, and whose interests can be fairly and adequately represented by the proposed representative plaintiff. The court must also conclude that a class proceeding is the preferred procedural route.

Different provinces have different procedures for determining who is part of a class. In some cases, class members are automatically included if they meet certain criteria unless they opt out. In other cases, they have to opt in. In both scenarios, it is important to provide adequate notice to potential class members so that they can choose whether to be part of the class. This is often accomplished via media publications, such as newspaper notices. A wide variety of substantive claims can be advanced in a class action. In the healthcare sector we have seen class actions about improper sterilization of equipment, nosocomial infections, faulty implants, monitoring of physicians and poor lab processes. There has also been a class action regarding the loss of a USB key with personal information of people who received H1N1 shots.

Those class actions of greatest concern to HIROC and subscribers are, obviously, those in which subscribers are named as defendants. However, subscribers can also be indirectly involved by being part of the notification process. In class actions alleging, for example, faulty implants, subscribers are uniquely positioned to be able to identify who might properly belong in a class and may be called upon (or ordered) to assist with notifying those individuals. This kind of participation still imposes burdens on subscribers, but not nearly to the same extent as actually being named as defendants.

Because the claims of a number of people are combined, the total costs of defending a class action can be very large even if each individual's award (or potential award) is relatively modest.

For example, the settlement of one class action related to nosocomial infections provided for payments of about $4,000 - $40,000 to each patient in the class and their family, depending on symptoms suffered. The total payments to this class amounted to about $7.5 million, not including class counsel fees. On top of those expenses, class actions such as this are complex and usually involve significant defence fees. They are therefore significant pieces of litigation for any subscribers involved and for HIROC. ■

HIROC was executive sponsor at this year's Canadian Association of Midwives Annual Conference, held in Ottawa in early November. (from left): Eileen Haghverdian (HIROC CSR), Sister Rose (midwife from Haiti), Gareth Lewis (HIROC Manager, Claims), Jessica Hanna (HIROC Claims Examiner) and Trina Davidson (HIROC Midwifery Team Leader).

LIABILITY RISK REDUCED WHEN MIDWIVES WORK AS PRIMARY CARE PROVIDERS

Physicans, nurses and healthcare organizations could all reduce their liability risks by allowing midwives to maintain primary care of their clients. "The minute a midwife is supervised by another practitioner, that increases the other practitioner's liability exposure," says Joanna Noble, healthcare risk management supervisor at HIROC. Joanna explains that if a hospital policy dictates that a doctor or nurse must share care when a midwife's client is undergoing an epidural, that physician or nurse may be exposed to liability by taking on this supervisory role.

"From our perspective," says Joanna, "that's increasing the risk because (monitoring a woman who has had an epidural) is within the scope for midwives." That perspective is shared by Dr. Douglas Bell, the Associate Executive Director and Managing Director, Risk Management and Communication Services at the Canadian Medical Protective Association (CMPA). "There's no requirement for a mandatory transfer of care when a midwife patient has an epidural, but for some reason, at some hospitals, they make that rule," he says. "The issue to be explored is: why make a non-mandatory transfer into a mandatory transfer? We caution against making a change if you're not solving an issue."

VICARIOUS LIABILITY A POSSIBILITY

Against their better judgment, hospitals may also be exposing their organizations and their nursing staff to vicarious liability when nurses are assigned to monitor the augmentation of labour and supervise midwives.

"The problem," says Joanna, "is that you're involving a practitioner who doesn't have the same scope of practice, philosophy, skill set and experience as the midwife."

HIROC and CMPA have issued a Joint Statement on Liability Protection for Midwives and Physicians that states, "Each healthcare professional, both individually and as a member of the healthcare team, is accountable for his or her own professional practice." In other words, each provider is only responsible for the care she or he provides to a particular client, not for the care provided by another health professional.

"Because there are three separate insurances in place – one for physicians, one for hospitals and their employees, and one for midwives – and each party has appropriate and adequate limits of liability, physicians shouldn't be concerned about being held responsible for the actions of a midwife," says Joanna and emphasizes, "Midwives are independent practitioners. Successful hospital integration comes down to processes, good communication and trust." ■

Jane Somerville, head midwife at KGH and a practice partner at Community Midwives of Kingston, says both clients and midwives benefit from the new protocol. (photo by Matthew Manor/KGH)

MIDWIVES MAINTAIN PRIMARY CARE UNDER NEW EPIDURAL PROTOCOL AT KGH

For midwifery clients at Kingston General Hospital (KGH), having an epidural used to mean a mandatory transfer of care from their midwife to an obstetrician. Now, a new protocol maintains primary care for midwives, ensuring high client safety and maximizing efficient use of health care resources.

As continuity of care is one of the main reasons that many women choose to have a midwife, clients were very disappointed to lose the primary care provider who had spent nine months building a relationship with them. It also meant that some clients didn't have access to epidural pain management until a registered nurse was available to manage the technique.

One year ago, after ongoing advocacy efforts by the midwives to work to their full scope of practice, the hospital changed their protocols regarding monitoring clients with epidural.

Jane Somerville, the head midwife at KGH and a practice partner at Community Midwives of Kingston, says both clients and midwives benefit from the new protocol.

"It has facilitated more understanding and respect among the professions on the labour floor," says Somerville. While the midwives had been advocating for full scope of practice for a number of years, Somerville says having a hospital President and CEO (Leslee Thompson) who believes that all practitioners in the organization should be working to their full scope helped move the process forward.

"It changed the culture of the institution. As an individual within a department, I was able to quote the hospital's strategic plan and ask 'how we can we work on this?' It was within the context of a bigger vision and that made a difference for us," says Somerville.

According to Somerville, the change in protocol has been well-received by members of the interprofessional maternity care team. "The overall impression is that nursing is very happy about this change, anaesthesia hasn't identified any concerns, and women are happy."

To read the Association of Ontario Midwives position statement regarding Maintaining Primary Care, go to, www.aom.on.ca/Communications/Position_Statements *(This article was reprinted from the OHA Today's Special Issue Newsletter on Maternal and Newborn Care, October 2013, with the permission of Kingston General Hospital.)* ■

NHH Director of Environmental Services Wayne Goodwin (holding award) and VP Human Resources and Quality Elizabeth Vosburgh (far left) with representatives from NHH's Environmental Services Department and Occupational Health and Safety Committee.

HIROC 'PROPERTY CHAMPIONS' RECOGNIZED WITH HPR AWARDS

This year, for the first time, the FM Global Highly Protected Risk (HPR) award was rolled out to six HIROC subscribers who passed a rigorous series of both physical deficiency management tests and critical human element programs.

FM Global presents the HPR award to organizations that show a continued commitment and dedication to achieving a higher level of property risk management. The signature of an HPR facility is that all reasonable precautions are used to reduce the likelihood and severity of property loss or damage. In presenting the award to Rouge Valley Health System, Daniel Kotwinski, FM Global Account Engineering Department representative said, "The HPR Award doesn't start with the first inspection. It's a philosophy the facility builds up over time and that philosophy is definitely evident at Rouge Valley."

In times of fiscal restraint, making all the necessary adjustments and improvements to the physical space can be a challenge, but it's not one that Mauro Camaganacan, Facility Manager at Rouge Valley has ever shied away from. "If there are gaps, the whole organization suffers," he says. "I'm always thinking of ways we can mitigate risk and taking those steps doesn't always cost money."

"At the end of the day, this award embraces the safety aspect of what you're trying to do with your facility," said Rick Gowrie, VP, Planning, Capital Redevelopment, Facilities and Support Services at Rouge Valley. "Being recognized for that is very motivating for the team."

THE LAST THING YOU WANT TO WORRY ABOUT IS A SYSTEM NOT WORKING RIGHT

From their very first site visit in 2009, FM knew that the Northumberland Hills Hospital in Cobourg was well on their way to completing key criteria. Only a few small human elements were outstanding at the next visit in 2012, and by 2013, the hospital had moved into the number one spot as the HIROC subscriber with no outstanding recommendations.

Elizabeth Vosburgh, VP, Human Resources and Quality thanked the the Northumberland team for doing a fantastic job. "We've consciously made an effort to deal with life safety issues, and being number one of 204 sites is a real honour."

Director of Environmental Services, Wayne Goodwin smiled slyly as he admitted, "I feel like I'm being awarded for having OCD!" When you're overseeing the operational continuity of a large healthcare facility, maybe being a bit obsessive compulsive isn't a bad thing. "We do fire drills in every shift at least once a month, we validate everything, and we do preventive maintenance all the time," he says. "We're in a hospital. The last thing you want to worry about is a system not working right."

The HIROC recipients of the FM Global/ HIROC HPR Award for 2013 are:

- Northumberland Hills Hospital
- Women's College Hospital
- William Osler Health System – Brampton Civic Hospital
- Rouge Valley Health System – Ajax & Pickering Site Hospital
- Interlake Regional Health Authority – Gimli Community Health Centre
- Interlake-Eastern Regional Health Authority – Pine Falls Hospital Health Complex

"Although all six facilities range in size and focus, they all share key qualities," said Daniel, "a strong willingness to implement the recommendations and continue ongoing programs in pursuit of a safer facility, and strong support from management in making that happen." ■

Mauro Camaganacan, Facilities Manager with the Facilities team at Rouge Valley Health System.

HIROC's Susan Bowen and FM Global's Daniel Kotwinski (right) presenting HPR awards to John Stinson, CEO, Interlake-Eastern Regional Health Authority, Pinawa, Manitoba.

HPR AWARD CRITERIA

DEDICATED TO **PROPERTY LOSS PREVENTION**

What goes into winning an HPR Award Qualification is based on the completion of key set criteria which collectively indicates a facility's ongoing commitment to the philosophy of property loss prevention and sound engineering judgment. Specifically, base criteria are defined as:

CRITICAL HUMAN ELEMENT PROGRAMS

Roughly 70% of all losses are generated by the actions, or inactions, of people. The following items have been found to be the most critical to reduce this fraction:

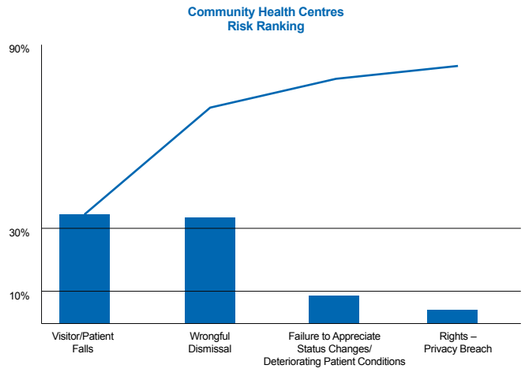
a. Ensuring fire protection system reliability through regular recommended valve inspections and impairment management using the Red Tag Permit System;

b. Ignition source management through use of systems such as the Hot Work Permit System;

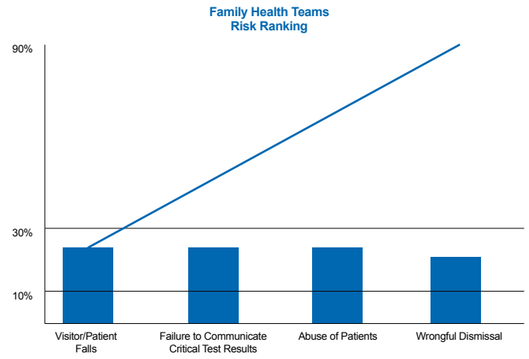
c. Flood risk mitigation through the preparation of an adequate Flood Emergency Response Plan *(if required)*.

2. PHYSICAL DEFICIENCY MANAGEMENT

To support the ongoing efforts of facility staff, adequate protection systems must be in place to ensure that any loss, should it occur, is mitigated to tolerable levels. This is achieved through installation of at least 90% of required automatic sprinklers and the elimination of other significant hazards that can cause lengthy displacement of patients and long-term restoration to operations. ■



Top risks for community health centres (CHCs), identified from claims reported to HIROC (all years). These four risks comprise 80% of claims costs for CHCs.



Top risks for family health teams (FHTs), identified from claims reported to HIROC (all years). These four risks comprise 100% of claims costs for FHTs.

RMA

ROLLOUT OF RAC TO NON-ACUTE CARE SECTORS

Risk Managers in acute care settings welcomed the introduction of the Risk Assessment Checklists (RAC) program into their facilities last year. We've continued to make refinements to the program, adapting it to different sectors and are now ready to roll out the RAC to the non-acute care sectors.

Like acute care, the RAC program for non-acute care sectors focusses on the highest-ranked risks for each sector, as identified from claims reported to HIROC.

Modules, or checklists, containing the ten most impactful mitigation strategies for each risk, form the basis of the program. Organizations then determine the extent to which mitigation strategies are in place.

Risk Assessment Checklists follow a straightforward three year cycle:

Year One: You have 6 months from start date to complete submission.
Year Two: HIROC provides a copy of Year One submission to your organization. Your organization updates responses. Due date – one year from Year One due date.
Year Three: HIROC provides a copy of Year Two submission to your organization. Your organization updates responses. Due date – one year from Year Two due date.

At the completion of each cycle year, organizations receive a 5% discount on their liability premium.

In Fall/Winter 2013, the program will be rolled out to:
- Community health centres – top 4 risks identified:
- Family health teams – top 4 risks identified
- Nursing homes – top 12 risks identified
- Hospices/non-hospitals with beds – top 6 risks identified
- Mental health hospitals – top 17 risks identified
- Colleges and regulatory authorities – top 5 risks identified

In early 2014, the program will be rolled out to:
- Chronic care/rehabilitation hospitals and facilities – top 13 risks identified
- CCACs – top 19 risks identified
- Home care providers and agencies – top 18 risks identified
- Cancer care organizations – top 2 risks identified
- Midwives – top 19 risks identified

For more information or to enroll in the program, please contact riskmanagement@hiroc.com or Sara Chow at 416.730.3084. ■

Heather Brown, VP, Insurance Operations at the 2013 HIROC AGM and Risk Management Conference.

SAVE THE DATE FOR HIROC'S ANNUAL GENERAL MEETING AND RISK MANAGEMENT CONFERENCE

MONDAY, APRIL 28, 2014

Who should attend – CEOs, Board Members, CFOs, Risk Managers, Patient Safety and Quality Managers, Patient Relations staff and those who manage claims and insurance. The detailed agenda and on-line registration information will be emailed to you in the new year and posted on our website: www.hiroc.com.

What to look forward to – Please arrive at 8:00 a.m. for a Continental Breakfast. The AGM starts at 8:30 a.m., followed by the Conference at 9:30 a.m. until 3:30 p.m. In addition to networking with your colleagues, at the AGM you will elect Directors, accept the 2013 Audited Summary Financial Statements, appoint the Auditors, and receive the annual reports from Board Chair Elizabeth Bardon and CEO Peter Flattery. At the Conference you will hear from a variety of speakers and participate in informative break-out sessions.

Webcasting – It was such a success last year, we will once again be simulcasting the Healthcare Risk Management Conference across the country. Why not make it an event at your organization as well? Gather your entire team and tune in.

Venue Partner – For this important event, HIROC is pleased to be bringing on a venue partner who understands the needs of our subscribers. This high-quality venue is ideally situated and was open to hosting our event at a lower price than what we've previously paid – thank you Ritz-Carlton, Toronto!

Accommodation – The Strathcona Hotel Downtown *(a 5-minute walk to The Ritz-Carlton)* 60 York Street, Toronto, ON, has also partnered with HIROC offering subscribers their Executive Rooms at a discounted rate of $159.00, plus taxes. Make your reservation **before March 28, 2014** by calling 416-363-3321 or emailing reservations@thestrathconahotel.com.

ATTENTION SUBSCRIBER CEOs OR YOUR DELEGATE: To ensure a quorum is present to conduct the business at the AGM (elect Directors, accept the year-end Financial Statements, etc.) it is very important that you or a delegate from your organization attend at 8:30 a.m. on April 28th. Should circumstances not allow a subscriber representative to be present in person, please complete and return to the Secretary, Heather Jakobsen, c/o the HIROC Toronto office, (or via email to: hjakobsen@hiroc.com) the Proxies on behalf of BOTH the Reciprocal and HIROC Management Limited before Friday April 25th.The Proxies will be included in the "AGM Package" that will be sent to you in March 2014. ■

CUT THROUGH THE CLUTTER WITH **RISK WATCH**

A publication launched by the Healthcare Risk Management Department at HIROC in January 2013, provides selected research, publications and resources to promote evidence-informed risk management in Canadian healthcare organizations.

You can download Risk Watch from the hiroc.com website. Visit the Risk Management page – the newsletters are located under Tools and Resources. ■

HIROC

WELCOMES NEW SUBSCRIBERS

ONTARIO

Central Ontario Healthcare Procurement Alliance COHPA is a non-profit, independent corporation owned by six member hospitals and governed by an independent Board of Directors. COHPA has implemented a standardized information technology platform and leading practices to provide integrated Supply Chain Management services to affiliates. Ms. Lynn Younis is Director of Finance for the Alliance located in Richmond Hill, Ontario.

The newly established practice of **Grand Valley Midwives** is located in the scenic town of Grand Valley, Ontario. The midwives are committed to providing expert, client-centred care to expectant mothers who reside primarily in rural areas including several Mennonite communities. Ms. Heather Clinch is the Registered Midwife and Sole Proprietor of this practice.

Lincoln Community Midwives is a new practice group providing excellent care to expectant mothers of the West Niagara region. Working in a team approach, the midwives offer all the care necessary to women and their babies during pregnancy, birth, and six weeks post delivery. Located in Beamsville, Ontario, Ms. Pilar Chapman is one of five dedicated midwives associated with this practice.

ALBERTA

The College of Midwives of Alberta (CMA) is the newly formed, independent regulator for over 70 practicing Registered Midwives in Alberta, and assumes all responsibilities and functions of a professional college. It is estimated that 2% of babies in Alberta are delivered by midwives, and approximately 50% of the births attended by midwives occur in hospitals. CMA promotes a model of care for the profession, and for women by providing standards and guidelines for the midwives that ensure quality of care and protection of the public. Ms. Diane Rach is President of the College located in Calgary.

SASKATCHEWAN

The **Saskatchewan Association of Health Organizations Inc. (SAHO)** works on behalf of Saskatchewan health agencies to negotiate and interpret collective bargaining agreements with healthcare labour unions. SAHO promotes positive employee relations, and consultants provide advice to members on contract administration and human resource management. Located in Regina, Mr. Bernie Young is Interim Chief Executive Officer, and Mr. Ian Billett is the Human Resources Services Manager.