SEIU-West:

Lab Services in the New Saskatchewan Health Authority: Submission of SEIU-West to the Transition Team Pathology and Laboratory Medicine Working Group

Submitted October 6, 2017

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EXECUTIVE SUMMARY

When the Pathology and Laboratory Medicine Working Group reached out to consult SEIU-West about the future of laboratory and pathology services in Saskatchewan, SEIU-West reached out to the real experts: the more than 600 SEIU-West members who work in the public lab/path sector. In face-to-face encounters and an online survey, members told us that:

- Workload has increased significantly in recent years.
- Some of this increase is due to population growth, population aging, and the growing prevalence of various chronic diseases, but a large proportion is due to inappropriate test ordering and poor management.
- Staffing levels have not kept up with the growing workload: 69 percent of members said that they work short-staffed at least once a week. Staff are facing mounting levels of stress and burnout, making it increasingly difficult to deliver precise, high-quality testing.
- Recruitment, training, and retention of sufficient numbers of competent staff is a growing challenge that will made worse by the Saskatchewan government's threats to impose a 3.5% compensation rollback followed by several years of freezes.
- The closure of the public bus company STC, at a time when the number of rural specimens being shipped to Saskatoon has been steadily increasing, has had major negative effects on access to timely laboratory services.
- There is significant anxiety around whether the creation of the Saskatchewan Health Authority will involve further privatization of lab services, and/or current lab sector employees losing some or all of the rights and negotiated benefits of belonging to their current union.

SEIU-West calls on the government and Health Ministry to be much more transparent about their plans for health care transformation, including their plans for the delivery of laboratory and pathology services. While we endorse the Working Group's September 2017 service delivery model document in principle, the document is woefully short on detail, and there are troubling hints in it of plans for further privatization. The Working Group's governance model document is even more short on details, but if the proposed governance structure is largely populated by the same senior managers who have presided over the lab sector for the past decade, we doubt that the critical issues that have been brewing in the lab sector for the past decade on their watch will be successfully addressed. The governance and transition models from other jurisdictions outlined in the files supplied by the Working Group offer few insights that are applicable to the Saskatchewan context, except that we should avoid structures that are too complex to be transparent, and above all avoid Alberta's experience of having to pick up the pieces of several ideologically-driven attempts to privatize lab services. Finally, SEIU-West insists on the right of all laboratory staff to be able to retain their current union membership during and after the transition to one health authority.

BACKGROUND

SEIU-West represents approximately 12,000 employees of the Saskatoon, Five Hills, Heartland and Cypress health regions, including approximately 630 who provide laboratory and pathology services. About 73% work in SHR, while the other three regions have 7-11% each. The four largest job classifications are Medical Laboratory Technologists (MLTs, including the MLT I, MLT II, and MLT Supervisor classifications) who make up 49% of this group, Combined Laboratory and X-Ray Technologists (CLXTs, 19%), Laboratory Assistants (MLAs, 15%), and Phlebotomists (11%). The remaining 6% includes technologists, assistants, support staff and supervisors working in laboratory information systems, (histo-)pathology, cytology, and cytogenetics.[1]

On July 20, 2017 SEIU-West President Barb Cape received a letter from Patrick O'Byrne, Executive Director of the Saskatchewan Disease Control Laboratory, on behalf of the Pathology and Laboratory Medicine Working Group of the Ministry of Health's Transition Team. The letter informed us that the group was working on how laboratory services would be delivered under the new Saskatchewan Health Authority, and invited our feedback on "creating an organizational structure best able to make…decisions" regarding "which tests or services are provided in different locations". The covering e-mail directed us to a Google Drive file[2] containing some 300 pages of documents on various aspects of lab services (re)organization and delivery in Alberta, BC, Manitoba, Ontario, and Saskatchewan.

This letter set in motion two lines of work within SEIU-West:

I. Assimilating and contextualizing these documents to determine (a) what the Ministry's plans for lab services might be (the latest iteration in our attempts to make sense, in a low-transparency environment, of the government's agenda for health system transformation); (b) what, if any, of the experiences and approaches of other jurisdictions is relevant to the Saskatchewan lab/path context.
II. Reaching out to our member-leaders who work in the laboratory sector, including development and preliminary testing of an online survey.

On September 18 Mr. O'Byrne sent Ms. Cape two documents: a "draft governance model" and a "high-level service delivery model" for laboratory services in Saskatchewan. The cover letter also included several discussion questions, and invited SEIU-West's written feedback no later than October 6: "We would like to use these draft documents as the basis for further consultation with you and your organization." The letter acknowledges that "many of the items in the service delivery model speak to day to day issues you experience in the laboratory system", and goes on to ask, "To help us prioritize where our attention should be focused, we would like to understand your experiences. Are there any specific examples you can provide…?"[3]

[1] Source: RHA seniority lists, Q2 2017.
[2] Lab Org Documents. https://drive.google.com/open?id=0B9TnfpyFw4NeZXNfVW5OY0M3bEE
[3] We gather that a similar letter was delivered to all RHA laboratory staff on the same day.

We immediately revised the survey to reflect the new service delivery model document. The survey went live on September 19.

After multiple telephone and email exchanges with Judy Archer (head of SHR labs and member of the Working Group) and other health region lab managers, we arranged the following occasions where SEIU-West and/or member-leaders explained and promoted the survey to our lab sector members:

- Sept. 19: Presentations at the various lab department huddles at 3 Saskatoon hospitals, and via conference call with SHR rural labs
- Sept. 20 Conference call with lab staff at Wigmore Hospital in Moose Jaw
- Sept. 21 Conference calls with FHHR rural, CHR, and HHR lab staff
- Sept. 27 reminder message sent out via RHAs' LIS.

We wish to acknowledge the support and assistance of Ms. Archer and the other lab leaders. However, it is worth noting that some of them wondered about whether a survey with a significant focus on workload issues was truly relevant to what they saw as a consultation about "high-level governance issues".

With respect, this attitude betrays a profound misunderstanding of the proper roles of (i) a union like SEIU-West and (ii) leaders engaged in public sector health governance reform.

SEIU-West's mandate obliges us to advocate on behalf of the needs and interests of our members. This requires that we accurately reflect their workplace experiences in all that we do. In addition, SEIU-West is mandated to advocate for a more just and humane society for all, not merely our members. We stand for economic and social justice, for dignity and respect, for having a voice on the job and in society, and for a secure job with the opportunity to advance. We believe that a public, universal health care system is fundamental to these goals. The majority of our members work in the public health care system. In short, for multiple reasons central to our mandate, the workplace experiences of our lab sector members, including their workload, must be a central part our participation in a lab services review.

As for those who are orchestrating health system transformation in Saskatchewan, they too must never lose sight of the facts on the ground, including the workload of health care employees. So far, the transition (or at least those parts that have been publicly visible) has been focused on high level governance. However, this transformation was untaken not merely or mainly to devise a more perfect governance structure. Governance reform is not an end in itself. The people of Saskatchewan were told that health sector governance reform was undertaken to improve patient care and make the system more sustainable. Sustainable patient-centred care depends on recruiting, training and retaining sufficient numbers of the front-line staff who actually deliver care. The workload that staff faces is an indispensable part of the picture.

Both the service delivery model and governance model the Working Group has asked us to review are remarkably brief and vague. While we do not question the good faith of those on

the Working Group, we are left with two highly troubling alternative explanations for the lack of detail, both of which point an accusing finger at the Ministry: (1) the Ministry has been making up health transformation on the fly, without a detailed plan; (2) much of the plan was set in stone months or even years ago, and is being revealed piecemeal to minimize opposition and create the illusion that the various consultation processes that have occurred in the past two years—including the current lab service consultation--are genuine and meaningful.

Reviewing the governance model document, "SHA Transition Management Structure & Membership", we wonder whether this new arrangement will focus narrowly on expenditure reduction, or focus on the holistic needs of patients, including the needs of the communities in which those patients live and on which they depend, and the needs of the workers who deliver their care.
A governance structure is only as good as the people who populate its upper levels. In filling the highest levels of the new Saskatchewan Health Authority the Ministry has declared a bias in favour of people who are already part of health care management in Saskatchewan. If the new SHA lab governance structure is run by the same people who have presided over a decade of neglect of the lab/path sector in Saskatchewan, we do not have confidence that the current challenges facing the sector will be properly addressed.

The Service Delivery Model document lists ten "items we consider essential to an effective service delivery model". We endorse all of them in principle, but the devil is in the details, which are sadly lacking in this document. There are aspects in the following that raise specific concerns.

- *Robust transportation infrastructure*
    - This item, particularly its statement that the transportation system "will be specialized" raises issues and concerns about whether this will involve further privatization of lab services. SEIU-West was well aware of the role played by the private provider Gamma-Dynacare in Saskatchewan. However, it was not until early September that we learned of the presence of Ontario-based LifeLabs LP in the province. Our SHR members informed us that LifeLabs has been providing lab courier service to and from SHR rural lab sites roughly since the closure of STC. Subsequent investigation into this arrangement leads us to wonder whether LibeLabs received advance information about the decision to close STC. A search of entries in the Saskatchewan Lobbyist Registry suggests that LifeLabs began lobbying the Saskatchewan Ministry of Health as early as April 2016, with a focus on "gather[ing] information related to policies and programs concerning diagnostic laboratory services in Saskatchewan", "promot[ing] the services of LifeLabs as a service provider in Saskatchewan," and "communicat[ing] LifeLabs' integrated diagnostic services capacity to support health system outcomes and sustainability". According to the ISC Corporate Registry, LifeLabs LP registered to do business in Saskatchewan effective January 4, 2017. The closure of STC was announced in March, to take effect in May. In April Saskatoon Health Region issued a Request for Proposals (RFP) for an Automated Specimen Tracking System. The RFP was to close in May. The RFP stated that Dynacare "as exclusive

agent for all laboratory products and services" for SHR "reserves the right to reject all proposals…and/or enter into negotiations with any party". SEIU-West does not endorse a privatization by stealth approach to the improvement of lab transportation in Saskatchewan. Transparency and accountability are vital parts of our public health care system, but they are not achievable if key aspects of the public lab sector are hidden behind a veil of corporate secrets. As seen in the discussion of the survey comments below, our members were blindsided by the closure of STC, with major impact on their workloads.

- *A short- and long-term HR strategy*
    - The document describes this as "critical". Our lab sector members agree, as is clearly seen in the survey results summary below. The question is: why has management allowed the situation to become so critical? The shortage of lab staff is not new: SHR's July 2010 list of "Hard to Recruit Opportunities" included MLAs and MLTs. The August 2017 list still included these classifications as well as CLXTs, Cytogenetics Technologists, and Phlebotomists. If the persons responsible for developing the SHA's lab HR strategy are the same people who presided over nearly a decade of "crisis", we are not confident.
- *Robust LIS*
    - Our survey results suggest strong support for this (but as the responses to Q23 indicate, some members have their doubts and misgivings).
- *Standardized test menus, "to ensure scare laboratory resources are being chosen wisely"*
    - As discussed in detail below, our survey suggests that our members strongly endorse this idea. We wonder, however, whether the impending ability of pharmacists to order laboratory tests runs counter to the goal of "choosing wisely".
- *Special focus on provincial public health system*
    - We endorse this item, but are concerned about the implications of the forced transfer of employees from the Saskatchewan Disease Control Laboratory (SDCL) to the SHA. Section 9-1 of the *Provincial Health Authority Act* states that "notwithstanding any other Act or law or any provision of any contract" employees can be transferred from the public service to the SHA or from the SHA to a prescribed "health care organization"—which need not be public. Rick Hischebett from the Ministry of Justice told a legislative committee[4] that the main driver for this provision was to override collective agreements so that SDCL employees could be transferred to the SHA without triggering contract provisions that require that the employees be given notice or compensation.
- *"specialized approach to materials management needs"*
    - As with the use of "specialized" in the transportation item, we have concerns that this implies a greater role for the private sector in the provision of lab services.

[4] Standing Committee on Human Services. Hansard Verbatim Report No. 31—May 3, 2017. http://docs.legassembly.sk.ca/legdocs/Legislative%20Committees/HUS/Debates/170503Debates-HUS.pdf

REVIEWING THE GOOGLE DRIVE FILES: LIMITED RELEVANCE TO THE CURRENT SASKATCHEWAN CONTEXT

In addition to a 3s Health business case on lab services in Saskatchewan, the file contains various documents on lab services in Alberta, Manitoba, BC, and Ontario. As seen below, in all of these provinces the lab sector is confronting challenges like:

- Rising test volumes and costs, due to:
    - aging populations
    - growing prevalence of chronic diseases
    - technological advances,
    - a more demanding patient population
- Governments looking to constrain health and overall expenditures
- Resistance to change from doctors, both within and outside hospital
- Aging buildings and equipment
- Training, recruitment, and retention
- Access to services in rural and remote areas

All of these provinces have a mix of public and private delivery of medical lab services, though the role of the private sector in Saskatchewan (specimen collection and transportation, in some communities) seems to be the smallest.

However, despite these commonalities, it is difficult to extract lab governance best practices from the other jurisdictions and implement them in Saskatchewan. There are tremendous interprovincial differences in the mandates, roles, financing, and history of the key players in the lab sector: the Ministry of Health, the provincial health authority (if any), the regional health authorities (if any), the shared health services agency (if any), the provincial disease control lab, etc. The case for creating a standalone provincial lab agency might be stronger, all other things being equal, if the provincial lab and health services agencies were relatively new, weak, and/or underdeveloped.

Our ability to openly discuss and consider lab governance options is further limited by the fact that, as discussed below, the Saskatchewan government has already decided to bring the provincial disease control lab within the provincial health authority, and wants lab services to somehow be aligned with the still-mysterious "integrated service areas" mentioned in s. 4-1 of the *Provincial Health Authority Act* (*PHAA*).[5]

SASKATCHEWAN

- One of the most useful documents in the Google file is the 92 page ***Business case for the delivery of medical laboratory services*** prepared by 3sHealth in June 2015. It discusses challenges facing medical laboratory services in Saskatchewan, and identifies

[5] *Provincial Health Authority Act*. http://docs.legassembly.sk.ca/legdocs/Bills/28L1S/Bill28-53.pdf

opportunities to address those challenges and save money. The analysis assumes that whatever governance model is chosen, lab services will continue to be publicly-funded. As for public delivery, however, the report ominously asserts that third-party partnership, a.k.a. third-party service delivery, is not a governance model, but "a tool that could be leveraged under any governance model". We reject this assertion. There is a fundamental difference between a governance body that presides over day-to-day operations and one that is merely a party to a contract under which presiding over day-to-day operations has been transferred to another party.

- The 3s report also suggests that costs might be saved through revisions to staff allocation and skill mix: the report recommends making revisions to scope of practice legislation, provincial job descriptions, and (in collaboration with unions) employment contracts to ensure "flexibility in aligning [human] resources with developing technologies and local needs". The authors believe this would take about 3 years to achieve. Is this part of the Ministry's plans for health care transformation? If not, why was this report included, without comment or explanation, in the files the Working Group shared?
- The December 2016 report of the Advisory Panel on Health System Structure[6] recommended that the province merge the 12 RHAs into a single provincial health authority. It did not discuss labs in detail, but made definitive recommendations about them. As part of "pursuing opportunities for consolidation of clinical services within and across service integration areas", the PHA should integrate "diagnostic services (including laboratory and diagnostic imaging) across the province". The services delivered by the Saskatchewan Disease Control Laboratory should be part of this integration, so the SDCL should be brought within the PHA. What these recommendations mean in practice will depend heavily on the structure and role of the service integration areas (called "integrated service areas" in the legislation[7]).

ALBERTA

- The Google file contains two detailed and very informative reports[8] prepared by the Health Quality Council of Alberta at the request of the Alberta NDP government. The main lesson to be drawn from these reports is a warning about lab privatization. Since the mid-1990s successive Alberta Conservative governments have made ideologically-driven attempts to privatize laboratory services. These attempts have been expensive failures, leaving the current government to pick up the pieces.
- We strongly endorse these remarks made about the Alberta lab experience by the spokesperson of a union local representing lab workers: "Acute lab services is an industry with fluctuating volumes, where individualized testing is extensive and when immediate turn-around of test results is key to a person's health…They must be

[6] Abrametz B, Bragg T, Kendel D. Optimizing and Integrating Patient-Centred Care: Saskatchewan Advisory Panel on Health System Structure Report. December 2016. https://www.saskatchewan.ca/~/media/news%20release%20backgrounders/2017/jan/saskatchewan%20advisory%20panel%20on%20health%20system%20structure%20report.pdf?la=en

[7] *Provincial Health Authority Act*. http://docs.legassembly.sk.ca/legdocs/Bills/28L1S/Bill28-53.pdf

[8] Moving ahead on transformation of laboratory services in Alberta (January 2016), Provincial plan for integrated laboratory services in Alberta (February 2017)

constantly operational, even when volume is low. Because of this, risks to profits discourage private lab companies from doing the work needed and it's Albertans who may pay the price."[9]

MANITOBA

- The Google file includes a 16-slide PowerPoint presentation headed "dsm Leadership Forum—November 2013—Welcome Saskatchewan". The presenter, audience, and content of this presentation are far from clear, and it says very little about DSM's governance structure. In any case, DSM's relevance as a model for Saskatchewan is called into question by the Manitoba's recent decision to dismantle DSM. In late June 2017 the government announced that it plans to create a new entity, Shared Health Services Manitoba (SSM), to centralize many functions currently performed by the 5 RHAs, including procurement, EMS, HR, legal, communications, food services, laundry, and labs. SSM will "repurpose the existing corporate shell" of DSM, and DSM's "functions…will be reviewed and reallocated" between SSM "and a scaled-back Winnipeg Regional Health Authority."[10]

BRITISH COLUMBIA[11]

- The Google file contains a 27-slide Power Point presentation from November 2016 titled "British Columbia Laboratory Reform". It is considerably more detailed and comprehensible than the Manitoba slideshow in the Google file. It summarizes the pressures and processes that led to the creation of the BC Agency for Pathology and Laboratory Medicine (BCALPM). While some of the pressures were/are common to all provinces (e.g. rising test volumes due to aging population and growing public demand), some were very unique to BC. No public body had clear authority under BC legislation to deliver, plan, or contract for lab services. BC labs, both public and private, could bill the government directly on a fee-per-service basis for outpatient tests. The amount they could bill for each test was part of the fees agreement of the BC Medical Association. None of these is true in Saskatchewan, which may limit what Saskatchewan can learn from the BCALPM model. BCALPM was formally established as a result of legislation that

[9] AHS's RFP privatizing Edmonton labs bad for Albertans. AUPE News. Dec. 11, 2013. www.aupe.org/news/ahs-rfp-privatizing-edmonton-labs-bad-for-albertans/

[10] News release—Manitoba. Province announces new provincial health organization with a focus on patient-centred planning. June 28, 2017. https://news.gov.mb.ca/news/?item=41692&posted=2017-06-28 Manitoba centralizing health care services including ambulances, ERs. National Post. June 28, 2017. http://nationalpost.com/pmn/news-pmn/canada-news-pmn/manitoba-centralizing-health-care-services-including-ambulances-ers/wcm/d0836db5-8c5f-42c8-a647-9be8d09b9910

[11] Sources for this section, unless otherwise noted, are:

- The report of the Lab Reform Committee, mentioned on slides 4 & 5 of the BCALPM PowerPoint in the Google file. British Columbia 2012 Laboratory Reform Committee. Laboratory Services Plan. February 1, 2013. https://www.doctorsofbc.ca/sites/default/files/964873_-_2012_plan_final_report_feb_1_2013_-_with_signatures.pdf
- A 16 page, partially redacted document made up of a backgrounder, Power Point slides, and tables—the result of an access to information request (number HTH-2014-00001) made in January 2014 to the BC Ministry of Health by a media outlet for "Any records detailing progress on lab reform" produced between June 1, 2013 and January 1, 2014. The file is here: http://docs.openinfo.gov.bc.ca/d23086914a_response_package_hth-2014-00001.pdf Details of the request (without which I would not have understood what the file I stumbled across was) can be found in this database: Data for all central government Freedom of Information (FOI) requests closed in the fiscal years 2010-11 to current quarter https://catalogue.data.gov.bc.ca/dataset/4e50c2dc-d66a-45a7-bfed-bcd4999bb204/resource/375dcbbb-6492-40e7-a61b-8289f5ec30f5/download/databc.xls

took effect in fall 2015,[12] but as slide 18 suggests, the organization is not fully up and running. Its Test Review Committee delisted 120 tests in its first year of operation. As slides 9, 25, and 26 suggest, its governance structure and relationship to other health stakeholders are highly complex.

ONTARIO

- The file contains four documents[13] relating to the **Eastern Ontario Regional Laboratory Association** (EORLA). However, these documents provide at best a fragmentary picture of EORLA. Further research indicates that, apart from some of the key performance indicators EORLA uses, there is very little about EORLA's highly complex governance structure that could be translated to the Saskatchewan context or that would serve the province's stated goals of a more coordinated and integrated provincial lab system. EORLA delivers hospital-based lab services in the Champlain Local Health Integration Network (LHIN) in eastern Ontario. Unlike regional or provincial health authorities in other provinces, Ontario's LHINs have no service delivery responsibilities. They do not own or operate health care facilities. Instead, according to the act that governs LHINs[14], their job is to "plan, fund and integrate the local health system". The province provides each LHIN with funding on terms set by the Ministry of Health. The LHIN in turn funds hospitals, long-term care facilities, home care services, and mental health and addictions services in its region, based on the terms of "service accountability agreements" the LHIN negotiates with the boards of the individual facilities and service providers. EORLA exists one level below these agreements. It is a sort of partnership of 18 hospitals in the Champlain LHIN. It has contractual arrangements with each of its member hospitals. Its board includes 6 directors appointed by members, 4 competency-based independent directors, and director from the University of Ottawa. The Ministry of Health must approve its bylaws. EORLA derives most of its revenue not from the LHIN but from billing the member hospitals for lab services on a fee-for-service basis. It appears that EORLA's top decisions require consensus among the members (who still have their own boards), which can give the smaller hospitals an effective veto. EORLA's most recent annual report suggests that this model is under pressure because "hospital funding" (presumably the money the member hospitals get from the Champlain LHIN) "is under extreme pressure". The report mentions a further pressure: in 2015-16 it was discovered that EORLA had overbilled 12 of the member hospitals a total of $8.6M over the previous 4 years. This amount had to be reimbursed.[15]

[12] Laboratory Services Act, SBC 2014, c 8, http://canlii.ca/t/52ppl; Table of Legislative Changes http://www.bclaws.ca/civix/document/id/complete/statreg/e3tlc14008

[13] From oldest to newest:

- Interim transitional management structure for the Eastern Ontario Regional Laboratory (EORL). October 10, 2000. 11 pages.
- East 1 Region Regional Coordinating Committee Terms of Reference. February 19, 2002. 3 pages.
- EORLA Regional Division Committee Terms of Reference. June 2010. 3 pages.
- EORLA Medical and Scientific Advisory Committee (EMSAC) Terms of Reference. June 2011. 4 pages.

[14] Local Health System Integration Act, 2006, SO 2006, c 4, http://canlii.ca/t/52vtt

[15] Annual report 2015-16. Eastern Ontario Regional Laboratory Association. http://www.eorla.ca/wp-content/uploads/EORLA-2015-16-Annual-Report-EN.pdf

THE SURVEY: BACKGROUND, METHODS, AND RESULTS

We began work on our lab/path sector survey in late August 2017. The questions we developed were based on:

I. issues identified in conversations with several SEIU-West member-leaders who work in lab/path services, and who also tested and gave feedback on the survey;
II. issues that have arisen in Saskatchewan and/or other provinces, according to the documents in the Working Group Google Drive file;
III. priorities mentioned in the Working Group's Service Delivery Model document (September 2017)

The final version had 38 questions, a mix of multiple-choice and short answer. 15 of the questions were designed to test and update SEIU-West's communications processes (e.g. preferred email address, level of interest in a possible town hall meeting, etc.). The results of the remaining 23 are discussed below.[16]

The survey was open online from September 18 through October 1. As noted above, it was promoted to members in their workplaces on more than one occasion during this period. We also extensively promoted it on our website and Facebook pages.

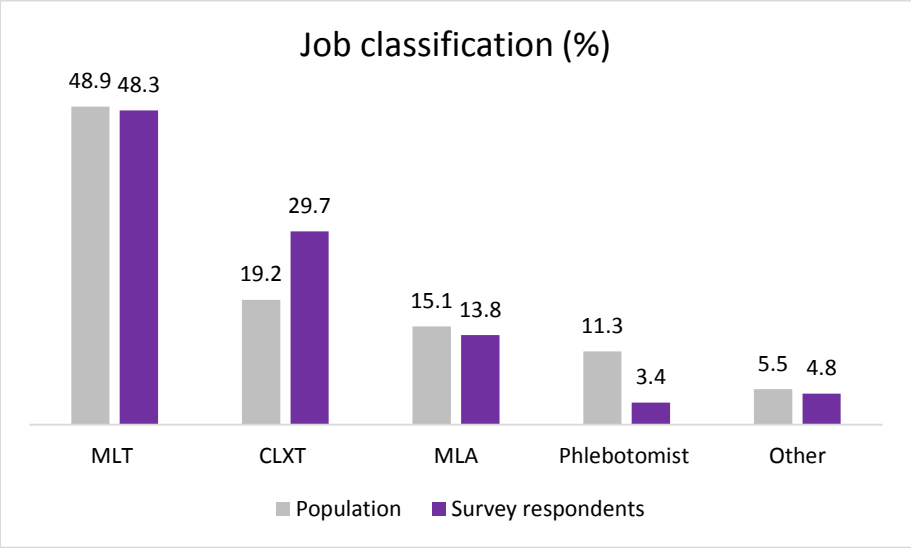
In the end, 145 surveys were submitted—a response rate of about 23%.[17]

Questions 1 through 4 (Q1-Q4) compare some key demographic characteristic of the survey respondents with those of the population that (we hope) they represent: the approximately 630 lab sector workers employed in the Saskatoon (SHR), Five Hills (FHHR), Heartland (HHR) and Cypress (CHR) health regions.[18]

As the figures show, CLXTs, FHHR and CHR employees, and full-time employees were overrepresented, while phlebotomists, SHR employees, employees with less than 5 years of experience, and casuals were all underrepresented. We experimented with various weighting schemes to try to compensate for this, but found in the end that surprisingly few variables were significantly affected. Noteworthy differences are discussed below.

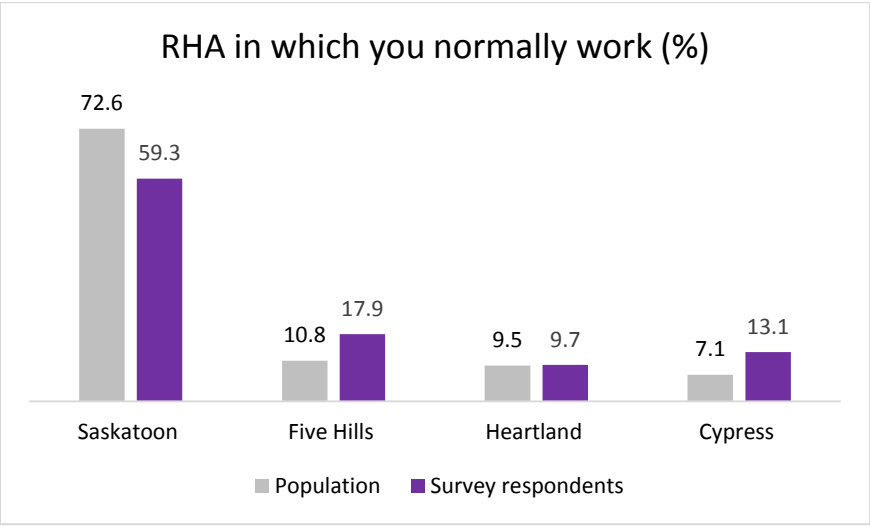
[16] Only Q1 (job classification) and Q2 (health region of usual employment) were mandatory. The median non-response rate for all of the other multiple-choice questions was zero percent, range 0-1.4%. The demography of the commenters was not significantly different from the non-commenters except that MLTs were slightly overrepresented, CLXTs slightly underrepresented. Note that when a commenter is quoted below, their job classification is indicated (except where doing so would risk identifying them), as is whether they are "SHR" or "non-SHR".
[17] After careful examination of each respondent's ISP, location data, and comments we found no evidence that the survey was filled out by persons other than SEIU-West members working in lab/path services in the four health regions we represent.
[18] All "population" data in the Q1-Q4 results is derived from the second quarter 2017 seniority lists of the four health regions.

Q1. Which of the following best describes your job classification?



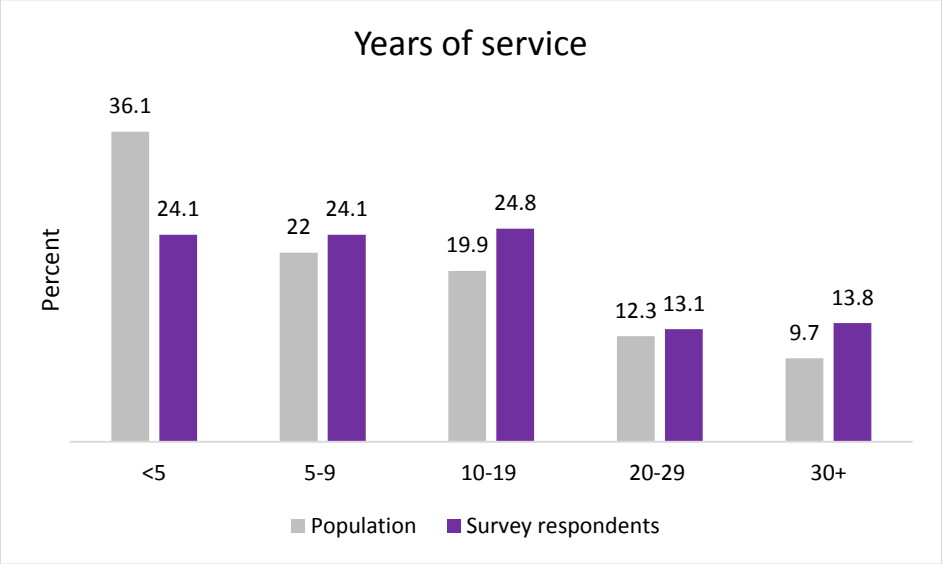
As compared to other respondents, MLTs tended to be older (Q5) and have more years of service (Q3). They were more likely than others (59% vs. 39%) to rate "number of tests rising" (Q6) as a 4 (a major obstacle). CLXT respondents were much less likely to be full-time (40% vs. 73% for non-CLXT respondents). They were less likely than others to say that their workload has increased (Q12-13) or that they frequently experience short-staffing (Q15). In light of this finding, it is not surprising that CLXTs were less likely than others to rate "number of tests rising" (Q6) as a major obstacle. Perhaps because most CLXTs practice outside of the province's largest centres, it is not surprising that CLXT respondents were less likely to mention population growth (Q7) as a cause of rising volumes. Perhaps because they work in rural and remote areas, they were more likely than others to choose "implement one, fully integrated laboratory information system" (Q21) as a priority.

Q2. In which health region do you normally work?



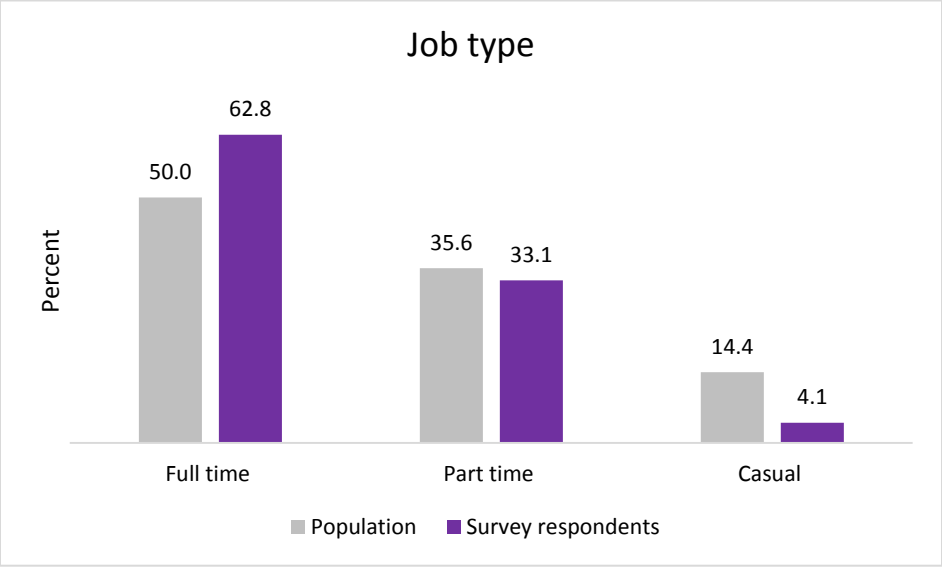
The most noteworthy differences were between the SHR and non-SHR respondents. SHR respondents were much more likely to rate “number of tests rising” (Q6) as a major obstacle to quality lab services. They were more likely than others to choose population growth and population aging (Q7) as reasons for the rising volumes. They were also more likely to view “old/obsolete/defective equipment and facilities” as a major obstacle (Q6), and to choose “rapid and reliable transportation of specimens” (Q21) as a priority. It would have been interesting to see if the views of SHR respondents working in rural sites were similar to those of non-SHR respondents, but unfortunately the survey did not ask SHR respondents whether they worked mainly in Saskatoon. (In discussing the comment questions below, we do separate the comments we quote into “SHR” and “non-SHR”.)

Q3. How many years have you worked in lab/path services in this health region?

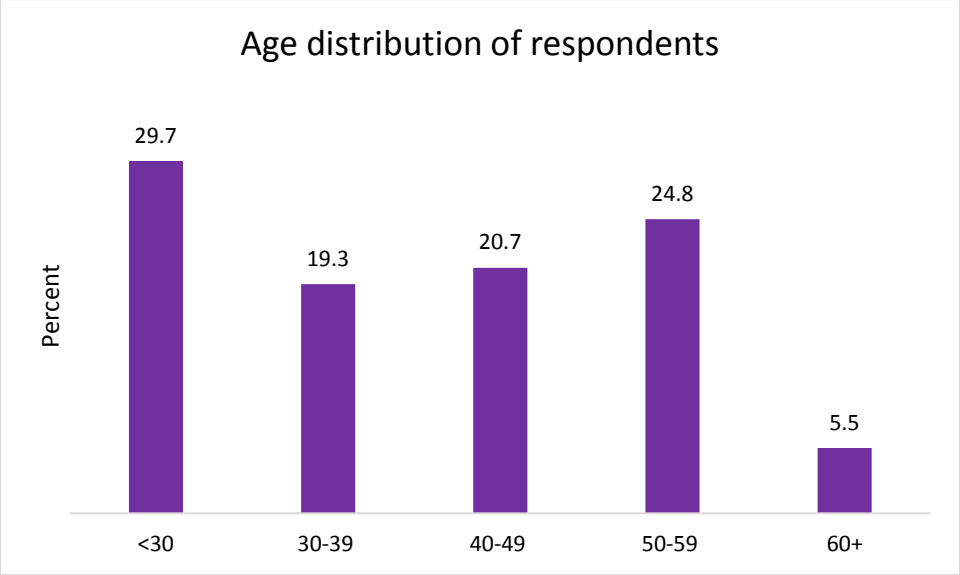


Not surprisingly, results for years of service are highly correlated with results based on age (Q5). In general, older/more experienced workers are less likely to work overtime, and are more opposed to private labs.

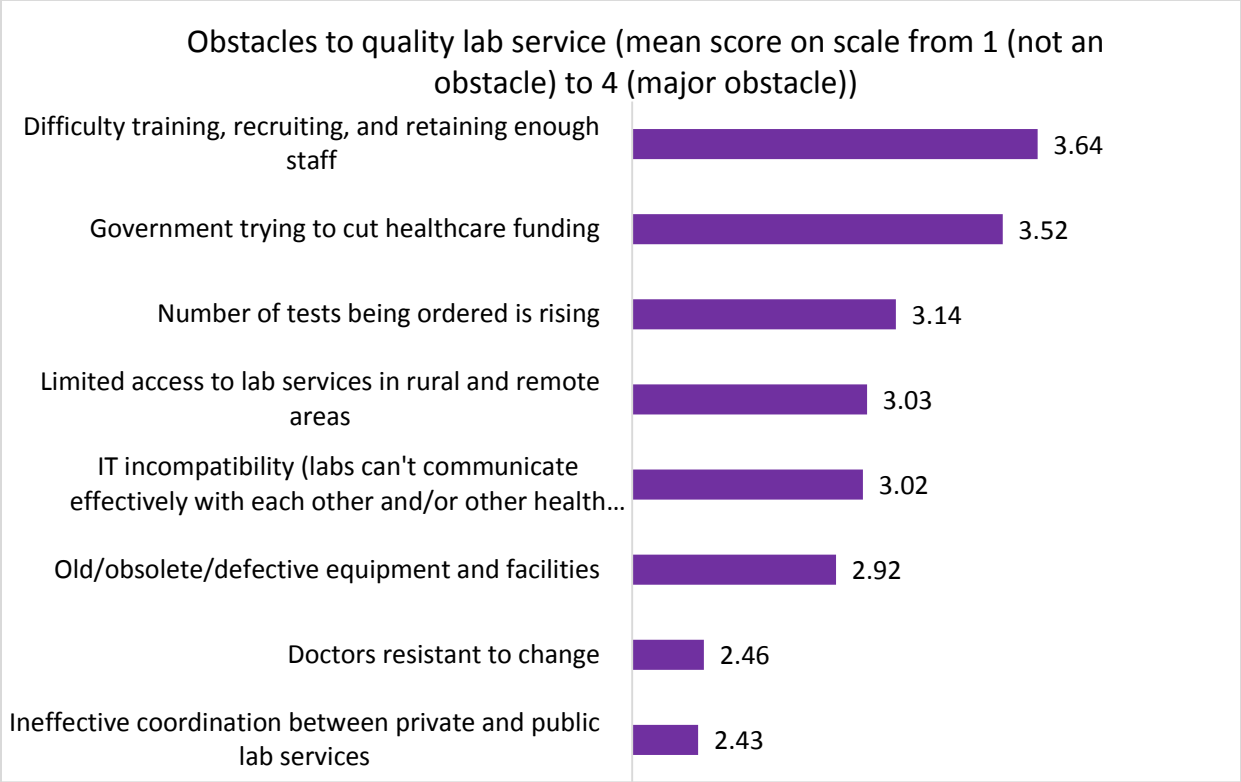
Q4. Your main lab/pathology job is:



Q5. Please indicate your age:



Q6. Studies of other provinces have identified the following as obstacles to the ability of the medical lab system to provide high-quality services. Based on your experience, please indicate on a scale from 4 (a major obstacle) to 1 (not a significant obstacle), how much of a problem each of the following is in Saskatchewan.

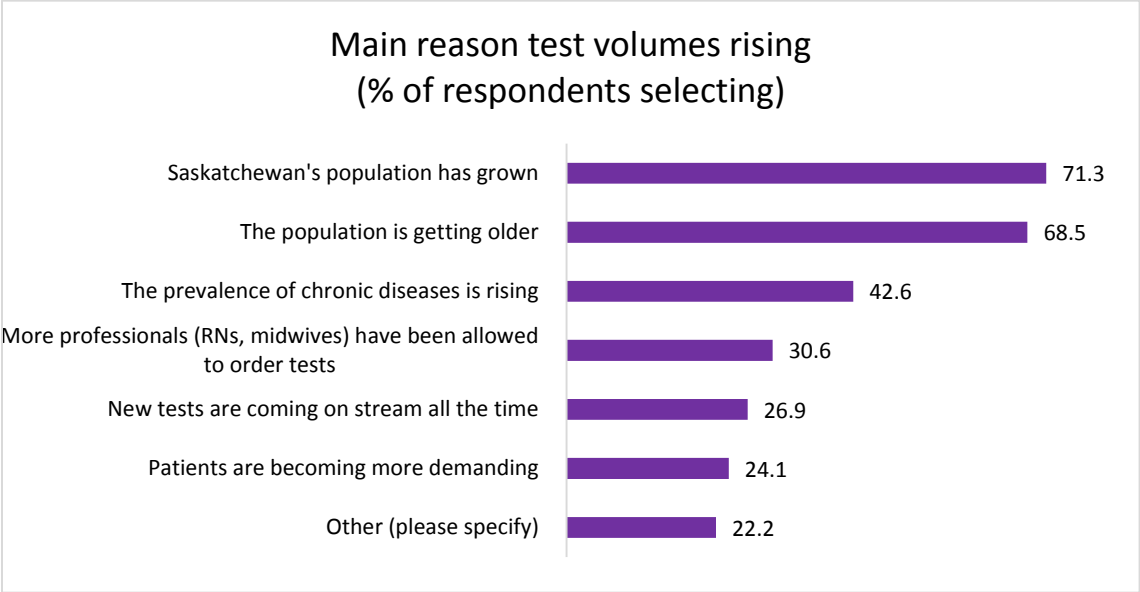


The suggested obstacles in this question were derived from the Google Drive documents supplied by the Working Group.

The recruitment and cutbacks options were each given a 4 by more than 70% of respondents; rising test volumes got a 4 from 48%.

The relatively low scores for “doctors resistant to change” and “ineffective public-private coordination” were somewhat surprising given the prominence of these issues in the other jurisdictions discussed in the Google Drive documents. The low score for public-private may reflect the fact that the role of private lab companies is significantly smaller in Saskatchewan than in most other Canadian jurisdictions. The issue of doctors resisting change was addressed by many respondents in various ways in the comment questions later in the survey. (Q8, Q14, and Q18)

Q7. In your view, what are the main reasons test volumes are rising? (You may check up to three answers)



This question only appeared to the 108 respondents (74% of all respondents) who gave a 4 or 3 to the rising test volumes option in Q6.

The factors listed were drawn from the experiences of other jurisdictions as described in the Working Group documents.

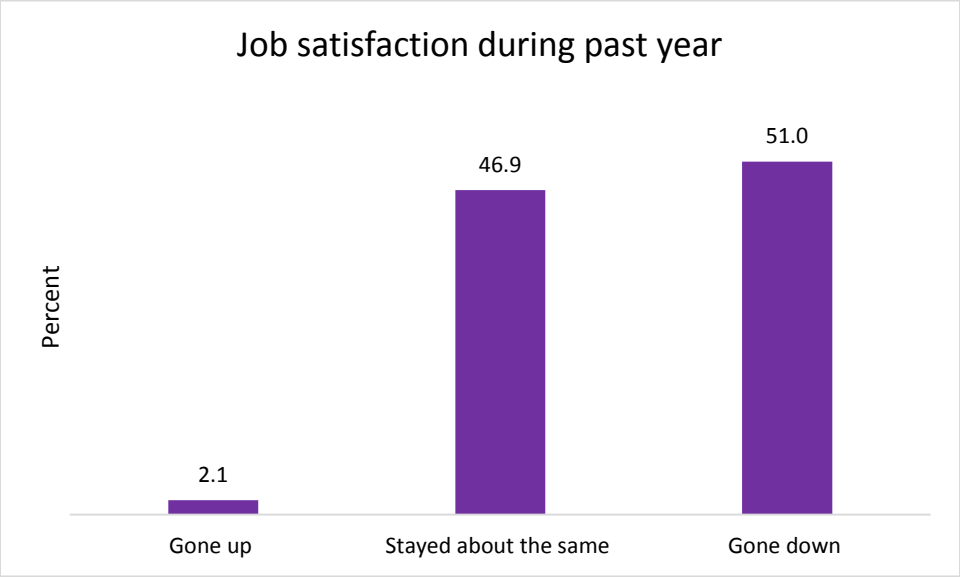
Q8. Other reasons test volumes are rising (please specify).

This question appeared only to the 24 respondents (17% of total) who selected "Other" in Q7. Of those, 22 wrote comments. The commenters were from all 4 regions, 5 different job classifications, and all experience levels.

The comments raise issues discussed in fuller detail in later comment questions such as Q10 (job satisfaction), Q14 (workload), and especially Q18 (ways to reduce medically unnecessary tests), which were available to much larger numbers of respondents. Two fairly representative comments:

- Non-SHR MLT: Doctors, nurses, ward clerks are ordering panels of tests before actually seeing the patients to see what really needs to be done. Multiple same tests ordered when patient moves hospitals or wards. Charts either not filled out to reflect testing was already done or charts not checked to see testing was already done.
- Non-SHR MLT: Every time a person is transferred to a new LTC facility admission tests are done, even if it has been a very short time since they were last done. Screening for MRSA, VRE and ESBL have increased the workload in Microbiology greatly.

Q9. In the past year, your job satisfaction has...



Q10. Please explain why your job satisfaction has changed.

This question was visible only to the 76 respondents (52% of total) who said in Q9 that their job satisfaction had either “gone up” or “gone down”. 75 survey respondents, from all regions, job, and experience levels, wrote comments. Three-quarters of the comments mention some combination of increasing workload, short staffing, and associated stress.

A non-SHR MLT eloquently expressed the views of many:

- We are constantly extremely short staffed. Shifts won't get filled, we are just expected to, "do our best with the staff we have." This, makes going to work every day very stressful and the morale around our Lab is extremely low. We feel very alone when raising any real concerns. Any concerns are brushed off. We are told their hands are tied and the "Higher ups" make the decisions. No one to back us up. No hope in any real good change. Any change around here is adding more work with less time to complete, placing a very stressful burden on our shoulders. Continually, more time consuming testing or protocols are being implemented, yet no more staff to help with the burden of changing conditions. We have a rotation, yet have been told it can be changed at any time because of operational needs. That doesn't make for a very happy employee when we have no idea if our schedule will work. Trying to plan any days off or holidays.

Note the following commenters whose workload pressures have been compounded by the trend to turn single-site positions into multi-site:

- A non-SHR CLXT: They have cut the hours in smaller centers and made my job into a multi-site which has me driving to 3 or more towns to work but not providing enough hours in each site to accommodate the hours I need plus what the community needs.

And with all this extra driving includes evening and weekends in 1 town 30mins away. All of this affects my home life. As I'm always at work or on the road and never at home. Yet none of our dept. have any casual staff so we are either denied time off or work short or depts. are closed for the day. Having us overworked and no relief doesn't encourage staff to stay.

- Non-SHR MLT: where I work, the MLA staff have been split into 3 different sites, without increasing staff! So there is no ability to redirect staff from one area to another, in time of need.

Several commenters mentioned growing pressures to train students and/or mentor new staff.

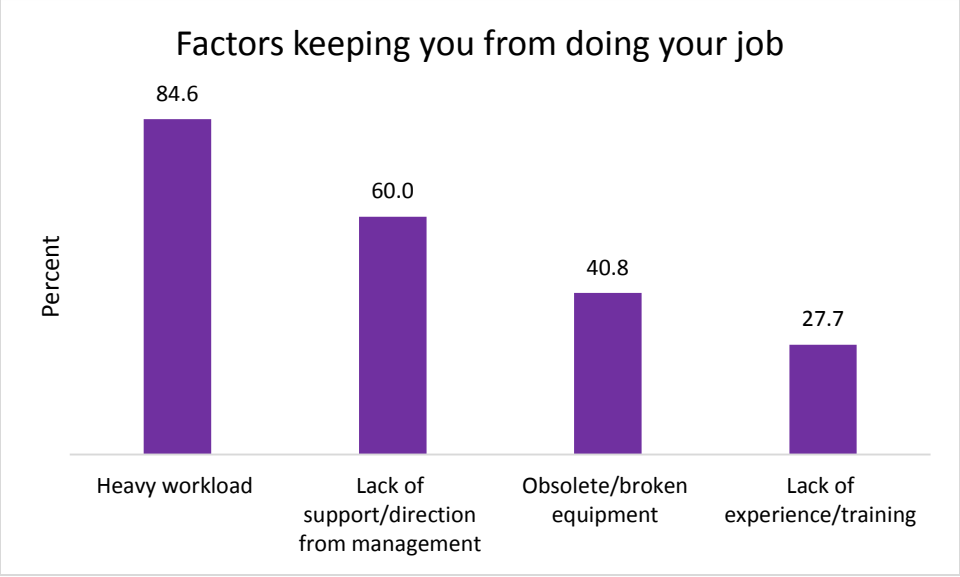
- MLT, SHR. Increased student intake with no assistance on the front line to handle the numbers effectively, no space for additional students for in hospital training.

Another common theme: anxiety about the potential impact of the move to one PHA:

- Non-SHR CLXT: I have fear that my job will become obsolete with the new SHA coming into effect, due to the fact that I work in a small rural lab. Even though I do put through a large volume of patients.

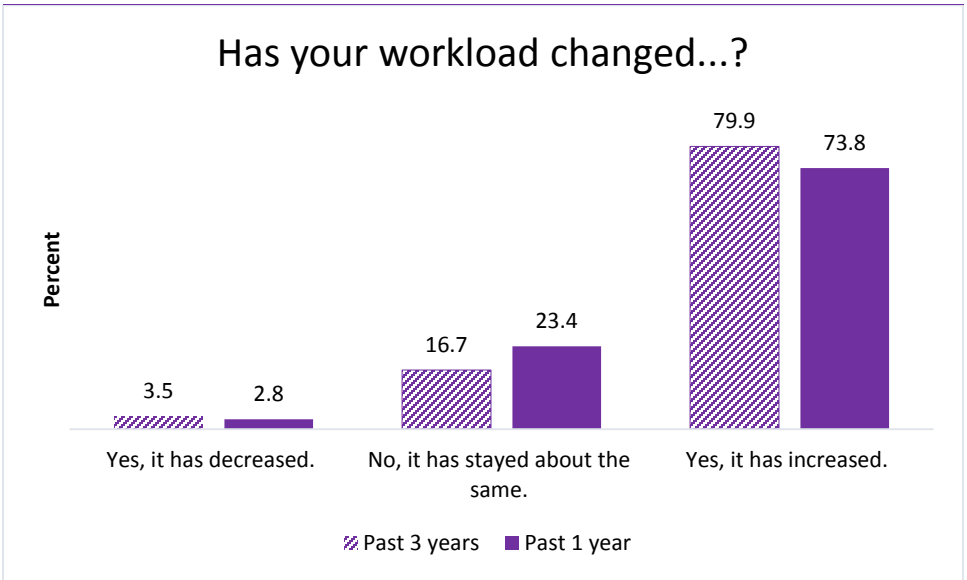
A final common theme: feelings of being disrespected and undervalued by government (multiple mentions of the proposed 3.5% pay cut), management, and other members of the care team (especially RNs). An MLT from SHR wrote, “We are expected to do more work, with less staff, and now with the government wanting to cut wages, for potentially less pay. It's unacceptable!” Another MLT from SHR wrote, “Poor management and abuse of policy (i.e. mandating) on staff results in a high turnover rate”

Q11. In the past year, have any of the following kept you from doing your job to the best of your ability? (Check all that apply)



The options were based on conversations with some of our lab sector members. Workload issues were the top choice by far, followed by concerns about mismanagement.

Q12. Have you noticed a change in your workload in the past three years?
Q13. Have you noticed a change in your workload in the past year?



This question was posed with two different time frames in an attempt to pinpoint whether recent policy changes such as this year's provincial budget or the transition to one health authority have had a significant impact on workload. We found no significant differences between the two timeframes. Nonetheless, regardless of the time frame, about ¾ of respondents said that their workload is increasing.

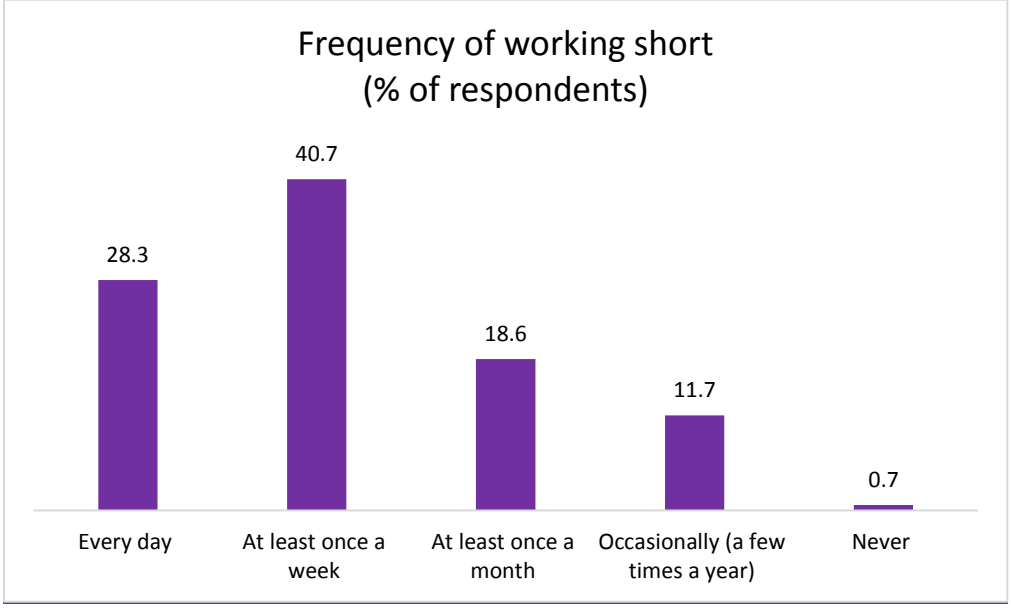
Q14. What is main reason that your workload has changed?

This question was visible to all respondents except the 10 (7%) who answered "stayed about the same" to both Q12 and Q13. 113 commented. The most common theme, found in about a third of comments, was that test volumes have risen. At least one also noted that the complexity of testing has risen along with volume. Some recurring themes:

- 15-20% of comments mentioned population growth and short staffing.
- About 10% mentioned population aging and inappropriate test ordering. A non-SHR MLT wrote, "more testing and repeat testing repeat testing and repeat…… read a chart already, and share results between care providers."
- At least 10 commenters from SHR mentioned an increase in the number of samples being sent to the city from rural facilities. As an MLT in SHR wrote, "We have been tasked with additional testing from rural sites. Transportation is a nightmare for both the shipping site and receiving site. It was much simpler with STC."

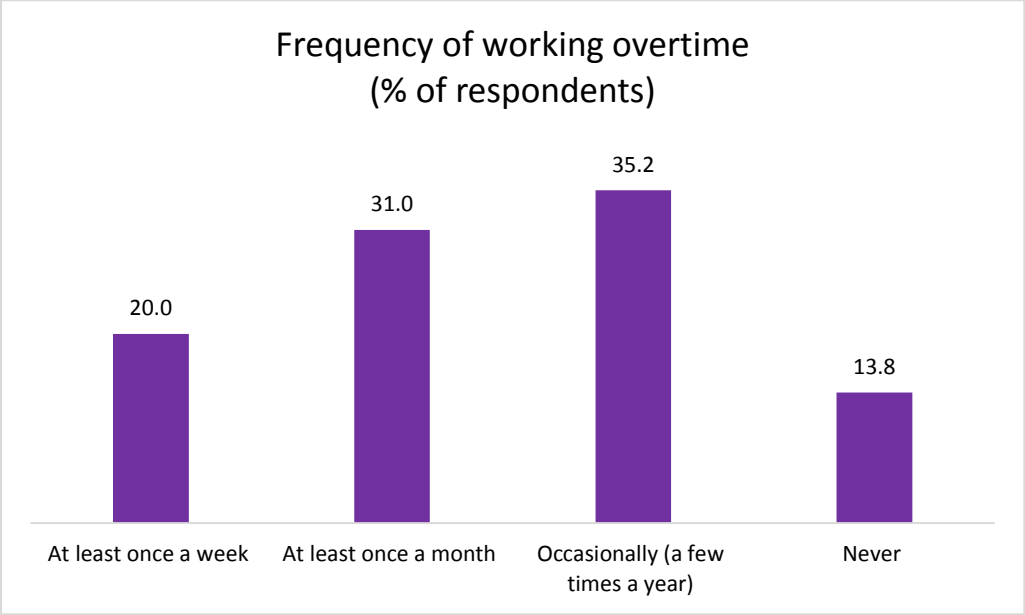
- While the arrival of new, additional doctors in a rural community is generally good news, several rural respondents pointed out that it can lead to an increase in testing, not just because there are more doctors, but because new doctors tend to order more tests than more experienced ones who know their patients well.
- A CLXT from SHR touched on many of the above themes in a single, heartfelt comment: Increase in patients, doctors, available tests. Aging population, increase in diabetes and other chronic diseases. Patients demand more and younger newer doctors tend to order more - partially as a diagnostic tool and partially to protect themselves from lawsuits - don't want to possibly miss anything so it's a lot more of a rule everything out rather than confirm a diagnosis mentality.
- Several mentioned infectious disease outbreaks (such as VRE) and associated protocols have increased the workload.
- One commenter mentioned an issue that others mentioned elsewhere in the survey (see Q10 above), and that we also heard in our conversations with member-leaders: workload increases caused by the employer turning a fixed pool of single-site positions into multisite positions: a non-SHR MLA wrote, “More locations to work at while staff number stayed the same.” On a related note, another MLA from SHR said that their workload had increased because the employer was transferring work from higher-paid classifications to lower-paid MLAs.

Q15. About how often is your lab/unit short-staffed (not enough staff to provide quality lab service in a safe and sustainable manner)?



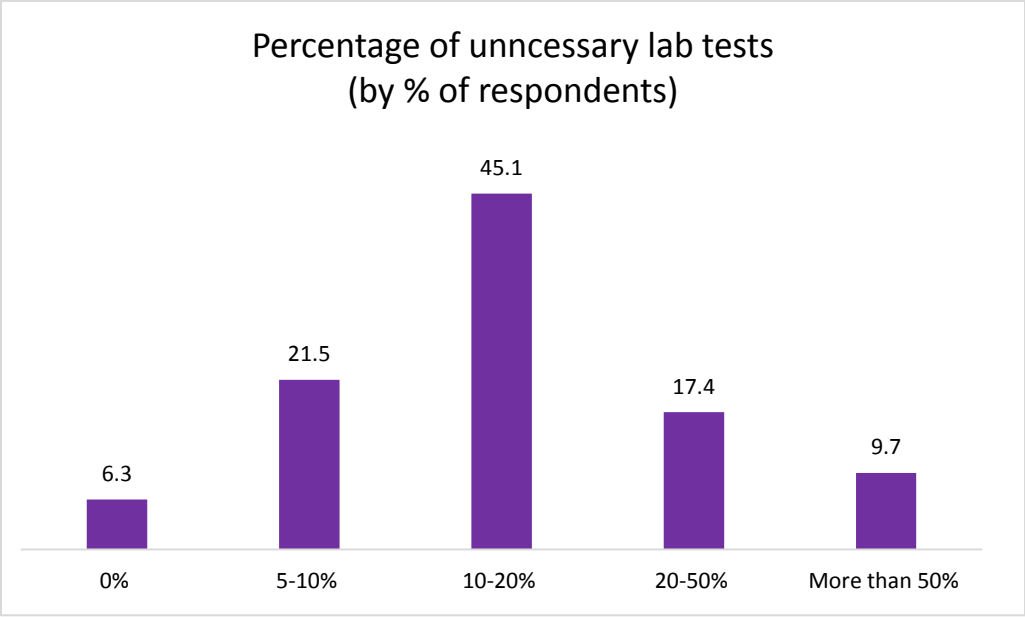
This was one of the most remarkable findings of our survey: in effect, 69% (28.3 + 40.7) of our lab sector workers experience unsafe staffing levels at least once a week, and 28% experience this every day.

Q16. About how often do you work overtime?



As responses to later comment questions (see Q22, below) revealed, these results do not take into account the growing amount of unpaid overtime that many of our members are working out of sense of obligation to their patients and colleagues.

Q17. In your opinion, what percentage of the lab tests that are ordered in Saskatchewan are medically unnecessary?



We only realized when the survey was closed and we were processing the data that we had neglected to include an option for values between 0% and 5%.

The most commonly-chosen value, 10-20%, is in line with estimates mentioned in the Google Drive documents.

Q18. What would be the best way to reduce the number of medically unnecessary tests? Do you have any other comments on this issue?

This question was not visible to the 9 respondents (6% of total) who answered "0%" in Q17. There were 113 commenters, from all regions, classifications, and experience levels. Among the more common themes: about a half-dozen respondents specifically mentioned doctors routinely/thoughtlessly ordering panels of tests, when only some or even none of the tests in the panel is likely to yield results that will affect the patient's treatment. These and many other respondents called for better education of both physicians and patients about the real costs and benefits of various tests. To encourage more appropriate testing, a few respondents suggested that requisition forms should indicate the costs (in both money and time/effort) associated with each test. Others suggested that health authorities track, compare, and report the test ordering patterns of physicians, and hold them more accountable for the tests they order. (A couple specifically mentioned the "Choosing Wisely Canada" campaign.) Test menus should be standardized across facilities, many said, and obsolete/low quality tests should be eliminated from the menu. To prevent unnecessary duplicate testing, EMR and LIS systems should be improved and standardized so that every professional thinking of ordering a test on a patient has access to up-to-date information on all tests ordered on the patient, and the results thereof. Perhaps more controversially, many respondents stated that no tests should be able to be ordered on a patient, especially in the emergency department, until the responsible doctor has actually seen the patient.

Here are several highly representative comments:

- Non-SHR CLXT: I think physicians have to be educated and more specific about testing instead of ordering certain tests in an emergency situation when it is unnecessary and will not have any outcome on the diagnosis in ER. For example a PSA, HBA1c, or B12 does not need to be ordered on a patient who appears in the ER for chest pain. If a physician sees the patient they are more likely to order only what is necessary instead of ordering over the phone. Patients can be demanding, therefore most patients tend to Google things either in ER or before they get to the ER--perhaps if there was a list of what tests cost the healthcare system they wouldn't necessarily demand that they need a certain test. So patient education could reduce the number the tests unnecessarily ordered by physicians.
- MLT, SHR: Stop duplicate ordering when patients present multiple requisitions from different doctors. Make doctors fill out a detailed form for tests that are referred out (specialty testing) and have these approved for testing by a biochemist based on clinical information. Tell the doctors no to testing that provided little value (see recommendations from the choosing wisely campaign). Stop routine screening blood

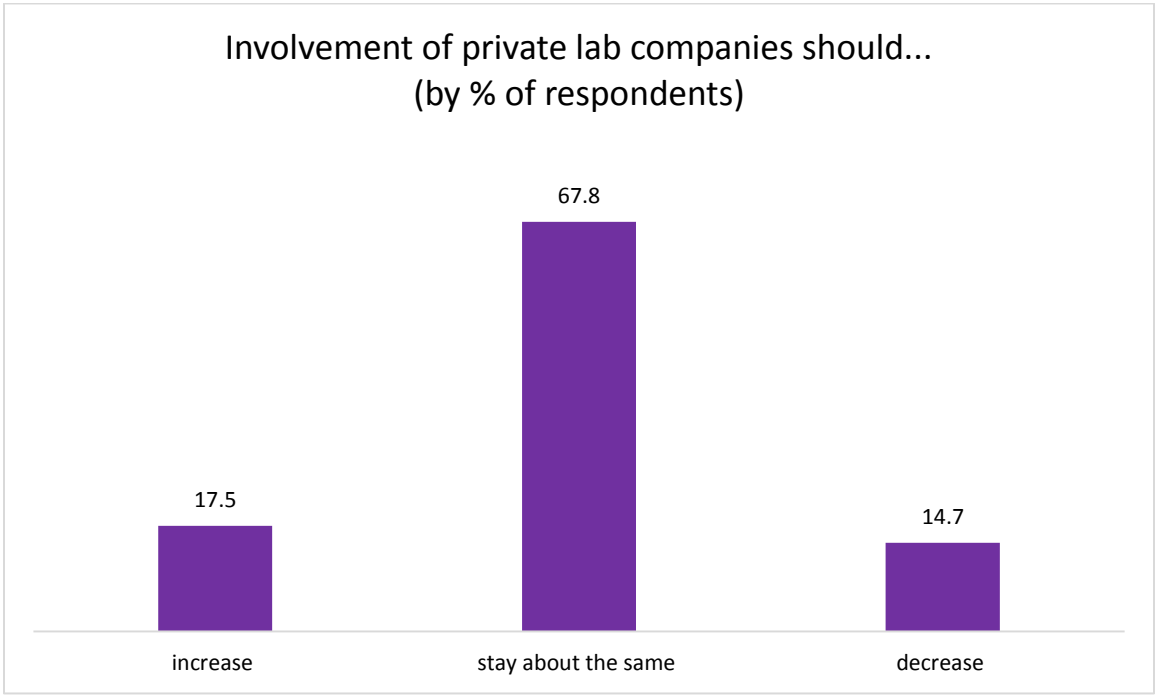
work on stable inpatients think before ordering--is it necessary to repeatedly collect blood from a patient that is 101 years old? Will the blood work change or improve the outcome. Physician education and auditing is required.

- Non-SHR MLA: limit what nurses can order and limit standing order requests, especially on residents of long term care and palliative patients.
- Non-SHR CLXT: If a patient brings in a requisition 3 months after their doctor appointment for their complaint because they "lost" or 'forgot" it or "knew they would have more in the future", you can't tell me that all those tests are still relevant anymore.

However, as a non-SHR CLXT noted, rigidly applying the sorts of suggestions above would not necessarily be patient-centred: “People should have access to testing when and if they think it is necessary. Reassurance is a large part of a patient’s medical treatment. As well it is not always easy for people (especially the elderly) to access testing when directed by others (they may be only able to access testing at certain times or dates).”

An MLT from SHR alleged that this question and the survey overall were “too slanted…Do we not trust doctors to know when to order tests? Or professionals to determine how best to coordinate provincial testing?”

Q19. I think the involvement of private companies like Gamma-Dynacare in the delivery of lab services in Saskatchewan should...

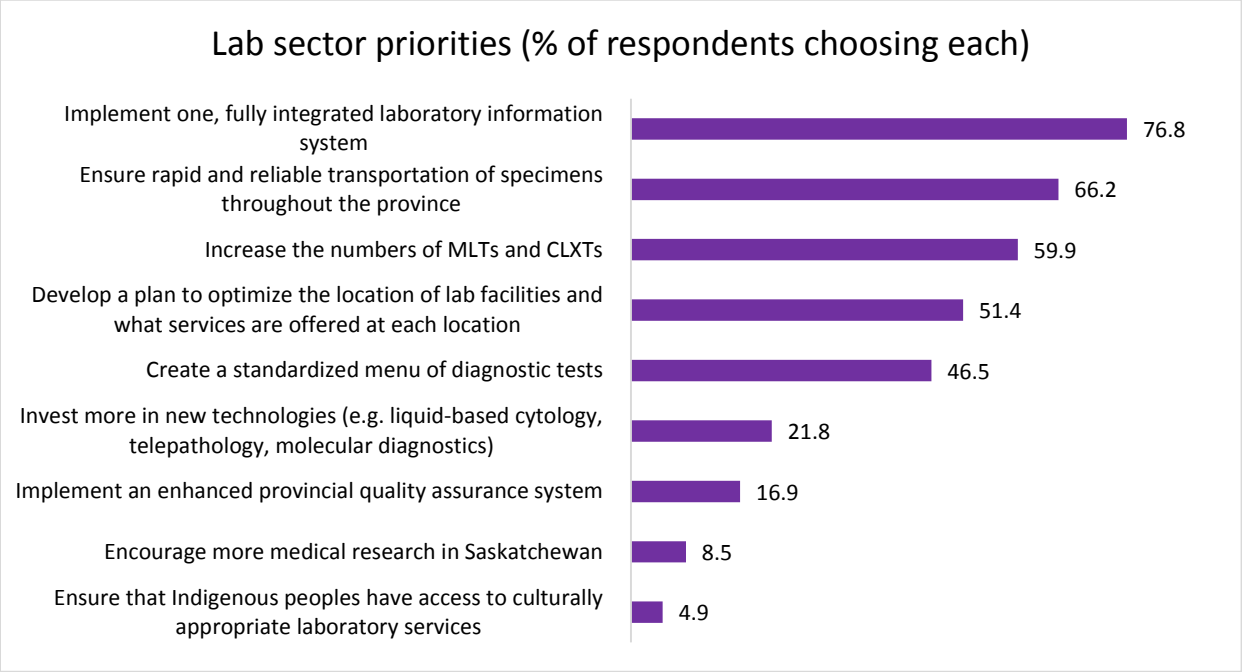


Q20. Please explain your answer. How and why should the role of private lab service providers change?

This question was visible only to the 46 respondents (32% of total) who said in Q19 that the role of private labs should increase or decrease. There were 39 responses, about equally divided between "increase" and "decrease".

- Main recurring themes among "increase" respondents:
    - More/most outpatient testing can and should be done by private providers, to take the burden off hospital labs. According to a non-SHR MLA, "private labs can do the outpatient collection much more effectively and thus leave more time for hospital staff to concentrate on acute care patients."
    - Private providers are needed to fill transportation/access gaps, especially the one created when STC closed. An MLT, from SHR wrote, "They should ship everywhere. Right now we are paying private companies and cabs to transport all over the province. One cab ride can cost upwards of $400. If we had Gamma shipping all over the province we wouldn't have to ship with expensive couriers as often."
- Main recurring themes among "decrease" answers:
    - Concerns, some based on first-hand experience, of the quality of work/service and staff/training of private, for-profit labs. An MLT from SHR wrote, "Quality provided by Gamma-Dynacare is appalling. It makes the whole lab system look incompetent when they incorrectly order or collect a sample. Their standards of education are not up to par." Another member from SHR added, "Their role is phlebotomy only. Everything else they mess up."
    - Several respondents stated that the kind of coordination and standardization needed in the lab sector (e.g. of planning, LIS, wages and working conditions) can only be achieved if it is wholly owned and operated by the PHA. An MLT in SHR wrote, "If one health region it should be ONE service provider and one employer. Standardization." Another not from SHR wrote that increased private sector involvement would mean that "quality control on the private labs would not be under the health region. It would also then make it difficult to communicate or access patient info because they would be under a different lab information system."

Q21. The Ministry of Health's stated goal is "to create a provincial laboratory service designed to ensure safe, positive patient outcomes". In your view, which of the following would most help to achieve that goal? (Check up to three answers.)



The options are drawn directly from the Working Group's "Service Delivery Model Outline" document sent to SEIU-West by Patrick O'Byrne on September 18, 2017. Support for LIS improvements was especially strong among CLXTs. Support for transportation improvements was especially strong among SHR respondents.

Q22. What other question(s) do you wish this survey had asked?

There were 32 responses, from all classes except phlebotomists, and from all regions and experience levels. There was great diversity of content. Some suggested question topics occurring multiple times:

- Best ways to maintain rural lab service and/or support rural lab staff
- Are you planning to retire soon? (useful information for planners)
- More questions about short-staffing
- Discontent with management/managers
- The role(s) of unions in the lab sector, especially post-PHA; e.g. will SEIU-West be willing/able to advocate effectively on behalf of its professional members?

Here and in a couple of other comment sections, a few respondents suggested that in recent years the employer, to address staffing shortages, had hired staff whose training or skills were subpar, putting patient safety at risk and leaving the others to take time to redo their work and

fix their mistakes. An MLT in SHR said, “We need better quality staff...over the past 2 years the quality of staff being hired is alarming!!!”

Finally, as especially poignant comment from an MLT from SHR: “I wish it would ask how much unpaid overtime I work - I stay late often without claiming it because I cannot justify my reasons for staying late and I just want to clean up my work. I wish the public understood that we are not allowed to eat or drink in the lab - if we skip coffee breaks we do not even get to have a glass of water to rehydrate.”

Q23. Any other questions, comments, or suggestions regarding lab services in Saskatchewan?

There were 48 responses. They were very thoughtful and on average about twice as long as the typical comments in the rest of the survey. There was great variety of themes within and among responses, but almost all hearken back to previous questions and synthesize and/or elaborate on previous answers. Some recurring themes:

- The most common theme, mentioned by about 15% of respondents, was the negative impact of the STC closure on both timely, reliable, and affordable transportation of specimens and patients. A non-SHR MLT wrote, “With STC being gone the transportation literally SUCKS! The turnaround time for lab testing has gone down and this is not acceptable. Of course this affects rural Saskatchewan and I am hoping that rural communities do not lose services with the new organization and have a say in how healthcare will look going forward.”
- This concern about potential loss of rural services with the move to the PHA was reflected in several other comments.
- Multiple respondents expressed concerns about how the move to one PHA will affect their union representation and seniority rights.
- Several were concerned or upset about the prospect of wage rollbacks and other cuts, and the impact this would have on recruitment, morale, and quality. Some examples:
    - MLT, SHR: We have incorporated lean initiatives and have applied 5S in most areas. Cut backs in lab is not an option if quality patient care is to be maintained.
    - MLT, SHR: Stop using a business model for healthcare. It is about health, not profit. Use the budget available to maximize the wellness of people
    - MLT, SHR: I have always said that it costs money to save lives. If the government wants to cut budgets, then we maybe have to stop supporting the very sick, the chronically ill, the prematurely born, etc, etc. Our healthcare team does VERY good work! We are helping chronically ill people live longer. We are helping trauma victims survive. We are helping premature infants survive. We are helping very sick people recover. If we are to continue saving lives, we can't have saving money be the primary concern! Every premie, every cancer patient, every HIV positive person, every person with kidney failure, every diabetic

requires extensive lab tests at a large cost. There is a cost associated with saving lives and helping people live well!

- Several mentioned lack of access to needed advice from pathologists and lab medicine specialists, especially after hours. A non-SHR MLT expressed hope "that I can see some good things happening for rural labs with going to one provincial authority, e.g. access to pathologists that can aid in making decisions in our lab regarding testing, etc."
- Several mentioned that an effective province-wide LIS is highly desirable, but expressed doubts that it would be attainable: a non-SHR MLT from wrote, "the cost and amount of time it would take to implement would be atrocious, and an MLT from SHR noted that "the data of certain patients who have had more stays and testing can take a very long time to load (up to ten minutes)" and wondered, "will the system be able to manage that amount of patients while keeping the results easily accessible in critical situations (nearly immediate result access)?"
- Increased standardization of test menus and protocols across facilities.
- Compared to front-line lab staff, managers are too out of touch, too powerful, and too numerous. A non-SHR MLT: Front line staff having more say in what is happening with their jobs. The managers and their managers and their managers don't see how the front line operates, therefore should not be making major decisions without their employee's input actually being considered.
- Compared to MLTs, MLAs & phlebotomists are too often ignored and disrespected
- Reiteration of workload and short-staffing concerns. Several people, here and in other questions, mentioned that employers should be making better use of part-time and casual positions, which would improve recruitment and retention, reduce workload pressures and overtime. Retired workers should be able to come back as casuals with no loss of seniority. And, in the words of an MLT from SHR, having more available part time or casual positions. Someone part time like a .6 or.7 retires and they turn it into a full time job. There may be a lot retiring but there is also a lot going on maternity leave and after 2nd child it's hard to be going by back full time and paying for day care also with more part time or casual positions less overtime will be paid out.
- A non-SHR CLXT suggested making greater use of CLXTs, and using them to their full scope of practice.

CONCLUSION

SEIU-West thanks the Working Group for engaging with us on the future of public laboratory and pathology services in Saskatchewan. We welcome all future opportunities for meaningful consultation with other stakeholders to ensure that these services remain publicly run, publicly accountable, and attuned to the needs of both patients and staff.