

# Patient First Review Update

## The journey so far and the path forward



The Honourable Dustin Duncan, Minister of Health

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# Minister's Message



It has been nearly six years since the release of the Patient First Review report, *For Patients' Sake*. It was the first independent review of its kind in Canada that began and ended

with consultations with those who use and those who provide health care services in Saskatchewan. More than 4,000 patients, family members, health care professionals and administrators shared their perspectives and their ideas for improving the health care system.

Tony Dagnone, the commissioner of the Patient First Review made 16 recommendations on how to improve the patient experience. Patient- and family-centred care was the main theme throughout the first part of the report that contained 13 recommendations for improving the patient experience. Those recommendations reflected the concerns raised by those patients and families who shared their stories with the commissioner. The second part of the report focused on improving the administration of health care services. It contained the last three recommendations for achieving the best value in care delivery and administration through innovation. These ideas, and the recommendations they inspired, still ring true.

Our government is confident that the recommendations and actions that have been taken will provide a bedrock of accomplishments that we can use to pursue even greater transformational reforms. The Premier asked me to report on what actions have been taken in response to the report, and what has been achieved. He also asked me to identify the challenges that must still be tackled.

The purpose of this Patient First Review Update is not to review in detail each of Mr. Dagnone's recommendations; instead, there is a detailed and transparent appendix that carefully summarizes the dedicated and fruitful work that has taken place over the past five-and-a-half years. The body of the update is instead a chance to take stock of the most successful reforms that resulted from the Patient First Review and to recognize the areas where our health care system still falls short. Throughout the report these examples and case studies further make the case for the central tenet of the commissioner's recommendations: the patient must come first.

As we continue with health system transformation for the benefit of patients, we must remain open to opportunities to leverage the innovation and efficiencies offered by private providers of health services and support services. To effectively meet the health needs of communities across the province, we must find ways to remove barriers that keep health care providers from working to the full capacity of their training. We must also explore ways to offer patients more choice of service suppliers, and increased participation in decision-making. And we must build on the innovative efforts under way to address our considerable infrastructure needs, for a sustainable health system.

A handwritten signature in black ink, appearing to read 'Dustin Duncan'. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Dustin Duncan  
Minister of Health



# Executive Summary

Since the October 2009 release of the Patient First Review report, health care leaders, administrators, and staff have been working hard to improve Saskatchewan's health care services. While not all recommendations have been fully accomplished, the strides that have been made are startling when compared to the staggering barriers to improvement our health care system faced just a few short years ago.

Our health system organizations, patient and family advisors, health care providers, employees, service suppliers, and other government ministries and agencies have shown a remarkable degree of commitment to improve the way health care is delivered in our province. Without their willingness to adopt new ways of thinking and acting together, our health system could not have made the gains it has.

## Reducing Wait Times for Patients

One of the most successful actions taken since the conclusion of the Patient First Review has been the Saskatchewan Surgical Initiative. Just a few short years ago patients faced massive wait lists, some that stretched on for over a year. Since 2010, the number of patients waiting more than three months for surgery is down by 89 per cent; the list of those waiting for surgery for more than six months is down by 96 per cent. To meet ambitious targets, innovative approaches that were wholly new to Saskatchewan have been used, involving patients, health care providers and partner organizations in a massive effort to transform how care is planned and delivered. One innovation was the use of private surgical clinics to eliminate the backlog and meet increasing

demand. Initially, some were hesitant about contracting out surgeries to a private clinic. More than 34,000 surgeries have been completed by private Saskatchewan centres on contract to health regions since 2010 with positive results. In fact, some people report that only later did they realize they had been to a private clinic.



Providing timely and high-quality diagnostic imaging services to Saskatchewan people is a high priority for our government. Since 2008, the number of MRI scans across the province has increased by more than 88 per cent and CT scans have increased by 22 per cent. We are looking to further improve services by adding a new CT scanner in Estevan and a new MRI in Moose Jaw in 2015. Despite the good work done to date, we know more must be done to ensure Saskatchewan's citizens have timely access to MRI services. This is why our government has introduced the *MRI Facilities Licensing Act*, which provides a legal and regulatory framework that paves the way for patients to choose to directly pay a private facility for an MRI scan in Saskatchewan.

**Patients waiting more than  
three months for surgery:**

↓ 89%

Since 2010

We know that many Saskatchewan residents who want quicker access to an MRI are making the choice to travel and pay for an MRI in another province. Our government is interested in removing legislative barriers to allow patients the option to pay for MRI services right here in Saskatchewan where there is an opportunity to improve patient access and satisfaction with health services.

Opposition to the concept of private payment for MRI services is primarily due to concerns that some patients will get preferential access, or will jump the queue, both for the exam as well as any treatment that follows. The changes in the *MRI Facilities Licensing Act* will give our government the ability to make and update regulations that will require private vendors to provide a second scan at no cost for the patient on the public wait list for every scan provided to someone who chooses to pay for their own MRI. Just like today, a physician referral will be needed before someone can obtain an MRI scan.

This model will give Saskatchewan people more options for accessing MRI services close to home without the added costs of travelling to another province. By requiring a private provider to deliver a second scan at no cost to a patient on the public wait list, we will increase MRI capacity in the health system and reduce overall wait times. Once again, we are leading the way with an innovative, made-in-Saskatchewan approach to ensure both access and fairness.

## Redirecting Cost Savings to Front Line Services

The health system also stopped to ask: what is our core business? Are there services that could better be provided by the private sector? In 2014, the Government of Saskatchewan spent \$4,461 per person on health care services; the national average

was \$3,960. With health expenditures continuing to escalate across Canada, a renewed conversation about value and expectations is long overdue. Commissioner Dagnone recommended that Saskatchewan's health partners establish a shared services provider (what would eventually become 3sHealth) in order to find efficiencies; it quickly became apparent that linen services represented one such opportunity.

**Government health spending per person in 2014:**

\$4,461

**National average:**

\$3,960

3sHealth subsequently developed a business case that included an option to privatize linen services, something that many other provinces had done successfully. Following an open competition, private company K-Bro Linen successfully negotiated a contract to provide linen services for provincial health facilities. Estimates indicate that privatizing linen services will save Saskatchewan taxpayers \$98 million over the next 10 years. 3sHealth was also able to secure contractual obligations for detailed financial reporting and agreed-upon service levels (with penalties for non-compliance), something that was not available under the previous model. 3sHealth is developing business cases for seven other service lines that show the potential for savings. The cases we are currently looking at require careful study and consideration; however, similar to linen services, these cases show a strong potential

to deliver savings to Saskatchewan’s health care system.

We will endeavour to ensure that resources are flowing to support frontline services, for the benefit of patients and communities.

Rising to the challenge to put patients first, Saskatchewan’s health care leaders have made remarkable progress in working together to set priorities, make targeted improvements in the patient experience, find efficiencies and improve safety for patients and staff. There remain many challenges to overcome in the transformation of our health system. We must find common ground for the path forward to continued improvement.

## Expanding Services for Patients

In his 2009 report, Commissioner Dagnone also touched on the idea of modernizing the scope of our health care professionals’ competencies and education.

Since 2007, we have seen a tremendous increase in our front-line staff, including 482 more doctors and over 2,600 more nurses of all designations. Despite this, there is a continuous struggle when it comes to securing an adequate pool of labour to support our needs. Further enabling health care providers to practice to their full scope of training could help increase access for patients. Prior to changes made last summer, pharmacists were not allowed to fill prescriptions provided to Saskatchewan residents by nurse practitioners from another jurisdiction. Now Saskatchewan patients, particularly those who live next to the Alberta border, can receive follow-up care from a nurse practitioner in another province. This is a common sense change that allows patients to move seamlessly between providers. A comprehensive and collaborative review of the practices that our medical professionals are licensed to conduct

is needed to ensure their scopes of practice are not limited by outdated restrictions.

Commissioner Dagnone, when referring to the primacy of the patient experience, coined the “customer-owner” model. He correctly noted that “Current funding models serve as a barrier to those providers who are keenly interested in providing patient-and family-centered care”. The commissioner noted that in the absence of competition, the “system’s leaders and providers may be less aggressive in pursuing excellence in the face of numerous pressures”. There are also very real limitations on what services the public health care system can provide. Sometimes, such as in the case of surgical innovations and new techniques, the latest advancements may not always be available when we need them.

**“A regulatory system that eliminates monopolies and restrictive scopes of practice and allows professionals to provide services to the full extent of their training should result in a more flexible, effective and efficient system that promotes quality care.”**

- Patient First Review  
Commissioner Tony Dagnone

Our government is looking closely at activity-based funding (ABF) as a solution to this problem. ABF creates a direct link between a hospital’s volume of activity and its funding. Currently, hospitals in Saskatchewan receive annual funding amounts from government to cover

operational expenses that are not tied to volumes (known as block funding). While this approach is administratively simple and relatively inexpensive to operate, funding is often determined in relation to historical funding levels that may no longer be appropriate, resulting in inequities between hospitals. In addition, block funding does not create an incentive for efficiency and may actually result in a decrease in the volume of service delivered in order to meet fiscal demands.

As our government seeks to expand services for patients, we will be closely reviewing these policies in order to seek out the best way to improve the quality and availability of health care in Saskatchewan.



**‘Patient First’ cannot be a mere lapel pin, button or logo; it must be a**

**way of doing business.**

- Patient First Review  
Commissioner Tony Dagnone

## Patient Choice

The focus on increasing access to services and improving their quality is why our government is exploring and evaluating approaches that will allow patients greater choices for their health care services. One solution that may work is the use of patient-directed funding for certain procedures – a system that has been used across Europe, the United States and Asia. Under this approach,

a patient would receive a credit that clearly identifies a number of treatment options. From these options, they would be able to take the credit and purchase the medical service that they feel would best address their health care concerns. The service provider would then return the credit to the provincial government for an agreed upon value. An innovative and personalized response like this could allow our health care service to be more responsive to patients.

Many existing programs already operate in a similar way. For example, home care clients can opt for Individualized Funding. This program provides funding (based on assessed need) to an individual who then arranges for supportive services, and manages the relationship with the care provider, rather than receiving services directly from a health region home care program. This allows clients to exercise choice as they determine their own needs and take responsibility for arranging their own care. Clients report receiving a higher consistency in care, better scheduling, and more control over the care they receive.

Recently our government was publicly asked to cover the cost of out-of-country surgeries for transvaginal mesh removal and severe endometriosis. Select variations of these procedures are not available in Saskatchewan, but are in other provinces. Provincial policy requires that patients receive treatment in Canada where coverage is available. In both of these cases however, the patients believed that their best option was a surgeon not in Canada, but in the United States. This is a subjective determination, one in which there is ample room to debate. A credit, limited to procedures that are not available in Saskatchewan, could provide these patients with the same financial compensation whether they decided to have the procedure completed in Canada or another country.

## Improving the Quality of our Facilities



*Premier Brad Wall helps kids fill their sand buckets at the ground-breaking ceremony for Children's Hospital of Saskatchewan, with Minister Responsible for Rural and Remote Health Greg Ottenbreit (centre) and Health Minister Dustin Duncan (right).*

Finally, and in some ways most importantly, Commissioner Dagnone in his fifteenth recommendation called on the Government of Saskatchewan to “explore ways and means to develop a coherent financing plan, including alternate financing partnerships, to address the urgent need for capital infrastructure investment”. Infrastructure has once more become a major news story in Saskatchewan. As part of the government’s ongoing commitment to transparency, the Vanderwiell Facility Assessors (VFA) report was released, identifying a backlog of \$2.2 billion in infrastructure work needed to bring existing health care facilities and offices up to modern standards of safety and comfort. This problem was not the sole responsibility of any one individual or government administration in Saskatchewan. The core of the problem is the ease with which governments for generations have simply deferred crucial maintenance, a policy that has compounded the backlog of needed maintenance.

The solution is not a simple one. The government and its health care system partners must commit to the renewal of our facilities and identify new and

innovative ways of building and maintaining infrastructure. We have begun the process of renewal by replacing outdated buildings and identifying new and pressing infrastructure needs. The new Moose Jaw Hospital under construction is scheduled to open in fall 2015. Construction has begun in Saskatoon to prepare for the Children’s Hospital of Saskatchewan and pre-construction site work has begun on a new integrated mental health and correctional complex in North Battleford.

In 2009, one of the first major capital investments across government included funding to replace 13 outdated long-term care facilities with brand new builds. Most of these projects are finished or nearing completion.

Also in 2009, planning began for what will be a 225-bed Swift Current long-term care facility. The project was carefully evaluated and became one of Saskatchewan’s first public-private partnerships (P3s) in health care. This method of financing and managing construction of public buildings has been used by eight provinces and the federal government and has been endorsed by political leaders of all backgrounds.

**“Health care costs could be reduced and patient care improved if governments adopt a long-term care strategy, which includes using public-private partnerships to increase the supply of long-term care beds.”**

- Janice MacKinnon, former Saskatchewan Finance Minister

P3s are a unique tool that government can use to contractually oblige the private partner to maintain the building over the life of the contract (usually 30 years). Using P3s where they make sense, we can reduce deferred maintenance in P3 facilities and allow government to concentrate on the backlog of maintenance. As part of an ambitious plan to usher in a new era of responsible infrastructure management, the government will continue to look at P3s and other means of alternative financing.

This report is intended to continue the discussion of how best to build on the results-oriented success of the Patient First Review. Over the past five years there have been many debates and discussions. These discussions have resulted in meaningful change and should be used as a starting point as we strive towards continuous improvement. Ultimately, when we have tried to look at health care from the perspective of the children, women and men who rely on our care, the health system has been able to deliver results. While we have had tremendous success over the past five years, much work remains. In the months to come, government and its health partners will seek to renew this conversation as we explore the ideas and solutions that show the most potential to ensure that Saskatchewan's health system continues to improve.

## Patient

In this report, “patient” refers to any person who receives services or benefits from a program in the health care system. For example, this includes patients in a hospital or rehabilitation facility, clients of mental health and addictions programs, or residents in long-term care facilities.

## Family

This report uses the term “family” to refer to one or more persons who are related in any way – biologically, legally, or emotionally – to the individual receiving care. Using the patient- and family-centred model of care, the degree of the family's involvement in health care is determined by patients, if they are developmentally mature and competent to make such decisions.

# Introduction

In 2008, the Saskatchewan government asked former health administrator Tony Dagnone to act as commissioner of the Patient First Review, conducting research and making recommendations on how to improve the patient experience and the performance and leadership of the health system.

The resulting report *For Patients' Sake* reflected the voices of the many patients, family members and health care providers who participated in the research and discussion. Patient- and family-centred care (PFCC) was the main theme throughout the first part of the report, containing 13 recommendations on improving the patient experience. Improving the administrative and leadership structures of the health system was the focus of the second part of the report, containing three recommendations on how to achieve the best value in care delivery and system administration through innovative ideas, such as shared services and alternative financing for health capital infrastructure.

Saskatchewan's health system partners have taken up the challenge set by the commissioner and the government. While not all recommendations have been fully accomplished, the gains made have been impressive in such a short period of time.

This update describes what has been achieved so far and, more importantly, acknowledges the gap that remains and the need to build on these successful innovative approaches that support continued improvement.

## Commissioner's Recommendations

On October 15, 2009, the commissioner presented the Minister of Health and a patient representative his 16 recommendations to improve patients' experiences and to improve the administration of the health system. In summary, the commissioner recommended that:

- Patient First be embedded as a core value in health care.
- Health care in Saskatchewan function as a cohesive system.
- Frontline health care providers be empowered to deliver patient- and family-centred care.

Foundational to all of the recommendations was the need to implement a patient- and family-centred care approach where patients, clients, residents and their caregivers become partners in how care is planned and delivered and in finding ways to improve services and programs.

Access to care has been an issue for our health system for some time and the commissioner heard many patients and family members discuss the challenges they had and their anxiety in waiting for needed services. The need for more convenient, timely care was identified for both surgeries and diagnostic procedures. The commissioner also suggested that the system make better use of system facility resources by exploring the use of underused rural facilities where urban facilities are at maximum capacity and exploring the establishment of urban urgent care centres.

Coordination of care was also an area identified for improvement, with the goal of providing a seamless system from the perspective of the patient. The commissioner suggested adding better navigation supports for anyone in need of multiple services, better linkage of services from various sectors for children and youth, stronger inter-sectoral cooperation where needed, and better coordination of services for patients with cancer and their families.

The commissioner heard from patients and their families, particularly those of First Nations and Métis ancestry. They said they want to feel listened to, have their concerns understood, and they want to be treated in the way that works best for them, within their life's context. He recommended collaboration with First Nations and Métis people in order to develop a culturally safe and competent health system.

For equitable care, the commissioner highlighted the need for improving services and programs for rural and remote residents, seniors, and those of First Nations and Métis ancestry. He recommended that rural Saskatchewan residents have more care provided closer to home. For seniors, he recommended bringing the care to their homes to enable independence for as long as possible. The system was also encouraged to provide more equitable care and improved access for patients and families with mental health needs, particularly for those experiencing a crisis.

**Improved service for rural and remote residents, seniors and those of First Nations and Métis ancestry.**



*Commissioner Tony Dagnone, meeting with a patient at the Wascana Rehabilitation Centre in 2009.*

Development and implementation of a Charter of Patient Rights and Responsibilities was also recommended as part of open, informative care. The commissioner discussed patients' need for clear and helpful information, options for treatment and the next steps in their road to better health.

Health promotion and disease and injury prevention were recommended as key components for comprehensive care. The commissioner noted that by keeping people healthy and out of the health system, services would be ready and waiting for those who needed them within our existing resources. Key to keeping people healthy was the need to provide patients and their family members with more time to communicate concerns and to understand treatment options. The services that a family doctor and a team of other health professionals could provide were seen as essential in supporting Saskatchewan residents in maintaining good health and managing chronic diseases.

With so many organizations in the province delivering health care, patients asked to have all of their test results, their medical history and treatment plans housed in one place.

With a “one patient, one record” approach to delivering care, patients and their family members would feel more secure in their treatment journey and would appreciate not having to repeat the same information to multiple staff and health providers. The commissioner therefore recommended that the province advance a plan for an integrated electronic health record.

Finally, the commissioner recommended establishing a provincial shared services organization, exploring alternate financing partnerships to address the capital infrastructure deficit, and enabling the Ministry of Health to assume a more strategy- and stewardship-focused role for the health system. The commissioner also noted ideas for governance improvement such as bolstering the skill sets of board members and staff leaders, finding economies of scale for delivering certain administrative functions, and engaging physicians more.

A complete list of the recommendations can be found as Appendix A of this document.

# Assessment and Next Steps

## Results of the Commissioner's Recommendations

The Patient First Review report was a call to action for better access to care, a renewed focus on the needs of patients and their families, and improved safety and efficiency in health care service delivery.

Within two weeks of the report's release, the Government of Saskatchewan took action, announcing a four-year plan to reduce surgical wait times, improve how patients experience health care, and strengthening the safety culture around surgeries. Five weeks later, it announced the establishment of the Physician Recruitment Agency of Saskatchewan. The following spring, the government announced that 100 new long-term care beds would be built in Saskatoon using an alternative funding arrangement.

The leaders of Saskatchewan's health system moved quickly to endorse the commissioner's recommendations and make improved patient and family experiences a priority.

After careful consideration, the provincial government decided not to act on some of the commissioner's recommendations. For example, the commissioner recommended the creation of a Charter of Patient Rights and Responsibilities. Government decided that the commissioner's recommendation to develop a patient- and family-centred care (PFCC) framework could bolster patient rights and responsibilities in a more robust way. The health system has adopted PFCC as a principle of service delivery. Health providers strive to ensure patients have the information they need in order to make informed decisions. Where possible, each patient's personal needs are considered in the provision of care.

Other actions in response to the Patient First report required a more long-term, ongoing approach. These include improving cultural responsiveness of the health system, improving health outcomes for First Nations and Métis residents, improving seniors' ability to remain in their own homes longer with easy transition options, coordination and integration of cancer care services, health promotion and illness/injury prevention, and the reorganization of the Ministry of Health. Progress has been made in these areas, and work continues with the goal of improvement. Appendix B of this document sets out clear and detailed information about work done to date on all of the commissioner's recommendations.

While these accomplishments have been substantial, they should not be taken for granted, further work needs to be undertaken in order to ensure that Saskatchewan's health system continues to undertake improvements.

## Key Accomplishments

### **CONVENIENT, SAFE, TIMELY CARE**

#### **Saskatchewan Surgical Initiative**

The four-year Saskatchewan Surgical Initiative helped focus health system partners on targeted efforts to reduce wait times while providing safer and smarter care. Leaders and teams realized they needed to embrace innovative methods. The initiative achieved tremendous improvements in the way surgeries are managed and delivered. **Surgical wait list numbers have fallen dramatically since March 2010.**

## Reduction in the number of patients waiting for surgery:

### Patients waiting more than:

18 Months  
↓ 100%

12 Months  
↓ 98%

6 Months  
↓ 96%

3 Months  
↓ 89%

(March 31, 2010 compared to March 31, 2015)

Some of the highlights of this initiative are:

- Surgical capacity has been expanded through the use of contracted private surgical and diagnostic services.
- An online Specialist Directory helps patients and family physicians identify options.
- Some groups of specialists now pool referrals, so patients can see the first appropriate specialist or choose to wait for a specific specialist.
- There are four established clinical pathways providing timely and appropriate care.
- The surgical safety checklist (an error prevention protocol) was adopted province-wide, and there are measures in place to prevent surgical site infections.
- Training spaces for operating room (OR) nurses have been increased to deal with a shortage of OR nurses.

The two largest and busiest health regions contracted out selected procedures to surgical and specialized diagnostic companies. One of the key principles in planning for procedures to be delivered in a private facility is that the cost to perform the procedure must be the same as, or less than, services delivered in the public system. Through competitive tendering processes, the contracts were awarded to companies with surgical centres in Regina and Saskatoon. From September 2010 until March 2015, a total of 35,744 surgical procedures were provided to patients in private facilities (14,660 in Regina and 21,084 in Saskatoon).

## Private Delivery of Surgical Services

The private delivery of surgical services has been a successful strategy implemented since 2010 by the Saskatchewan Surgical Initiative to reduce wait times and to improve access to care for surgical patients. It helped Saskatchewan increase its surgical capacity, freed up hospital operating room time for more complex cases, and addressed the backlog of patients waiting for surgery. Further, patient feedback has been positive: patients can access a day-surgery procedure in a community-setting, away from hospital congestion.

Contracts for outpatient surgical services have been awarded through competitive tendering processes: Surgical Centres Inc. (SCI) in Regina, and SCI (under the name Prairieview Surgical Centre) in Saskatoon.

Contracted day surgical procedures vary by site, but examples include cataracts, dental, knee and shoulder arthroscopies, knee anterior cruciate ligament (ACL) repair, select gynecological procedures, select ear, nose, throat (ENT) repairs and select plastic surgeries.

In 2013-14, about 14 per cent of surgeries performed in the province were performed in a private facility.

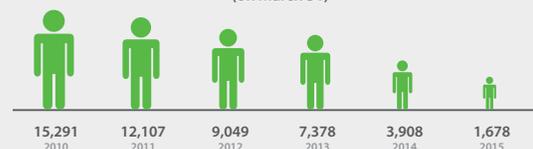
Building on the success of the Surgical Initiative, further uses of private centres may hold promise for improving access and boosting patient satisfaction with provincial services.

## PRIVATE CLINICS HELP SHORTEN WAITS FOR SURGERY

Volume of Surgeries in Saskatchewan 2010-2015



Patients Waiting more than 3 Months (on March 31)



Day surgeries provided by private clinics are one of the factors helping reduce surgical wait times.

saskatchewan.ca



## Emergency Department Use

### Our government recognizes the negative impact on patients caused by excessive waits for emergency department treatment.

The province has embarked upon the Emergency Department Waits and Patient Flow Initiative to tackle lengthy wait times for emergency room service and inpatient admissions to hospitals. Long waits in the emergency department are often a symptom of complex issues affecting patient flow across the health system. Through extensive engagement with stakeholders, including patient and family representatives from across the province, the initiative team has clearly identified how the patient flow process currently works and how it can be improved. Building on the experience of the Saskatchewan Surgical Initiative and lessons learned, a multi-year plan has been developed and will be implemented over a four-year period.

Crescent View Primary Health Care Clinic is one of eight innovation sites announced following the release of the health system's Primary Health Care Framework, in 2012. Crescent View Clinic in Moose Jaw was designed primarily to manage acute, episodic illnesses in support of reducing wait times in the emergency department for patients requiring urgent but not emergent care. In addition, the clinic provides support to patients of family physician practices for episodic illnesses when they cannot see their practitioner on short notice.

The team is co-located with Five Hills Health Region mental health and addictions staff, providing an integrated team approach for the community. The team includes four nurse practitioners, three clinical assistants, two healthy-living consultants and six physicians supporting the equivalent of one full-time physician. Initially operating with part-time services, the clinic was able to serve about 120 clients each month. This number has increased since July 2014, when Crescent View began providing services seven days a week. As of May 2015, the Crescent View Clinic has the capacity to provide care to approximately 930 clients per month, supporting the goal of significantly reducing the number of patients seeking urgent but not emergent care in the hospital Emergency Department. Currently around five per cent of those clients do not have family physicians. Crescent View also offers adult mental health and addiction services (group classes both days and evenings, and single session drop-in services).

## **EQUITABLE CARE**

### **Rural and Remote Service Delivery**

From March 2007 to March 2015, the number of licensed physicians in Saskatchewan increased by 27.7 per cent to 2,224 (482 more doctors). There are 220 more family physicians (up 23 per cent) and 262 more

specialists (up 33.5 per cent). However, access to health services – particularly physician services – is still a key issue of concern by many residents in rural and remote communities.

There have been a number of efforts made to address issues related to the retention and recruitment of physicians, including:

- The Physician Recruitment Agency of Saskatchewan (saskdocs) was created.
- A Saskatchewan-based foreign-trained physician assessment program was developed in 2011. Currently, 165 foreign-trained physicians have completed the assessment and are practicing throughout the province. Of those, 96 per cent are practicing in rural and remote communities. These physicians are from various countries, but the majority of them are from South Africa, Nigeria, Egypt, and Iran.
- The government also compensates physicians who choose to serve as full-service physicians, such as providing on-call coverage to the local emergency department. Those physicians are provided with a 10.5 per cent premium on rural physician earnings.
- Post graduate residents are now being trained in rural and remote communities, including Prince Albert, Swift Current, La Ronge, North Battleford and Moose Jaw.
- The Rural Family Physician Incentive Program was launched in 2013 to recruit recently graduated family physicians to rural communities.
- The Rural Physician Locum program has stabilized services in many rural communities, such as Arcola, Kipling, Maidstone, Balcarres, Wolseley, and La Ronge.



The designation of the Whitecap Health Centre as a primary health care

innovation site is already paying dividends through enhanced services in our community. As we move forward with our federal and provincial partners and Saskatoon Health Region, we are breaking down the walls of segregation to share these services with our residents, visitors and neighbours.

- Chief Darcy Bear, Whitecap Dakota First Nation

The province has been also undertaking a team-based primary health care (PHC) approach to improving access to health care services in rural and remote communities. The provincial PHC framework, *Patient Centred, Community Designed, Team Delivered: A Framework for Achieving a High Performing Primary Health Care System in Saskatchewan* was released in May 2012. The goal of the framework is to have a patient-centred system that provides increased access and navigation to care, improved patient experiences and better health outcomes.

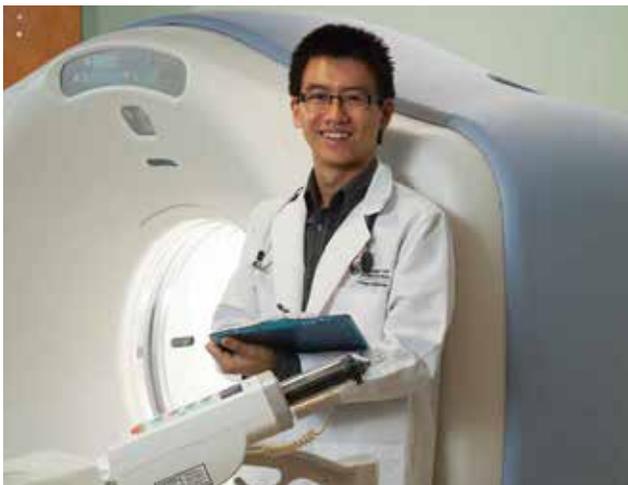
PHC teams focus on enhanced patient case management, increased access to mental health and addictions services within the PHC setting and extended hours of service. Team-based PHC allows health providers to work to the top of their scope of practice. New roles for providers have been introduced, including RN case managers who provide advice and support to patients outside of office visits, and PHC counselors who provide mental health and addictions services. Improved primary care increases patient access to expanded and better coordinated services closer to home, reduces pressures on emergency departments and inpatient beds, and reduces referrals to more costly specialty care.

**There are 90 PHC teams in Saskatchewan, as of March 2015:** 60 in rural areas, 22 in urban/metropolitan areas, and eight in northern Saskatchewan. **About 37 per cent of Saskatchewan residents have access to a PHC team, which includes family physicians.**

Health regions with innovation sites are building new models of service delivery using patient and community input and Lean methods to build services that best meet the needs of patients, families and communities. **Lessons learned from testing models will be shared across the province to help design models that work in other communities.**

In 2013-14, eight new PHC innovation sites using new models of team-based care were established in Leader, Lloydminster, Meadow Lake, Moose Jaw, Saskatoon (health region partnership with Whitecap Dakota First Nations), Yorkton, Regina inner city, Fort Qu'Appelle/Balcarres/Lestock (Touchwood Qu'Appelle). In addition, new PHC teams have been established in several other communities in response to service disruptions related to shortages of physicians and other providers. Kelvington, Watrous, Wakaw, Weyburn,

Oxbow, Kipling and Assiniboia have re-established “close-to-home” access to PHC and acute services. These PHC sites support local community needs with services delivered by a team of health professionals, including a physician. These communities have recruited new physicians who work within a team-based model.



## 482 MORE PHYSICIANS IN SASKATCHEWAN

*Saskatchewan Licensed Physicians 2007-2015*



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## Meadow Lake Primary Health Centre

The Meadow Lake Primary Health Centre is using a team approach to service delivery, introducing Nurse Case Managers, Chronic Disease Educators, Dietitians, Mental Health and Addictions Workers, Pharmacists and Exercise Therapists, among others, to work alongside the physicians. This creates a one-stop shop for patients and provides holistic health care services.

This approach supports Saskatchewan’s new primary health care framework which outlines a new primary health care system that will make better use of a full range of health professionals, working collaboratively at the top of their scope of practice. The team approach allows health professionals to enjoy the benefits of team-based care, including higher job satisfaction and better information sharing. It also supports the vision that every patient has access to a team that meets their unique care needs.

Now that most of the groundwork has been completed, practitioners are concentrating on their areas of expertise and quickly conferring with colleagues when they have questions. Better communication between practitioners improves not only patient service, but fosters better relationships between team members.

The introduction of multi-skilled care teams is just one of the ways the clinic better serves patients. It has also introduced Clinical Practice Redesign™ and continuous improvement methodologies to focus on improving access to services and enhancing the patient experience.

Primary health care is the foundation of the health system. The best practices gleaned from Meadow Lake will result in a stronger and more robust system that is better able to meet the needs of Saskatchewan's diverse population. A patient- and family-centred health system means not only a healthier population, but stronger communities as well.



Before the changes in Meadow Lake, patients struggled to get access.

With an RN case manager, patients are now guided through the system based on their specific needs. It's a complete paradigm shift for physicians, but I now can't imagine working any other way.

- Family physician  
Dr. Gavin Van de Venter

In 2012 the Saskatchewan Cancer Agency began to use Telehealth videoconferencing to improve access to cancer services, allowing a patient in their home community to have a remote appointment with their oncologist and other team members. **In 2014-15, the use of Telehealth enabled cancer patients to avoid 589,692 kilometres in travel to Regina or Saskatoon for their appointments.**

The Cancer Agency plans to expand use of Telehealth in 2015-16 to provide more care closer to home for patients.

More than 1,700 patients each year use the Community Oncology Program of Saskatchewan to receive chemotherapy closer to their homes. This saved them more than 3.7 million kilometres in travel during 2014-15. Patients can receive oncology services like chemotherapy in 16 hospitals located outside Saskatoon and Regina. Clinicians in these locations can view and update patients' charts in the secure Clinical Management System, resulting in improved communication and enhanced patient care.

**Three Collaborative Emergency Centres (CECs) were opened in Maidstone (September 2013), Shaunavon (November 2013) and Canora (July 2014). Two additional CECs are in development.**

A CEC uses a team-based primary health care (PHC) model that provides extended hours of PHC and 24/7 emergency care, to improve stability and access to health services for patients in rural and remote communities. The public can access PHC teams including physicians during the daytime and nurse practitioners with extended hours on evenings and weekends. Between 8 p.m. and 8 a.m. daily, care is handled by a registered nurse and paramedic team with phone oversight by a STARS emergency physician.

In 2012, STARS helicopter air ambulance service was added to the fixed-wing air ambulance and road ambulance teams that

provide a vital link for rural and remote areas of Saskatchewan. **Over 1,000 patients have been transported or treated on-scene by STARS.** Government continues to provide a safety net for individuals with low income to cover or mitigate the costs of road ambulance services.



*STARS offers another option for getting critical patients to care as soon as possible.*

## Seniors

The majority of seniors continue to live healthier lives and remain independent in their community. Seniors are telling us they want to live at home longer. Research shows that for many seniors, “aging in place” can provide significant emotional, social, and economic benefits while also reducing health system costs.

While the aim is to support seniors in their homes, care needs can change, so flexible approaches for clients and families are needed. The health system is committed to ensuring that seniors can remain in their own homes as long as is appropriate, and transition easily to other options such as assisted living, personal care homes, or long-term care as their care needs change.

High-quality, responsive, resident-centred long-term care is a must, and needs to be integrated well with community services. The public health system has been bolstered in order to provide appropriate supports. For example, additional care providers have been added, and innovative programming has been established.

It is anticipated that from 2014 to 2020, Saskatchewan’s population aged 65 and older will increase from 14.2 per cent to 16.3 per cent of the total population. This growing segment of the population will put increased demands on home care and long-term care. While the number of long-term care beds has remained relatively stable, the number of full-time-equivalent positions (FTEs) for Continuing Care Assistants (CCAs), Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) in long-term care and integrated facilities has increased over the past six years.



**There are now many health providers with the same goal but a slightly different focus, so the patient benefits from all the interactions.**

- Melanie Bauman, registered nurse and case manager in Meadow Lake

**The process is smoother and wait times have decreased.**

- Becky Lockhart, registered nurse and case manager (left in photo)



*Dr. Clare Kozroski consults with a resident of the Gull Lake Special Care Centre.*

Between 2006-07 and 2013-14, the number of paid FTEs in long-term care and integrated facilities for LPNs, CCAs and RNs increased in all health regions:

- LPNs increased by 40 per cent;
- CCAs increased by 11 per cent; and
- RNs increased by 6 per cent.

Innovative new ideas that provide a range of policy options are currently being tested throughout the province. For example, approaches such as Purposeful Rounding can help caregivers interact with residents in a meaningful, purposeful way while they are awake. This is the practice of regularly checking on residents' needs using the Four Ps – positioning, personal needs, pain and proximity of personal items. Evidence suggests that Purposeful Rounding results in increased resident and family satisfaction and improved safety while improving the quality of care. Gentle Persuasion is an evidence-based training program for individuals that care for adults with dementia, who can display challenging responsive behaviours. This training enhances care for residents and safety for staff.

**To improve accessibility and quality of long-term care (LTC), the government has invested \$237.4 million to replace 13 outdated LTC facilities. As well, a new long-term care facility is being built in Swift Current, and new LTC facility (Samaritan Place) in Saskatoon is operating. Planning funds have also been allocated for new LTC facilities in La Ronge and Regina to address growing demands for LTC beds in these regions.**

The government also invested \$10.04 million in a Long-Term Care Urgent Issues Action Fund to address priority issues, such as new equipment, improved nutrition, improved responsiveness and training to care for residents who have dementia. Beginning in 2014-15, \$3.8 million in annual funding was provided to support these efforts. CEOs, or designates, will be touring all of their LTC facilities in 2015-2016 to continue to monitor, identify and review progress that has been made, and to maintain a continued focus on quality improvement.

To ensure the focus on quality continues, in response to quality of care issues at a specific Special Care Home the Minister of Health asked the Saskatchewan Ombudsman to review the care provided in the facility and to identify issues specific to that facility or that are relevant to the health system as a whole. The Ombudsman released her report in May 2015. The Government is committed to working with our health system partners to address the recommendations the Ombudsman made to the Ministry of Health, including:

- Require all health regions to develop policies and procedures to operationalize the Program Guidelines for Special Care Homes, which currently articulate minimum care standards, and identify specific, measurable indicators of performance specific to those care standards that will be tracked and reported on a regular and ongoing basis.

- Development of a process to publicly report on how long-term care facilities are meeting the standards included in the Program Guidelines for Special Care Homes, similar to current reporting of results of personal care home inspections.
- Ensuring concerns are handled in a fair and responsive manner by providing more information on concern handling and the appeal process that currently exists within the Program Guidelines for Special Care Homes and strengthening this process where needed.

Also in response to an Ombudsman recommendation, the Ministry will work with health system partners on a broader long-term care strategy to meet the needs of long-term care residents and address the factors affecting the quality of long-term care in the province. The health system will build on what was learned from a seniors engagement session held in December 2013 and work with our partners to consider best practices through innovation and initiatives that will meet the needs of seniors in our province now and in the future.

The Ombudsman's insight and recommendations will be valuable in our ongoing work to improve long-term care in our province.

The Ministry has already implemented a process to improve on seven key quality indicators (pressure ulcers, restraint use, worsened pain, antipsychotic drug use without diagnosis of psychosis, falls, and worsened bladder continence) generated by a standardized health status assessment tool. Regions are working to make improvements in areas where they are not better than the national average.

Government continues to make new investments in seniors care. In 2015-16, government is investing \$10 million in new

targeted funding to support seniors living in their own homes as well as improving the quality of long-term care:

- \$3.5 million to enhance the Home First projects in Regina Qu'Appelle, Saskatoon, and Prince Albert Health Regions, and to expand to an additional site in Prairie North Health Region (total funding is now \$8.25 million);
- \$2.8 million for capital renovations in Regina Qu'Appelle and Saskatoon Health Regions to develop specialized units for individuals with dementia or challenging behaviours;
- \$2.0 million to eliminate the current wait lists for the Individualized Funding program through home care;
- \$1.0 million to implement Purposeful Rounding in LTC facilities; and
- \$700,000 to develop a new geriatric program in Regina.

To make life more affordable for Saskatchewan seniors, the government has:

- Increased the amount of the monthly supplement under the Seniors Income Plan (SIP) for those seniors who have little or no income other than the Federal Old Age Security Pension and Guaranteed Income Supplement from \$190 in 2009 to \$260 in 2014 for single seniors. The supplement for each member of a married couple increased from \$155 to \$225. Nearly 15,000 Saskatchewan seniors receive SIP each month, and are also entitled to additional health benefits such as an annual eye examination, chiropractic services (to a maximum of 12 services per year), a reduced prescription Drug Plan semi-annual deductible, a home care subsidy and an exemption from many of charges under the Saskatchewan Aids to Independent Living Program (SAIL).

- Introduced the Personal Care Home Benefit in 2012, to provide financial support for low-income seniors living in a licensed personal care home. The amount of the monthly benefit has increased from \$1,800 in July 2012 to \$1,950 in July 2014. The subsidy helps about 800 seniors access the care they need each month.

## A PATIENT- AND FAMILY-CENTRED CARE HEALTH SYSTEM

### Patient- and Family-Centred Care

Patient- and family-centred care (PFCC) is about providing respectful, compassionate, culturally-responsive care that through collaboration meets the needs, values, and preferences of patients and their family members. It is grounded in mutually beneficial partnerships among patients, families and health providers.

PFCC is an approach that places the patient at the centre of all decisions and care processes. With this approach, patients and their family members (no matter how the patient defines family) are treated with respect and dignity; they are provided evidence based information about their condition and are encouraged to choose their level of participation in the development of a care plan and decisions about treatment.

Patient and family advisors are also important partners in improving the health system and its related processes. They are viewed as essential allies and true partners.

Soon after the release of the Patient First Review report, patient- and family-centred care began to be adopted within the health system. A provincial framework for adopting PFCC was released in June 2011. The Ministry of Health, health regions, Saskatchewan Cancer Agency, 3s Health and Health Quality Council have developed multi-year action

plans and are putting this approach into practice across their organizations.

Engaging patient and family advisors is now a standard process for all quality improvement projects and provincial strategic initiatives. To date, more than 300 patients and family members have been involved in various improvement events across the system.



Patients and family members are the real experts. We don't need to

look everywhere else and ignore what our patients and families are saying they need.

- The late Lawrence LeMoal,  
Patient and Family Advisor

## CO-ORDINATED CARE

### Cross-Ministry Work: Services for Children and Youth

**The provincial government has provided \$62.5 million in new funding to the Saskatchewan Child and Family Agenda since it was created in 2011**, including \$8.725 million in the 2014-15 budget. The budget for 2015-16 includes \$546,000 for annualized funding for pre-kindergarten programs, and a \$2.14 million increase for ongoing costs of recently developed child care spaces. There have been some early successes and promising initiatives, demonstrating the value of cross-ministry

collaboration that focuses on the needs of the client, rather than the constraints of organizational silos.

The Hub and Centre of Responsibility (COR) are intersectoral approaches to addressing domestic violence, housing, mental health and addictions. A Hub provides immediate, coordinated intervention to address situations facing individuals and/or families with acutely elevated risk factors, as recognized by a multidisciplinary group of service providers. The COR is focused on longer term community goals and initiatives. The establishment of the first Hub in Prince Albert was followed by decreases in the crime rate (14 per cent), public prosecutions (12 per cent), and ER visits (10 per cent). This approach has been adopted in 10 other communities across Saskatchewan.

The Hub and COR model focuses on case management, research and the broader social determinants of health, which is strongly aligned with the approach of the health system's hotspotting initiative. Hotspotting focuses on coordinating services around high-use patients who are repeatedly hospitalized and/or frequently attend emergency departments. Like the Hub and COR model, hotspotting seeks to place an individual's circumstances in a broader context, rather than treating each interaction in isolation. The Hub, COR and hotspotting all seek to coordinate services with the intention of providing every individual with the most effective treatment, support or service through the most appropriate avenue.

In an effort to transform child welfare, Government has introduced innovative initiatives such as intensive in-home supports and Triple P (Positive Parenting Program) through a partnership with seven communities. The province-wide results between March 2011 and March 2015 show a decrease in the number of children in out-of-home care (2.5 per cent). While a

slight increase was seen in the number of child protection cases due to neglect (0.5 per cent), the overall number of open child protection cases decreased by 6.9 per cent.

To prevent fetal alcohol spectrum disorder (FASD), ministries began providing targeted programs for individuals and families in 2011-12. These programs address parenting skills and provide information about accessing services, such as mentorship and life skills services. In 2012-13, three pilot projects (Saskatoon, Regina, and Prince Albert) were launched to provide intensive FASD prevention programming to pregnant women at high risk for having a child with FASD and their families. The targeted supports include healthy birth outcomes, community supports for individuals with FASD and interventions for children and youth with FASD.



**Patients know when they're right. We're not here to question the care or the**

**expertise, but we are going to ask questions.**

**I really want to partner with my health care providers. I guess now it's in their court if they want to partner as well.**

**- Patient Advisor  
Heather Thiessen**

## COMPREHENSIVE CARE

### Chronic Disease Management

The health system leadership team has identified primary health care as a key priority critical for transforming the health system. They set out ambitious goals:

- By 2017, people living with chronic conditions will experience better health as indicated by a 30 per cent decrease in hospital utilization related to six chronic conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, depression, congestive heart failure, and asthma).
- In 2013-14, analysis of hospital admissions showed that Saskatchewan has 173 hospitalizations for these conditions for every 100,000 total hospitalizations. The goal is to reduce this baseline by 30 per cent, to 121.51 hospitalizations for these conditions for every 100,000 hospitalizations. To date, a reduction of 17 hospitalizations per 100,000 has been achieved. This represents an improvement of nearly 10 per cent.
- By 2017, there will be a 50 per cent improvement in the number of people who say “I can access my primary health care team for care on my day of choice either in person, on the phone or via other technology”.
- By 2020, 80 per cent of patients with six common chronic conditions are receiving best practice care as evidenced by the completion of provincial templates available through approved electronic medical record (EMR) and the eHR viewer.

These targets and related initiatives are focused on improving access to care, and better managing chronic conditions. Patients with diabetes and other chronic conditions will benefit by living healthier lives, with reduced risk that they will need hospitalization due to symptoms or complications related to their chronic condition.

Work in 2013-14 focused on implementing new models of care that improve access to care and support chronic disease prevention and management. Primary health care clinics are ideally suited to promote best practices for chronic conditions. New primary health care models focus on improved patient case management, integrated mental health and addiction services, expanded hours of service, and new chronic disease management approaches such as a shared medical visit. A shared medical visit, also known as a group visit, occurs when multiple patients are seen as a group for follow-up care or management of chronic conditions. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physicians, the benefit of counseling with additional members of a health care team (for example a primary health care counsellor, nutritionist, or health educator), and can share experiences and advice with one another<sup>1</sup>.

The Ministry of Health and Saskatchewan Medical Association (SMA) negotiated and developed the Chronic Disease Management - Quality Improvement Program (CDM-QIP) to help ensure the best possible care for patients living with a chronic disease. The program was launched in 2013, in partnership with eHealth Saskatchewan, and with assistance from clinical leaders. The CDM-QIP gives health care providers tools to

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1 American Academy of Family Physicians (AAFP) - <http://www.aafp.org/about/policies/all/shared-medical.html>

help them follow best practices when they provide care. It also collects data that gives providers a clear and complete picture of a patient's condition and care history.

Initially, the program is focusing on diabetes, coronary artery disease, chronic obstructive pulmonary disease, and congestive heart failure. Patient information important for monitoring chronic disease is being collected from participating clinics in the province where the patients received health services. The program tracks indicators that have been shown to improve patient outcomes. Data is stored centrally to give physicians a comprehensive picture of a patient's health and help them provide better care. All family physicians are being encouraged to participate in this new program. As of March 31, 2015, 594 physicians have enrolled.

The Ministry and SMA also negotiated the Family Physician Comprehensive Care Program (FPCCP). It provides funding to better enable physicians to provide a full range of services, including chronic disease management. The program is also intended to strengthen family physician recruitment and retention efforts and encourage more physicians to provide comprehensive care. About 700 family physicians in the province receive funding under the program.

The province has introduced coverage of several medications that improve symptoms for patients with chronic diseases, including the new oral medication Tecfidera for some adult patients with relapsing-remitting multiple sclerosis.

## **SYSTEM PERFORMANCE AND LEADERSHIP**

### **Shared Services Organization**

3sHealth (Health Shared Services Saskatchewan) was formed in 2012 through a partnership between the Saskatchewan health

regions and Saskatchewan Cancer Agency to identify and provide services collectively through a shared services agency.

3sHealth has successfully implemented group purchasing contracts to increase the health system's buying power through provincial and national procurement contracts for supplies and services. The organization has increased the proportion of goods procured through group purchasing from a starting point of 20 per cent to what is now more than 60 per cent of all goods procured through 3sHealth, achieving an average cost reduction of 12 per cent.

Since the release of the Patient First Review report in October 2009 **3sHealth has implemented initiatives that have saved the health system \$110.6 million as of March 31, 2015.** 3sHealth has also put in place **a provincial linen service contract with KBro Linen Services, expected to save the health system \$98 million over the next 10 years.**



I believe we have one of the nicest facilities in the province. The residents, patients and staff have a beautiful and more functional building to live, recover and work in.

- Kipling Mayor Duane Leicht

## Financing Capital Infrastructure Investments

**Since November 2007, the Government has invested more than \$1 billion in health facilities, new capital projects, building maintenance, and life safety infrastructure.**

Investments include the 13 new long-term care (LTC) projects announced in 2009 and, more recently, the Children's Hospital of Saskatchewan, a new 225-bed long-term care facility in Swift Current, and replacement of the Saskatchewan Hospital in North Battleford. The 2014-15 and 2015-16 budgets included funding for planning additional LTC beds in La Ronge and Regina, the regeneration/replacement of the Victoria Hospital in Prince Albert and a new hospital for Weyburn.

Lean 3P (the production, preparation process) has been applied to the design phase of various capital projects, including Moose Jaw's regional hospital, Children's Hospital of Saskatchewan in Saskatoon, Saskatchewan Hospital North Battleford, Swift Current LTC, Kelvington Integrated Facility, and Saskatoon Cancer Centre. This project management and design approach supports the delivery of more efficient and effective processes of care. Patients are an important part of the cross-functional teams that ensure the new facilities are designed to provide care that meets the needs of patients and families.

**The government has invested over \$178.4 million since 2007 in life safety and emergency infrastructure funding** to address the significant backlog of building and equipment maintenance and repairs and to improve safety in our facilities. Examples of projects include fire alarm systems, fire protection sprinkler systems, nurse call systems, stand-by generators, roof/window replacements and other structural work.



I was able to contribute my thoughts and perspectives on the design of the new

long-term care facility in Swift Current.

It will have brighter living areas with natural light, wider hallways to promote independence, and will result in less congestion for everyone.

- Patient/family representative  
Sheila Pilgrim

## Capital Innovation: Public-Private Partnerships (P3s)

The Swift Current Long Term Care project is the first design-build-finance-maintain (DBFM) public-private partnership (P3) for the Province, and is expected to be completed in Spring 2016. This project will replace three aging facilities in Swift Current with a new 225-bed facility.

A P3 model was selected for the Swift Current project because it offers a number of important advantages, such as an integrated process to

design that considers the whole facility life cycle costs to accommodate the long-term maintenance component. P3s also offer the opportunity for the private sector to provide innovations and efficiencies since private companies are responsible for cost overruns at every stage through design, financing, construction and maintenance (if included). Performance-based contracts, give the private contractor a financial incentive to deliver the project in a timely manner.

Some benefits of using the P3 model in place of traditional procurement methods:

- P3s can reduce lifecycle costs and improve quality;
- Evidence shows that the total cost of P3s is less than the total cost of traditional projects – a project that is on time and on budget more than offsets any higher financing costs;
- The private partner assumes the risk of cost overruns – not the taxpayer;
- Value through design innovations;
- Performance-based agreement with penalties for poor performance; and
- Guaranteed maintenance over the life of the project (30 year warranty).

In addition to the P3 procurement model, Government has also used other innovative approaches to replace health facilities in Saskatchewan.

Design-Build (DB) is a procurement method whereby the design and construction of a project is procured from a single contractor. This allows for early mobilization, as construction activities can proceed concurrently with the design. The Kipling Integrated Facility project used DB as its procurement method to construct a new integrated facility to house 32 LTC beds, 12 acute care beds, and one multi-purpose bed. The project was completed in November 2014.

Integrated Lean Project Delivery (ILPD) is a collaborative procurement and project delivery approach that brings together project owners, contractors, and consultants to work together as a team from the earliest stages of a capital project through to its completion.

Different from other procurement methods where various parties work on the project at various points in time, ILPD requires that all parties are involved in every stage of development. This approach: ensures that those with the necessary expertise are in the room to pinpoint any problems at any stage of design; maximizes the engagement of all parties who share responsibility for the success of the project; and often lowers the project cost and delivers the project in a shorter timeframe compared to other methods.

A unique feature of the ILPD procurement method is the Lean 3P (Production Preparation Process) events that take place during the collaborative design process. Lean 3P involves a team comprised of facility staff and health care providers, patients and families, and an architect. The team works through a simulation of the end product (such as a health facility) in order to learn about and embed delivery requirements before making commitments to a floor plan.

## 3P and P3 Explained

**3P** (described above) is a method of designing a **work space to optimize work flows and space use.**

**P3** (public-private partnerships) is a **method of structuring agreements between governments and private contractors**, in many cases so the contractor assumes financing costs and the risk of construction and maintenance problems in exchange for a long-term contract to build (and sometimes also maintain) a building.

The first ILPD project for Saskatchewan is the Moose Jaw Union Hospital replacement project, which was announced in 2009 and is expected to be completed in Fall 2015. The use of the ILPD approach led to a facility design that will enable major improvements in operational efficiency, space utilization, patient movement, and handoffs between departments.

As of May 2015, there have been 15 3P events undertaken for eight different health capital projects. 3P has become a standard approach to facility planning that is used in all health capital projects, regardless of the procurement method.

### Lean Management System

The Lean methodology originated in the manufacturing sector. In health care, it is a continuous improvement approach for delivering the highest quality and the safest care in ways that provide the patient with the most value. Many high-performing health care organizations around the world have successfully adopted Lean as their quality improvement approach.

Lean was first adopted by the health system in 2006, starting with a pilot in the Five Hills Health Region. The results of the pilot were promising, and it was expanded to the Ministry of Health in 2008 and to the entire health system in 2009. Since then, the Saskatchewan government became the first in Canada to adopt Lean as a management system across its entire health system. A total of 18 health care organizations use the Lean Management System for strategic planning and day-to-day management of operations. Using this integrated planning process allows these organizations to jointly agree on health system priorities and commit resources for priority projects, so the system can truly “act as one”.

Between March 1, 2012 and April 30, 2015, nearly 1,000 Lean improvement events were held across the health system. These include 402 Rapid Process Improvement Workshops (RPIWs). An RPIW is a disciplined and rigorous five-day process where an engaged team of senior leaders, frontline staff, and patients work together to eliminate waste in a specific process. RPIWs allow changes to be identified and tested in a controlled way. When successful changes can be replicated across the health system, there is tremendous potential for improved safety, improved quality of care and significant savings in staff time and direct costs.

The Patient First Review commissioner noted that health region leaders need to feel that leading and sustaining change is a priority. Organization leaders, supported by the Lean Management System, are:

- paving the way to sustain positive, necessary changes in care processes;
- developing standard practices; and
- removing the frustrations their teams experience every day because of stagnant and inflexible procedures.

## Lean Improvements

↓ 50%

Pediatric cardiology outpatients in Saskatoon no longer walk to different areas of the hospital. Service providers come to them, cutting the length of an average clinic visit in half.

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↓ 90%

EMS staff in Regina Qu'Appelle Health Region are available for calls faster at the beginning of their shifts now that checking their supplies takes 90 per cent less time.

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↓ 44%

Late starts for the first surgical procedure of the day are down 44 per cent in Prairie North Health Region, resulting in shorter waits for other patients undergoing surgery that day.

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↓ 99%

Adults who need mental health appointments in Five Hills Health Region are getting them much more quickly. There has been a 99.7% reduction in wait times for individual adults, and a 94% reduction for adult groups.

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↓ 25%

Five Hills Health Region reduced Intensive Care inventory costs by 25 per cent.

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↓ 93%

In Mamawetan Churchill River Health Region, 100% of clients now have access to a registered dietitian within 30 days. Previously, patients waited up to 405 days.

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↓ 65%

A Ministry of Health team is saving families time and stress by providing required follow-up injection of a drug that prevents a common respiratory virus in fragile infants. Travel will be reduced by 65% for infants and their families, many of whom were missing their final doses due to the need to travel from rural areas.

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↓ 90%

eHealth Saskatchewan is processing birth certificates more quickly, reducing the turnaround time from 49 days to 5 days. This 90% reduction has led to the elimination of a charge for expedited service.

## Outstanding Issues

Much has been accomplished since the release of the Patient First Review report, particularly in the areas of surgical access, savings achieved through the establishment of a shared services organization and a number of collaborative emergency centres. There have also been more incremental-level achievements in a number of other areas, such as health promotion and prevention of illness and injury. Evidence indicates however, there are still a number of areas which require additional strategic focus in coming years. These are as follows:

### **Steady Rise of Health Expenditure**

Saskatchewan's total health expenditure (both the public and private sectors) increased from 6.4 per cent of gross domestic product (GDP) in 1981 to 8.6 per cent (forecast) in 2014. However, differing from the Canadian experience as a whole, there was a downward trend in Saskatchewan health expenditure as a percentage of GDP over the past decade. Saskatchewan's health spending as a percentage of total government spending over this same period increased from about 25 per cent to almost 39 per cent. The pace of health spending growth is slowing. The 5-year average growth rate of Saskatchewan's total health expenditure decreased from 7.1 per cent (for 2002 to 2007) to 4.4 per cent (for 2009 to 2014). This growth rate, however, was higher than that for Canada as a whole (which decreased from 6.9 per cent to 3.4 per cent). Saskatchewan's health care costs will continue to rise to meet the increased demand for health care services. Demographic changes, such as population growth and aging, are driving this demand.

### **Aging Healthcare Facilities Infrastructure**

A long-term backlog of needed facility maintenance increases the risk of infrastructure failure, which can pose health risks for patients and staff.

### **Improved Home-based Services for Seniors**

Given that most seniors want to live in their home for as long as possible, seniors would benefit from improved access to home-based care services, thereby helping them stay at home as long as they can.

### **High Rate of Adverse Events**

In hospitals, the main sources of patient harm are related to surgery, medication, and infection. The Canadian Adverse Events Study (Baker et al., 2004) has shown that 7.5 per cent of inpatient admissions experience one or more adverse events and of these 37 per cent could be prevented. Based on this research, the estimated rate of adverse events in Saskatchewan is approximately 5,600 in our province's hospitals each year. The Saskatchewan health system is currently addressing this issue through Lean. Mistake Proofing, a Lean technique, is being used to eliminate mistakes that can lead to patient harm. To date, 77 Mistake Proofing projects have been undertaken: 44 have reduced the errors or defects to between zero and less than one per cent. The Mistake Proofing project conducted at the Mental Health Unit of Five Hills Health Region reduced medication errors from 17 per year to zero.

### **High Rate of Workplace Injuries**

In 2012, Saskatchewan's health care industry had the highest number of reported injuries in the province and 4,895 reported injuries with claims. Health care workers missed over 403,982 days of work due to work-related injuries between 2008 and 2012. This translates to 323 full-time-equivalents each year.

## Increasing Chronic Disease Conditions

The prevalence of chronic conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD) and high blood pressure, is increasing (Statistics Canada, 2009). Three in four seniors have at least one chronic condition (Canadian Institute for Health Information, 2009). Particularly, diabetes is a major health problem in Saskatchewan. The prevalence (number of persons living with diabetes in Saskatchewan) is increasing by approximately 3,000 per year<sup>2</sup>.

## Difficulty Accessing Mental Health Services

In any given year, one in five people are affected by mental illness or addictions. A recent provincial survey completed by more than 3,000 mental health and addictions patients, families, service providers and concerned citizens, shows that the top three priorities for improving mental health and addictions services are timeliness of access, service capacity, and early intervention. In 2012-13, the hospitalization rate for self-injury in Saskatchewan was the third highest in Canada (77 per 100,000) after Newfoundland and Labrador (97 per 100,000) and New Brunswick (81 per 100,000)<sup>3</sup>.

## Emergency Department Wait Times

The health system has committed to resolving wait time issues in emergency departments. The demand for services in the three Saskatoon and two Regina emergency departments increased significantly between 2009-10 and 2012-13. In response to the rising demand, health system leaders made this goal the top strategic priority for 2014-15. Improvements have already been made, however further work is needed.

## Strategic Health System Priorities

To address these outstanding issues, the Saskatchewan health system is currently undertaking various initiatives to achieve the following targets over the next five years:

- People living with chronic conditions will experience better health as indicated by a 30 per cent decrease in hospital utilization;
- Seniors who require community support can remain at home as long as possible, enabling them to safely progress into other care options as needs change. There is a high-quality, responsive, resident-centred long-term care system that is integrated well with community services;
- Emergency room waits will be reduced;
- There will be increased access to quality mental health & addiction services and reduced wait times for outpatient and psychiatry services;
- There will be a 50 per cent decrease in wait times for appropriate referral from primary care provider to all specialists or diagnostics;
- As part of a multi-year budget strategy, the health system will bend the cost curve by achieving a balanced or surplus budget;
- All infrastructures (IT, equipment & facilities) will integrate with provincial strategic priorities, be delivered with a provincial plan, and adhere to provincial strategic work; and
- There will be no harm to patients or staff.

There are a number of provincial strategic initiatives currently underway in order to achieve these outcomes and targets.

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2 Source: Population Health Branch, March 2013. It is estimated that about one-third more have diabetes but remain undiagnosed.

3 Source: Canadian Institute for Health Information, 2015.

Some of these, such as Primary Health Care, ER Waits and Patient Flow, and Access to Specialists and Diagnostics, are directly linked to the Patient First Review report recommendations. Others are more recent ideas that are well aligned with the report. These new initiatives include:

### **Mental Health and Addictions Action Plan**

A public consultation process focusing on client and family voices has been completed. A 10-year Mental Health and Addictions Action Plan was delivered in December 2014. The plan outlines 16 recommendations that fall into seven categories:

- Enhance access and capacity and support recovery in the community.
- Focus on prevention and early intervention.
- Create person and family-centred and coordinated services.
- Respond to diversities.
- Partner with First Nations and Métis Peoples.
- Reduce stigma and increase awareness.
- Transform the system and sustain the change.

Addressing and improving mental health and addictions services across many sectors is complex, and will take the efforts of many ministries and organizations collaborating together. The recommendations in the Mental Health and Addictions Action Plan provide a guide to approach this issue with new ways of thinking and working together over the next 10 years.

### **Seniors House Calls**

The Throne Speech in October 2013 referenced plans for a program that “will enable some seniors with complex issues to receive house calls from physicians, Nurse Practitioners and other health care providers”. This initiative was rolled out in Saskatoon Health Region in mid-March 2015 and to date the program has assisted over 25 seniors in managing challenging chronic illnesses. The Regina Qu’Appelle Health Region pilot will begin in summer 2015.

### **Hotspotting**

This initiative identifies high-cost, high-use patients who are repeatedly hospitalized and/or coming to emergency departments and provides them with care that focuses on managing their complex medical, social, and mental needs to drive down costs and ensure better patient outcomes. A pilot program called Connecting to Care was launched in January 2015 in Regina Qu’Appelle Health Region, with a similar pilot rolled out in Saskatoon Health Region in Spring 2015. This initiative is closely linked to improvements to primary health care, ED waits and patient flow, and services for seniors.

### **Clinical Appropriateness**

Appropriateness is about providing evidence-based care that meets patients’ needs, values and preferences. Overuses, underuses and misuses of health care services often indicate inappropriate care within the health system. Appropriateness is closely linked to outcomes of Patient- and Family-Centred Care and the effort to Bend the Cost Curve. There are a number of projects underway to address unwarranted clinical variation in several clinical areas.

## **Culture of Safety**

The government wants to build a culture in the Saskatchewan health system where anyone -- patient or provider -- feels comfortable bringing safety issues to light. Everyone is collectively responsible for ensuring patient and staff safety.

For patient safety, a prototype of the Safety Alert System/Stop the Line process went live at Saskatoon's St. Paul's Hospital in March 2014. This allows anyone, including providers, patients and families who encounter a situation that is likely to harm a patient or staff, to make an immediate report and to call a halt to any activities that could cause further harm until the issues have been resolved. This will be replicated throughout the province.

For workplace safety, the Safety Management System is being implemented across the system. It focuses on improving management and leadership around safety, identifying and controlling hazards, and ensuring there is enough training and communications to achieve awareness, understanding and changes in behaviour.

It is important to note that all of these key strategic priorities are somewhat interconnected and interdependent. The root causes of the issues can be attributed to multiple internal and external factors. This means that gains made toward achieving an outcome can potentially contribute to the achievement of other outcomes. Similarly, a lack of progress made toward one outcome may impede the progress on other outcomes. This also means that inter-sectoral collaboration - engaging partners outside the health system, such as different levels of governments (federal and municipal), other ministries (such as Social Services, Corrections and Policing, Justice, and Education), and patients and families, will be critical to addressing health issues.

In addition to these more recent initiatives, further work will be required to continue on the path first laid out by the ground-breaking Patient First Review. The path forward will build on the good work already underway, and will also require some new and innovative approaches to achieve the Patient First vision. The approaches that follow will help achieve the goal of providing a health system that is truly patient-centred, where patients can move seamlessly throughout, frontline care providers are better supported in their efforts to provide the best care to the residents of the province, and the system itself is financially sustainable into the future.

# The Path Forward

After decades of incremental change, Saskatchewan's health system has risen to the challenge of making meaningful changes to the role patients and families can play, the design of work processes, the way organizations work together and the use of alternative approaches. To make continued gains in service quality, patient empowerment, safety and value for money, we must put the patient first when considering options for the future.

## Finding Efficiencies

Saskatchewan's health care costs will continue to rise to meet demand, but must do so at a sustainable rate. Annual increases in health spending that exceed the rate of inflation often occur at the expense of other program areas.

As of March 2015, 3sHealth reported the health system had achieved cumulative savings (since 2010-11) of \$110.6 million from joint contracts to purchase medications, linen services, surgical supplies, bulk purchases, lab supplies and utilities. 3sHealth estimates the health system will achieve cumulative net savings to the health system of \$430 million, including capital cost avoidance, over its first 15 years (see chart).

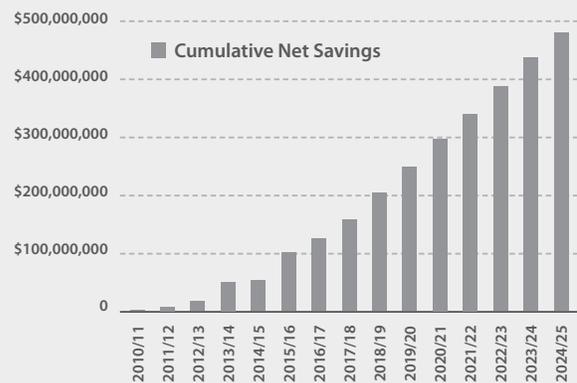
To bend the cost curve from its increasingly sharp upward trajectory, 3sHealth is developing business cases for seven service lines including medical imaging, laboratory services, environmental services, supply chain, information technology/information management, enterprise risk management, and transcription services.

Each business case analyzes the current state of service delivery, data and input from stakeholders, best practices in other

jurisdictions, and a vision for the future state. The development of these business cases involved extensive stakeholder engagement, including health region and Cancer Agency leaders, patients, unions, frontline workers, health care providers and vendors. A number of options for delivery of shared services are evaluated within each business case, including enhanced status quo; lead agency delivered; 3sHealth delivered; third party delivered; or a combination of the above. Delivery of shared services by third party partners will be leveraged when it makes sense to do so to benefit patients and their families, and to help sustain the publicly-funded health system.

## EFFICIENCIES WILL SAVE \$430 MILLION

3sHealth Actual and Projected Savings 2010-2025



saskatchewan.ca



## \$98 Million in Savings Over 10 Years: Contracted linen services

To meet a pressing need for investment in safe, modern linen facilities, 3sHealth developed a business case that considered multiple options for the replacement of health system linen service plants. After careful consideration, privatization was included as an option. Other jurisdictions indicated they had positive experiences with private delivery related to quality and cost. It was also thought that by leveraging private providers health regions could better focus on their core business of patient care.

After an open and objective request for strategic partnership process, K-Bro Linen Systems was awarded the contract to build and operate a plant to be located in Regina that will serve all health facilities currently served by regional laundry plants. K-Bro is the largest provider of health care linen services in Canada with operations in BC, Alberta, Ontario and Quebec. It has a robust quality audit process that ensures a high level of cleanliness and quality of linen. K-Bro is investing the capital required to build the new plant, saving the health system from a capital investment of over \$30 million. In addition, the service contract will cost taxpayers \$6 million per year less than current operating costs. The Regina plant is expected to open by fall 2015, and will be supported by distribution hubs in Saskatoon and

Prince Albert. The new linen service will save the health system \$98 million in operating and capital cost avoidance over the next 10 years.

### **Third-Party Provision of Publicly-Funded Health Services**

Many publicly-funded health services are currently delivered by private providers, such as Physicians, Physiotherapists and Pharmacists, in private practice. In 2000, the Alberta government introduced legislation to enable contracting out medically-necessary surgical services to the private sector. Currently, there are a number of third-party providers in Canada that provide surgical and diagnostic imaging services (in Saskatchewan, British Columbia, Alberta, Quebec, and Ontario).

With its commitment to achieving the ambitious three-month surgical wait time targets made under the Saskatchewan Surgical Initiative, the government decided to adopt an approach to using private providers to deliver publicly-funded and -administrated surgical services and diagnostic imaging services (CT scan and MRI) to patients. The Saskatchewan health system needed additional capacity to address an issue related to the large backlog of patients who had been already waiting a long time for surgery and diagnostic imaging services. The purpose was to add capacity to the publicly delivered health system, not replace existing services.

Radiology Associates of Regina has been contracted by the Regina Qu'Appelle Health Region (RQHR) to provide CT scans to patients since May 2011. This arrangement has successfully reduced patient wait times and improved access in a community-based location at a reduced cost when compared to providing the same service in a hospital setting. RQHR recently entered into a

contract with Mayfair Diagnostics to provide community-based MRI services, which will expand health system capacity by 5,500 scans per year for at least three years.

Private delivery of surgical and diagnostic imaging services has successfully reduced wait times in Saskatchewan. This approach helped Saskatchewan increase capacity by freeing up hospital services for more complex cases, and addressing the backlog of patients waiting for these procedures.

**For patients' sake, professionals such as registered nurses, licensed practical nurses, nurse practitioners, pharmacists, paramedics, dietitians, chiropractors and physiotherapists should be entrusted with the roles that are appropriate to their training.**

**- Tony Dagnone, Commissioner of the Patient First Review**

A number of new PHC Innovation Sites and Collaborative Emergency Centres (CECs) have been launched in various communities since 2013. The ultimate success of this model hinges on the ability of physicians, nurse practitioners and others to work to their full scope of practice, thereby enabling members of the team to perform functions that might have historically been performed by other members of the team. For example, RN Case Managers now provide advice and support to patients outside of office visits, and PHC Counsellors provide mental health and addictions services.

However, there are a number of challenges to fully adopting a collaborative, team-based PHC approach. These include existing legislation and regulations that hinder health care professionals from functioning to their full scope of training and practice, a silo mentality, power structures among different health care disciplines, unclear roles and responsibilities, and professional liabilities. In order for the PHC model to be successfully implemented across Saskatchewan, these challenges need to be addressed.

### **Scope of Practice**

A collaborative, team-based approach to primary health care (PHC) is viewed as an enabler for improving the quality of patient care as well as addressing some of the challenges associated with the availability of physicians and other providers in rural and remote parts of the province. Key to this is the creation of an environment in which individual health care professionals are able to fully utilize their training and work to their full scope of practice.

Changes to scope of practice can be an important avenue for improving both access to service and team-based collaboration and effectiveness. Efforts to achieve positive change include:

Professional Designation	Expanded Scope of Practice
<b>Registered Nurses and Nurse Practitioners</b>	Diagnose conditions, write prescriptions, order tests and perform minor surgical activities (with additional training).
<b>Paramedics</b>	Scope unchanged, but paramedics now work in teams at some hospital emergency departments, providing overnight emergency care with nurse practitioners, supported remotely by a STARS emergency physician.
<b>Pharmacists</b>	Prescribe medications for continuing therapy, refills and emergency situations, fill in necessary details where a prescription is incomplete, and prescribe drugs for minor ailments. With advanced training: make appropriate substitutions of drugs, alter dosages or dosage regimens, and select specific forms of drug therapies within the limits of an agreement with the physician or other health care provider.

## INNOVATIVE APPROACHES TO ADDRESSING INFRASTRUCTURE ISSUES

Since 2007, the Saskatchewan government has invested more than \$1 billion in health infrastructure to address Saskatchewan’s aging facilities and outdated or worn-out equipment. As part of this significant

investment, the Government has used innovative procurement approaches to deliver these projects in a timely and cost-conscious manner. These approaches include alternative financing, public-private partnerships (P3s), and Integrated Lean Project Delivery (ILPD).

Growing pressure for long-term care (LTC) beds in Saskatoon created an opportunity to implement a form of alternative financing to quickly procure additional LTC beds. In 2012, Samaritan Place, a 100-bed facility, opened in Saskatoon. The facility was constructed and is currently operated by Amicus Inc., a non-profit corporation owned by the Catholic Health Ministry of Saskatchewan. This form of financing allows the Government to repay the construction and financing costs over a 25-year term. Under the Continuing Care and Service Agreement between Amicus and the Saskatoon Health Region, Amicus assumes responsibility for all maintenance costs for the facility and has an agreed-upon debt-servicing rate that includes the mortgage, interest, and operating costs. The facility was opened on time and on budget, helping to reduce strain on hospital beds and acute care services in Saskatoon.

The Samaritan Place project operated by Amicus Inc. serves as an example of an innovative approach to addressing the significant and increasing deferred maintenance costs currently facing the health care sector in the province.

### Deferred Maintenance

Saskatchewan has over 270 health care facilities, including facilities owned by health regions, affiliate-owned facilities, and some leased facilities where the regions are responsible for maintenance. Over two-thirds of these facilities were constructed in the 1960s, 70s, and 80s. The average facility age is 39 years.

Nearly \$2.2B in infrastructure maintenance requirements exist throughout the province. Many facilities are also functionally inadequate, causing challenges to the delivery of patient and family centered-care in outdated facilities.

Despite the more than \$1 billion invested in health infrastructure since 2007, the significant deferred maintenance backlog remains a pressing issue facing the health system. In addition to the annual funding from the Province for maintenance and repair of health facilities, alternate financing and procurement approaches are needed to guarantee that new health facilities are properly maintained over their lifespan. The partnership with Amicus for the Samaritan Place project in Saskatoon and the P3 procurement approach for the new Swift Current LTC facility guarantee that these two projects will be properly maintained.

## **PATIENT CHOICE**

### **Patient-Directed Funding**

There are a number of health services that are not insured under the Canada Health Act but are covered by provincial health insurance. Some of these provincially funded services are fully insured while others may be covered only partially, covered only for low-income patients, or patients with disabilities.

Even if the cost of the service is partially or fully covered through the provincial health system, the manner in which the service is delivered can serve to limit patient choice. For example, most eligible services are those provided directly by staff employed by a health region or by providers who are on contract with a health region. Patients must cover the cost of services delivered by providers who work outside the system, although these costs are sometimes covered by private, third-party insurance.

There are a number of options for expanding patient choice in terms of both services and service providers. One such option is a patient-directed funding system. Similar systems have been used by many countries in Europe and Asia, as well as in the United States. With this approach, patients receive a credit that specifies the service they are eligible to purchase upon presentation of the credit to a health service provider. The service provider then returns the credit to the government or agency that issued it and they receive a sum (agreed upon in advance) for each credit returned.

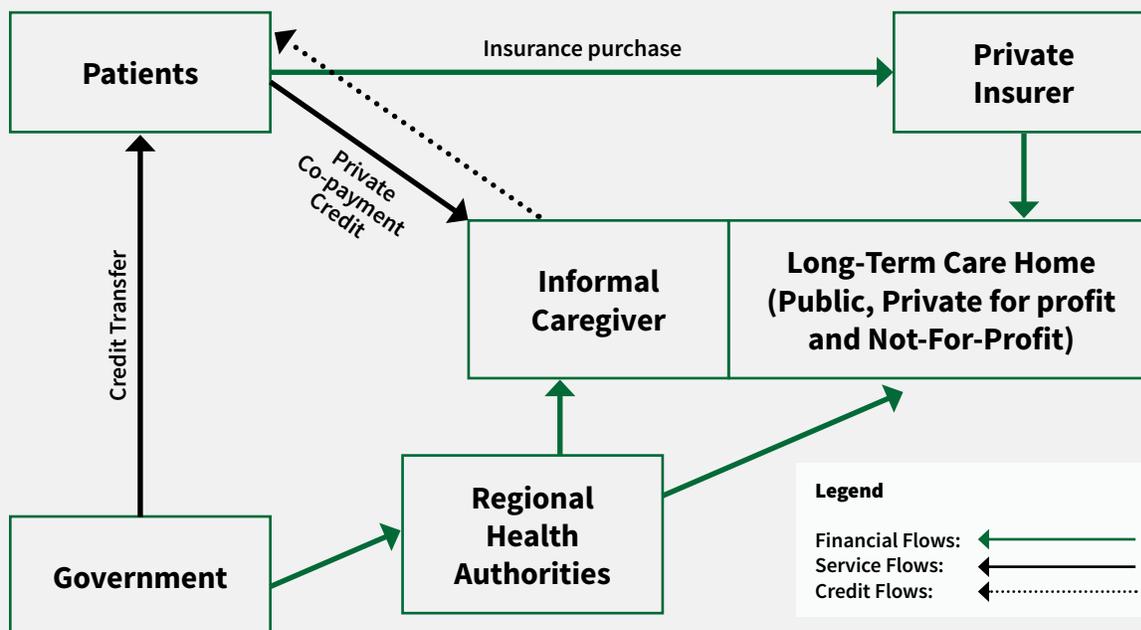
Some of the advantages to the patient-directed funding system include<sup>4</sup>:

- encouraging greater competition among providers;
- providing more individual choice for patients;
- being more responsive to patients' needs;
- helping patients organize their care based on their needs and preferences;
- helping the government reach the targeted population more effectively;
- being easy to administer; and
- reducing provider-induced demand.

The patient-directed funding system can increase quality of services through increased competition and can, therefore, increase patients' satisfaction with their services. Although the government no longer contracts with providers directly on behalf of patients, it still plays a crucial role in regulating and monitoring providers to ensure that they meet a minimum quality of care.

One of drawbacks of the this system is that it could create a cream-skimming problem where, for example, providers seek out the healthiest patients with low care needs

## Funding System for Long-Term Care in France, Sweden, Denmark and Finland



Source: Adapted from Blomqvist and Busby, 2012

relative to costs. One way to manage this risk is through legislation or policy that prohibits providers from rejecting patients due to pre-existing conditions.

Home care and long-term care (LTC) are areas where a patient-directed funding system has been well utilized. According to a report published by the Organization for Economic Co-operation and Development (OECD), Sweden, Finland, and Denmark introduced a patient-directed funding system in the 2000s to provide their LTC clients with the option of choosing their own service provider. Customer surveys conducted in Denmark and Finland indicate that LTC users, particularly among those who chose a private provider, showed general satisfaction related to their freedom of choice.

In 2002, France also introduced a LTC program, called Allocation Personnalisée d'Autonomie (APA), which is similar to patient-directed funding. The APA program provides cash allowances to individuals who have limited independence and need assistance for their daily activities. The government pays a portion of the costs associated with the LTC facility through the APA program, and the resident pays the remainder either out-of-pocket or through private insurance.<sup>5</sup>

Adopting patient-directed funding in Saskatchewan could address some of the challenges patients face in seeking coverage for out of country treatment. Every year the Government of Saskatchewan receives several requests from patients seeking

4 Blomqvist and Busby, *Long-Term Care for the Elderly: Challenges and Policy Options*, November 2012. C.D. Howe Institute, Commentary No.367. The World Bank, *A Guide to Competitive Vouchers in Health*, 2005.

5 OECD (Organization for Economic Co-operation and Development), *Help Wanted: Providing and Paying for Long-term Care*. Final Report. 2011

coverage for out of country care. When a procedure is not readily available in Saskatchewan, patients are eligible for coverage to receive treatment in another Canadian jurisdiction. In some instances where a procedure is available elsewhere in Canada, a patient would prefer to seek treatment out of country. This may be for several reasons including that the patient perceives the wait time for treatment in Canada as too long, or because they prefer a certain specialist who resides out of country.

In these circumstances, under current provincial policy patients are not eligible to receive any funds from the Government of Saskatchewan towards their treatment. The adoption of patient-directed funding could allow patients to choose where they would like to receive treatment for a procedure not readily available in Saskatchewan, whether that is elsewhere in Canada or out of country. Under this system, a patient could receive the same coverage for a procedure out of country, as they would if they sought treatment elsewhere in Canada. Examples of the type of out-of-country procedures that would be covered by this system include:

- Transvaginal mesh removal;
- Severe endometriosis;
- Thoracic aortic aneurysm;
- Heart, lung and bone marrow transplants;
- Transcatheter aortic valve implantation; and
- Some cancer services such as radioisotopes, brachytherapy, cancer joint prosthesis and stereotactic radiosurgery.

In Canada, individualized funding, which is similar to a credit system, has been in place in many provinces including British Columbia, Alberta, Manitoba, New Brunswick and Prince Edward Island. In British Columbia, individualized funding has

been implemented to provide people with disabilities with greater choices that support their needs as well as their personal goals for a good life in the community.

Saskatchewan also provides individualized funding as part of the health region home care programs. This provides home care clients with an option for arranging, managing, and paying for the supports and services they need. This allows the client to exercise choice as they ascertain how to meet their own needs. Individuals take responsibility for arranging their own care. Clients report receiving a higher consistency in care, better scheduling, and more control over the care they receive.

## **INFORMED/SHARED DECISION MAKING**

Currently, patients and their family members are often not given the opportunity to make informed choices about the best possible health care services for their individual needs. With good intent, health care providers often believe that they know what's best for their patient and make decisions "for" the patient rather than "with" the patient.

With increased access to information technologies, today's patients want to be more informed and involved in their own care and treatment decision-making. However, there exists a significant gap between the amount of information that patients want to receive and the information that clinicians are disclosing to patients. Studies indicate that patients often don't receive enough well-balanced information to support an informed decision as their clinicians tend to discuss the pros of their treatment recommendation more than the cons<sup>6</sup>. For example, 77 per cent of patients who received coronary artery stenting reported that their clinician talked about the reasons for stents, while only 19 per

cent of patients reported that their clinician talked about the risks. Those patients who feel that the information they received is not sufficient tend to conduct their own research online and consult their social networks. The quality of information obtained from the Internet, however, can vary widely, with much a lack of scientific, evidence-based information and can potentially contain misleading information<sup>7</sup>.

There is mounting evidence that more informed and involved patients have better satisfaction with the treatment choices, less anxiety, more confidence and better adherence to their treatment plan, with improved health outcomes<sup>8</sup>. Various high performing health care systems around the world, such as Britain's National Health Services, Dartmouth Hitchcock Healthcare System, Massachusetts General Hospital, Group Health Puget, and Mayo Clinic, understand the importance of patient involvement in treatment decision making. These organizations employ a shared decision making (SDM) approach to involving patients in their treatment decision-making process.

SDM is a collaborative decision making process shared between the patient and their clinician using evidence-based information. During the process, these two parties exchange information about treatment options, risks and benefits of each option and the patient's preferences and values. At the end of the process, they make mutually agreed upon health care decisions that reflect the needs, values and preferences of the patient.

Under this approach, both clinicians and patients recognize and share each other's expertise to make decisions –

that is, clinicians are experts in diagnosis, prognosis, treatment options and outcome probabilities based on population data, while patients are experts in their own life, the impact of the condition on their daily life, tolerance for pain and discomfort, social circumstances, and personal attitude to risks, values and preferences.<sup>9</sup>

SDM is applicable to any clinical condition where there is more than one medically reasonable treatment option (including status quo, “do nothing”) with no clear best choice for outcomes. These clinical conditions and areas may include cancer care, elective surgery, screening and prevention, chronic disease management, end of life care, mental health, pregnancy and childbirth. In practise, SDM can have a significant impact on the clinical appropriateness of care and, consequently, on the cost of care. Experience indicates that patients who are fully informed about their treatment choices will often choose the least invasive treatment option. Some studies found that the use of patient decision aids (PtDAs) reduced the rates of surgery for prostatectomy, orchiectomy, cardiac revascularization, mastectomy, hip and knee replacement, back pain and hysterectomy without adversely affecting patients' health outcomes, satisfactions, or anxiety.<sup>10</sup>

For end of life care, studies suggest that most patients wish to die at home. Despite their wish, many still die at hospitals receiving aggressive life sustaining treatments which result in the worst quality of death and high costs for the system. According to the Canadian Institute for Health Information (CIHI) report, Health Care Use at the End of Life in Western Canada released in 2007, 52 per cent of Saskatchewan residents aged

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6 Fowler et al (2011)

7 Griffiths and Christensen, 2000; Kisely et al, 2003

8 Cochrane Collaboration Review, 2012

9 Coulter and Collins, 2011; and Frosch and Kaplan, 1999

10 O'Connor et al, 2003; Stacey et al, 2011

65 and higher who died did so in hospitals during 2003 and 2004. The costs associated with those seniors who died in hospital were three times higher than those who died at home or in a long-term care facility.<sup>11</sup> Studies also found that patients who actively participated in end-of-life decisions often had positive experiences through the latter stages of their lives and therefore, achieved a 'good death', while patients who passively participated failed to get their preferences or wishes heard, and often received prolonged unnecessary treatment, inadequate pain relief and suffered a 'bad death'.<sup>12</sup>

In Saskatchewan, SDM has been incorporated into all clinical pathways, including hip and knee, prostate cancer, spine, and pelvic floor. Clinical pathway projects were first developed as part of the Saskatchewan Surgical Initiative.

eHealth Saskatchewan's Citizen Health Portal pilot project is expected to launch in August 2015, and will run for six months. The Citizen Health Portal is a new

interactive tool that allows users to access their personal health information online. The key features of this tool were selected by a citizen advisory panel, which will also be the primary means of citizen feedback in the development of the strategy. Participants in the pilot project will be able to view general laboratory results, immunization history, prescription history and medical visit history.

The Citizen Health Portal will also provide individual participants with the ability to add their personal health history information, view results using interactive tools and set reminders to take medications or for upcoming appointments. Health information in this portal is always confidential, private and secure. The Citizen Health Portal will allow citizens to be more informed about their own health and help them to be active participants in the care process. The pilot will help eHealth to make a recommendation for the future of an electronic health record and to potentially prioritize what is needed for full launch for all Saskatchewan residents in 2016.

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11 Hollander and Tessaro (2008) estimated the costs associated with end of life care in Saskatchewan by types of services which patients received prior to their death (e.g. hospital, long-term care, community with home care) using the 2003-04 CIHI data. He found that the highest cost was for those who started the palliative time period in the hospital. For the 30-day time period prior to death, the average total cost per person for the hospital group was \$17,171, which is much higher than the long-term care facility group (\$5,412 per person) and the community with home care group (\$6,932 per person).

12 Frank, 2009

# Appendix A

## Patient First Review Commissioner's Recommendations

### 1. **Patient and Family-Centred Care (PFCC)**

The health system will make PFCC the foundation and principal aim of the Saskatchewan health system through a broad policy framework.

### 2. **Rural and Remote Service Delivery**

That the health system develop a comprehensive and innovative strategy for rural and remote services delivery that:

- Improves access to primary health, diagnostic and specialist services for rural and remote residents;
- Examines the cost burden of emergency transportation, including interfacility transfers; and
- Includes a range of supports for people who must obtain health services away from their home communities

### 3. **Seniors' Care Strategy**

That the Ministry of Health's Seniors' Strategy under development focuses on strengthening:

- System capacity to support independent living;
- Accessibility to personal care homes by addressing the current financial barriers for low-income seniors;
- Accessibility and quality of assisted living and long-term care;
- Programming for seniors with extraordinary behaviours that cannot

be safely managed in the general long-term care population (e.g. specialized assessment and treatment units); and,

- Capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day therapy/services, and a specialized outpatient clinic.

### 4. **Health of First Nations and Métis**

That health regions, the Cancer Agency and other health-care organizations work with First Nations and Métis organizations, Elders, and patients to develop partnerships aimed at improving the health of First Nations and Métis people. This joint work may include but not be limited to:

- Assisting First Nations and Métis patients to navigate the health system and advocating for better care;
- Developing linkages with First Nations- and Métis-run health programs and services to better integrate care;
- Working with the provincial and federal governments to develop new information sources to help First Nations and Métis people understand government programs and services;
- Adapting health services to better meet the needs of First Nations and Métis patients, including accommodation and transportation needs, and cultural supports and services;
- Addressing health system gaps as identified by the Memorandum of Understanding on First Nations'

Health and Well-Being Steering Committee and the renewed partnership with the Métis Nation of Saskatchewan; and,

- Encouraging First Nations and Métis organizations to partner in the provision of healthcare services that will directly benefit their communities.

**5. Services for Children and Youth**

That the health system develop a more integrated and inter-sectoral approach to services for children and youth.

**6. Co-ordination and Integration of Cancer Care Services**

That the Cancer Agency and health regions improve the coordination and integration of cancer care services across the continuum of cancer care.

**7. Saskatchewan Surgical Initiative**

That the health system take immediate action to improve Saskatchewan patients' surgical experiences, from initial diagnosis through to recovery, through an aggressive, multi-year, system-wide strategy that is reported to the public with clear targets and regular updates.

**8. Emergency Room Utilization**

That the health system address inappropriate usage of emergency rooms by exploring the applicability of urban urgent-care centres. The appropriate health regions should explore alternate financing partnerships in developing these projects, which should incorporate state of the art design and leading technologies.

**9. Charter of Patient Rights and Responsibilities**

That the Ministry of Health, in collaboration with health regions, the Cancer Agency, provider organizations and patient and family advisors, develop and implement a Charter of Patient Rights and Responsibilities.

**10. Health Promotion and the Prevention of Illness and Injuries**

That the Saskatchewan government and health system pursue an aggressive and targeted emphasis on the promotion of good health and the prevention of illness and injury in Saskatchewan. Not only will this pay dividends in a healthier and more productive populace, it will help to ensure that Saskatchewan's health system is ready and able to help all of us when we need it most.

**11. Chronic Disease Management**

That the health system develop and implement a province-wide chronic disease management strategy that ensures patients receive evidence-based, standardized care, wherever they live, and connects patients with multidisciplinary healthcare teams.

**12. Development of a Culturally Safe and Competent Health System**

That the health system, in collaboration with First Nations and Métis Elders, and patient and family advisors, work to develop a culturally safe and competent health system that better serves First Nation and Métis citizens.

### **13. Information Technology (IT) Capabilities**

That the Ministry of Health, in consultation with the health regions, the Cancer Agency and clinical leaders, invest in and accelerate development of provincial information technology (IT) capabilities within a provincial framework. This will involve:

- Assisting Developing an e-health implementation plan by early 2010;
- Securing and stabilizing funding for both the provincial electronic health record requirements and health region implementation requirements; and
- Determining the preferred service delivery structure for IT at the health region level to ensure the realization of one provincial system.

### **15. Financing Capital Infrastructure Investments**

That the Saskatchewan government explore ways and means to develop a coherent financing plan, including alternate financing partnerships, to address the urgent need for capital infrastructure investment.

### **16. Ministry of Health Reorganization**

That the Ministry of Health move forward with organizational changes that will enable it to assume more of a strategist-integrator-steward role for the health system.

## Recommendations for Improving System Performance and Leadership

### **14. Establishment of a Shared Services Organization**

That the Ministry of Health achieve greater value for patients' tax dollars by establishing a provincial shared-services organization that would gain buying power and realize significant savings. This organization would initially be responsible for supply chain management, (competitive tendering, procurement, storing, distribution, and payment), with the subsequent addition of responsibility for health regions' transactional business functions.

# Appendix B

## Key Accomplishment Details

### Patient First Review Recommendation

#### 1. Patient and Family-Centred Care

*The health system will make patient- and family-centred care the foundation and principal aim of the Saskatchewan health system through a broad policy framework.*

#### Key Accomplishments

The provincial Patient and Family-Centred Care (PFCC) framework was developed and implemented in June 2011.

- ▶ The key accomplishments include:
  - Establishment of the provincial PFCC Forum in November, 2011;
  - Regional PFCC Steering Committees/Patient and Family Advisory Councils established in regional health authorities (health regions) and Saskatchewan Cancer Agency;
  - Increased involvement of patients/families in development and implementation of policies and programs (e.g. participation in committees and working groups) as well as in quality improvement activities including RPIWs, 3P events; and
  - PFCC best practices being incorporated into Lean continuous improvement efforts.
- ▶ The PFCC Forum has been instrumental in:
  - Sharing innovative ideas, tools, knowledge and experiences in adopting PFCC between organizations;
  - Identifying provincial priorities for adopting PFCC; and
  - Integrating PFCC with Lean and other quality improvement activities across the system.
- ▶ Involving patient and family advisors is now mandatory for all Rapid Process Improvement Workshops and 3P events.
- ▶ Patient and family advisors have also been involved in various Ministry and provincial strategic initiatives, such as:
  - The Saskatchewan Surgical Initiative;
  - ED Waits and Patient Flow,
  - Patient Safety Alert/Stop the Line;
  - Seniors' Care;
  - The Family Physician Comprehensive Care (visioning sessions, working groups, etc.); and
  - Health system strategic planning.

#### Assessment

- ▶ Since the release of the Patient First Review report, the Saskatchewan health care system has made significant progress toward adopting PFCC.
  - Despite this progress, PFCC hasn't become the standard for care in Saskatchewan yet. According to high-performing organizations that have adopted PFCC, it often takes more than a decade to change the entire organizational culture from system-centred to patient- and family-centred.
- ▶ The role of leadership is critical to creating an environment and a culture that embraces PFCC.
  - With continued leadership commitment to PFCC, adoption now needs to expand from mostly acute-care settings to other care settings such as long-term care.
  - Measuring and monitoring the impact of PFCC is also important for sustainable adoption. Tools for accurately measuring impact of PFCC at the unit level have not been developed.

### Patient First Review Recommendation

#### 2. Rural and Remote Service Delivery

*That the health system develop a comprehensive and innovative strategy for rural and remote services delivery that:*

- *Improve access to primary health, diagnostic and specialist services for rural and remote residents;*
- *Examines the cost burden of emergency transportation, including interfacility transfers; and*
- *Includes a range of supports for people who must obtain health services away from their home communities.*

#### Key Accomplishments

Health system organizations have worked together to improve access to services in rural and remote areas.

- ▶ A Saskatchewan-based foreign-trained physician assessment program was developed in 2011. More than 160 of those doctors have passed, and have fulfilled or are fulfilling their service commitments to the province. Of those, 96 per cent are practicing in rural and remote communities. These physicians are trained in various countries, but the majority of them are from South Africa, Nigeria, Egypt, and Iran.
- ▶ The Primary Health Care (PHC) framework was released in May 2012, with the goal of having a patient-focused system that provides timely access and navigation to care. PHC sites are designed to support local community needs and be delivered by a team of health professionals, including a physician.
- ▶ Eight new PHC sites were announced in 2012 and implemented in 2013-14: Leader, Lloydminster, Meadow Lake, Moose Jaw, Saskatoon Health Region partnership with Whitecap Dakota First Nations, Yorkton, Regina Inner City (Meadow Clinic), Fort Qu'Appelle-Balcarres-Lestock (Touchwood Qu'Appelle). These sites use new models of team-based care, focused on increasing patient case management, integrating mental health and addiction services into PHC, expanding hours of service and using new approaches for chronic disease management.
- ▶ Access to PHC has improved through initiatives meant to increase the supply of family physicians and allied health professionals in the province:
  - The number of licensed physicians increased by 482 (27.7 per cent) from March 2007 to March 2015. Over the same period, the number of licensed family physicians increased by 220 (23 per cent) and the number of licensed specialists increased by 262 (33.5 per cent).
  - Starting in 2013-14, funding was increased to \$3 million (a 100 per cent increase) for a rural locum program. This program provides longer-term locum relief to physicians practicing in rural communities and ensures access to physician services when communities face the possibility of short- or long-term service disruptions.
  - Additional funding has also allowed health regions to increase the number of allied health professionals who are working as part of a primary health care team. The equivalent of more than 40 full-time positions (FTEs) have been added, including nurse practitioners, RNs, mental health and addictions workers, RN case managers, and primary health care counsellors.
- In efforts to develop linkages with primary care providers in Prince Albert, Prince Albert Parkland Health Region launched a mental health pilot project in August 2014. It enables a region mental health service staff member to serve clients in two fee-for-service physician clinics.
- In response to community needs, several PHC sites now provide extended hours and after-hours access (evening and weekend clinics).
- ▶ New care models are also being tested, including:
  - Shared medical visits (bringing a group of patients together who share the same condition, either for educational purposes or to provide clinical services in a group setting);
  - Early mental health screening;
  - Empanelling (defining a group of patients within the practice that the team is responsible for); and
  - Introducing new roles for health care providers, such as registered nurse case managers (provide improved coordination and continuity of care) and PHC counselors (provide mental health and addictions services within a PHC setting).
- ▶ There is a network of over 90 PHC teams throughout the province, located in cities and rural centres. All teams work to increase access to health services, improve the patient experience, and expand the role for patients and communities through continuous engagement. These teams reflect a variety of different models and partners, and are designed to meet individual needs of a community.
- ▶ Three Collaborative Emergency Centres (CECs) have opened in Maidstone (September 2013), Shaunavon (November 2013), and Canora (July 2014) to improve patient access to health care services in rural and remote communities. Work on two additional CECs (in Wakaw and Spiritwood) is underway.
- ▶ Specialized diagnostic services are closer to home. Plans have been announced for:
  - MRI in Moose Jaw announced in May 2014; and
  - Computed tomography (CT) services in Estevan announced in June 2014.
- ▶ Dialysis services at Moose Jaw and Swift Current expanded to decrease patient travel to Regina for treatment.
- ▶ Home hemodialysis treatment is now an option for patients throughout the province.
- ▶ Northern Medical Services is piloting the use of

remote presence technology in Pelican Narrows. This technology allows providers to interact with patients from a remote location, increasing access and timeliness of care, especially after hours or when local physicians are unavailable.

- ▶ Government continues to provide a safety net for individuals with low income to cover or mitigate the costs of road ambulance services.
- ▶ Through service agreement with STARS, helicopter air medical transport started in southern and central Saskatchewan in 2012. Care is provided enroute by a nurse/paramedic team with critical care skills. Since this service began, over 1,000 patients have been transported by, or received on-scene care from, STARS.

## Assessment

- ▶ Maintaining adequate access to primary health care (PHC) and acute care services in rural and remote areas must continue to be supported with innovative service delivery methods.
- ▶ Reliable access to physician and/or nurse practitioner services at community hospitals and health centres in smaller communities is needed to avoid short- and long-term service disruptions.
- ▶ Health service access and delivery is affected by many factors, including appropriate health human resources and broader regional health authority decisions of how to best provide services to their population.
- ▶ Studies show that a team-based PHC model:
  - lowers health care delivery costs;
  - provides more coordinated, integrated, comprehensive care;
  - improves patient experience and health outcomes of patients with chronic conditions; and
  - reduces hospital admissions and emergency room use.
- ▶ Most PHC services in Saskatchewan are still delivered by independent physician clinics.
- ▶ The Ministry continues to work with health regions to engage family physicians throughout the province, and support them to develop team-based models of care. These types of models encourage all health professionals to work to their full scope of practice, leading to greater work/life balance for health care providers, increased access for patients and more appropriate use of health resources.

- ▶ The addition of new roles in a Primary Health Care setting (PHC counselor and RN case manager), along with increased teamwork and collaboration amongst providers, has resulted in decreased wait times and increased access to services.

- ▶ Continued implementation of a team-based PHC model will improve issues related to access to health care services in rural and remote areas.
- ▶ Improved health information systems are a promising component of Saskatchewan's approach to chronic disease management (CDM). Improved medical records, data repositories, and practitioner portals to those data have the potential to simultaneously improve practitioner practice, enhance the quality of care, improve patient outcomes, and reduce the burden of chronic disease on the provincial health care system.
- ▶ CECs offer a number of benefits to patients including fewer emergency service disruptions, urgent care sooner and closer to home, increased primary health care access and a team-based approach that offers continuity of care. The CEC model also promotes better work/life balance for providers and can have a positive impact on recruitment and retention.
- ▶ CECs support predictable and stable services in rural communities. Saskatchewan CECs have not experienced a service disruption to date.

## Patient First Review Recommendation

### 3. Seniors' Care Strategy

*That the Ministry of Health's Seniors' Strategy under development focuses on strengthening:*

- *System capacity to support independent living;*
- *Accessibility to personal care homes by addressing the current financial barriers for low-income seniors;*
- *Accessibility and quality of assisted living and long-term care;*
- *Programming for seniors with extraordinary behaviours that cannot be safely managed in the general long-term care population (e.g. specialized assessment and treatment units); and,*
- *Capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day therapy/services, and a specialized outpatient clinic.*

## Key Accomplishments

A number of seniors' health initiatives have been undertaken over the last few years.

- ▶ In 2015-16, government is investing \$10 million to enhance services for seniors at home or in long-term care: \$3.5 million to support seniors who wish to remain at home as long as possible by enhancing the Home First/Quick Response Program in Regina Qu'Appelle, Saskatoon, and Prince Albert Parkland Health Regions and expanding the program in the Prairie North Health Region to an additional site. This brings the total funding for Home First/Quick Response to \$8.25 million; \$2.8 million in capital renovations in Regina Qu'Appelle and Saskatoon health regions to develop specialized units for individuals with dementia or challenging behaviours; \$2.0 million to eliminate the current waitlists for the Individualized Funding program through home care; \$1.0 million to implement Purposeful Rounding in all LTC facilities; and, \$700,000 to develop a new geriatric program in Regina.
- ▶ The Ministry of Social Services introduced the Personal Care Home Benefit in 2012, to provide financial support to low income seniors in a licensed personal care home.
- ▶ 13 special-care homes (long-term care facilities) are being replaced throughout the province.
- ▶ In 2014-15, funding was provided for upgrades and repairs to Saskatoon's Parkridge Centre, as well as planning dollars for replacement facilities in Regina and an expansion for the long-term care (LTC) facility in La Ronge. As well, a new LTC facility (Samaritan Place) in Saskatoon is operating and a new long-term care facility is being built in Swift Current.
- ▶ The average wait for placement in a LTC facility is about 28 days, down from 48.5 days in 2011-12.
- ▶ Saskatchewan continues to have one of the highest ratios of LTC beds in the country with 112.7 beds per 1,000 people over 75 years old, well above the national average of 86.4 beds.
- ▶ Staffing in LTC facilities increased 13 per cent from 2006-07 to 2013-14, with a total of 781 more full-time-equivalent (FTE) positions. FTEs increased 40 per cent for Licensed Practical Nurses, 11 per cent for Continuing Care Assistants and six per cent for Registered Nurses.
- ▶ Initiatives were undertaken to improve the quality of care in special care homes, such as:
  - Using Lean methodology to identify and implement improvements for work processes and patient care;
  - Monitoring LTC quality indicators such as use of daily physical restraints, use of anti-psychotic medications without a diagnosis, newly occurring pressure ulcers, worsening pressure ulcers, falls, worsening incontinence and worsening pain; and
- A \$10.4 million long-term care Urgent Issues Action Fund was announced 2013-14, to address priority issues such as new equipment, more frequent resident baths, improved nutrition, improved responsiveness to call bells and training to care for residents with dementia. An additional \$3.8 million annualized was provided for ongoing pressures, beginning in 2014-15.
- ▶ In 2011 a Saskatchewan Falls Collaborative was established to reduce falls and injury from falls among special-care home residents and home care clients. For those facilities and home care programs that participated, implementation of evidence-based innovative ideas resulted in approximately 25 per cent reduction in total number of falls and total number of falls per 1,000 resident days as well as significant reductions in injury rates.
- ▶ The Ministry provided the Alzheimer Society with \$404,470 in 2014-15 for the expansion of the First Link program (funding to the Alzheimer Society since 2007-08 has been \$1,014,719).
- ▶ Seniors House Calls is another program that will help seniors stay home as long as they can. It will enable some seniors with complex issues to receive house calls from physicians, nurse practitioners and other health care providers. It is currently under development.
- ▶ The Ministry also provided the Rural and Remote Memory Clinic at the University of Saskatchewan with \$152,939 of funding in 2014-15 and with a total of \$701,485 since October 1, 2009. This program provides multidisciplinary services that focus on diagnosis and management of atypical and complex cases of suspect dementia, where an assessment is needed, particularly for those living in rural and remote areas.

## Assessment

- ▶ The seniors population (65+) in Saskatchewan is predicted to grow from 14.3 per cent of the total population in 2013 to 20.8 per cent in 2028. This has implications for future service demand and costs.
- ▶ It is estimated that the cost of providing health care to seniors is approximately double the cost for those under age 65, and the most complex 10 per cent of seniors account for 60 per cent of total health care spending. In Saskatchewan, seniors account for 20 per cent of emergency department (ED) visits, and 37 per cent of all hospitalizations.

- ▶ Studies show that effective home-based programs not only lead to increased patient, caregiver, and health care provider satisfaction, but also decreased pressures/costs on the health system through a reduction in ED visits and admissions to hospitals and long-term care (LTC) facilities. Furthermore, most seniors wish to live in their home
- ▶ Enhanced home care services and more targeted management of multiple chronic conditions through PHC teams will benefit senior patients.
- ▶ The Home First/Quick Response Home Care program developed to improve seniors' access to supports in the community will allow them to safely age within their own homes and progress to other care options as their needs change.
- ▶ Client care co-ordinators will identify and arrange supports in the community to help seniors maintain independence and optimal health status at home and make referrals where appropriate. Care co-ordinators collaborate with other areas of health care including acute and emergency services, primary health care, and home and community services to improve seniors' journey within the health system.
- ▶ CEOs, or designates, will be touring all of their LTC facilities in 2015 to continue to monitor and identify issues, review progress that has been made, and ensure a continued focus on quality improvement.
- ▶ On November 19, 2014, the Saskatchewan Ombudsman was asked to review the care provided in a specific Special Care Home, with the goal of also determining system-wide issues. This Ombudsman issued a report in May 2015 with 19 recommendations. Government committed to working with our health system partners to address the Ombudsman's recommendations. This work will include policy development to operationalize special care home program guidelines and track and report compliance with minimum care standards. The Ministry and its health partners will communicate more effectively how people can get concerns handled and the appeal process for unresolved concerns.

## Patient First Review Recommendation

### 4. Health of First Nations and Métis

*That health regions, the Cancer Agency and other health-care organizations work with First Nations and Métis organizations, Elders, and patients to develop partnerships aimed at improving the health of First Nations and Métis people. This joint work may include but not be limited to:*

- *Assisting First Nations and Métis patients navigate the health system and advocating for better care;*
- *Developing linkages with First Nations- and Métis-run health programs and services to better integrate care;*
- *Working with the provincial and federal governments to develop new information sources to help First Nations and Métis people understand government programs and services;*
- *Adapting health services to better meet the needs of First Nations and Métis patients, including accommodation and transportation needs, and cultural supports and services;*
- *Addressing health system gaps as identified by the Memorandum of Understanding on First Nations' Health and Well Being Steering Committee and the renewed partnership with the Métis Nation of Saskatchewan; and,*
- *Encouraging First Nations and Métis organizations to partner in the provision of health care services that will directly benefit their communities.*

### Key Accomplishments

A number of collaborative efforts have been undertaken to close the health status gap between First Nations members and other Saskatchewan residents.

- ▶ Under the 2008 Memorandum of Understanding (MOU) on First Nations Health and Well-Being in Saskatchewan, the Federation of Saskatchewan Indian Nations (FSIN), Health Canada, and the Ministry of Health are engaged in a collaborative process for addressing First Nations health issues in Saskatchewan and improving the health status of FN members.
- ▶ Since 2009, the Ministry of Health has provided support to the Northern Health Sector Training and Human Resources Strategy for programs such as registered nursing, continuing care aide, mental health and addictions worker, licensed practical nursing and others, as identified by the committee and its member organizations.
- ▶ Health region/SCA and First Nations/Métis partnership initiatives: since the release of the Patient First Review in 2009, the Ministry of

Health, health regions and Saskatchewan Cancer Agency (SCA) have become involved to various degrees in partnership initiatives which seek to improve relationships and FN/Métis health. A few examples:

- Positioned within SHR's Integrated Health Services, the First Nations and Métis Health Service (FNMHS) provides:
  - i) clinical and cultural support for health staff, clients and families;
  - ii) interpretation services for the Cree and Dene languages as well as assistance to the patient and their family in understanding medical tests and procedures;
  - iii) a diverse perspective focusing on cultural competency; and
  - iv) problem solving points and resources for complex care issues.
- The team maintains close ties and linkages to First Nation and Metis communities and organizations and works to address jurisdictional issues that hamper equitable access to health services.
- Prairie North Health Region partnered with surrounding First Nations communities (Thunderchild, MLTC and BATC) to establish four health liaison positions. The positions are meant to serve as key points of contact within the health care system, helping First Nations patients and families navigate the system, bridging cultures, coordinating care (e.g., discharge planning) and promoting a better understanding of the needs and customs of First Nations people among region staff.
- The SCA will continue to work collaboratively with the Métis communities on cancer surveillance.
- ▶ Through the Provincial Tobacco Strategy introduced in October 2010, three grants were awarded in Spring 2012 to the following projects that involved partnerships between health regions and First Nations and Métis organizations:
  - Northern Saskatchewan Tobacco Reduction Initiative (a partnership between the three northern health regions), to reduce tobacco usage rates among youth, pregnant women and young families in Northern Saskatchewan (\$250,000).
  - The Green Light Program: Building on Success and Celebrating Smoke-Free Homes in Métis Communities is a partnership between the Saskatoon Health Region, the University of Saskatchewan and Métis Nation Saskatchewan (\$248,735).

- Battlefords Family Health Centre: Change Can Happen with a Smoke Free Community! - A partnership between Battleford Tribal Council Indian Health Services and Prairie North Health Region (\$203,791).

- ▶ Saskatoon Health Region (SHR) is partnering with the Whitecap Dakota First Nation (WDFN) to develop a primary health care service model that addresses care needs in an accessible, culturally appropriate way. This initiative seeks to identify practical arrangements to integrate health services, reduce fragmentation in health programs and services delivered by three separate systems, and increase clarity about roles and responsibilities.
- ▶ Currently, SHR is providing clinical supervision and support for chronic disease management and mental health and addiction services, with a view to further collaboration and provision of more services in the future. A health region nurse practitioner also provides services at Whitecap. WDFN has established an arms-length, not-for-profit incorporated entity called Whitecap Health Alliance to assume responsibility for health services. The organization is overseen by a board appointed by Chief and Council, with qualified members from WDFN and SHR.
- ▶ Regina Qu'Appelle Health Region (RQHR) worked with All Nations Healing Hospital and the File Hills Qu'Appelle and Touchwood Tribal Councils to develop the Touchwood Qu'Appelle PHC Collaborative, which provides services to several communities.

## Assessment

- ▶ The gap in health status between First Nations people and other residents in the province remains large.
- ▶ Changes in personnel at the provincial Ministry of Health have led to some challenges to moving forward with activities under the MOU.
- ▶ The Saskatchewan Ministry of Health has continued to pledge its commitment to the MOU, the implementation of the First Nations Health and Wellness Plan, and related activities.
- ▶ As shown in the examples provided for the RHA/SCA and First Nations/Metis Partnership initiatives, there has been some improvement in relationships with First Nations and Métis organizations, Elders and patients of First Nations and Métis health status.

- ▶ The Ministry of Health and health regions are unable to, accurately track health indicators for First Nations and Métis individuals. This makes it difficult to measure effectiveness of the initiatives.
- ▶ Going forward, efforts need to be closely monitored and, if successful, sustained and spread throughout the province.

## Patient First Review Recommendation

### 5. Services for Children and Youth

*That the health system develop a more integrated and inter-sectoral approach to services for children and youth.*

#### Key Accomplishments

- ▶ The province has committed a total of \$62.5 million to the Saskatchewan Child and Family Agenda (SCFA) to meet the needs of children, youth, and families at risk since it was created in 2011. There have been some early successes and promising initiatives to date as a result of this investment. These successes have highlighted the value of cross-ministry collaboration, focusing on the needs of the client, rather than the constraints of bureaucratic silos.
- ▶ Family centre pilots in Regina, Yorkton and Sandy Bay provide an opportunity for the health, justice and social services systems to become active partners to provide services on site (e.g., dental screening/varnishes, public health services, prenatal care).
- ▶ KidsFirst provides support at the community level. The Coordination of services provided for early childhood development, families, and youth provide an opportunity to align resources and services to ensure gaps are filled by each sector and no duplication of services or funding is being provided. An inter-sectoral approach is required at the government level so services can be reorganized and resources can be aligned to ensure a holistic approach to services for children and families in the community. Health regions are accountable partners for seven of nine targeted programs.
- ▶ The Hub and Centre of Responsibility (CoR) model, an inter-sectoral approach to addressing domestic violence, housing, mental health and addictions, has been implemented to address situations facing individuals and/or families with acutely elevated risk factors and to address longer term community goals and initiatives. The first Hub (a group of multidisciplinary frontline providers who provide immediate intervention

and short-term solutions) was established in Prince Albert (P.A.), and has been spread to 10 other communities across Saskatchewan as of March 2014. The early results of the first Hub and CoR model in P.A. show a decrease in crime rate (14 per cent), public prosecution rate (12 per cent), and ER visits (10 per cent).

- ▶ In an effort to transform child welfare, various innovative initiatives were introduced in partnership with seven communities. These initiatives include intensive in-home supports and Triple P (Positive Parenting Program). The province-wide results between March 2010 and March 2014 show a decrease in number of children in out-of-home care (five per cent) and the number of open child protection cases due to neglect (six per cent).
- ▶ To prevent Fetal Alcohol Spectrum Disorder (FASD), targeted programs for families and individuals were introduced in 2011-12. These programs address parenting skills and provide information about accessing services, such as mentorship and life skills services. In 2012-13, three pilot projects (Saskatoon, Regina, and Prince Albert) were launched to provide intensive FASD prevention programming to pregnant women at high risk for having a child with FASD, and continuing until the child reaches two years of age.

#### Assessment

- ▶ A number of other initiatives under the SCFA are currently underway. These include: the Mental Health and Addictions Action Plan which completed in 2014; 500 additional licensed child care spaces; and 15 new additional pre-kindergarten programs for vulnerable children and families.
- ▶ The Ministry of Education is leading the implementation of recommendations from the Joint Task Force on Improving Education and Employment Outcomes in Saskatchewan and will continue to work with First Nations and Métis partners to ensure equitable education outcomes for all those of First Nations, Métis and non-Aboriginal status.
- ▶ Further, the Ministry of Justice is supporting a program to expand access to legal representation for children in child protection matters through the creation of a Counsel for Children Office which began serving clients in 2014.

## Patient First Review Recommendation

### 6. Co-ordination and Integration of Cancer Care Services

*That the Cancer Agency and health regions improve the coordination and integration of cancer care services across the continuum of cancer care.*

#### Key Accomplishments

- ▶ Being able to receive some chemotherapy services closer to home reduces the travel burden for patients. One of the Saskatchewan Cancer Agency's 2014-15 priorities was the review and enhancement of these community oncology services, in collaboration with health regions.
- ▶ Through the Community Oncology Program of Saskatchewan (COPS), more than 1,700 patients annually receive chemotherapy closer to their place of residence. In 2013-14, this program resulted in the avoidance of more than 7 million kilometres of patient travel. Additionally, travel for patients is saved through the successful utilization of Telehealth. Through this technology, patients are able to consult with their oncologists and other care providers without having to travel to the tertiary centres.
- ▶ There are 16 COPS centres located in hospitals throughout Saskatchewan: Estevan; Humboldt; Kindersley; Lloydminster; Meadow Lake; Melfort; Melville; Moose Jaw; Moosomin; Nipawin; North Battleford; Prince Albert; Swift Current; Tisdale; Weyburn; and Yorkton.
- ▶ All 16 COPS Centres have been provided with access to the Saskatchewan Cancer Agency's Clinical Management System. Through use of this technology, clinicians at all COPS centres can view and update patient charts directly, resulting in improved communication and enhanced patient care.
- ▶ A community of practice model has been used to develop a peer navigation program as collaboration between the Prince Albert Parkland Health Region and the Cancer Agency. Thirteen volunteers have been trained to provide patient education, connect patients/families to local services and supports, and provide psychosocial, practical and informational support, and some assistance with case coordination, to all patients and families of the PAPHR COPS center.
- ▶ To improve the cancer treatment experience, the SCA provides patient navigation assistance to patients newly diagnosed with cancer and their

families. This program provides assistance and information for social or psychological needs, financial concerns, health system concerns, family issues, and coping issues. Patient navigators also assist First Nations people in working with provincial and federal governments in order to better meet their accommodation and transportation needs. They also work with First Nations communities to provide more culturally appropriate supports and services.

- ▶ To provide seamless and timely care for patients with cancer, the Saskatchewan Cancer Agency (SCA), in collaboration with its health system partners, developed and implemented symptom management and a palliative care clinic in the Saskatoon Cancer Center in December 2013. This clinic is a team-based multidisciplinary clinic comprised of a palliative care physician, nurse, social worker, and pharmacist.
- ▶ The SCA offers three province-wide screening programs for cervical, colorectal and breast cancer. A Screening Program for Colorectal Cancer, launched in 2009 in Five Hills Health Region, has been fully implemented across the system. Between April 2012 and March 2014, 38 per cent of the population aged 50-74 participated in the program. We expect overall participation to reach almost 50 per cent in 2015. Patient navigator services have also been provided to patients in five health regions. These services include preparatory counselling and scheduling assistance for patients requiring colonoscopy procedures. The patient navigator services have not only reduced wait times for follow up after colonoscopy (from 60 days to 90 days), but also improved patients' experience with their care, including reduced anxiety.

#### Assessment

- ▶ Patients want options for care that allow them to remain in their home communities and to be surrounded by their families and friends. To achieve this, SCA is currently working towards expanding the programs and services offered within the Community Oncology Program of Saskatchewan (COPS). This work involves introducing new approaches to care such as peer navigation, and working with health regions to increase capacity so more patients can be treated. In addition, this work will build new connections and partnerships with regional primary health care networks to integrate health promotion and cancer prevention activities with community oncology services.

- ▶ The Saskatchewan Surgical Initiative monitored invasive cancer surgery rates to ensure improvements made to elective surgical wait times were not at the expense of cancer surgeries. The government wants to ensure all cancer surgeries are done within clinically appropriate time frames (three weeks, six weeks, or three months), depending on the urgency of each surgery. Province-wide, as of March 31, 2015, 83 per cent of cancer surgeries were completed within the appropriate time frames. The health system continues to work toward achieving 100 per cent by March 31, 2015.
- ▶ Since 2010, third-party delivered services in the community – CT service in Regina, day surgery service in Regina and Saskatoon – has supported increased service capacity and has been very well received by patients. Community-based MRI services became available in Regina in October 2014.
- ▶ Pooling referrals has shortened the wait time for patients to see a specialist while protecting patient choice to see their preferred surgeon. As of September 2014 there are 16 specialist groups pooling referrals, representing 109 specialists. Four other groups are working to implement the model.

## Patient First Review Recommendation

### 7. Saskatchewan Surgical Initiative

*That the health system take immediate action to improve Saskatchewan patients' surgical experiences, from initial diagnosis through to recovery, through an aggressive, multi-year, system-wide strategy that is reported to the public with clear targets and regular updates.*

#### Key Accomplishments

The four-year Saskatchewan Surgical Initiative helped focus health system partners on targeted efforts to reduce wait times while providing safer and smarter care. To ensure transparency and celebrate the system's achievements, the Surgical Initiative issued monthly wait times on the public website (a practice that continues post-Initiative) and published annual progress reports from 2010-11 to 2013-14.

For more information on the results of the Surgical Initiative, and a link to the Year 4 Report, visit [www.sasksurgery.ca](http://www.sasksurgery.ca).

#### Sooner:

- ▶ The four-year Saskatchewan Surgical Initiative began on April 1, 2010 with the goal that no patient would wait longer than three months for surgery by March 31, 2014.
- ▶ The system continues to work to ensure that every patient is offered surgery within three months.
- ▶ As of March 31, 2015, the number of patients waiting more than three months and six months were reduced by 89 per cent and 96 per cent respectively, compared to the numbers in March 2010.
- ▶ Eight of the 10 regions performing surgery have achieved the wait time target. Saskatoon and Regina Qu'Appelle Health Regions are expected to meet the target by March 2015.

- ▶ The online Specialist Directory (accessed through [www.sasksurgery.ca](http://www.sasksurgery.ca)) which provides patients and providers with current information to assist in a referral decision (including listing specialists and their wait times) receives approximately 4,000 monthly visits.

- ▶ The Surgical Initiative provided funding to train additional operating room nurses to help regions continue to perform a higher volume of surgeries and utilize the resource of existing operating rooms. Funding for over 100 additional OR nurses was provided through the Surgical Initiative, and SIAST has now doubled the number of training seats available annually (from 18 to 36). The coordination of additional OR seats for nurse training was the result of cross-ministry cooperation.

- ▶ The Surgical Initiative has fostered the development of several other projects directly related to improving patient flow. The Improving Access to Specialists and Diagnostics project (also known as Wait 1) and the Emergency Room Initiative are two examples of projects using tools developed through the Surgical Initiative to improve the system for patients and providers.

#### Safer:

- ▶ The Surgical Initiative's focus on providing safer surgical care was a key priority, particularly for the Initiative's patient advisors.
- ▶ The surgical safety checklist, an internationally validated safety tool, has been adopted in all regions that perform surgery, with near 100 per cent compliance.
- ▶ All 10 health regions that perform surgery have begun to implement the national Surgical Site Infection Prevention Bundle.
- ▶ All health regions and the Saskatchewan Cancer Agency have introduced Medication Reconciliation at admission to acute care. Provincially, we have achieved a compliance rate of 93 per cent (based on April 2014 results).

- ▶ A falls prevention initiative has helped identify risk factors and measures that will prevent injuries from falls.
- ▶ Mistake-proofing projects (Lean based safety tools) are underway in health regions to determine the root cause of errors and develop safeguards to prevent them before they can cause harm to patients and providers.

#### **Smarter:**

- ▶ The Surgical Initiative engaged patients in the governance of the project from the earliest stages, with patient advisors part of the membership of both the Guiding Coalition and Executive Sponsorship Group, and later chairing the Transition Steering Committee. Patient representation continues on the Provincial Surgical Oversight Team which has been formed to ensure that the gains of the Initiative are maintained.
- ▶ Patient pathways were introduced to streamline the care process and ensure patients receive appropriate, timely care. Five pathways have been developed (hip and knee replacements; lower-back pain; bariatric surgery; prostate assessment; and pelvic floor conditions) with two more are in development (acute stroke care, and lower-extremity wound care).
- ▶ A Variation and Appropriateness Working Group is working with four groups of surgeons to study and reduce unnecessary variation and standardize care.
- ▶ Rural/Remote service delivery is being improved with the development of a pediatric dental surgery program in Prince Albert Parkland Health Region (PAPHR). This program will provide an option for patients from the region and from northern Saskatchewan to receive service closer to home. Similarly, a cataract surgery program in Sun Country Health Region is being developed so patients can receive services without having to travel to Regina.

The Enhanced Preventive Dental Services Initiative began in 2011 as part of the SK Surgical Initiative to address the wait times of children needing dental surgery and to enhance preventative services to prevent early childhood tooth decay. The number of patients waiting longer than three months for oral surgery decreased from 1,569 in April 2010 to 318 in March 2014.

- ▶ The Lean Management System has been introduced across all health regions with the aim of promoting continuous improvement to eliminate waste and add value.

- ▶ Much of the Surgical Initiative's success can be attributed to system-wide collaboration to meet very aggressive targets. The system has embraced the idea of thinking and acting as one (an example is smaller, rural regions repatriating their patients sooner, and utilizing their resources first before referring to another region).
- ▶ The system remains committed to maintaining the three-month surgical wait time and the other important improvements that have been achieved over the last four years. The role of strategic leadership has now been passed to the Provincial Surgical Oversight Team. This small group of patients, health providers, health region and ministry representatives will monitor results to ensure that continuous improvement remains entrenched in surgical services.

### **Assessment**

- ▶ Although the Surgical Initiative has ended as a project, the work continues. The system will continue to monitor achievement of the wait time target and to implement improvements to the safer and smarter delivery of surgical care. Over the four years of the Initiative, \$176 million was invested in surgical services. The investment continued with funding of \$60.5 million in 2014-15 and \$48.8 million in 2015-16 committed to support the volume of surgeries necessary to meet the three-month target.
- ▶ Building on the success of the Saskatchewan Surgical Initiative and lessons learned, attention is being focused on reducing the wait time from when a referral is made by a primary care provider to when the patient is seen by the specialist.
- ▶ Many Saskatchewan patients currently wait six months or longer for their first consult visit with a specialist. Inconsistent coordination and communication processes, and lack of clear referral guidelines, contribute to these waits. The current referral process often results in repetitive visits and testing and poorly coordinated treatment planning.
- ▶ The Canadian Institute for Health Information reports that in 2011 Saskatchewan had 21.8% of patients waiting three months or longer to see a specialist for a new illness, the second highest in the country. British Columbia had the lowest proportion with 12.4 % and New Brunswick had the highest with 23.8%.
- ▶ The national average was 16.4% of patients waited longer than 3 months to see a specialist. This measure looks at how many Canadian patients age 15 and older reported waiting longer than 3 months to see a specialist doctor for a new condition.

- ▶ Variability in what and how information is shared between physicians is a significant barrier to timely access to specialty care for patients. Canadian jurisdictions have turned to technology such as EMR's, online referral forms, video conferencing, and telephone consults to improve the flow of information transferred between physicians and to involve patients in the referral process.
- ▶ On January 13, 2012, Premier Brad Wall announced a number of new provincial priorities for the health care system, including: all people (in Saskatchewan) will have improved access to specialists and diagnostic services.
- ▶ The Saskatchewan health system is working to reduce the wait time to see a specialist and access diagnostics by 50 per cent by March 31, 2019. The Improving Access to Specialists and Diagnostics initiative was established to achieve this goal. The initiative focuses on reducing the wait time from when a patient is referred by their primary care provider to when they are seen by the specialist. Patients can expect improvements to wait times, more efficient timing of diagnostics and greater involvement regarding where, when and by whom their health concerns will be addressed.
- ▶ The Patient First Review indicated that some patients in Saskatchewan may not receive appropriate care. Many complex factors contribute to appropriate health care. Depending on where they live and which provider they see, patients with the same health conditions may receive very different care.
- ▶ Overuse, underuse, misuse and variation in care are all areas of concern that may impact patient outcomes, and add costs to the health care system.
- ▶ An Appropriateness of Care team has been established to develop a standard method to improve care.
- ▶ MRI in the lower spine has been selected as the first Appropriateness project in 2015-16.
- ▶ Evidence suggests that there is a degree of inappropriate MRI testing in Canada. According to the Canadian Association of Radiologists, 10 to 20 per cent of these tests may be unnecessary.
- ▶ Once the testing of the Appropriateness framework in the MRI project is completed, it will be replicated in other clinical areas.
- ▶ The Variation and Appropriateness Working Group work will continue under the Appropriateness of Care Initiative.

## Patient First Review Recommendation

### 8. Emergency Room Utilization

*That the health system address inappropriate usage of emergency rooms by exploring the applicability of urban urgent-care centres. The appropriate health regions should explore alternate financing partnerships in developing these projects, which should incorporate state of the art design and leading technologies.*

### Key Accomplishments

- ▶ The health system has selected the Emergency Department Waits & Patient Flow initiative as one of the strategic priorities for the health system. To meet the ambitious targets of *no waits in the emergency department by March 31, 2017*, the initiative team engaged various stakeholders, including patient and family representatives from across the province. They mapped out a provincial current and future state, adopted a standard patient flow framework and developed a multi-year implementation work plan that employs evidence-based initiatives across the continuum of care.
- ▶ Initiative plans include:
  - Pre-hospital-primary-care-based initiatives, identifying high users of the emergency department (ED) and acute care, and targeting interventions to better suit their needs (hotspotting); linking ED patients who do not have a regular health care provider to a primary health care team or general practitioner; and establishing care coordinators to help coordinate care for vulnerable populations.
  - ED-based initiatives: optimizing triage protocols, optimizing the model of care in the ED; capturing the patient voice through service experience surveys; and establishing a process for patients who are currently seen in the ED for pre-arranged specialist consultation and diagnostics.
  - Acute-care-based initiatives: improving transfer of care (discharge) planning upon admission; and ensuring physicians round on the wards daily.
  - Post-hospital community initiatives: supporting safe, timely discharge for complex patients and preventing readmissions and revisits to the ED.
- ▶ There is currently work underway to identify the most frequent users of health care services in order to provide them more targeted, comprehensive and holistic care through care

management and team-based primary health care approach. This work is called “hotspotting”.

- ▶ A pilot program called Connecting to Care began in January 2015, in Regina Qu’Appelle Health Region to adopt the hotspotting approach. A similar pilot is scheduled to begin in Saskatoon Health Region in Spring 2015.

## Assessment

- ▶ The demand for services in the three Saskatoon and two Regina emergency departments (EDs) increased significantly between 2009-10 and 2012-13. The average time to disposition increased to 5.8 hours (4.5 per cent longer) and the average wait for an inpatient bed decreased to 9.2 hours (19.7 per cent shorter).
- ▶ In 2012-13, 123,676 patients made a total of 212,164 ED visits in Regina and Saskatoon hospitals. Of those ED visits:
  - 14 per cent were for conditions which could have been treated (likely more effectively) in another setting;
  - 17 per cent of patients needed to be admitted to the hospital for further treatment;
  - 10 per cent of ED visitors accounted for 32 per cent of all visits;
  - one per cent of hospital patients accounted for 22 per cent of the inpatient costs; and
  - The average length of stay in the ED is six hours.
- ▶ About 10 per cent of ED visitors are patients with complex needs, including seniors with multiple chronic conditions and patients suffering from mental health and addictions. Seniors account for 20 per cent of ED visits. Annually, there are over 10,000 approaches to emergency wards for mental health reasons in Regina and Saskatoon.
- ▶ The recent analysis by the Health Quality Council suggests that one percent of hospital patients account for approximately 20 percent of health-system costs in the province.
- ▶ An individual’s health is determined by complex interactions between social and economic factors, the physical environment and individual behaviors. To successfully address the ED waits issues, it requires an intersectoral, interministerial collaboration as those individuals are likely to be the users of other systems, such as social services, housing, justice and correctional services.

- ▶ The Saskatchewan health system is currently working collaboratively with other Ministries and sectors (Justice, Correction and Policing, Social Services, and Education) to address ED wait times.

## Patient First Review Recommendation

### 9. Charter of Patient Rights and Responsibilities

*That the Ministry of Health, in collaboration with health regions, the Cancer Agency, provider organizations and patient and family advisors, develop and implement a Charter of Patient Rights and Responsibilities.*

### Key Accomplishments

- ▶ No actions have been undertaken. With the creation of the Patient- and Family-Centred Care (PFCC) Framework and resulting PFCC plans within the system, work to develop a Charter of Patient Rights and Responsibilities was not pursued.

## Assessment

- ▶ N/A

## Patient First Review Recommendation

### 10. Health Promotion and the Prevention of Illness and Injuries

*That the Saskatchewan government and health system pursue an aggressive and targeted emphasis on the promotion of good health and the prevention of illness and injury in Saskatchewan. Not only will this pay dividends in a healthier and more productive populace, it will help to ensure that Saskatchewan’s health system is ready and able to help all of us when we need it most.*

## Key Accomplishments

### Health Promotion

► Comprehensive School Community Health (CSCH) continues to provide a cross government approach for health promotion in schools. The approach has been used to develop a number of resources to support healthy eating, physical activity and tobacco reduction in school settings. New work includes:

■ *KNOW Tobacco... Think. Learn. Live* resources are complete and available at [www.sk.lung.ca/index.php/got-lungs-home](http://www.sk.lung.ca/index.php/got-lungs-home);

■ *Nourishing Minds: Towards Comprehensive School Community Health: Nutrition Policy Development in Saskatchewan Schools (2009)* is currently under review; and

■ *Inspiring Movement: Towards Comprehensive School Community Health: Guidelines for Physical Activity in Saskatchewan Schools (2010)*.

- The Ministry of Health continues to work with the Ministry of Education to promote healthy eating and physical activity in licensed child care centres.
- Funding for the Enhanced Preventative Dental Services Initiative was rolled out in 2011. The enhanced services are intended to supplement existing regional efforts to help improve children's oral health by increasing access to dental care, preventive services and early education. These services focus on oral health assessments, fluoride varnish, and dental sealants for grade 1 and 7 students in high risk schools. Evaluation of the third year of the program began in October 2014.
- The Ministry's tobacco reduction work supports the goals of tobacco use prevention, cessation and protection. In the area of prevention, the innovative social marketing campaign, [Smokestream.ca](http://Smokestream.ca), encouraged youth aged 11-14 years to honestly share their thoughts about tobacco use. An advertising campaign featuring the words and voices of Saskatchewan youth aired in January 2013, and has been re-run in different mediums. View and Vote ran from January to April 2014, featuring ads from Thailand, USA, UK and Canada. The winning ad aired online and at movie theatres in June 2014. For cessation, a range of training/resources/tools, including the [makeapact.ca](http://makeapact.ca) website and the Smokers' HelpLine are available to health professionals and the public.

Saskatchewan continues to have among the highest smoking prevalence rates. Based on the 2012 Canadian Tobacco Use Monitoring Survey results, 18.5 per cent of the Saskatchewan population smokes on a daily or occasional basis, compared to 16.1 per cent nationally

- Protection work continues through amendments to *The Tobacco Control Act* implemented in 2010-2011. Restricting where people can smoke creates a change in perception of our youth that smoking is no longer a common, safe, socially acceptable activity. We are concerned about the impact tobacco use has on the health of our residents, as it is widely recognized that tobacco use contributes to significant health problems for smokers and those exposed to environmental tobacco smoke. Young people are particularly vulnerable to this exposure.

### Prevention of Illnesses and Injuries

- Since the implementation of the 4-year HIV Strategy (2010-2014), the number of new HIV cases annually has declined from 200 in 2009 to 129 new cases in 2013 (a decrease of 36 per cent)<sup>1</sup>. In First Nations communities this has led to increased case identification and earlier access to treatment. The last case of mother-to-child transmission of HIV in the province occurred in 2010. Improvements in HIV testing, treatment and support have resulted in no further perinatal transmission. Access to testing, treatment and care has improved in areas of the province where it was not previously available. Regina Qu'Appelle, Saskatoon and Prince Albert Parkland health regions and some rural/remote communities have more HIV patients engaged in treatment and experiencing successful treatment outcomes.
- Since 2003, the Ministry of Health has expanded the provincial publicly-funded immunization program to protect children from several vaccine-preventable diseases including rotavirus disease (program started in 2012) and human papilloma virus (HPV) for Grade 6 girls (started in 2008), as well as additional protection against meningitis, pneumonia, influenza and chicken pox.
- The annual influenza immunization program is available to all Saskatchewan residents. The main goal of the program is to protect people at increased risk of complications from influenza disease including children, people over the age of 65, pregnant women and people with a compromised immune system.

## Assessment

### Communicable Diseases

- ▶ Saskatchewan has historically not done well in controlling or preventing the spread of various communicable diseases. From 2004 to 2011, Saskatchewan's average rates for several diseases were: tuberculosis (TB) 1.9 times the national rate; chlamydia 1.8 times the national rate; hepatitis C 1.7 times the national rate; and gonorrhoea more than double the national rate. The human costs associated with communicable diseases are significant, particularly for those socio-demographic groups most affected, such as the First Nations and immigrant populations. In 2004, the cost to the health care system of treating one case of active TB was estimated at \$47,000 (Menzies, 2006). The lifetime cost of treating one case of HIV is an estimated \$250,000 (Canadian AIDS Society, 2009).
- ▶ The provincial HIV strategy has demonstrated that strategic interventions, such as an integrated model of care for prevention and management of communicable diseases, can reduce the disease burden. In June 2013, government released its TB Strategy to reduce the rate in Saskatchewan. The initial focus is on high incidence in northern communities as well as enhanced programming in nursing, pharmacy and outreach services for the Provincial TB Prevention and Control Program.

### Preventable Patient Harms at Acute Care

- ▶ In hospitals, the main sources of patient harm are related to surgery, medication, and infection. The Canadian Adverse Events Study (Baker et al., 2004) has shown that 7.5 per cent of patients admitted to a hospital experience one or more adverse events (AEs). Of these, 37 per cent could be prevented. Based on this research, the estimated rate of adverse events in Saskatchewan is approximately 5,600 AEs in our province's hospitals each year.
- ▶ There is a lack of comprehensive, reliable and accurate data about AEs. Only Critical Incidents are reported to the Ministry, and these represent a small subset of the most serious actual or potential harms. The number of critical incidents reported to the Ministry in a fiscal year since the legislation came into force has ranged from 115 (2009-10) to 185 (2013-14 year to date, as of March 26, 2014).
- ▶ In an effort to reduce risk of harm to acute care patients, an initiative called Safety Alert System and Stop the Line process (SAS/STL) was piloted at Saskatoon's St. Paul's Hospital. This allows anyone -- including providers, patients and

families who encounter a situation that is likely to harm a patient -- to make an immediate report and to cease any activities that could cause further harm until the issues have been resolved.

### Workplace Injuries

- ▶ In 2012, the industry with the highest number of reported injuries in Saskatchewan was health care.
- ▶ From 2008 to 2012, health care workers missed over 403,982 days of work due to work-related injuries. This translates to 323 full time equivalents each year.
- ▶ In 2012, Saskatchewan's health care industry had 4,895 reported injuries with claims. From 2008 to 2012, the most common cause of injury in the health care industry was bodily reaction and exertion (46 per cent), followed by contact with objects and equipment (18 per cent), and exposure to harmful substances or environments (12 per cent).
- ▶ The Workers' Compensation Board, Ministry of Labour Relations and Workplace Safety and the Saskatchewan Association for Safe Workplaces in Health have developed a new 2014 health care strategy that focuses on addressing the three specific issues that are driving injuries in the 13 health facilities with the highest volume of injuries. The three key issues are: safety culture; effective safety management systems; and safe patient and object handling.

## Patient First Review Recommendation

### 11. Chronic Disease Management

*That the health system develop and implement a province-wide chronic disease management strategy that ensures patients receive evidence-based, standardized care, wherever they live, and connects patients with multidisciplinary healthcare teams.*

### Key Accomplishments

- ▶ Care for patients living with chronic conditions is being enhanced through increased patient access to team-based care, better co-ordination and continuity of care through case management and provider adoption of best practices consistent with evidence-based clinical practice guidelines.
- ▶ The Ministry of Health, in partnership with eHealth Saskatchewan and the Saskatchewan Medical Association, launched the Chronic Disease Management - Quality Improvement Program to improve the continuity and quality of

care for people living with chronic conditions. It will leverage Saskatchewan's health information system (e.g. EMRs and eHR Viewer) to better meet the needs of patients. As of October 2014, 560 family physicians have enrolled in the CDM-QIP.

- ▶ “LiveWell™ with Chronic Conditions” is a patient education program that teaches patients with chronic conditions how to take an active role in managing their own chronic conditions. It has been successfully implemented across Saskatchewan since March 2006. Patients are being offered a six-week workshop held in community settings, such as senior centers, churches, libraries, and hospitals.
- ▶ In Saskatchewan, the number of residents treated for diabetes increased by about 63 per cent between 2000-01 and 2010-11. This number has increased because of population growth and because diabetes is a long-lasting chronic disease where each year more new cases are identified than existing cases are lost to death or follow-up. We are currently addressing diabetes through a coordinated approach of prevention, care, and management of the disease and its complications and through surveillance of the incidence, prevalence, complications, and health service use of diabetes utilizing the infrastructure of the Canadian Chronic Disease Surveillance System. Under the Provincial Diabetes Plan developed in February 2004, health regions provide various activities, including primary prevention workshops, optimum care projects, education resources for residents and health care providers, and monitoring of the incidence and prevalence of diabetes in partnership with the Canadian Chronic Disease Surveillance System.

## Assessment

Addressing chronic disease is important because in Saskatchewan, 6.8 per cent of the population – more than 75,000 people – live with diabetes (2010-11 estimates) and most of those people also have hypertension. The prevalence of other chronic diseases are higher: hypertension 26.2 per cent; asthma 10.3 per cent; and chronic obstructive pulmonary disease (COPD) 9.4 per cent (with significant numbers of patients with two or more conditions).

- ▶ The Canadian Diabetes Association predicts that by 2020, the prevalence of diabetes in Saskatchewan will increase to 9.9 per cent (an estimated growth of 36,000 people), and that one in four Saskatchewan residents will suffer from diabetes or pre-diabetes.

- ▶ Clinical practice guidelines were established in 2013-14 for diabetes, coronary artery disease, chronic obstructive pulmonary disease (COPD) and congestive heart failure. Tracking providers' use of the guidelines for diabetes and coronary artery disease has been built into electronic medical records and paper flow sheets, and released for clinical use. Tracking will be in place for chronic obstructive pulmonary disease and congestive heart failure by the fall of 2015.
- ▶ The Primary Health Care initiative, including Collaborative Emergency Centres, focuses on improving access to care and better management of chronic diseases.
- ▶ Continued spread of the successes and innovations achieved through various chronic disease management programs and tools will help to reduce the prevalence of chronic conditions in Saskatchewan.

## Patient First Review Recommendation

### 12. Development a Culturally Safe and Competent Health System

*That the health system, in collaboration with First Nations and Métis Elders, and patient and family advisors, work to develop a culturally safe and competent health system that better serves First Nation and Métis citizens.*

## Key Accomplishments

- ▶ With the support of the Ministry of Health, the Federation of Saskatchewan Indian Nations (FSIN) completed a draft First Nations Cultural Responsiveness Framework (CRF) in November 2013. The framework is one of the priority actions listed in the First Nations Health and Wellness Plan and was developed to provide guidance in the delivery of culturally sensitive, competent and safe health care services.

## Assessment

- ▶ The provision of culturally safe and competent health care has been part of several key provincial initiatives including the Patient- and Family-Centred Care Framework, the 10 Year Health Human Resources Plan, the Primary Care Redesign Framework and the pending Mental Health and Addictions Action Plan. The Primary Care Redesign Framework is intended to bring about a better understanding of the subject matter and stimulate further conversation about what “culturally responsive” care means in practical terms for all health stakeholders.

- ▶ Once the First Nations Cultural Responsiveness Framework is finalized, the health system will need to work with FSIN to implement it across the system.

## Patient First Review Recommendation

### 13. Information Technology (IT) Capabilities

*That the Ministry of Health, in consultation with the health regions, the Cancer Agency and clinical leaders, invest in and accelerate development of provincial information technology (IT) capabilities within a provincial framework.*

*This will involve:*

- *Developing an e-health implementation plan by early 2010;*
- *Securing and stabilizing funding for both the provincial electronic health record requirements and health region implementation requirements; and*
- *Determining the preferred service delivery structure for IT at the health region level to ensure the realization of one provincial system.*

### Key Accomplishments

- ▶ Through an Order-in-Council the Saskatchewan Health Information Network (HISC) was renamed eHealth Saskatchewan, and has an expanded Board for broader representation and an updated mandate to lead Saskatchewan Electronic Health Record (eHR) planning and strategy for the Province of Saskatchewan, including procuring, implementing, owning, operating and managing the eHR.
- ▶ The Saskatchewan eHR ensures patient information flows seamlessly across regional and sectoral boundaries. The eHR ensures relevant health information is available wherever and whenever it is required, which supports patient- and family-centred care. A 2013 value-for-money audit on some of the core components of the Saskatchewan eHR found over \$70 million of annualized savings or cost avoidance.
- ▶ The Saskatchewan eHR gives authorized health care providers rapid access to patients' pertinent, up-to-date health information to support clinical decision-making and case management. A shared patient-centric health record provides a longitudinal view of an individual's key health history and care including:
  - prescribed drugs;
  - immunizations;
  - chronic disease management;

- laboratory test results;
- diagnostic reports and images; and
- clinical visits and discharge summaries.
- ▶ Nearly all Saskatchewan health care professionals access some portion of the existing electronic health record:
  - pharmacists using the Pharmaceutical Information Program (PIP);
  - 80 per cent of family physicians checking lab results directly through the Electronic Medical Record (EMR) they use in their daily work; and
  - more than 3,800 authorized health providers who can use the secure, web-based eHR Viewer to access lab results, prescription drug information, immunization histories, chronic disease management tools, clinical encounters and discharge summaries.
- ▶ Telehealth Saskatchewan links patients to health care from a distance. In collaboration with health regions and partners, Telehealth enables secure videoconferencing access to specialized and general health care providers across the province.
- ▶ Examples:
  - Telehealth sites in more than 270 sites in 115 communities.
  - More than 10,200 clinical consults with patients each year.
  - Patients and families save more than three million kilometres of travel each year.
  - Over 1,600 public attendees took part in public education events in 2013-14.

### Assessment

- ▶ The Saskatchewan health system needs an integrated information technology/information management (IT/IM) system to ensure high-quality, timely access to health services. The current IT/IM system is not keeping pace with health system needs.
- ▶ Information systems are required to provide the best care to patients, whether in the ED, operating room, or another care setting.
- ▶ With the addition of diagnostic imaging to the eHR Viewer in 2014-15, eHealth Saskatchewan has completed the core components of the electronic health record as defined by Canada Health Infoway. New elements and features will continually be added in the future. There is a three-year plan to deliver eHR Viewer across Saskatchewan. The implementation started in 2013/14 and will conclude at the end of 2015/16.

- ▶ eHealth Saskatchewan is engaging and working with citizens on the development of a Citizen Health Portal. The team is working directly with patients to understand what they want to see in a health portal. The Patient Portal will be a web-based service for citizens, allowing them to view their electronic health record, monitor their health using self-generated information and interactive tools, and share or receive information from the health system. This combination of information and tools has been identified as a key contributor to achieving lifelong health quality for individuals and their families. eHealth is partnering with Canada Health Infoway, with plans for a pilot group of patients to begin using the portal in 2015, with additional features and services for a wider audience to follow.
- ▶ eHealth and health regions have also been working toward using the same IT vendor within the health system. The Radiology Information System/Picture Archiving Communication System (RIS/PACS) is a single system for the entire province. eHealth, the RHAs and other stakeholders are now evaluating the opportunity to move to one common system for the hospital pharmacy, patient registration and hospital information systems.
- ▶ Panorama, a comprehensive, integrated public health information system, helps public health professionals work together to effectively manage immunizations, family health, vaccine inventories, investigations and outbreaks. The system is now the repository for immunization information within the Electronic Health Record. Immunization information from the Saskatchewan Immunization Management System is currently available in the eHR Viewer.
- ▶ In January 2014, the Ministry of Health procured a single software solution to replace aging database systems for the Public Health Inspection and Personal Care Home Inspection programs. The new system will allow inspectors to perform inspections on electronic handheld devices (i.e. tablets) while providing greatly expanded capabilities in terms of data collection, analysis, reporting, and public disclosure. The system can be integrated with a public website to disclose the results of restaurant and personal care home inspections to the public.

## Improving System Performance and Leadership

### Patient First Review Recommendation

#### 14. Establishment of Shared Services Organization

*That the Ministry of Health achieve greater value for patients' tax dollars by establishing a provincial shared-services organization that would gain buying power and realize significant savings. This organization would initially be responsible for supply chain management, (competitive tendering, procurement, storing, distribution, and payment), with the subsequent addition of responsibility for health regions' transactional business functions.*

#### Key Accomplishments

- ▶ Health Shared Services Saskatchewan (3sHealth) was formally established in 2012 through a partnership between the Saskatchewan health regions and the Saskatchewan Cancer Agency (SCA) to identify and provide services collectively through a shared services agency.
- ▶ When 3sHealth was created, a target was established for the organization to achieve \$100 million in cumulative savings over a five year period. Based on initiatives already implemented, savings exceeded \$109 million by March 31, 2015.
- ▶ 3sHealth has successfully implemented group purchasing contracts to increase the health system's buying power through provincial and national procurement contracts for supplies and services. 3sHealth has increased the proportion of goods procured through group purchasing from a starting point of 20 per cent to what is now more than 60 per cent of all goods procured through 3sHealth. This has resulted in an average 12 per cent savings on procurement initiatives which has contributed to the cumulative savings.
- ▶ 3sHealth has also developed a plan to assume responsibility for health care supply chain management and is expected to implement this plan in the short term. 3sHealth developed a business case that considered multiple options for the replacement of health system linen service plants. It issued a request for strategic partnership to explore third party options and evaluated all options. The result was a contract awarded to K-bro Linen Systems to build and

operate a plant in Regina that will serve all health facilities currently served by regional laundry plants. This plant is expected to open in June, 2015 and will be supported by distribution hubs in Saskatoon and Prince Albert. The new linen service will save \$98 million in operating costs and capital cost avoidance over the next 10 years.

## Assessment

- ▶ 3sHealth, working with its health system partners, has developed a three-year plan to examine other business functions conducive to shared service models. These services include medical imaging, medical lab, transcription, information technology, enterprise risk management, capital project management, facilities, pharmacy, internal audit, food, and business intelligence (including human resources and finance). These services were ranked as having the greatest potential to deliver savings and quality improvements in a shared service model. A strong business case will be required before any of the potential plans is approved to proceed.
- ▶ 3sHealth has obtained the agreement of CUPE, SEIU-West and SGEU to work collaboratively to promote and develop standardized work, identify improvement initiatives, engage in training, and support subsequent activities resulting from the collaborative process. They have already signed a specific plan about environmental services and will proceed accordingly as other business cases develop.

## Patient First Review Recommendation

### 15. Financing Capital Infrastructure Investments

*That the Saskatchewan government explore ways and means to develop a coherent financing plan, including alternate financing partnerships, to address the urgent need for capital infrastructure investment.*

### Key Accomplishments

- ▶ Since November 2007, the Government has invested more than \$1 billion in health care facilities, new capital projects, building maintenance, and life safety infrastructure. Some of these investments include the 13 new long-term care (LTC) facilities announced in 2009.
- ▶ The Ministry of Health has pursued a number of alternative financing projects to procure new health care facilities. For example, Samaritan

Place in Saskatoon is a 100-bed facility that was constructed in 2011 (opened in 2012) by Amicus Inc. The government will repay the construction costs, over a 25-year term. Amicus assumes responsibility for all maintenance costs for the facility and has an agreed upon debt-servicing rate with the Saskatoon health region that includes the mortgage, interest, and operating costs. The project was delivered on time and on-budget and helped to reduce strain on hospital beds and acute care services in Saskatoon.

- ▶ The Swift Current LTC project, coordinated by SaskBuilds, is the first design-build-finance-maintain public-private partnership (P3) for the province. It will replace three aging facilities in Swift Current. The facility design will be feature a more home-like environment for residents. The Saskatchewan Hospital North Battleford-Integrated Correctional Facility is also being procured as a P3 project.
- ▶ Construction is nearly complete on Moose Jaw's new regional hospital, which is using an innovative procurement/project delivery method called Integrated Lean Project Delivery (ILPD). This method requires project owners and consultants to work as a team through design phases to commissioning to increase value, maximize efficiency, and reduce waste. The new hospital will also use a model of care that allows services to be pulled to patients, rather than requiring patients to travel throughout the facility.
- ▶ Other major new capital projects that are underway include the Children's Hospital of Saskatchewan in Saskatoon, the new 225-bed Swift Current LTC facility, the Leader integrated health care facility and the Saskatchewan Hospital North Battleford-Integrated Correctional Facility project.
- ▶ A number of new capital projects have also received funding for planning. These include Victoria Hospital in Prince Albert, the La Ronge LTC facility, and the Regina Qu'Appelle Health Region LTC Strategy.
- ▶ Lean 3P (the production, preparation process) has been applied to the design phase of various capital projects, including Moose Jaw Union Hospital, Children's Hospital of Saskatchewan in Saskatoon, Saskatchewan Hospital North Battleford-Integrated Correctional Facility, Swift Current LTC, Kelvington Integrated Facility, Saskatoon Cancer Centre, Victoria Hospital in Prince Albert and the Leader integrated health care facility. Lean 3P is a project management and design approach that creates more efficient

processes. Patients are important part of the cross-functional team ensuring that the new facilities are designed to provide care that meets the needs of patients and families.

- ▶ The Government has also invested over \$178.4 million since 2007 in life safety and emergency infrastructure funding to address the significant backlog of maintenance and repairs and to improve safety in our health care facilities. Examples of projects include fire alarms systems, fire protection sprinkler systems, nurse call systems, stand-by generators, roof/window replacements and other structural work.

## Assessment

- ▶ Saskatchewan has over 270 health care facilities, which include facilities owned by the Regional Health Authorities (RHAs), affiliate-owned facilities, and some leases where the RHAs are responsible for maintenance. Over two-thirds of these facilities were constructed in the 1960s, 70s, and 80s. The average facility age is 39 years. A significant number of these have not been properly maintained and there is an increasing risk of infrastructure failure, putting the safety of patients, families, and staff at risk.
- ▶ According to facility condition assessments conducted by VFA Canada Corporation in the summer of 2013, the average provincial facility condition score is 33%, which is considered to be fair to poor condition. Furthermore, it was found that nearly \$2.2 billion in infrastructure maintenance would be needed to address all facility deficiencies in the province. Many facilities are also functionally inadequate, causing challenges to continued operation in the facilities.
- ▶ Although the Ministry has made an unprecedented investment of more than \$1 billion in health infrastructure since 2007, the Ministry continues to work towards addressing Saskatchewan's aging infrastructure. The Ministry's capital plan supports overarching health system goals of delivering patient and family-centered care, as well as, providing a safe environment for patients and health care workers. This plan requires ongoing prioritization of capital replacement and maintenance needs according to the available resources.

- ▶ Work is also underway to improve the capital development and planning processes to make way for a more efficient procurement of capital projects. As well, improvements to the life safety and infrastructure funding process are being made to improve how maintenance needs are addressed through the annual budget process. The Ministry of Health will also continue to investigate various financing options to address capital infrastructure needs on a case-by-case basis.

## Patient First Review Recommendation

### 16. Ministry of Health Re-organization

*That the Ministry of Health move forward with organizational changes that will enable it to assume more of a strategist-integrator-steward role for the health system.*

#### Key Accomplishments

- ▶ The Ministry of Health has been improving its organizational structure to better align its work with health system priorities and to effectively lead the transformational changes required for achieving a patient- and family-centred health care system.
- ▶ The Ministry of Health has also introduced a new, innovative approach to strategic planning to create a culture of “thinking and acting as one” within the health system. A Lean-based approach to planning, known as Hoshin Kanri, helps senior leaders focus and align the work of their organizations around a few key goals. Under the traditional approach, the Ministry identifies key priorities and provides funding to health regions and the SCA to deliver the services. Under this new approach, the Ministry of Health works collaboratively with its health system partners, including health regions, Saskatchewan Cancer Agency, Health Quality Council, eHealth Saskatchewan, 3sHealth and other stakeholder organizations. Together, key priorities are identified, outcomes and targets are set, implementation plans to achieve these are developed, and progress is regularly monitored and assessed, with corrective action taken as needed.

## Assessment

- ▶ The strength of the Lean Management System is engaging all levels of the health system, including physicians and other frontline care providers, in determining health system strategic goals and priorities. This helps everyone within the system understand and work toward achieving the same goals. There is a need to strengthen the understanding of performance measurement across the health system. The Health Quality Council has taken a lead role in supporting the system in developing the knowledge and tools needed to develop a strong measurement infrastructure. This work is ongoing.
- ▶ In recent years, the health system has undergone significant changes. In order to improve the health system and provide the best possible patient- and family-centred care for Saskatchewan residents, the health system needs to be focused and strategic in its approach. The Lean Management System helps system leaders stay focused on priorities and work together on joint initiatives.



Thank you to patients, families, health care providers, staff, professional organizations, health system unions and service suppliers for your contributions and commitment to a Patient First health system.