

In Conversation with Brian Postl

Ken Tremblay



For over a decade, Dr. Brian Postl, a pediatrician by training and now seasoned chief executive officer (CEO) through experience, has led the Winnipeg Regional Health Authority (WRHA), Manitoba's largest health region. WRHA operates or funds over 200 agencies with more than 27,000 staff with an operating budget of some \$1.7 billion. Under his leadership, the WRHA has matured into a showcase for regionalization, at a time when other jurisdictions are stepping back from such models.

With organizational values that centre on caring, excellence, innovation, collaboration and accountability, the WRHA has sponsored new approaches to Aboriginal health, wait list management, clinical teaching and research. Ken Tremblay spoke with Brian over the summer.

HQ: You have been at the helm for over a decade. What's your take on those 10 years – the high points, the low points?

BP: In some ways, the high and low points are the same. It has been very gratifying that we have seen a huge number of positive changes in healthcare: the face of healthcare has changed dramatically. Ten years ago, I don't think we would have envisaged what it looks like today. On the other hand, when you're in the middle of it, the pace of change seems much slower than it needs to be. There's a tension between your disappointment about the pace of change and the excitement of the changes that are either possible or in place – for example, the idea of moving a regional system toward a single standard of care so that the patient does not need to know which hospital has the best outcomes or who the best surgeon is.

It is incumbent on the system to ensure high quality of care at each and every site; that has been an important change and feature of our regional model that has gone remarkably well. We have achieved that through program consolidations, establishing common standards across multiple sites and regional [clinical] leadership. These are big cultural changes that take lots of time.

HQ: What are your biggest leadership challenges?

BP: Having the system thinking and behaving as a system instead of a group of cottage hospitals working in sequential fashion without any real connection. As a pediatrician, I saw the health system 10 years ago as a system of parallel play – which is really two-year-old behaviour – as opposed to systematic approaches to patient flow where the patient is at the centre of our activities within a patient – or family-centred framework. These cultural changes are just huge.

HQ: Why did Alberta “blink”? What would make Manitoba’s experience with RHAs different?

BP: I’m not sure why they blinked. The issues of government interest, ministry interest and [public] accountability continue to grow everywhere in the system. It may be that the government felt it needed more direct input into system operations. Perhaps they thought that they could accomplish more economies of scale or reduce competition between regions through a single structure. We’re going to have to wait to learn both why they blinked and what outcomes will differ.

Manitoba has smaller and more rural health regions within a relatively smaller province, meaning our relationships with government are a bit easier to maintain. Our region – Winnipeg – is the largest, so our connections with government are more frequent. But time will tell. To date, I believe that Manitoba has been satisfied with the regional structure, but structures are structures; they can change over time as they have in Ontario and Alberta.

HQ: I note you have deployed wait list navigators to assist patients with access to care. How have they helped reduce wait times for the public?

BP: They are part of a number of initiatives around wait list management. In many clinical activities, we are moving toward a single wait list, where one wait list is managed across the system, that is, a first available slot process where specialty groups may pool their wait lists in order to reduce wait times.

We have several examples where the application of aggressive wait list management strategies has driven down wait lists by 20–30%. Wait list navigators are more attentive and receptive to public needs; they improve the communication [among providers] and work through obstacles to patient flow. Our results stem from a combination of many initiatives, including

new capacity funded by federal wait time money. All have made a significant contribution to wait list reductions.

HQ: How has the WRHA responded to growing public concerns about quality and safety?

BP: We’re increasing our focus on both of these areas and have made substantial investments in patient safety. We have patient safety coordinators in each of our acute care sites. We have a medication reconciliation program at each hospital site as well. We have built a program that involves patients and families that have experienced adverse events to work with us to improve safety. We are beginning to see some results as safety concepts permeate the health system more so than they did two or three years ago.

HQ: How does the public view regional health authorities in Manitoba? For example, what healthcare improvements would the person on the street cite as the value of regionalization?

BP: They would see centres of excellence and program consolidation as ultimately positive in that they improved both quality of process and quality of outcome. They would see our efforts in wait list management as positive. They would see our expansion in service and improved access to technology as positive. I think most Canadians, not just Manitobans, grew up within a system of single hospitals and single agencies; the systems approach of large RHAs is only beginning to settle in the public mind 10 years later. As well, they are such big organizations that they are beyond what most people see as a single organization; that is, when you employ 27,000 people and have a budget of close to \$2 billion, that is a big model to comprehend.

HQ: What metrics of system performance have improved in the past 10 years, and what are your next priorities?

BP: We’re moving beyond issues of wait times or length of stay and into measures of public satisfaction. For example, in the next five years we hope to book patients into slots for surgery and give them that appointment on the day that it’s desired or required. We’re hoping to get into a booking system that’s not unlike the airline industry, where you can book a seat for an activity and the system is able to deliver on that date.

We’re moving to access centres for home care and long-term care that do a better job of coordinating patient access and patient flow. By increasing our efforts around the issue of patient flow, all the sectors – acute care, long-term care and home care – work together to eliminate log jams at the transition points between the [provider] silos.

If we were to measure the level of participation in decision-making and management of the system, we would see improvements too. All the sectors of the system meet with us regularly. We have a senior management table that meets weekly for acute care and monthly for the long-term care sector. In the future, I

think we will see a substantial improvement in communication, collaboration and understanding about how the system works.

HQ: How has shifting your career to leadership affected your relationships with physician colleagues? What advice or commentary do you give physicians about the changing landscape of healthcare?

BP: I spend about a quarter of my time practising pediatrics at Children's Hospital, and I think that most physicians like that – the CEO with clinical activities that keeps him or her informed about how things are actually working. I think most physicians in the region see physician leadership as positive, that it contributes to a better understanding of clinical care. In terms

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of advice to my colleagues, this is a dynamic and exciting time; it's about change, about increased public accountability around the services that we provide and the outcomes of those services. It is about the inevitable change that comes with these new expectations. Leadership is about managing change and being open to change. And if you are a leader, it is a very exciting time to be in healthcare.

HQ: In an era of community engagement and transparency within healthcare, what are your challenges in Winnipeg?

BP: They are everywhere. The issue of matching public expectations with [the limits of] public funding is always a challenge. There are many vested interests in healthcare; depending on the question you ask, you will get many different answers. The public has been frustrated by how long they wait for services and, perhaps more importantly, the uncertainty when things disappear into a bit of a black box.

The media has a major role to play in how it portrays the health system. There is a tendency in Canada to look for things that haven't worked, which is a bit negative. I think that [bias] influences how the public view the healthcare system. Healthcare is clearly seen as the most important public resource that comes with being a Canadian. The expectations for disclosure and public transparency that come with that are very high.

We have worked hard to develop policies about disclosure of untoward outcomes. We have determined thresholds for disclosure and a process of actually apologizing in meaningful ways to patients. As a third leg to that, we've worked out some ways of providing compensation where it is evident that compensation might be expedient to the parties.

HQ: What new skills and competencies are key for success within a large organization like yours – specifically, how have your senior team meetings changed over time?

BP: That is an issue when you're dealing with so many aspects within a large organization. You have to focus on your key priorities in order to move things forward. There is a lot of background noise you have to sift through to make sure that it is not impeding progress. Our senior team meetings have become much more focused, much more directed. They are intense because the issues are important, for example, resource allocation and change management – both of which generate intense debate within the healthcare system. We have wonderful senior management team members that work well together, are able to sort things out at the table and can move forward in a cohesive way.

HQ: WRHA is one of the largest healthcare provider organizations in Canada. Is there a trade-off between scale and span of control – can becoming too big mean that you are too far away from the people you serve and the people who work in the system?

BP: There is a risk that organizations can get so large you lose contact with the coal face, the front line where services are being provided. We have to be careful not to become so large that the place becomes either unmanageable or unconnected. We work hard to avoid that, and one of the strategies is to find balance between the delegation to individual sites that operate their facilities on a day-to-day basis – that's where the staff work, that's where the patients go – and the need for a consistent approach associated with a comprehensive health system where the seams are managed and a single standard of care prevails.

HQ: Tell us more about the Clinical Learning and Simulation Facility that was recently opened in Manitoba? How will this approach change the student experience?

BP: It is a joint effort with our Faculty of Medicine, stemming from a trip to Tel Aviv where they had built and operated a similar facility. In essence, the model ties into our earlier discussion about patient safety. When I trained, there was a phrase: "See one, do one and teach one." That mantra has really changed as we needed to ensure medical students had a broad and comprehensive clinical experience while patients received effective and safe care. One of the strategies that is evolving is this approach using simulation – both technical and person-oriented simulation – to ensure that they have that experience. Our capacity to teach students through repeat experiences and to test their performance gains improves dramatically through simulation facilities. We are seeing growing interest by our teaching faculty and [the resource] as a great way of improving clinical learning without involving patients prematurely.

HQ: What makes your approach to Aboriginal health both unique and successful?

BP: In our province, this community is a big part of our population – somewhere between 10 and 20%. They are a significant patient population in terms of their health needs and the important role they play within our community. Many of us [at WRHA] have had experience working in northern Canada and witnessing the health issues faced by First Nations and Metis. Through that experience and our deliberations, we have learned that we need to respect the leadership and elders within that community, especially when we ask for advice about how to improve our services. And when that feedback is provided, we need to make the necessary investment. We have made those investments, and we continue to build partnerships as we try to move that agenda forward. First Nations continue to be one of our key focuses with patient safety and patient flow. The third leg of our priority stool, as a management team, has been the whole area of Aboriginal health.

For example, we have an extensive clinical support unit that works with patients when they come from the north to coordinate appointments, to provide interpreters and to sponsor cultural awareness teaching for all of the staff so that they have a better understanding of the perceptions and needs of the Aboriginal community. This has been a priority for us.

HQ: Manitoba's smaller scale means healthcare leaders are more accessible to government and political leaders. What system relationships are pivotal to your success as CEO of the WRHA?

BP: Our success is about building networks, where system leaders can be brought together and learn how to work with their “shoulders to the wheel,” all moving in the same direction. That approach is true for all the chief operating officers at the hospitals, personal care homes and clinics. The relationship with the deputy minister of health has always been strong and an important one for us, that we need to be working in sync with the needs of the ministry. We need a forum where we can debate issues, from time to time disagree, and test new ways of thinking so we can move [the system] forward in a productive way. From a government perspective, [access] to the deputy ministry is important to us.

HQ: What would you like HQ readers to know about Brian Postl?

BP: I continue to find this work fascinating and exciting, and I'm always ready to embrace new changes to try to improve the services we provide to the people of Manitoba.

HQ: Thank you. HQ

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