

# *For Patients' Sake*

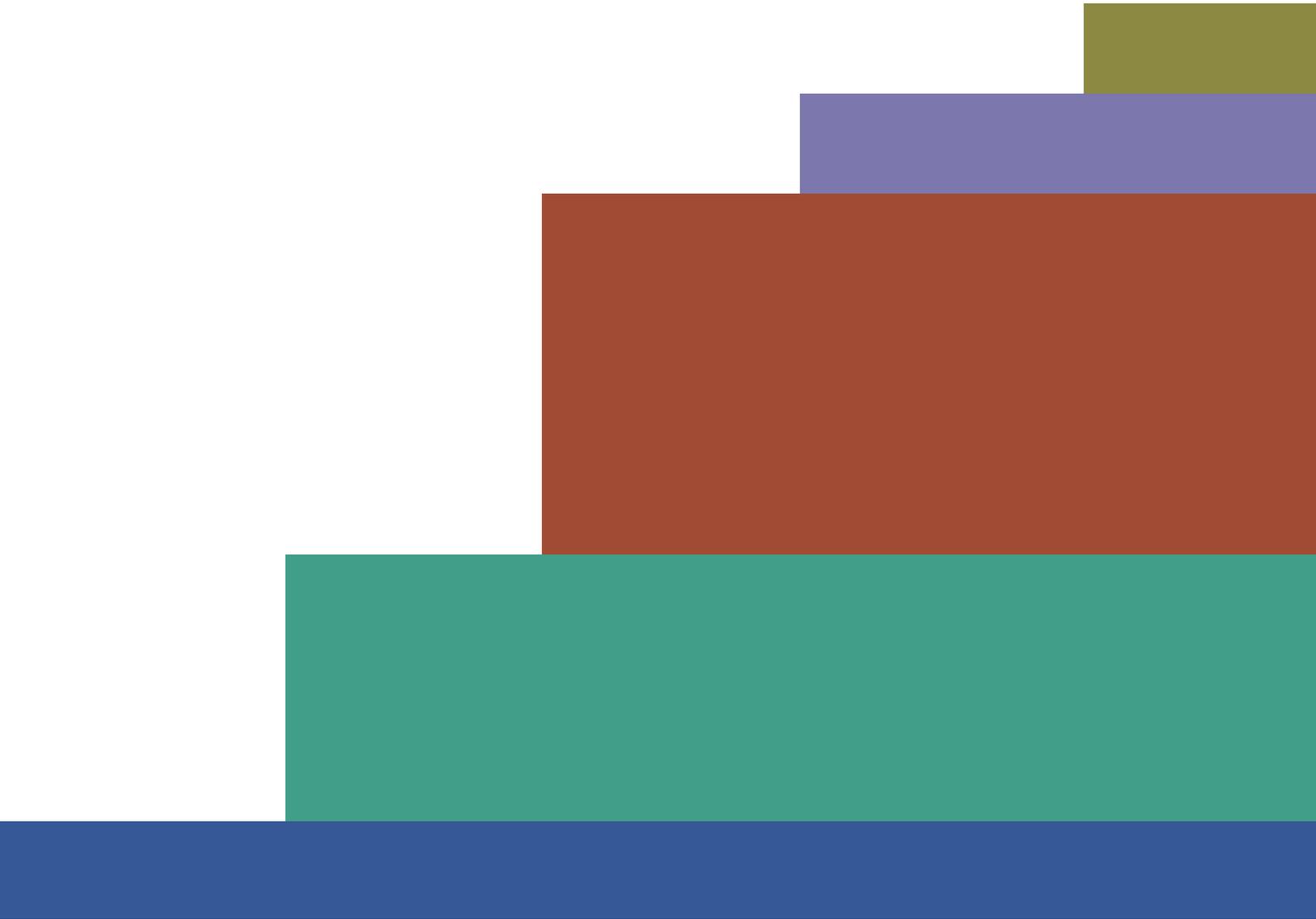
Patient First Review Commissioner's Report  
to the Saskatchewan Minister of Health



Tony Dagnone, CM, FCCHSE  
Commissioner, Patient First Review

October 2009





*Patient First*

Letter of Transmittal	ii
Acknowledgements	iv
Why a Patient First Review?	1
Summary of Findings and Recommendations	6
I. Improving the Patient Experience	11
A Patient- & Family-centred Health System	11
Equitable Care	15
Coordinated Care	22
Convenient, Timely Care	26
Communicative, Informative Care	31
Comprehensive Care	33
Respectful Care	38
Functional e-Health Care	42
II. Improving System Performance and Leadership	45
Effective Governance, High-performing Management	46
Executive Staff/Medical Staff Partnership	50
Catching Up On Capital	50
A Renewed Role for The Ministry of Health	51
Strong Leaders and Accountability to the Public	53
Conclusion	54
Endnotes	56
References	57
Appendices	58

October 2009

**To The Honourable Don McMorris  
Minister of Health**



I am pleased to present the findings and recommendations of the Patient First Review, *For Patients' Sake*. My report is founded on the voices and perspectives of health care patients and their families, providers and system leaders, as detailed and analyzed in reports and recommendations I have received from consulting firms KPMG and Deloitte.

I have been honoured to lead this defining review on behalf of all those who want the health system to care more about them. I continue to have a strong affinity to Saskatchewan, which I was proud to call home for more than 40 years.

As Commissioner of the Patient First Review, I directed two distinct but related inquiries. One focused on the patient experience of care, while the other addressed the management of the health system. The patient experience component challenged me to bring forward recommendations for fostering a culture that would provide timely, quality, safe care to all Saskatchewan residents regardless of their postal code. The challenge embodied in the administrative component of the review was to advance a “new way of doing business” and thereby improve the performance of the health care enterprise.

Unlike previous reviews of the health system, the Patient First Review is unique in its focus on the care and caring experience. The term patient is used broadly in this report and represents patients, clients, and residents who receive a variety of health services that go beyond the treatment of illness or injury. Patients were given the first and last voice in the research, and by the time the public research was completed, approximately 4,000 Saskatchewan residents had shared perspectives, ideas and opinions. What we heard from them became the foundation for consultations with health care providers and health system leaders. Our approach embodied a candid, unabashed dialogue with those who seek to improve the delivery of patient care in the province, followed by the development of recommendations for high-impact change based on the advice received. Patients, health care providers, and health system leaders participated with honesty and openness to meaningful change.

Using a combination of focus groups, personal and telephone interviews, online submissions, a weblog, and a telephone survey, Patient First researchers gathered significant qualitative and quantitative data from patients and their families, health care professionals and workers, managers and system leaders. This data is reflected in a summary report prepared by KPMG and its research partner, available at [www.health.gov.sk.ca/patient-first-review](http://www.health.gov.sk.ca/patient-first-review). Additionally, the conclusions of the administrative review directed by Deloitte offer avenues for transformational change and improved system performance in concert with and beyond the recommendations contained in my report.

The Patient First Review has examined the patient experience and the administration of the health system with attention to both strengths and concerns. There are many positives to build upon; however, in order to achieve the vision of a patient- and family-centred health system, policy makers, health system leaders and health care providers will need to address the concerns identified in this report.

*Patients were given the first and last voice in the research, and by the time the public research was completed, approximately 4,000 Saskatchewan residents had shared perspectives, ideas and opinions.*

The research findings make clear that those associated with health care must renew their commitment to putting the patient first. Patients ask that health care workers and their respective leadership see beyond their declared interests so that the interest of patients takes precedence at every care interaction, every future contract negotiation and every policy debate. Only in this way will we achieve a patient- and family-centred health system for Saskatchewan citizens. Similarly, government leaders and policy makers must keep the patient front and centre when policies, programs, and new models of care are designed and implemented.

Patients spoke volumes on their desire to receive timely access to quality care from the most appropriate programs, delivered by the most appropriate professionals and skilled workers. Their collective message to me was, "Action, not more words." I share this bias for timely action. While patients accept that change can be difficult, this report provides evidence of the need for significant change to the health system's culture and some of its modes of service delivery.

One of the most striking features of our consultations was the level of agreement we encountered between patients and providers concerning the areas of Saskatchewan health care that need to be strengthened. After hearing the themes and stories shared by patients, the providers we met with consistently affirmed their views and perspectives. There is great potential in this province for an alignment of patient-provider interests that could have a profound impact on how health care is modeled and delivered.

Any prescription for bold change will be met by resistance from some interested parties. As you and your colleagues and advisors review and consider the following findings and recommendations, it is my hope that the overriding consideration will always be the interests of the patient.

Change is a constant phenomenon to which the health system is not immune. You initiated this unique review in order to improve both the patient experience and the efficiency and effectiveness of the health system. This report and its recommendations represent the start of a change journey. What is required now is resolve, leadership, commitment, and courage on the part of all.

For the sake of patients, I call upon the Government of Saskatchewan to implement the recommendations that follow to ensure that no patient is excluded when it comes to living up to the core promises of Medicare. And I call upon health system leaders and health care providers to adopt and practice the values that support a truly patient- and family-centred health system.

Saskatchewan, the birthplace of Medicare, can now seize the opportunity to reframe, rejuvenate, and ingrain a caring attitude and culture that offers dignity and compassionate care to all patients. I am confident that the people of this proud province can respond to the challenges before them.



**Tony Dagnone, CM, FCCHSE**  
Commissioner, Patient First Review

cc: Dan Florizone, Deputy Minister of Health

*Patients ask that health care workers and their respective leadership see beyond their declared interests so that the interest of patients takes precedence at every care interaction, every future contract negotiation and every policy debate.*

*I call upon health system leaders and health care providers to adopt and practice the values that support a truly patient- and family-centred health system.*

# Acknowledgements

*My report is dedicated to those patients who believe in Medicare but want a health system in Saskatchewan that cares more about them.*

While I remain responsible for the contents and conclusions of this report, many individuals played significant roles in bringing this project to fruition. I would like to acknowledge:

The Honourable Don McMorris, Minister of Health, for boldly initiating the Patient First Review and affording me the opportunity to serve as its independent Commissioner;

The dedicated health care providers and health system leaders who gave of their valuable time to offer their perspectives and expertise in the interest of improving health care delivery for their fellow citizens;

The researchers and consultants with KPMG, Innovative Research Group, and Deloitte, for their valuable expertise and our spirited dialogues throughout this review;

Dan Florizone, the Deputy Minister of Health, and his leadership team, for making this review their collective priority;

Staff at the Ministry of Health, for their outstanding cooperation and assistance throughout the entire review process; and

Finally, and most importantly, all those patients and family members who came forward to share their stories, through focus groups, individual interviews, and online submissions. It is not an easy task to recount personal, difficult, and painful experiences. Their courage and honesty will help pave the way for profound and lasting change. Thank you also to the individuals who agreed to have their photographs included in this report.

Saskatchewan people responded to the Patient First Review with great interest and high hopes for positive change. I was overwhelmed at times with requests from individuals and organizations who wished to share their perspectives with me. I extend my regrets to those with whom I was unable to consult due to time or logistical limitations.

While this report will not serve to 'fix' every problem identified by every patient, its conclusions have been tempered and sharpened by the voices of these individuals.

*My report is dedicated to those patients who believe in Medicare but want a health system in Saskatchewan that cares more about them.*



# Why a Patient First Review?

1

## Must changes be made to Saskatchewan's health system? Absolutely.

On the surface, the system seems to be performing relatively well. Most people who interact with the health system indicate a measure of satisfaction with their experience.

'Good' however, does not necessarily mean 'good enough'. Saskatchewan residents continue to pay high costs for health care services that do not appear to offer high value. Rather, the system struggles to meet demand and maintain basic safety and accessibility standards while often failing to adopt practices that ensure high quality. And for those whose experiences in the system are not positive, the consequences can be profoundly upsetting – even dire. With health and lives at stake, nothing less than excellence should be expected of a system in which all Saskatchewan citizens have a share.

### Growing pressures

Saskatchewan's health system faces many of the challenges experienced by jurisdictions around the world: an aging population, increased chronic disease, unrelenting competition for health care workers, inadequate access, inconsistent quality, rising costs, and new, expensive technologies and treatments. The impact of these challenges is even greater when considered in the context of Saskatchewan's geography, with a population of just over one million people, widely dispersed communities, climate extremes, and significant health disparities between Aboriginal and non-Aboriginal citizens.

*Nothing less than excellence should be expected.*

*[Saskatchewan residents] clearly want value for this investment and assurance that their tax dollar is put to best use. The Patient First Review found room for improvement in this regard.*

2

Saskatchewan has one of the oldest and, paradoxically, one of the youngest, populations in Canada. Baby boomers, who typically have high expectations of all service industries (and particularly the health system), are likely to be healthier in old age than past generations. Still, their numbers alone will create pressures on the system. From 2001 to 2008, about 14.5 per cent of the Saskatchewan population was over the age of 65 years. Statistics Canada estimates that nearly 25 per cent of Saskatchewan's population will be over the age of 65 by 2031. Government and health care leaders must look to the future and plan accordingly. For example, the system must prepare to respond to an increased need for joint replacements, home care and supports for self-managed care, and long-term care. The glaring disparity between the health of Aboriginal and non-Aboriginal citizens must also be addressed with urgency.

### Escalating costs

The people of Saskatchewan continue to make significant investments in health care – \$4 billion in 2009-10. Average per capita spending in Saskatchewan was \$5,393 in 2008 and is above the national average of \$5,170<sup>1</sup>. Since 1996, health care expenditures have grown an average seven per cent each year, which have consumed over 40 per cent of overall government program spending in Saskatchewan. Despite this increasing investment, unacceptable gaps in the quality and safety of health care persist.

While Saskatchewan residents who participated in the Patient First Review did not criticize increased spending on health care, they clearly want value for this investment and assurance that their tax dollar is put to best use. The Patient First Review found room for improvement in this regard.

### Quality and efficiency issues

Saskatchewan patients deserve health care characterized by quality standards and leading clinical practices. Quality in health care is also seen in the training, knowledge, skills, attitudes and behaviours that care providers bring to their relationship with patients and colleagues. Continuous improvement in quality and safety is integral to a progressive workplace culture and is what patients expect from those who deliver health care.

Inadequate health care results in increased disease, illness and mortality. When the health care system fails to alleviate conditions that cause pain and disability, the results include a lower quality of life for individuals, a less productive workforce and unnecessary costs.

Many of the quality concerns expressed in our consultations with patients and providers are echoed by leading voices for quality health care in North America. For example:

*Variation in services.* Despite well-documented leading practices and well-established guidelines for many types of care, patients with the same health issues will often receive very different care, depending on where they live<sup>2</sup>.

*Underuse of services.* Too many patients do not receive necessary care and, as a result, suffer needless complications that add to costs<sup>3</sup>.

*Overuse of services.* Too many patients receive services that are unnecessary, increase costs, and may even endanger their health<sup>4</sup>.

*Misuse of services.* Too many patients are injured during the course of their treatment, and some die prematurely as a result. Approximately 16,000 people hospitalized in Canada in 2000 died from an adverse event<sup>5</sup>. In Saskatchewan, this translates to 300-600 avoidable deaths per year or at least one avoidable death each day.

### High quality does not necessarily mean high cost

It is possible to improve the quality of health care in Saskatchewan AND control health care's spiralling costs. In fact, best quality practice can, in many cases, result in savings to the system.

Other industries have long understood the costs of poor quality; when something isn't done right the first time, there are inevitable costs associated with repairing the damage that is done. In health care, this waste, redundancy, and ineffectiveness means increased cost to the patient (and to society), not to mention increased risk of harm from multiple unnecessary procedures, adverse effects of medication changes, infections from longer hospital stays, and progression of disease caused by delay in receiving the right care.

In a recent Commonwealth Fund report<sup>6</sup>, Canada had the second-highest rate of health care spending among six countries – and yet ranked fifth in health care quality. The United States had the highest rate of health care spending and had the worst health outcomes of the six countries.

Spending and quality are not necessarily linked, which means that simply spending more is not the solution. The solutions are to be found in a better integrated network of services, populated by providers who are enabled to use all of their skills and training, who provide care in accordance with evidence-informed best practices, and who interact effectively with the patient and with each other.

### Health care provider-oriented culture

Our current health care system has been designed around the people who deliver the care. It is time to realign the values of Saskatchewan's health system so that the patient is again made the centre of attention.

This does not necessarily imply a realigning or wholesale restructuring of the services themselves. In fact, the perpetual change agenda in health care, with its continuous restructuring and disruption, has eroded organizational loyalty and distracted individual care providers from a focus on the patient's interests.

Changes to the health system must serve to meet patients' needs, and a publicly designed health system must reflect the values of the patients and citizenry, while enabling providers to do their work in a stable, safe, supportive, and collaborative environment.

As my researchers and I listened to patients, families, providers, and health-system leaders, we heard them describe significant inconsistencies in accessibility, quality, and patient focus within Saskatchewan's health system. Add to these concerns the issues of questionable value-for-money in some spending areas and ongoing financial sustainability challenges, and we heard a compelling case for change.

*Waste, redundancy, and ineffectiveness means increased cost to the patient ... and increased risk of harm.*

*It is time to realign the values of Saskatchewan's health system so that the patient is again made the centre of attention.*

*The term patient is used broadly and represents patients, clients, and residents who receive a variety of health services.*

4

*Profound structural change to the health system at this time would only serve to distract from what needs to be the immediate and first priority – restoring the patient to the centre of the system.*

Health care leaders, including Ministry of Health officials, must reject the notion that the Saskatchewan health sector is too unique or constrained to adopt innovative and creative solutions seen in the broader public sector, other health jurisdictions and the corporate sector. Saskatchewan's demographics and geography have always made partnership and cooperation necessary to achieve meaningful and lasting improvement.

### The Patient First Review

As demonstrated by the issues described above, Saskatchewan's health system is in need of change. Its current culture and structure do not equip it well for its current challenges, let alone the challenges that will arise and intensify in coming years.

In November 2008, the Minister of Health launched the independent Patient First Review of the Saskatchewan health system<sup>7</sup>. Within the parameters of this review, the term patient is used broadly and represents patients, clients, and residents who receive a variety of health services.

The review comprised two distinct streams of research: an examination of the patient experience across the full continuum of health care services; and the administration of health care in regional health authorities (health regions), the Saskatchewan Cancer Agency and the Saskatchewan Association of Health Organizations (SAHO). Focus groups were held with randomly selected patients and frontline health care providers, and consultations were held with selected health professionals and health care leaders throughout the province. This dialogue was supplemented with written and online submissions, a Commissioner's weblog, analysis of financial and statistical data, and consideration of leading practices and policy innovations in other jurisdictions.

While the methodology used for each research stream differed substantially, the findings and recommendations are integrally connected in this report. The administration of health care has a profound effect on the efficiency of service delivery and the quality of care that patients experience.

The diversity of Saskatchewan's population was reflected in the patient consultations, which included seniors and young people, and rural, northern, urban, First Nations, and Métis people, the prosperous and the disenfranchised. More details concerning the Patient First Review's methodology can be found in the research reports released with this report (see [www.health.gov.sk.ca/patient-first-review](http://www.health.gov.sk.ca/patient-first-review)).

The review process itself embodied a spirit of openness and transparency that should characterize how health care services are designed and delivered in the future. As the review proceeded, I have shared information with health care leaders, providers, stakeholders, and the public and have been encouraged by the response. Action is already underway to address some identified issues.

Given the mandate for this review, I have not examined or made any recommendations respecting changes to the existing regionalized model of governance. Profound structural change to the health system at this time would only serve to distract from what needs to be the immediate and first priority – restoring the patient to the centre of the system. This should not, however, deter the government from considering such changes in the future, and this report will include some ideas on how to streamline the integration and effectiveness of services for the benefit of patients and taxpayers alike.

Patients clearly value health care. They recounted positive experiences with the health system, and believe we should build on the system's strengths. They also expressed urgency about fixing longstanding issues of concern in the system. Frontline providers and system leaders affirmed what I heard from patients, and shared their own ideas for positive change.

While I have attempted in this report to reflect all of the significant themes that were encountered during the review's research, I do not pretend to have provided a "fix" for every concern that was expressed. Some of the health system's struggles are due to factors largely beyond Saskatchewan's control, such as a global shortage of certain categories of health care professionals, cost escalations, and growing demand for progressive health care.

*I do not pretend to have provided a "fix" for every concern that was expressed.*





## Summary of Findings and Recommendations

### Guiding principles:

- ▶ Patient First as a core value;
- ▶ Cohesive health care system; and
- ▶ Empower frontline providers.

After hearing from more than 4,000 Saskatchewan citizens and hundreds of health care providers and system leaders, the Patient First Review team received the clear message that Saskatchewan's health system is a good basic system, but needs serious and immediate remedy and rejuvenation in a number of areas. "Keep the best and fix the rest" could be the summary message. Following are three themes that emerged as guiding principles in my report's roadmap for change:

1. **"Patient First" must be embedded as a core value in health care** and ingrained in the "DNA" of all health care organizations. The health system has lost its focus on the patient and lost sight of the fact that health care is a service industry. The best interests of patients and families must be the primary driver of policy decisions, collective agreements, priority setting and resource allocation decisions, and the operation of workplaces. Keeping the patient voice alive after this review has been concluded will assist in maintaining focus and ensuring that other factors do not override patient and family needs.
2. **Health care in Saskatchewan needs to function as a cohesive system.** Only a well-integrated system can respond to patients as whole people rather than parts that need fixing. Health care has been

compromised by a piecemeal approach that has failed to recognize the interconnectedness between one part of health care and others. This fractured mode of operation manifests itself at the care-giving level, where team-based, interdisciplinary care remains the exception rather than the rule. Care is delivered in silos, and new care models are resisted by providers guarding their own interests – to the detriment of patients. There is also a lack of coordination and standardization within the health system’s administrative and leadership structures. The health system needs to operate as one virtual entity with consistent policies that have one primary objective: to put the patient first.

- 3. Frontline providers must be empowered to deliver patient- and family-centred care.** Health care providers consulted during the course of this review consistently affirmed and echoed patients’ pleas for a more patient- and family-centred system. Unfortunately, poor communication and ineffective relations between providers and health system management have often prevented both parties from instituting positive change. Effective leadership and improved system performance are critical to supporting that care model.

My report is divided into two sections, in keeping with the two research streams that comprised the Patient First Review. The first group of recommendations concerns the experiences of patients and families and is based upon specific elements of patient- and family-centred health care. The second section builds on the findings of the health care administration review and contains recommendations for administrative and leadership structures that will support Patient First as the driving philosophy in Saskatchewan health care. Supporting facts and details for each recommendation, along with additional observations and ‘possible pathways’ to implementing more patient- and family-centred care, are included in the main body of my report.

It is important to note that the order in which these findings and recommendations are presented does not imply any particular order of importance or priority. If Saskatchewan’s health care system is to become truly patient- and family-centred, progress must be made on all aspects of care planning and delivery. Progress in one area will have a natural impact on others.

Some of my recommendations are addressed to specific groups or organizations – the Ministry of Health or health regions, for example. Many, however, are a call to action for the health system as a whole, which would encompass the above organizations as well as affiliates and health care organizations, and other health care provider agencies.

This report’s findings are addressed to all of the health system’s leaders — clinical and non-clinical, political and professional, patient advocacy groups, labour organizations — all those individuals who, by virtue of their roles within the system, can contribute to developing more patient- and family-centred health programs and services. In fact, I believe every single care provider and manager, every policy-maker and leader, no matter what their formal title or job description, has an opportunity to respond in some way to Saskatchewan patients’ voices as expressed through my report. Strong, focused leadership will be essential in translating those voices into lasting change. Equally critical, however, will be those changes introduced at the service level by proactive care providers who are passionate about patient- and family-centred care.

*If Saskatchewan’s health system is to become truly patient- and family-centred, progress must be made on all aspects of care planning and delivery.*

*Many [of my recommendations] are a call to action for the health system as a whole ... Every single care provider and manager, every policy-maker and leader, no matter what their formal title or job description, has an opportunity to respond in some way to Saskatchewan patients’ voices ...*

Finally, the work of the Patient First Review has produced more recommendations and possibilities for positive change than are found in my report alone. Researchers and analysts with KPMG and Deloitte have produced reports of their own containing numerous recommendations based on discussion with patients, families, care providers and system leaders. Many of these recommendations are incremental and/or operational in nature, as they should be. The recommendations contained here in my report are, I believe, most fundamental to achieving a truly patient- and family-centred health system.

*These are the transformative changes that make other changes possible and which will bring about progressive change.*

## Commissioner's Recommendations

### I. Improving the Patient Experience

#### For a patient- and family-centred health system:

1. That the health system make patient- and family-centred care the foundation and principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system wide. Developed in collaboration with patients, families, providers and health system leaders, this policy framework should serve as an overarching guide for health care organizations, professional groups and others to make the Patient First philosophy a reality in all workplaces.

#### For equitable care:

2. That the health system develop a comprehensive and innovative strategy for rural and remote service delivery that:
  - a) Improves access to primary health, diagnostic and specialist services for rural and remote residents;
  - b) Examines the cost burden of emergency transportation, including interfacility transfers; and
  - c) Includes a range of supports for people who must obtain health services away from their home communities.
3. That the Ministry of Health's Seniors' Strategy under development focuses on strengthening:
  - a) System capacity to support independent living;
  - b) Accessibility to personal care homes by addressing the current financial barriers for low-income seniors;
  - c) Accessibility and quality of assisted living and long-term care;
  - d) 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
  - e) Capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day programs, and a specialized outpatient clinic.



4. 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:
  - a) Assisting First Nations and Métis patients to navigate the health system and advocating for better care;
  - b) Developing linkages with First Nations- and Métis-run health programs and services to better integrate care;
  - c) Working with the provincial and federal governments to develop new information sources to help First Nations and Métis people understand government programs and services;
  - d) Adapting health services to better meet the needs of First Nations and Métis patients, including accommodation and transportation needs, and cultural supports and services;
  - e) 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 - Saskatchewan; and
  - f) Encouraging First Nations and Métis organizations to partner in the provision of health care services that will directly benefit their communities.

### **For coordinated care:**

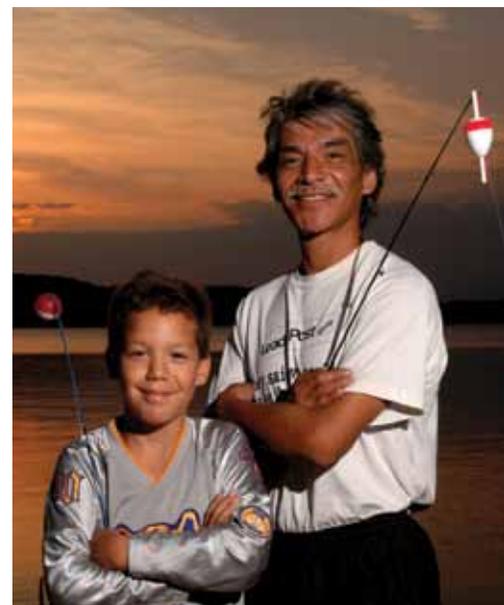
5. That the health system develop a more integrated and inter-sectoral approach to services for children and youth.
6. That the Cancer Agency and health regions improve the coordination and integration of cancer care services across the continuum of cancer care.

### **For convenient, timely care:**

7. 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. 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.

### **For communicative, informative care:**

9. 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.



**For comprehensive care:**

10. 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. 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 health care teams.

**For respectful care:**

12. 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.

**For functional e-health care:**

13. 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:
  - a) Developing an eHealth implementation plan by early 2010;
  - b) Securing and stabilizing funding for both the provincial electronic health record requirements and health region implementation requirements; and
  - c) Determining the preferred service delivery structure for IT at the health region level to ensure the realization of one provincial system.

**II. Improving System Performance and Leadership**

14. 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.
15. 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. 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.





# I. Improving the Patient Experience

11

## 1. A Patient- and Family-centred Health System

*"It's easier to go home and risk losing your leg or your foot than be hassled at the very place that is supposed to help you."  
(Patient)*

*"...we have built a system around clinicians that makes it impossible to customize care the way it needs to be. We don't have a standard of services or processes that are comfortable for patients. We have built a technocratic castle, and when people come into it, they are intimidated."  
(Donald Berwick, President/CEO, Institute for Healthcare Improvement)*

Patient- and family-centred health care considers the patient's needs and interests first and foremost. Patients who shared their stories and perspectives want their needs, values, culture and spirituality respected. They want support during times of illness and trauma, and effective, compassionate communication that can help to relieve fear and anxiety. They want complete information about care and treatment options.

Saskatchewan people want their health care to be of high quality, safe, readily accessible and timely, with well-coordinated, seamless and reliable transitions between health care sectors and regions. Patients want support to navigate the system and responsive avenues for recourse when treatment concerns arise.

*Saskatchewan people want their health care to be of high quality, safe, readily accessible and timely, with well-coordinated, seamless and reliable transitions between health care sectors and regions.*

*We know that 'Patient First' will be a reality in Saskatchewan when a patient, hurriedly preparing to leave his family doctor's treatment room, hears the physician say, "We still have some time. Is there anything else you'd like to talk about?"*

12

This will require a new culture within the health system: a culture of listening to patients, sharing decisions at an individual care and policy level, and evaluating those decisions based on how they affect the patient.

Patient- and family-centered care is grounded in mutually beneficial partnerships among health care patients, families, and providers. Patient- and family-centered care applies to patients of all ages, cultures and socioeconomic backgrounds and recognizes their unique social, emotional, spiritual and cultural needs. This becomes particularly important for First Nations and Métis people and for new Canadians requiring health care services.

Fundamental to achieving patient- and family-centred care is patient-centred governance and policy-setting, beginning with the Ministry of Health and supported by unified, prudently managed, high-performing health care administration that enables, empowers and expects everyone to put the patient first.

As health care systems around the world wrestle with the concept of "patient- and family-centred care", there have been numerous attempts to define the term. After all, most health care systems comprise hundreds or thousands of care providers serving thousands or hundreds of thousands of people, and it becomes important in an enterprise of such magnitude to have a clear picture of the organization's goals.

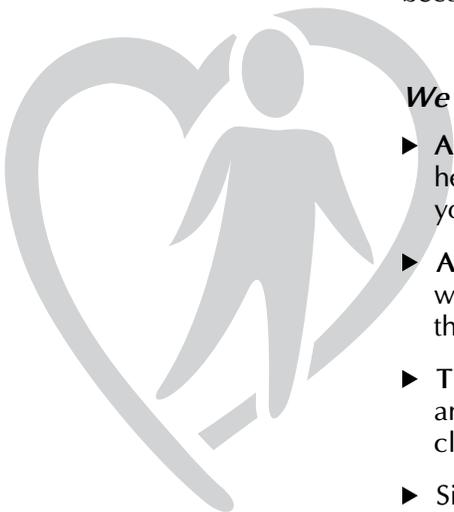
How do we know when we've achieved patient- and family-centred care? How do we know when 'Patient First' has become the way of doing business in Saskatchewan's health system? What does it look like?

Based on the thousands of interactions my researchers and I had with Saskatchewan people, it is possible to provide a number of brief sketches or snapshots of what Patient First can look like in the province that gave our nation Medicare.

Taken together, I believe these brief portraits comprise a compelling vision of excellence – of a health system that puts its patients first, and in doing so, also becomes an endlessly rewarding career base for thousands of care providers.

***We know that 'Patient First' will be a reality in Saskatchewan when:***

- ▶ **A patient**, hurriedly preparing to leave his family doctor's treatment room, hears the physician say, "We still have some time. Is there anything else you'd like to talk about?"
- ▶ **A patient needing a hip replacement** is referred to a group of surgeons who work as partners; while this means a shorter wait for the procedure, the patient still has the option of choosing a surgeon.
- ▶ **The farmer needing to travel** to Regina to see a specialist, physiotherapist and orthotist is able to see them all on the same day – or even in the same clinic room;
- ▶ **Signs in workplaces** that say "ABUSE WILL NOT BE TOLERATED" are replaced by signs saying, "We promise to treat you with compassion and respect. We ask that you do the same."



- ▶ **A senior with complex health issues**, who spends much of his day surrounded by care providers, can know their first names by reading them on their name-tags. The providers, meanwhile, also know their patient's name and work as a team to meet his needs.
- ▶ **An elderly Dene man** in a northern community, about to be placed on an ambulance for medical transport to Saskatoon, is encouraged to bring his English-speaking daughter with him.
- ▶ **A 40-year-old woman** recently diagnosed with Type II diabetes gets a surprise call from her dietitian, who asks, "How are you doing with your new meal plan? Are you finding it difficult? Any questions?"
- ▶ **A single mother** whose youngest son requires regular blood testing receives an email notification that he is due for his next test. When she appears at the lab, the test is completed promptly. Three days later, she is able to access the result on a confidential website and compare it to previous results.
- ▶ **Every one of the patients** in the emergency room on a busy Saturday night knows roughly how long they will need to wait, and why.

These are only a few examples of what can happen in a health system when the system serves the patient, rather than the other way around. Imagine this kind of patient- and family-centred care as the norm in Saskatchewan. Imagine the satisfaction and pride that would follow among patients and their families, and also among Saskatchewan's valued health care workers.

These scenarios help to illustrate a number of the elements of patient- and family-centred care that I wish to emphasize in my report and recommendations. A health system that is characterized by the following qualities is one that would be the pride of its citizens and serve as a model for other jurisdictions around the world.

Without making any claims to a comprehensive or exhaustive definition of patient- and family-centred care, we can say that it is characterized by:

- ▶ **Equitable care.** Patients receive the amount of care they need when they need it, regardless of where they live, their age or ethnicity, or other factors.
- ▶ **Coordinated care.** Whether working in the same unit or across multiple programs, disciplines and sites, providers are working together to meet the patient's evolving health care needs and help the patient and their family to navigate the system. Effective care coordination can also improve continuity and stability by reducing the number of providers a patient must interact with on his or her care journey.
- ▶ **Timely and convenient care.** Patients can access the care they need without waits that prolong pain or debilitation, or barriers that introduce prohibitive expense or difficulty. Intervals between needed services are short, and the need to travel to different locations is minimized.
- ▶ **Informative care.** Patients are always well informed about their health and the factors affecting it, treatment options, and the "5 W's" of their next care steps (Who? What? When? Where? Why?). Providers take the time to explain, to clarify, and perhaps most importantly, to listen to patients and their families.

*The entire health system must share a common patient- and family-centred vision and direction and systematically implement actions to achieve this vision.*

- ▶ **Comprehensive care.** Health care providers are attuned to all, not just some, of a patient's needs, and are equipped and empowered to deliver holistic care that respects the complexity and interrelation of physical, psychological, spiritual, and socioeconomic factors. Patients and families are given the time to express their needs.
- ▶ **Respectful care.** Patients are treated with empathy and understanding for their fears and hopes. The relationship between patient, family and provider is a balanced, mutually respectful partnership, not an imbalanced power dynamic that favours the provider.
- ▶ **Functional e-health care.** Patients only need to provide information once, after which it becomes accessible to those who need it to deliver care. Patients have ease of access to their health records and the opportunity to add relevant information.

This is the kind of health system that Saskatchewan patients have told me they want to see. Wherever their experiences with the system have failed to meet their expectations, it was due to inconsistency or outright failure in at least one of these elements of patient- and family-centred care.

Taken as a whole, these elements comprise nothing less than a significant shift in Saskatchewan's health care culture. While the vast majority of health care providers want to deliver patient- and family-centred care, they are too often constrained, discouraged or disabled by a system that encourages them, implicitly and explicitly, to put other interests ahead of patient interests.

The entire health system must share a common patient- and family-centred vision and direction and systematically implement actions to achieve this vision. "Patient First" cannot be a mere lapel pin, button, or logo; it must be a way of doing business for all those associated with health care, regardless of their role, title, or tenure.

**This leads to my first recommendation, which forms the foundation for all of the recommendations that follow:**

### Commissioner's Recommendation:

1. **That the health system make patient- and family-centred care the foundation and principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system-wide. Developed with patients, families, providers and health-system leaders, this policy framework should serve as an overarching guide for health care organizations, professional groups and others to make the Patient First philosophy a reality in all work places.**



Throughout the report, I have included "possible pathways" for consideration as a mechanism to help achieve the recommendations.

*Patient First possible pathway:* The Patient First philosophy could also be applied to Saskatchewan's health care labour relations model, an obsolete, adversarial, industrial relations approach that currently exiles patients from the process as employers and employees bargain from positions of strict self-interest. A new, collaborative approach could restore patient interests to the process.

### Customer-owners

A patient's relationship with the health system is more complex and profound in its impact than a typical "customer" relationship. In the absence of any "competition" to publicly funded and administered health care, the system's leaders and providers may be less aggressive in pursuing excellence in the face of numerous pressures. Nonetheless, Saskatchewan citizens do fund their health system, and the concept of good customer service is therefore applicable.

Current funding models serve as a barrier to those providers who are keenly interested in providing patient- and family-centred care.

The Southcentral Foundation (SCF), a non-profit health system serving approximately 50,000 Native and American Indian people in Alaska, acknowledges that patients in the system are not only "customers," but "owners" as well. SCF refers to its patients as "customer-owners" and uses multiple methods for hearing the customer-owner's voice, including personal interaction with staff, satisfaction surveys, an annual "Listening Conference" and a formal complaint process.

While physicians and clinical teams provide expertise, keep track of preventive matters, explain options and make recommendations, the customer-owner is in control and ultimately makes the decisions<sup>8</sup>.

*Patient First possible pathway:* Patient- and family-centred care utilizes patient and family advisors to bring about positive change in hospital units, in developing and revising health programs and services, in strategic planning and in evaluation of all of these activities. Advisors may be identified when they express an interest in serving in this way or through recommendations from health care providers and administrators. These advisors, who would undergo a selection screening process, typically have had recent interaction with a particular service or program and genuinely want to work with staff and providers to improve the system.

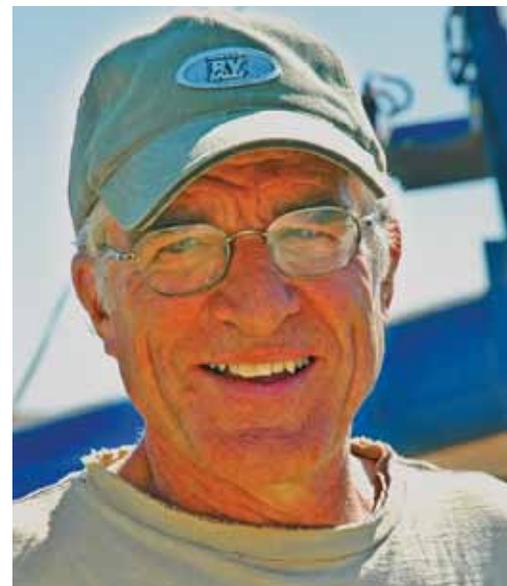
## 2. Equitable Care

*What it looks like:* Patients receive the amount of care they need when they need it, regardless of where they live, their age or ethnicity, or other factors.

### A strategy for rural and remote communities

Concerns about inequities between urban and rural or remote communities were continuously voiced. Generally, people expect to travel to larger centres to see specialists or to have complex surgeries. Stories were told of patients travelling three to four hours by bus or medical taxi and returning home the same day, of children who go without occupational therapy because their family cannot afford to travel two hours, and of mothers who have to leave their families four to six weeks before their due date to go "south" to have their babies.

*"Patient First" cannot be a mere lapel pin, button, or logo; it must be a way of doing business...*



*More needs to be done to ensure equity and fairness in the health system, including the development of a comprehensive plan for rural and remote service delivery...*

*"In our small community, we have three patients who need dialysis three times a week. The nearest town has a satellite dialysis unit, but it is full. Our three patients leave home at 6:00 or 6:30 in the morning, travel over a long bumpy section of gravel highway, which is really hard on the body, and arrive in Saskatoon at about noon. When they are finished their treatments around 5:00 p.m., we stop to have some supper. Then we head home and get back to our community around 11:30 p.m. or midnight."*  
(Medical taxi driver)

These are examples of basic health needs that the system must plan to meet closer to home for the sake of patients. I also urge urban regions to coordinate patient appointments and tests in order to avoid multiple long-distance journeys for patients.

More needs to be done to ensure equity and fairness in the health system, including the development of a comprehensive plan for rural and remote service delivery which can be informed by this report. In addition, the Regina and Saskatoon health regions, with their prevalence of specialists, should show leadership by providing more clinics in rural and remote areas outside Regina and Saskatoon. Residents of rural and remote communities would then be spared long-distance travel for what are often brief appointments.

Urban health regions should coordinate mobile diagnostic resources that would eliminate travel to Regina and Saskatoon.

16

*Saskatchewan's growing seniors population ... will need a broader range of health care and affordable living options ... from supported independence to institutional care.*

### Commissioner's Recommendation:

2. That the health system develop a comprehensive and innovative strategy for rural and remote service delivery that:
  - a) Improves access to primary health, diagnostic and specialist services for rural and remote residents;
  - b) Examines the cost burden of emergency transportation, including interfacility transfers; and
  - c) Includes a range of supports for people who must obtain health services away from their home communities.



*Patient First possible pathway:* Though not new, telehealth technology can improve access to health care services and help disseminate knowledge. Over time, providers have become more adept at the use of technology, and patients, especially those familiar with distance technology, appreciate the convenience. Telehealth also offers increased access to learning tools, such as the opportunity to participate in "clinical rounds" and training. Other emerging technologies, such as telemonitoring, provide patients with immediate feedback on health indicators such as blood pressure, and guidance to self-manage their care.

### Equitable care for seniors

Saskatchewan's growing seniors population is projected to nearly double to 25% by 2031. In addition, life expectancy is projected to increase to 81.1 years for men and 85.9 years for women by 2031<sup>9</sup>. This will necessitate a broader range of health care and affordable living options for older people,

from supported independence to institutional care. Patients, frontline providers and stakeholders all indicate that the health system is challenged to match resources to the level of care and support required by individual seniors. The consequences for seniors living alone in their home with few supports can include social isolation, poor nutrition and worsening health.

Seniors needing long-term care are ill-served by a system that leaves them in hospital beds, without the requisite supports and programming, while awaiting placement in an appropriate facility. The financial, physical and emotional costs can be significant, and at times overwhelming, for the individual, their spouse and family.

*“Adult Day Centre spaces are crucial to the well-being of the adult with dementia or other people with high care needs and provide much needed respite to the family caregivers.”*  
(Health care provider)

Families told stories of long waits to get into special-care homes and parents who were separated after 55 years of marriage, often in different towns, because their care needs could not be met at the same care homes.

*“In order for my parents to stay together, they had to purchase service from the private sector. The cost of this for two people, one level 4, the other level 2, was over \$60,000 per year.”*  
(Patient’s family member)

*“There were no beds in the long term care facility in the community my mother-in-law lived in, so she had to be put in a nursing home in a neighbouring town – it was really hard for her – she had roots in her town.”*  
(Patient’s family member)

Concerns about care for seniors formed a consistent theme in all of the patient-experience focus groups, with many participants sharing stories about less-than-ideal quality of care. Some were concerned about a lack of attentiveness to long-term care residents’ needs. This manifested itself in such issues as infrequent bathing, or seniors being left in their beds with very little social interaction and few opportunities to move and exercise their joints and muscles. Some families spoke of expensive medications, or said they lacked confidence that medications were being administered properly or safely. Others felt that institutional scheduling practices were of more benefit to staff than to residents.

*“In facilities, family members should have input on the types of activities their elderly family members could participate in and also in the choice of their diets.”*  
(Patient’s family member)

After hearing patients and their families recount their negative experiences, I suggest that the Saskatchewan model of assisted living be expanded for the elderly in Saskatchewan. This model would fill the current gap between home care and personal care homes or long-term care. It should be designed to promote a philosophy of service for those elderly citizens who need flexibility in the menu of services and programs they may require as they age. Designed with a home-like environment, such facilities can offer more independence for residents. In principle, the cost to the patient should be less than long-term care covered by government policies. If designed properly, assisted living can reduce the expected future demand for services for the aging population.

*Families told stories of long waits to get into special-care homes and parents who were separated after 55 years of marriage, often in different towns...*

*Despite modest increases in resources for home care, demand exceeds availability, leaving people to rely on informal caregivers such as an aging spouse, children, and other relatives and friends.*

To live in their own home, many seniors rely on home care for regular supportive care and nursing or other professional services intermittently. Despite modest increases in resources for home care, demand exceeds availability, leaving people to rely on informal caregivers such as an aging spouse, children and other relatives, and friends. Home care, when it works well and is responsive, will allow Saskatchewan residents to age at home and maintain good health and relative independence. This will pay huge dividends in easing the pressure on hospital beds, emergency rooms, and long-term care institutions.

*“My 74 year old brother with dementia is being looked after by my 74 year old cousin because the district can't accommodate him. He only has his old age pension and security so he can't afford private care. Luckily our cousin is kindhearted and willing to look after him. But she is of the age that soon she won't be able to and then what?” (Patient's family member)*

The provincial government has appointed a Legislative Secretary for Surgical Wait Times and Long-Term Care. This indicates both an acknowledgement of and commitment to seniors' issues. The province is also developing a Seniors' Strategy, which will include a full and focused review with comprehensive recommendations. The findings and recommendations within this report should inform this broader strategy development.

### Commissioner's Recommendation:

3. That the Ministry of Health's Seniors' Strategy under development focuses on strengthening:
  - a) System capacity to support independent living;
  - b) Accessibility to personal care homes by addressing the current financial barriers for low-income seniors;
  - c) Accessibility and quality of assisted living and long-term care;
  - d) 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
  - e) Capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day programs, and a specialized outpatient clinic.



### Equitable care for First Nations and Métis people

The health and well-being of First Nations and Métis citizens in Saskatchewan is influenced by culture, shifting demographics, geography, increasing population and the challenge of blending contemporary medicine with traditional healing.

My researchers and I took steps to ensure that the First Nations and Métis voice was heard during this review. In all of the general-population focus groups, at least one First Nations person and one Métis person were invited to attend. Four additional focus groups were held for First Nations and Métis people exclusively, in urban, rural and northern locations. Focus groups were also held on three reserves. Registered nurses working on reserve were invited to attend the provider focus groups and the Federation of Saskatchewan Indian Nations (FSIN), the Métis Nation - Saskatchewan (MN-S) and the Northern Inter-Tribal Health Authority were invited to attend the stakeholder forums. We decided that a minimum of 15 per cent of individuals we spoke to through our telephone survey should be self-identified as First Nations and Métis. I also attended meetings of the FSIN Health and Social Development Commission, the MN-S Health Roundtable and the Memorandum of Understanding on First Nations Health and Well Being Steering Committee. Through all of these mechanisms, we were able to distinguish the First Nations and Métis patient experience from the rest of the population.

The number of First Nations and Métis people living in Saskatchewan is growing faster than the number of non-Aboriginal people and they currently comprise about 15 per cent of the provincial population, projected to increase to 21 per cent by 2017. With this faster growth rate, it's not surprising that Saskatchewan has the youngest Aboriginal population in Canada, with a median age of 22. In 2001, 25.9 per cent of the total Saskatchewan population aged 0-14 years was First Nations or Métis. This is projected to increase to 36.6 per cent by 2017<sup>10</sup>. These two groups of people typically experience lower health status than other Saskatchewan people. For example, First Nations and Métis people have significantly higher incidences of diabetes, tuberculosis, cardiovascular disease, obesity, arthritis and rheumatism. This disparity in health status is frequently attributed in large part to socio-economic disadvantages.

During our consultations, we heard stories of hardship associated with obtaining health care. Some people spoke of having to choose between buying groceries or their medications, while others related the need to hitchhike from their small communities to larger centres to get chemotherapy or dialysis treatments because they didn't have the money for appropriate transportation. Métis people residing in fly-in communities told of how they are making health care decisions based on whether or not they can pay for multiple, subsequent flights in and out of their community to receive the prescribed treatment.

*My researchers and I took steps to ensure that the First Nations and Métis voice was heard during this review.*

*First Nations and Métis people have significantly higher incidences of diabetes, tuberculosis, cardiovascular disease, obesity, arthritis and rheumatism.*

### Commissioner's Recommendation:

4. 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:
  - a) Assisting First Nations and Métis patients to navigate the health system and advocating for better care;
  - b) Developing linkages with First Nations- and Métis-run health programs and services to better integrate care;
  - c) Working with the provincial and federal governments to develop new information sources to help First Nations and Métis people understand government programs and services.
  - d) Adapting health services to better meet the needs of First Nations and Métis patients, including accommodation and transportation needs, and cultural supports and services;
  - e) 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 - Saskatchewan; and
  - f) Encouraging First Nations and Métis organizations to partner in the provision of health care services that will directly benefit their communities.



*Mental health continues to be a significant health issue for a large portion of the population, and the lack of attention to it brings untold costs to society.*

### Equitable care for patients and families with mental health issues

*"When I really needed the help there was no one available. I had to wait for six weeks. Then when we finally got in, the one I was seeing was changing jobs so I had to wait again. So I said, 'Forget it!'"*  
(Patient)

Due to the ongoing social stigma connected with mental illness, patients and their family members are often reluctant to speak up about quality and access concerns. Yet mental health continues to be a significant health issue for a large portion of the population, and the lack of attention to it brings untold costs to society.

Most of Saskatchewan's psychiatrists are based in the province's urban centres and practice without any province-wide system for accepting referrals. Mental health referrals should be organized on a provincial level so that access to psychiatrists is equitable for all Saskatchewan residents, regardless of where they live.

*"The only way to get to see a psychiatrist here is to threaten to commit suicide."*  
(Patient)

With a limited number of psychiatrists distributed unevenly throughout the province, family physicians — with limited training in managing mental health issues — become the default option for many patients needing mental health care. Health system leaders need to examine whether the most effective use is being made, not only of psychiatrists' time and skills, but of the entire range of mental health professionals.

*“Family physicians are treating over 75 per cent of mental health disorders – and almost every family has been touched by that. Providers need education about seeing this as a ‘normal’ health problem that can and should be dealt with in a normal way.”*  
(Health care provider)

*“We moved here from Ontario where we had an excellent family doctor and a wonderful cognitive psychologist to provide excellent medical care. When we asked our first family doctor here about a cognitive psychologist, he replied ‘A what?’ This does not inspire confidence.”*  
(Patient's family member)

Mental health care for children and youth is extremely important, and has been the subject of other reports. I received input that the waiting list in some places for services is still between eight months and one year for children who are in urgent need of those services, which places tremendous pressure on both families and the school system.

Appropriate suicide education and prevention programs should also be available across the province, but especially in the education system.

*“If you are depressed or injured, the system will dismiss you as an attention seeker—they think you are faking. They take you seriously when they find your body.”*  
(Patient)

Finally, I also received considerable input from families with children diagnosed with autism. These individuals spoke passionately about the need for early diagnosis and treatment and the limited availability of autism care in Saskatchewan as compared to other jurisdictions.

*“There is no coordinated autism service in this province and that is a huge negative to our health system. There is also a waiting list for services with over 200 children on it and this is unacceptable. Early intervention is the key in this disorder and the early intervention dollars spent now will be miniscule compared to the long term costs the government will face when these children become adults.”*  
(Patient's family member)

*“It took almost three years for my son to be assessed for pervasive development disorder.”*  
(Patient's family member)

A strategic plan, based on review of the current resourcing and configuration of mental health services, would help to pave the way for a more patient-centred network of services.

I heard considerable comment on the emergency experience for mental health patients. People with chronic mental health issues deserve to have their concerns taken seriously when they present at the emergency room. The employment of members of the psychiatric care team in emergency

*Mental health referrals should be organized on a provincial level so that access to psychiatrists is equitable for all Saskatchewan residents, regardless of where they live.*



departments may speed intervention times for mental health patients. Many expressed the need for improved access to those services. A number of patients also called for 24-hour support for mental health crises.

*"I have accessed the mental health system for treatment of my son. The response was poor. I have accessed the ER on two occasions. Once because he was suicidal. We were sent home. Within two weeks we had to commit him to access treatment. Again, a year later, the experience was no better. He was considered an emergency with an appointment three weeks down the road. Somehow we have kept him alive in spite of the lack of support he received. Mental health services need 24-hour response to crisis."  
(Patient's family member)*

*Patient First possible pathway:* Regina and Saskatoon should explore the feasibility of 24/7 service for people experiencing a mental health crisis. Services could include medical and mental health screening and assessment, crisis intervention and initial treatment services, and psychiatric consultation. This may ease pressure on emergency departments.

### 3. Coordinated Care

*What it looks like: Whether working in the same unit or across multiple programs, disciplines and sites, providers are working together to meet the patient's evolving health care needs and help the patient and their family to navigate the system. Effective care coordination can also improve continuity and stability by reducing the number of providers a patient must interact with on his or her care journey.*

#### Help in navigating the system

Patients and their families are often anxious and frequently feel "lost" in the system. Lack of information and unfamiliarity with the health system are a great source of patient anxiety and dissatisfaction. We repeatedly heard about the need for assistance and basic information, direction, and referral information.

*"It can be very difficult when you are sick to take control of all of your appointments and what you need to do, especially if you are not used to it. You need someone to help you."  
(Patient)*

*"There is so much lack of communication between the system and the regular Joe Blow out there, it is incredible. To try and find the appropriate person in whatever department, at whichever hospital at whatever level is an absolute nightmare."  
(Patient)*

Our researchers heard about the many navigation issues experienced by First Nations and Métis people, and also about their positive experiences when Elders were engaged to assist health care providers.

In a truly patient- and family centred health system, patient navigators would not be necessary. It would be the job of every health care professional, provider and support person to be attuned to patient needs and ensure patients are equipped with the information they need to continue their care journey.

*Patients and their families are often anxious and frequently feel "lost" in the system. Lack of information and unfamiliarity with the health system are a great source of patient anxiety and dissatisfaction. We repeatedly heard about the need for assistance and basic information, direction, and referral information.*

*Patient First possible pathway:* There is opportunity within every Saskatchewan health region and the Cancer Agency to develop a variety of information and support mechanisms to help patients access and navigate programs and services. Some health systems have introduced a user guide for patients to equip them with essential knowledge about interacting with the health system.

### Coordinating services for children and youth

Shortfalls in care coordination were particularly prominent in the narratives of parents sharing their experiences accessing health care services for their children. Many said emergency needs were generally well met, but noted significant gaps in service and supports for children with life-long needs resulting from physical, intellectual, and cognitive disabilities, mental illness, and chronic conditions such as obesity and diabetes. While gaps were identified in urban centres, they were magnified for children and families in rural, northern and remote communities.

*“We had excellent care in the critical care ward, but felt completely on our own when transferred to the ward, and even more alone when discharged home.”  
(Patient’s family member)*

*“The waiting list for specialists is too long. One and a half years for a child psychiatrist, 12 months for a speech language pathologist or occupational therapist. The window of opportunity to help these children and families is very small, and too often spent on a waiting list.”  
(Health care provider)*

*“We are bound within our health region. If your child has a severe physical condition, they will send them to one of the big hospitals for pediatric care. But if your child’s problem is more of a mental disorder, you will have to stay within your own region because there are general mental health services around. This means that there have been times when my child had to be hospitalized with adults with mental health problems and this can be scary for him.”  
(Patient’s family member)*

*“Children with mild to moderate needs can often improve the most from rehab services. However, these kids are receiving few resources as more kids with high needs are presenting.”  
(Health care provider)*

Families identified financial, emotional, and physical burdens and their spinoff effects. Supports and services are available through many agencies such as health regions, school divisions, social services, and federal agencies, but they are not coordinated, and it seems to be up to the families to determine how to access services. This is in addition to the burden of care they carry on a daily basis, often in addition to other family and work-related responsibilities.

*Supports and services are available through many agencies such as health regions, school divisions, social services, and federal agencies, but they are not coordinated, and it seems to be up to the families to determine how to access services.*

*"There is very little communication between the government departments. It seems each is more interested in protecting its boundaries than helping families."  
(Patient's family member)*

*"The health system and the school system pass the buck between each other in terms of who should provide the services such as speech language pathology or occupational therapy."  
(Patient's family member)*

### Commissioner's Recommendation:

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



*Patients and families dealing with cancer should not have the additional worries of disjointed care and dysfunctional professional relations among those coordinating and delivering their care.*

### Coordinated care for patients with addiction issues

Individuals with co-occurring addictions and mental health conditions, in addition to other health concerns, require specialized, coordinated services that meet their specific needs. To provide a comprehensive continuum of care, service providers must collaborate effectively with other supports, particularly mental health programs.

### Coordinated care for patients with cancer and their families

Over time, the convergence of increased service demands, workforce shortages, and the inability to keep abreast of enabling treatment technologies has challenged the Cancer Agency.

Long clinic waits, limited community supports and delayed treatments are all signs of poor integration and coordination. Many people spoke of appointments not being coordinated and described communication gaps between clinical staff, health regions and the Cancer Agency. There is pressing need to work toward an integrated health record between the Cancer Agency and health regions.

Patients and families reported generally that cancer care itself was good. However, a number of them also recalled incidents of disrespectful, unkind behaviours on the part of some providers. Some patients and system leaders also called my attention to instances of ineffective, strained relationships among clinical staff, management and health regions. Patients and families dealing with cancer should not have the additional worries of disjointed care and dysfunctional professional relations among those coordinating and delivering their care.

The recently formed Saskatchewan Oncology Collaborative, with membership from the Cancer Agency, health regions, and Ministry of Health, is positioned to address some of these challenges.

*"I was diagnosed with a rare form of cancer. Passed around to several doctors, surgeons and oncologists. Then referred out of province. It felt like no one was responsible for my care. Follow-up would be recommended, but no one knew who was in charge of my care. So it was never done. I found this out by getting a copy of my chart to ensure that I receive the appropriate follow-up.*

*I feel like the only one looking out for my care is me, however, the health system is not user-friendly for patients. For example, obtaining copies of my notes or radiology films usually involved several visits, signatures and sometimes requires me to get other health care people to request on my behalf. One department's release of information policies would be different than the rest. In my situation, I was going through the system on an urgent basis and did not have the time, energy or knowledge to be looking after my own care. There was also a lack of communication between facilities, departments, specialists, hospitals that made my care not very consistent."*

*(Patient)*

*"...back to her family doctor, more pills. Then one night the pain was so bad she went to the hospital. She got to see an oncologist, did some tests and was sent home. Went to the oncologist office and was told about the cancer. But was told if it was found a few months earlier it could have been taken care of. Often she has appointments with different specialists and has to make numerous trips. Why can't there be some coordination to reduce trips?"*

*(Patient's family member)*

The case study "Matthew's Story" (available for reference at [www.health.gov.sk.ca/patient-first-review](http://www.health.gov.sk.ca/patient-first-review)) highlights the challenges a child with cancer and his family faced during their care journey. It also illustrates that when a health system pays attention to the patient, the care experience can be dramatically improved.

Patient voices, validated by health care provider views, point to the need to improve the delivery of cancer services in the province. If the Cancer Agency is to meet its core obligation to citizens, cancer services need to be more effectively coordinated with health region service plans. To be successful, this process must start with dedicated and effective leadership at the governance level.

The opportunity exists to develop an action plan that speaks to ways of involving medical, clinical, and support staff to improve coordination of service and repatriate the 'caring spirit' that patients are longing for as users of the system.

An operational review of the Saskatchewan Cancer Agency, conducted in 2006, highlighted areas for improvement. For whatever reason, there is minimal evidence that progress has been made to address issues that affect the patients and the workforce. For example, a great deal can be done to standardize care in the Regina and Saskatoon clinics by adopting leading treatment protocols and care maps from other jurisdictions.

*A great deal can be done to standardize care in the Regina and Saskatoon clinics by adopting leading treatment protocols and care maps from other jurisdictions.*

### Commissioner's Recommendation:

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



*Access issues are complex, and service gaps or delays in one area of health care create backlogs and bottlenecks in another.*

## 4. Convenient, Timely Care

*What it looks like: Patients can access the care they need without waits that prolong pain or debilitation, or barriers that introduce prohibitive expense or difficulty. Intervals between needed services are short, and the need to travel to different locations is minimized.*

Concerns about timely access to health care were voiced time and again by the majority of patients, providers and stakeholders throughout the Patient First Review.

### Access issues were linked to the:

- ▶ Length of time that patients currently wait for certain services;
- ▶ Lack of availability and best use of health care providers;
- ▶ Lack of availability of services in rural, northern and remote communities;
- ▶ Number, location and role of facilities;
- ▶ Lack of availability and use of diagnostic equipment and treatment technology; and
- ▶ Range and quality of services provided.

Sometimes, access issues had a fairly clear origin. For example, a number of working parents expressed frustration with the business hours observed by some health care facilities and programs. Limited weekday hours often force these parents to choose between earning income and keeping an appointment for their children.

On the whole, however, access issues are complex, and service gaps or delays in one area of health care create backlogs and bottlenecks in another. Therefore, a system-wide perspective is critical to address these issues in a meaningful and sustainable way.

### Shorter waits for surgeries and diagnostic procedures

Our researchers consistently heard from patients who waited too long for surgical procedures. Long waits for surgery have dramatic implications for patients. Through dialogue and written submissions, I heard what waiting means for patients: their lives put on hold; loss of income, mobility, family interaction, social mobility, and confidence. They live with anxiety, fear and secondary complications.

Waiting changes people's lives, and the longer they wait, the greater the impact. Patients wait to see a family physician – many indicate that family physicians are not available to them. They wait to see specialists, then wait

*Access delayed is access denied.*

for diagnostic testing. Then they wait again to see their physician or specialist and then often wait for surgery. Access delayed is access denied.

*“To me my condition is serious enough that I need to be on pain killers, but I’ll just never make it to the top of the waiting list.” (Patient)*

I heard from many patients that access to a lengthy surgical wait list or to a queue in an emergency room is not their notion of timely care.

Clinical pathways that set target timeframes and map the sequence of decisions and care for specific conditions are proving to be an effective mechanism for consistency and quality as well as reduced waits. I strongly support the recent efforts that the Ministry and the health regions have taken together to move forward in this regard, but more needs to be done, and it needs to be done expeditiously. The case study “Emma’s Story” (available for reference at [www.health.gov.sk.ca/patient-first-review](http://www.health.gov.sk.ca/patient-first-review)) illustrates the current experience of waiting for and receiving hip replacement surgery, and what that care experience could be in a transformed health system.

Eliminating the backlog of patients waiting for surgery is a priority and a recommendation of this review. This includes, but is not limited to, a number of strategies:

- ▶ Providing more and better information to patients about their condition and treatment options, and ensuring patient participation, to the extent they desire it, in decisions about their care;
- ▶ Providing patients with the option of a “pooled referral”, which should serve to reduce waiting times; patient choice is protected, as they would retain the ability to select their surgeon knowing what the waiting time would be;
- ▶ For patients with a desire to see a specific surgeon, providing them with information on that surgeon’s wait times;
- ▶ Improving system efficiency by streamlining processes;
- ▶ Expanding surgical and diagnostic capacity with the assistance of independent partners who meet quality and safety standards; and
- ▶ Increased capacity for post-surgical supports such as home care and therapy services.

Addressing surgical and diagnostic wait lists is of critical importance. It demands full, mandatory participation and collaboration of health regions and health care providers. I urge the province to examine all options to address this top-of-mind patient concern. If the system’s current configuration proves unable to address the backlog of patients awaiting surgery, the system must explore other alternatives.

The current situation provides an opportunity to innovate, and planning is underway for a freestanding ambulatory surgery/diagnostic centre in Regina, designed to perform surgical procedures more efficiently than in a hospital setting and enhance hospital operating room capacity for more complex surgeries, which are currently being cancelled at an unacceptable rate. If this initiative is planned and implemented appropriately and in a timely manner, it can serve as a model for all of Canada to transform the way tomorrow’s care will be delivered.

*Addressing surgical and diagnostic wait lists is of critical importance ... I urge the province to examine all options to address this top-of-mind patient concern.*

### Wait lists *are* long

As of May 31, 2009:

- ▶ Over 27,000 people were on the surgical wait list; and
- ▶ 4,000 (16%) had waited longer than 12 months.

On March 31, 2009:

- ▶ Wait times for CT scans ranged from 20 days to 190 days depending on the region; and
- ▶ Waits for MRIs were 150 days in Regina and 390 days in Saskatoon.

*Patients awaiting placement in a hospital bed are frequently held in the emergency department, resulting in backlogs and long waits for emergency services.*

28



### Commissioner's Recommendation:

7. 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.



### Making best use of facility capacity

While hospital beds are frequently under-used in rural areas, bed capacity is often maximized in larger centres (and often exceeded in Regina and Saskatoon's provincial hospitals). As a result, patients awaiting placement in a hospital bed are frequently held in the emergency department, resulting in backlogs and long waits for emergency services.

Changing population needs, along with ongoing workforce pressures, have created the need to examine hospital services with attention to:

- ▶ Reviewing the roles of hospitals or other facilities that are in close proximity or underutilized and redesigning their purpose based on the needs of the community;
- ▶ Determining which, if any, highly specialized services should be provided in one location (Regina or Saskatoon);
- ▶ Identifying those services that can be provided outside of expensive hospital settings in alternate sites (e.g. day surgery, diagnostic imaging) or, in some cases, a patient's home (e.g. dialysis);
- ▶ Improving sustainability of some hospital services which are regularly jeopardized by the closure of facilities when providers (often physicians) are not available; and
- ▶ Relieving pressures on the major hospitals in Regina, Prince Albert and Saskatoon, resulting from consistently high bed occupancy.

The cascading impact of backlogs and bottlenecks cannot be overstated and is well illustrated by former Saskatchewan Medical Association president Dr. Milo Fink, who said, "Resolving a series of bottlenecks is one of the most important challenges in improving access to care for the province's patients." During a recent tour of the emergency room at Regina's Pasqua Hospital, he noted that "12 of the approximately 45 patients in the ER had been waiting to be admitted, some for more than 48 hours. Meanwhile, fifty to seventy people were waiting for long-term care beds in Regina." (*Medical Post* June 2009) I personally visited the Pasqua Hospital, where I witnessed incredibly dedicated staff who were coping with 11 patients who had been housed in the corridor for more than 24 hours.

The emergency rooms in urban hospitals were identified as a serious pressure point in the system. In many respects, the emergency room has become the default option in health care and reflects the negative effects of access issues across the system.

*"I don't understand why they can't tell you how long the wait is going to be when you're in the ER. It would make it more bearable."  
(Patient)*

Many patients resort to walk-in clinics, and many complained that the outcome was only to be referred back to their physician or to acute care services. Some jurisdictions have introduced 18-hour urgent care centres, located close to or adjacent to emergency rooms, that can respond to non-life-threatening conditions.

Through a blend of primary and emergency care, the purpose of these centres is to efficiently respond to health concerns that require attention but not the full resources of an emergency room, while freeing hospital emergency rooms' staff to attend to life-threatening conditions.

*"There needs to be a back-up 24-hour on-site walk-in clinic to alleviate the clogs in actual ER."  
(Patient)*

*"I believe our ER is used for a lot of things that aren't emergencies, and I think that is where we should have that help line."  
(Patient)*

### Commissioner's Recommendation:

8. 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 incorporate state of the art design and leading technologies.



### Providers working to their full scope of practice

Given the current global demand for physicians and other health care professionals, it is unlikely that Saskatchewan will enjoy a surplus of providers in the foreseeable future. However, innovative and progressive approaches to the use of health care professionals' competencies and education can do a great deal to alleviate this pressure. Saskatchewan must enable all of its care providers to work to their full scope of training and practice. This would make a significant difference in care access for patients, particularly those who are without a family doctor.

Full scope of practice will free up physicians and other care providers for the activities only they can perform. Several medical leaders I spoke with estimated that up to 50 per cent of the work most Saskatchewan physicians do today could be done by other professionals. 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. If "it takes a village to raise a child", it also takes a health care "village" to deliver quality health care. All providers are dependent on other providers to ensure that patients experience a safe and high-quality journey.

*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.*

*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.*

Ongoing advancements in health care delivery and technology will create a need for new and evolving roles among care providers. Health care employers and training/educational institutions must work together to anticipate these needs in order to facilitate interprofessional practices.

*Patient First possible pathway:* The Ministry of Health could engage with educational and professional representatives in a formal collaborative to develop a plan for optimizing the training and skills of health care professionals. This work could be an integral part of the Ministry's Health Human Resource Strategy and include professional reform as a means of expanding scope of practice and enhancing professional collaboration for the sake of patients.

*"Nurses are so capable, and have so much knowledge, but they don't have the power, the doctors have all the power. They need to be better utilized."  
(Patient)*

*"If every doctor's office had a nurse practitioner, it would cut down a huge amount of the physician's work load."  
(Health care provider)*

In response to concerns that patients cannot always find a specialist when needed, the Registrar of the College of Physicians and Surgeons has observed that some patients "fall between the cracks" of the health system as doctors become more selective in their scopes of practice. He suggested the medical profession needs to reflect on this scope-of-practice trend and its impact on patients.

I also heard that while registered nurses provide certain types of care in some settings, that same care is provided by licensed practical nurses in other settings. Surprisingly, clinical roles and responsibilities are sometimes determined on a unit-by-unit basis. 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.

To date, professionals have expressed openness to expanded scopes of practice in theory, but in reality have been hesitant to relinquish responsibilities to others. Reforming and modernizing the regulation of health professions could provide the impetus for collaborative practice – an opportunity that Saskatchewan cannot afford to miss, for the sake of patients.

If necessary, new health care professions could be added to address capacity gaps. However, new roles and additional credentials for existing professions must be thoughtfully considered to avoid unintended consequences for the supply and affordability of health professionals.

## 5. Communicative, Informative Care

***What it looks like:*** Patients are always well informed about their health and the factors affecting it, treatment options, and the “5 W’s” of their next care steps (Who? What? When? Where? Why?). Providers take the time to explain, to clarify, and perhaps most importantly, to listen to patients and their families.

Patients and families have always had the need for, and the right to expect, clear and helpful information about their health-related issues, their options, next steps, and what they can expect along the way. As developing technology continues to make information more readily available and easily shared, there are fewer excuses for failing to provide patients and families with the information that can make the difference between a positive health care interaction and a negative experience.

### Commissioner’s Recommendation:

9. 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.



*Patients and families have always had the need for, and the right to expect, clear and helpful information about their health related issues, their options, next steps, and what they can expect along the way.*

### Understanding of rights and responsibilities

Patients want to know what they can expect from the health system and, in turn, what those in the system should reasonably expect from them. An overarching statement of patient rights would formalize the province’s commitment to patient-and family-centred care, while reinforcing an individual’s responsibility for their own health and responsible and appropriate use of the health system. This could be achieved through a Charter of Patient Rights and Responsibilities, which could include a range of provisions such as: principles (fairness, accountability, and transparency), patient rights (dignity, respect, safety, informed decision making, disclosure, and consent), mechanisms for recourse or appeal, as well as a statement of patient responsibilities such as asking questions, sharing information, or maintaining a healthy lifestyle.

### Better communication, more information

Positive relationships and effective communication between care providers are essential for quality patient care and professional satisfaction. Communication between providers is a cornerstone of an effective and efficient health care enterprise.

Communication between the patient, the patient’s family and care providers was a recurring theme in patient focus groups, interviews and small-group discussions. Many patients recounted experiences of being confused or uncertain about diagnosis, treatment options, protocols, and next steps. The behaviour and attitudes of physicians, nurses and others in the health system

*Patients must be free to communicate their questions, concern and fears, and to receive the information they need to fully participate in their course of care and treatment.*

were often described as exemplary; however, they were also described too frequently as dismissive, disrespectful and uncaring.

*"He made me feel like I wasn't a person, just a number to push out the door as quickly as he could."  
(Patient)*

*"I feel like even when I do ask a question, they are brushing me off. They look at me like 'why are you asking me these questions?'"  
(Patient)*

Patients must be free to communicate their questions, concerns and fears and to receive the information they need to fully participate in their course of care and treatment. They must understand their condition, their treatment options and their responsibilities. Providers, in turn, must recognize that patients have unique insights about the status of their health and a desire to share both responsibility and decision-making about their care and treatment options.

*"Physicians are experts in a particular field of medicine, but patients are experts on how they feel."  
(Patient)*

Patient- and family-centred care provides patients with information throughout their care journey. They should know the expected next steps, receive regular updates on the timing and progress of their care, be able to reach a provider when needed and be informed about what to expect when discharged from care.

Many of the ideas presented by patients, providers and stakeholders are consistent with practices in health care systems that have adopted patient- and family-centred care. Patients are encouraged to bring family members or other supports to their appointments to ensure important information is heard, remembered and/or recorded. Patients and their family members are encouraged to ask questions, provide information and explore options. Providers ensure that patients are fully informed and understand next steps, options and responsibilities. This is particularly important at the time of discharge from a facility and when moving from one part of the system to another. A strong provider-patient relationship and a health system that encourages communication and inquiry will support patient safety, avoid unnecessary recurrence, relieve patient anxiety and invite shared or informed decision-making.

Good decisions are made when the patient is informed and understands the implications of a choice, there is evidence supporting the choice, and the patient's values and preferences have been respected. In other words, the partnership includes an expert on the facts, the health care provider, and an expert on what matters most, the patient. The combined expertise is applied to arrive at the "right" decision for that individual at that time.

*Patient First possible pathway:* The health system, in partnership with patient and family advisors, could develop and demonstrate a decision-making model that empowers patients to take an active role in decisions related to their care and treatment.

### Two-way communication: the opportunity for feedback and recourse

Patients want their voices to be heard and acted upon when their health care experiences prompt them to speak out. When they encounter serious concerns, including quality-of-care issues and decisions respecting health coverage, they seek formal appeal mechanisms that allow for an objective review of those concerns. A patient- and family-centred health system requires a culture that invites and acts on positive and negative commentary and implements accessible and public recourse and appeal mechanisms. Discussions with the Ombudsman of Saskatchewan should explore ways to strengthen the opportunities for public feedback and recourse concerning health care.

There are tremendous opportunities for this kind of two-way communication whenever a health care program is undergoing an evaluation or changes of any kind, or when a new program is being considered. This is when program planners, designers and providers can actively seek patient and family input, thereby embedding the Patient First philosophy into the very fabric of the service.

## 6. Comprehensive Care

*What it looks like: Health care providers are attuned to all, not just some, of a patient's needs, and are equipped and empowered to deliver holistic care that respects the complexity and interrelation of physical, psychological, spiritual, and socioeconomic factors. Patients and families are given the time to express their needs.*

### Keeping people healthy

By its very nature, a Patient First review must focus its findings and recommendations on patients – those people who, for any number of reasons, find themselves in need of health care services. From its very conception, this review was intended to scrutinize Saskatchewan's network of health care programs and services from the perspective of the people who use them. The recommendations contained in this report, therefore, contain ideas for improving the patient journey – making health services more accessible, better coordinated, and more patient-centred.

It is critical to note, however, that most Saskatchewan people have no great desire to become patients in the first place. At best, what we call the patient journey is usually an inconvenience to the person making the journey – they are diverted from family or work or other important areas of their lives in order to resolve a health-related problem. At worst, the journey can be catastrophic – a serious illness or injury that changes the entire trajectory of a person's life and the lives of those who care about them. This is why the patients we spoke to ask to be treated with compassion, dignity, respect and sensitivity. Very few of us want to be patients, and the journey can be profoundly difficult and upsetting.

One of the most powerful ways to build a sustainable, patient- and family-centred health system is to help Saskatchewan people avoid becoming patients in the first place. This is one element of truly comprehensive health care — educating, enabling and empowering individuals and families to protect and promote their own good health.

*One of the most powerful ways to build a sustainable, patient- and family-centred health system is to help Saskatchewan people avoid becoming patients in the first place.*





There are many factors that play an important role in determining the levels of health and well being we enjoy throughout our lives. These include our income and social status, our levels of employment, education and literacy, our social and physical environments, formative childhood development and experiences, social support networks, our personal health practices and coping skills, quality and availability of health services, biology and genetics, gender, and culture.

Enlightened public policy can do a great deal to help people stay healthy. We also need to promote the realization that to a great extent we are in charge of our personal health.

We now know that many illnesses and injuries are entirely preventable. If we learn how to maintain our own health through proper nutrition and exercise, or care for our own safety by adopting safe practices at work, home and play, we will likely cut down significantly on the number of 'patient journeys' we need to make in our lifetimes. Even as we begin to experience the inevitable effects of aging, we are more likely to remain healthy, mobile and independent for a longer period of time.

Of course, some illness and injury is unavoidable or due to factors beyond our control, such as genetic inheritances, reckless activity by others, or simple bad luck. While some of us have ongoing and intensive health care needs that require more frequent interactions with the system, the majority of Saskatchewan residents will receive at least one type of health care service over the course of a year.

But imagine how many resources in the system are freed up by just one socioeconomically disadvantaged youth who, thanks to early intervention and education, avoids a lifetime of addiction. Imagine the benefits to the individual and society when a person with Type II diabetes is helped to manage their condition and thereby becomes dependent on intensive medical intervention much later in life. Imagine the difference made by one safe driver, or by one person who quits smoking — or better yet, doesn't start smoking in the first place. Prevention of illness and injury means fewer patients, which means more readily available resources for those who need the health system<sup>11</sup>.

In personal-finance terms, this is known as paying yourself first – making a long-term investment now that pays huge dividends in the future. Several of this report's recommendations require up-front, one-time investment of fiscal and human resources if they are to answer Saskatchewan patients' calls for a better health system. However, the 'problem' of sustainable, quality health care will never be addressed by short-term spending.

***That is why I urge the Government of Saskatchewan to pay itself first – in fact, to pay the citizens of Saskatchewan first – by emphasizing health promotion and the prevention of illness and injury<sup>12</sup>.***

### Commissioner's Recommendation:

10. 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.



### More time with the patient

Patients and providers alike expressed the need for more time for direct interaction. Saskatchewan, like other jurisdictions, has addressed workforce capacity through recruitment and retention strategies (i.e. international recruitment, expanded training seats, bursaries, relocation bonuses, and higher wages). These strategies are important, but are not sufficient to respond to service expectations and increased demand. Saskatchewan's number of physicians per 100,000 population is lower than most other provinces.

*"But the burden to change the system falls on the leaders, the stewards, and the people who create the organizations where the workforce works. Doctors want to do their work in a patient-centred way; they really do. We have to fix the health system so that it gives doctors the time to do the job they want to do."*  
(Pauline Chen M.D.)<sup>13</sup>

The province has been applying lessons learned and best practices from high-performing health systems in other jurisdictions. Releasing Time to Care, an initiative led by the Health Quality Council, was first implemented in the National Health Service in England. Its purpose is to create more time at the bedside for hands-on care. It focuses on freeing up caregivers' time for more direct patient care. Nurses and other caregivers often spend time away from the patient hunting for supplies, searching for information about patients and their plan of care, duplicating charting, and dealing with constant interruptions. Releasing Time to Care helps care teams identify where they are spending time on activities that do not add value for patients and provides guidance on implementing changes to improve care.

Releasing Time to Care is currently being piloted in the Five Hills and Regina Qu'Appelle Health Regions. Plans are now underway to roll the initiative out to all health regions. Early results are demonstrating that improvements to nursing unit processes and work environments help providers spend more time on patient care. Standardized, efficient processes supported by technology will also enable more patient-provider time.

The province is well equipped to take a creative and powerful approach to human resource planning that will, in concert with other initiatives, address many of the system's capacity issues. A physician recruitment and retention strategy, announced in May 2009, is in the early stages of implementation. Legislative Secretary Laura Ross has recently led a comprehensive

*Improvements to nursing unit processes and work environments help providers spend more time on patient care.*



*Primary health services represent some of the most promising routes to improving the comprehensiveness of Saskatchewan health care, and yet ... [they are] serving only 31 per cent of Saskatchewan's population.*

examination of nursing recruitment and retention issues. The administrative research undertaken as part of the Patient First Review provided additional insights into workforce capacity. This information can and should be used to inform the development of a new and visionary health human resource strategy that moves beyond the traditional approach.

*Patient First possible pathway:* The Ministry of Health's 10-Year Health Human Resources Plan, currently under development, should not be based upon the 'status quo' for health service delivery in Saskatchewan, but upon a provincial model for health services that is guided by the Patient First Review's findings and recommendations, anticipated population health needs, and evidence-based best practices. Only in this way, and in collaboration with health regions, the Cancer Agency, and health professions' groups and unions, will this plan help to build a patient- and family-centred health workforce designed to meet the unique needs of Saskatchewan's people and communities.

### **Primary health services as a priority**

Primary health services represent the first level of contact between individuals or families and the health system. It is often referred to as "every-day" health care and is closely connected to public health, health promotion, and community development activities.

Effective primary health services represent some of the most promising routes to improving the comprehensiveness of Saskatchewan health care, and yet there has been minimal progress in the formation of primary care teams in Saskatchewan. As of March 31, 2009, primary health services teams were serving only 31 per cent of Saskatchewan's population. A fundamental re-design of primary services delivery is urgently required in this province to serve patients better.

Some primary health service providers work in interdisciplinary teams to provide care. Although collaborative care has been in use for decades in other high-performing health systems such as the Mayo Clinic and Kaiser Permanente, Saskatchewan has yet to realize the full benefits of team-based care or technological supports such as telehealth, remote monitoring, the internet, and e-mail communication.

A number of potential barriers may be impeding the full expression of primary health services in the province. These include lack of information technology support, disincentives created by compensation systems, and lack of physician leadership and participation on primary service teams.

It is my belief that the Ministry of Health and pertinent health care provider associations need to collaborate on a fundamental re-thinking of what constitutes a 'primary health services' facility, site or team in Saskatchewan. Both parties need to put the patient first in these discussions and reach an agreement that will result in a proliferation of primary health service sites throughout the province.

The Mobile Primary Health Centre in Saskatoon, locally known as the Health Bus, is an example of an innovative, award-winning approach that responds to the health needs of a previously under-served population<sup>14</sup>. The bus, staffed with a nurse practitioner and emergency medical technician, offers health services in locations and at times that meet the needs of the community.

In Nova Scotia, paramedics are used to deliver mobile health care services in rural communities, providing chronic care in patients' homes and preventive care in community clinics. These paramedics and their ambulances remain available for emergency calls, but lend their training and expertise to the health system when not out on a call.

*"There is a diabetes collaborative in place in my community. Access to lab testing is quick. We have a nurse educator to assist in care if needed."*  
(Patient)

Primary health services can have a tremendous impact on the management of chronic disease. One in every three Canadians lives with a chronic disease such as diabetes, cardiovascular disease, arthritis, cancer, asthma, chronic respiratory disease, or a mental health disorder, and their incidence is on the rise. Traditional care approaches, with the physician as sole provider, do not always serve this population well: appointments are often rushed and the physician may not effectively connect the patient with community supports.

By helping patients understand their condition and know where to turn for advice and support, primary health services improve their quality of life and reduce their reliance on more intrusive and costly acute care. The current economic impact of chronic disease in Saskatchewan is estimated at \$1.9 billion per year in direct health care costs and \$2.5 billion per year in indirect costs associated with lost productivity and income. The case study "Walter's Story" (available for reference at [www.health.gov.sk.ca/patient-first-review](http://www.health.gov.sk.ca/patient-first-review)) illustrates the complexity of chronic care in the absence of a primary health services team that employs leading practices.

The Saskatchewan Chronic Disease Management Collaborative initiated by the Health Quality Council in 2005 is one approach used to improve quality of care for people with chronic conditions.

About 18,000 people with coronary artery disease or diabetes were involved in the collaborative along with 25 per cent of all family physicians and hundreds of other health care workers. By improving quality of care and access to health providers, improvements in key clinical measures for these conditions were achieved. The next collaborative, which will focus on chronic obstructive pulmonary disease (COPD) and depression, is expected to be launched by the Health Quality Council this fall.

*By helping patients understand their condition and know where to turn for advice and support, primary health services improve their quality of life and reduce their reliance on more intrusive and costly acute care.*

### Commissioner's Recommendation:

11. 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 health care teams.



*Health care is about much more than science and medicine. It's also about relationships.*

### Primary services and substance abuse

Saskatchewan has participated in the development of The National Treatment Strategy, a pan-Canadian working group charged with developing recommendations for people with substance abuse problems. Its report recommends a flexible, tiered model of services and supports that effectively matches the intensity of the treatment to the intensity of the addiction problem. The report highlights the key role played by primary health services in responding to substance abuse problems when they are presented. An increased focus on primary health services will allow treatment providers such as longer-term residential addiction programs to focus their services more effectively.

Addiction issues are among the most challenging for a health system that wants to deliver comprehensive care. Individuals with complex mental health issues, addictions issues, justice issues and/or disabilities such as acquired brain injuries require enhanced case management that will address a continuum of needs. It is important that health and allied professionals are given the training and supports to enhance their ability to help patients and families with alcohol and drug issues.

## 7. Respectful Care

***What it looks like:*** *Patients are treated with empathy and understanding for their fears and hopes. The relationship between patient, family and provider is a balanced, mutually respectful partnership, not an imbalanced power dynamic that favours the provider.*

*"We don't want them to be dismissive or belittle our concerns. After all, we are not only a lump in the breast, or a damaged heart – we are people who seek your help."  
(Patient)*

*"When you go to the ER, it's almost like you are intruding on the nurse's time. They have their tasks they need to do, and they are always so busy doing their tasks that it's almost like a 'don't bug me, you are invading my space' attitude, which is very frustrating."  
(Patient)*

The Patient First Review has reminded us that health care is about much more than science and medicine. It's also about relationships.

We repeatedly heard about the importance of the provider-patient relationship and the qualities that make a good relationship – respect, time, listening, clear communication, openness, empathy and understanding. The importance of relationship does not discount the need to change how health care is designed, organized and delivered, but it does redirect our attention to the quality of interaction – the attitudes and behaviours – between health care providers and patients. The importance of this relationship to patients cannot be overstated. Their health and their lives are at issue.

*"We want safe, quality care, delivered within a reasonable timeframe by health care providers who are kind, respectful, empathetic and caring."  
(Patient)*

Patient-centredness is not about refocusing on patients to the detriment of providers. A patient- and family-centred system provides a safe and high-quality care experience for patients and a rewarding work environment for providers. Our research showed that patients and frontline care providers shared similar views on the issues and solutions in health care.

### **Meaningful, positive interactions between patients, families, and providers**

During our consultations with patients, the quality of interaction between patients and health care providers received mixed reviews. Patients recounted troubling examples of inappropriate conduct which were subsequently affirmed by providers and managers. A variety of causes were identified, ranging from the complexity and time-demand of addressing staff performance to the lack of system support for staff. Rude, demeaning or rough treatment of patients cannot be tolerated, especially when it involves seniors. Leaders, human resource managers, union representatives and regulatory bodies must accept their responsibility and send a clear message that such behaviour is unacceptable.

Across the country, nursing management has shifted from a clinical to an administrative focus, with significantly expanded responsibilities. Some nurse managers are responsible for 50 to 200 staff members who work at more than one site and include both clinical and non-clinical staff representing diverse training, job functions and responsibilities. Both literature and the individuals consulted for this review report undesired consequences in patient care, management of staff and work unit culture, and job satisfaction. Nurse managers' roles have become increasingly complex. On top of this, nurse managers often carry the additional work burden associated with introducing new programs or initiatives in their nursing units or facilities.

Nurse managers' time must be freed up for clinical responsibilities, including oversight and accountability for patient care, and mentoring, coaching and developing staff<sup>15</sup>. Their job descriptions should be clear and unequivocal in emphasizing these clinical responsibilities. The Ministry of Health, meanwhile, should consider what could be done to support health regions in training these and other frontline 'care culture leaders' and implementing patient- and family-centred care practices.

*"...it all depends on the relationship you have with your physician whether they advocate for you....."*  
(Patient)

*"I don't think he hears me when I talk."*  
(Patient)

Many patients described their overall health care experience as positive or negative based on their experience with their physician.

Patients want physicians who can understand their needs as a whole person. Physicians have long described their role as being, in part, an advocate for their patients. Yet hurried visits, poor scheduling, minimal dialogue, poor engagement, and a myriad of independently developed protocols do little to put the patient first. The same can be said of systemic disincentives, fiscal and otherwise, that reward volumes more than quality of care.

*Rude, demeaning or rough treatment of patients cannot be tolerated, especially when it involves seniors. Leaders, human resource managers, union representatives and regulatory bodies must accept their responsibility and send a clear message that such behaviour is unacceptable.*

The question of “who owns the patient” was frequently raised in relation to managing the complexity of the health system or providing an ongoing resource for advice and information. In a modern health system, the physician’s role needs to shift to include helping patients to self-manage and participate in their care. It is time that providers and the system recognized that the bulk of a patient’s care needs will, over time, be met by the patient himself/herself or by his/her family/friends. The health system must support physicians in making this shift and patients in understanding the importance of their own role.

In fact, providers need to trust and encourage patients who want to be actively engaged in the management of their own health. Health care should be a partnership between patients, their families and providers, not an imbalanced power relationship.

*Patient First possible pathway:* Health regions could provide nurse managers with the tools they need to spend more time supporting their staff’s engagement with patients.

### Cultural competence and safety for First Nations and Métis people

First Nations and Métis participants in the Patient First Review identified examples of understanding and accommodation of their cultural needs and differences through programs and services provided by the All Nations Healing Hospital in Fort Qu’Appelle, Saskatoon’s Mobile Health Bus, and the spiritual room at the Pasqua Hospital in Regina. However, many troubling experiences were also brought forward.

While First Nations people on reserve have access to prescribed federal funding for medical transportation, some Métis and First Nations people in remote northern locations expressed feelings of displacement and isolation when they traveled long distances alone for care, particularly when English was not their first language. Such feelings were not confined to residents in the north. First Nations and Métis residents across the province indicated they were less likely to ask questions of their health providers when they didn’t understand what was said either due to language, providers’ accents or medical terminology. And many experiences reflected a sense of being treated differently because of their cultural background.

*“Now relating to the Cardiac Rehab program, I notice that it appears to be for white people only. No Aboriginal people there except myself. When I asked the staff about this, they said yes, the Aboriginal people don’t seem to come. And Cardiac Rehab is doing what to address this? I also noted that in the Diabetes Education program that Aboriginal people do not come, either. This inequity needs to be addressed, especially with the numbers of Aboriginal people with diabetes and heart disease.”*

*(Patient)*

*“I haven’t been able to talk to anyone about the prejudice – I think that’s the way it is. A white woman in the ER had stubbed her toe and she was taken in before me, even though I had been there for 4 hours and was really sick. Nurses have made inappropriate comments that were rude and not called for. I just let it go, because that is just the way that some people are and it’s not going to change.”*

*(Patient)*



In order for the Saskatchewan health system to effectively administer patient- and family-centred care to First Nations and Métis people, it must incorporate both cultural safety and cultural competence concepts. Typically, health regions engage their employees in cultural awareness and sensitivity training activities, which assists them in recognizing their personal attitudes and biases toward First Nations and Métis people and educates them about these cultural groups' customs, beliefs and behaviours. However, the next step for these and other organizations is to adopt an agenda of cultural **safety** along with cultural **competence**. Like patient safety, cultural safety exists when the patient feels safe and involved in their care, and the provider is aware of her or his own attitude while delivering care.

Cultural competence builds on these personal interactions between patient and provider, and addresses First Nations and Métis care at the system level by incorporating culture into health care delivery practices. Every working part of the system must align its behaviours, attitudes and policies to ensure its First Nations and Métis patients are effectively and respectfully provided the care they need. Each staff person, professional group, health region or health care organization and the system itself must “address collective issues of equity in health care access and health outcomes.” (Nguyen, 2008)

Saskatchewan has begun this journey through its participation in the Aboriginal Health Transition Fund, the Memorandum of Understanding on First Nations Health and Well-Being and its renewed partnership with the Métis Nation - Saskatchewan. Through these processes, gaps in services for First Nations and Métis people are being identified and discussions are being held as to who is in the best position to deliver needed services and who is responsible for the funding of these programs and services. I have confidence that through these initiatives and others, through a transformation to patient- and family-centred care that incorporates cultural safety and competence, and through the concerted effort of all, that the health and well-being of First Nations and Métis people will improve.

*Every working part of the system must align its behaviours, attitudes and policies to ensure its First Nations and Métis patients are effectively and respectfully provided the care they need.*

### Commissioner's Recommendation:

12. 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 Nations and Métis citizens.



## 8. Functional e-Health Care

*What it looks like: Patients only need to provide information once, after which it becomes accessible to those who need it to deliver care. Patients have ease of access to their health records and the opportunity to add information.*

Patients and providers alike spontaneously identified the system's inability to collect and share vital, personal health information electronically as a key barrier to integrating health care. Patients complained about having to repeat their histories to several different providers at several different sites, or being asked to elaborate on or explain the decisions or recommendations of another provider. Clinicians too often depend on a patient to inform them about previous reactions to medications or other important details, as these often slip through the cracks when information is not shared between sites in a consistent, reliable manner.

An electronic health record was most frequently identified as a solution to these issues. The electronic health record is a series of information systems and technological infrastructure that, when integrated, will enable health care professionals to share patient information efficiently and securely.

*Put e-records in every doctor's office, new  
[Canadian Medical Association] president says:  
[Dr.] Anne Doig believes goal to have electronic records in  
place by end of 2011 part of shift to patient-centred care  
(GlobeandMail.com headline, August 19, 2009)*

In addition to the need for electronic health care records, patients identified challenges in navigating what can be an overwhelmingly complex system.

### One patient – one record

Numerous patients have multiple, redundant patient records scattered among several health care facilities. Saskatchewan patients repeatedly provided examples of misplaced, unavailable, or scattered health information and consequent errors, adverse events and duplication of costly and/or painful tests and procedures. Accessible patient information is vital to improving service integration and coordinating patient care.

*"An electronic health record would be worth its weight in gold.  
People die waiting for the mail or returned phone calls."  
(Patient)*

*"Files should be transferred so that a history can be maintained through to new doctors. At least that way the new doctor will know what was going on at the time, and can move forward from there. Why wouldn't your new doctor want to know what you have been through so far, because how are you supposed to remember everything yourself? I just want to get everyone on the same page and that shouldn't be a crime, especially when you put your trust in your doctors and the health care system."  
(Patient)*

*Saskatchewan remains largely paper-based, with ... manual records which cannot be readily transferred from one part of the health system to another.*

The future of health care in the province has everything to do with reducing long wait times, streamlining the patient journey, unclogging emergency rooms, reshaping the primary-services model, moving care closer to home, adopting leading clinical practices, managing chronic diseases, designing the system around patient needs, and promoting healthy lifestyles. This is a tall order for Saskatchewan's 40,000 care providers, even those who expressed openness to positive change. Information technology is a prerequisite to improving patient care and safety, reducing costly duplication and delays, and supporting increased accountability.

In the health sector, investment in information technology (IT) is substantially below that of other industries that have seen the benefits of IT in enhanced service delivery. Health is one of the least technologically developed sectors. Saskatchewan remains largely paper-based, with most practitioners writing diagnostic and therapy orders and maintaining manual records which cannot be readily transferred from one part of the health system to another. Yet the highly complex nature of health care demands greater access to information through technology.

Health care involves many points of contact between patients and care providers. General practitioners, specialists, pharmacists, technicians and nurses, in both urban and rural locations, may all be involved in a patient's care and work out of both hospital and community-based settings. Historically, there has been no means of electronically recording and transmitting information between care providers. This forces patients to provide their health history and related information multiple times and obligates providers to duplicate costly tests.

*"Our files are all on paper only, so when people are asked to go to the city to be treated, their files don't follow them there."  
(Health care provider)*

*"How can a doctor make a diagnosis if they don't have all the information?"  
(Patient)*

The Ministry of Health has made progress. The three major components of the provincial electronic health record currently in development are:

1. The electronic health record project – which provides provincial data repositories for clinical use (i.e. radiology and laboratory tests);
2. Electronic medical records – computer systems to support physicians in creating electronic charts and sharing patient information across the province; and
3. Integrated clinical systems in health regions – enhancing and upgrading systems such as the Mental Health Information System, and Procura, the home care information system used by staff in health regions and the Ministry.

Canada Health Infoway was established in 2000 as an independent not-for-profit corporation with the mandate to build the foundational elements of an electronic health record for use across Canadian jurisdictions. Through this organization, the province can leverage federal funding with the appropriate business case.

*Now is the time to accelerate electronic health record development. Patient, provider, and health stakeholder support is strong, federal funding is available, and many components of the provincial electronic health record are works in progress.*

*Patients will soon demand easy and immediate access to their own health care records. Patients expect to be better informed about their health conditions and treatments.*

Now is the time to accelerate electronic health record development. Patient, provider, and health stakeholder support is strong, federal funding is available, and many components of the provincial electronic health record are works in progress. However, without significant and sustained investment, those initiatives will not translate soon enough into tangible benefits such as improved access, safety, quality, and communication and information-sharing for the patient. The province should seize this opportunity and develop a provincial game plan that will lead to successful implementation.

As is typical of a provider-centred health system, patients' health information has been considered the providers' property. Patients wanting to access their medical records often face numerous hurdles in doing so. I strongly suggest that the Information and Privacy Commissioner be involved in formulating policy regarding appropriate access to health records. When almost every other industry in the developed world is utilizing technology to make information more readily accessible to its customers, we can expect that patients will soon demand easy and immediate access to their own health care records. Patients expect to be better informed about their health conditions and treatments.

*"There is a real lack of transfer of patient records. My mom has moved out of Prince Albert, but she has years and years of medical issues and I would really like the doctor where she is now to have access to all of those interventions."  
(Patient's family member)*



### Commissioner's Recommendation:

13. 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:
  - a) Developing an e-Health implementation plan by early 2010;
  - b) Securing and stabilizing funding for both the provincial electronic health record requirements and health region implementation requirements; and
  - c) Determining the preferred service delivery structure for IT at the health region level to ensure the realization of one provincial system.





## II. Improving System Performance and Leadership

45

Health care in Saskatchewan is provided through a network of professionals and agencies that include the Ministry of Health, 13 health regions including the Athabasca Health Authority, the Cancer Agency, 40 affiliated health care organizations and approximately 40,000 health care providers, some of whom operate in independent practice. The interaction between these agencies and professionals has a significant impact on the quality of patient care and overall patient experience.

The concerns that were expressed about the lack of coordination and integration in the health system, as well as the difficulties that many patients had in navigating the system, tell me that the health system is not functioning as a “system.” This quasi-network of somewhat independent agencies and professionals must begin to think and act as one system for the benefit of the patients. The role and relationship of the Ministry within the health sector must also be made more clear.

*The health system is not functioning as a “system.” This quasi-network of somewhat independent agencies and professionals must begin to think and act as one system for the benefit of the patients.*

*The regional structure is intended to ensure responsiveness to local needs. Consequently, this model also leads to variations in leadership style, management performance and capacity for service delivery.*

## Effective governance, high-performing management

In 1993, regionalization was a defining milestone in Saskatchewan health care. In what has been described as “a tidal wave of change”, health regions assumed responsibility for the planning, budgeting, organization, delivery and evaluation of health services. The community-based nature of the regional structure is intended to ensure responsiveness to local needs. Consequently, this model also leads to variations in leadership style, management performance and capacity for service delivery. The health regions differ significantly in size, scope and the nature of their activity. The province’s two largest regions include half of the province’s population, more than half of the health services activity and almost 60 per cent of the health budget that is allocated annually specifically for health region base operating costs. In addition, health regions receive additional funding for capital and other project-specific initiatives. Acute care activity is a dominant health service in the urban regions, while long-term care is a dominant service in most rural areas.

The administrative component of the Patient First Review was designed to determine whether the health system is “over-resourced, under-resourced or over-managed.” Enablers of, and barriers to, system effectiveness were to be identified and improvements suggested. Corporate functions subject to review included general administration, finance, human resources, information technology, and nurse management. All health regions, the Cancer Agency, and SAHO came within the review’s scope. Affiliates were also consulted about their working relationship with health regions.

Findings as detailed in Deloitte’s report (available for review on [www.health.gov.sk.ca/patient-first-review](http://www.health.gov.sk.ca/patient-first-review)) show that while the province’s relative level of resourcing for combined administrative areas (which includes general administration, finance, human resources, and information technology) is lower among Canadian jurisdictions, there are a number of considerations that provide important insights:

- ▶ Low relative resourcing is driven by general administration and information technology (IT), and does not necessarily represent efficiency, effectiveness or value.
- ▶ While general administration spending is lower compared to Canadian jurisdictions, Saskatchewan has greater relative spending on board and executive costs, which leaves fewer resources for key general-administration support functions such as strategic planning/decision support, quality/risk management, and patient safety.
- ▶ Lower IT resourcing translates to insufficient resourcing across health regions, where IT is not able to meet the business requirements in many organizations, and will be challenged to support the provincial e-Health strategy going forward.
- ▶ Finance and human resources have higher relative resourcing compared to Canadian jurisdictions.
- ▶ These functions are largely transactional in nature, particularly in the non-urban regions, and the needs of internal customers (i.e. managers/employees) are reportedly not being met.

- ▶ The current corporate management model is not sustainable from a workforce perspective. In particular, finance, human resources, and IT functions are experiencing and anticipating recruitment and retention challenges of qualified leadership and frontline staff.
- ▶ Economies of scale are difficult to achieve, given the duplication of transactional functions across 14 service provider organizations.
- ▶ Varying levels of consistent strategic leadership are evident across provider organizations, including affiliate organizations.

Focus group discussions with affiliate organizations (e.g. faith-based facilities and services) indicated their desire to receive more attention from regional leadership. Some affiliates feel orphaned from the regions' strategic planning processes, despite their willingness to become involved.

We heard numerous concerns from patients, frontline staff, and the public, that health regions were becoming a "growth industry for management." This perception seems often to be aggravated by a lack of understanding among frontline staff and community residents as to the purpose and value of newly created management positions. In an environment where health care resources are often stretched to the limit, patients and frontline staff need to see a direct link between a manager's role and patient care. It is incumbent on each region to ensure that link exists and to communicate it to the public and to regional staff.

The review also identified differences in the nature of the administrative functions performed in the health regions, which tend to be more heavily weighted to the transactional (as opposed to strategic) in the non-urban health regions. As a result, these health regions have less capacity to support functions requiring higher-level planning and analysis. Questions were raised about the efficiency and cost effectiveness of functions that are duplicated across regions and about the capacity of small and medium-sized regions to respond to the demands of a changing and complex environment.

An additional, pragmatic consideration is the capacity of the managerial workforce. Not unlike the clinical areas of the health enterprise, administration is also experiencing workforce pressures. There have been instances where health regions have been unable to consistently carry out essential corporate functions due to workforce shortages.

Leading and sustaining change must be a priority for health regions. Given the scope of transformation recommended in this report, making it happen is no small feat. However, for the sake of tomorrow's patients, inaction is not a viable option. At the same time, each region must ensure it has adequate and meaningful leadership involvement from its medical staff.

It is time that business be done differently and better for the sake of patients. Health regions must ensure best value is harvested province-wide in the purchase of goods and services required to deliver quality health care. In other provinces, numerous non-clinical and clinically-related corporate functions have adopted alternate service delivery models. Health regions would be well-advised to explore some of these successful models for possible applicability in Saskatchewan.

*Economies of scale are difficult to achieve, given the duplication of transactional functions across 14 service provider organizations.*

*In an environment where health care resources are often stretched to the limit, patients and frontline staff need to see a direct link between a manager's role and patient care.*

*Province-wide purchasing of goods and services will substantially increase the province's buying power and save resources for all health regions so they may be allocated to direct patient care.*

48

*A new, provincial, shared-services organization should be established to undertake supply-chain management and standardization at a provincial level.*

Inaction by health regions, affiliates, SAHO, and the Cancer Agency, along with physician and provider preferences among health regions, have cost the province millions of dollars in unrealized savings over the years due to the absence of province-wide purchases of supplies, equipment, and services. Recent announcements in Alberta and B.C. attest to a compelling need for the Saskatchewan health care enterprise to finally come together for the benefit of taxpayers. Province-wide purchasing of goods and services will substantially increase the province's buying power and save resources for all health regions so they may be allocated to direct patient care.

A new, provincial, shared-services organization should be established to undertake supply-chain management and standardization at a provincial level. This would signal a new way of doing business on behalf of Saskatchewan people. All health regions, affiliates, and the Cancer Agency must be full participants if maximum value is to be achieved.

An expert board of directors can work with the Ministry of Health, health regions and respective affiliates, and the Cancer Agency in defining the new organization's mandate. Strong corporate leadership will be needed to break through traditional ways of doing business and enshrine a province-wide perspective. Only then will value-for-money be realized for Saskatchewan citizens.

Providers have a leadership role to play in evaluating and standardizing health system equipment and supplies. The key to success is a strong resolve on the part of health regions, respective affiliates and the Cancer Agency to share as many services as possible. Adopting new and enabling technologies will be essential to this new endeavour. That is why I would urge up-front, one-time investment to ensure successful implementation.

Province-wide purchasing for major items such as radiology equipment and computer technology could yield significant savings to taxpayers. In addition, purchasing insurance and pooling short-term borrowing needs for all health regions and the Cancer Agency can save significant dollars. Over the past year, health regions collectively paid over \$4 million in collective interest expense for short-term cash management. Therefore, it behoves the Ministry of Health and the health regions to explore financing options that will reduce interest expense significantly and direct savings to patient care programs.

Patients, staff, and members of the public questioned the effectiveness of the current regional model. Given the distractions that can result from structural and organizational change, I have not recommended revising the current regional model for the time being, although there should be a focused effort to improve the efficiency of the regions' corporate functions. It is important that the Government of Saskatchewan identify and consider options for broader change.

My view is that if one were to design a contemporary model for overseeing health care to one million citizens, there would be little chance that Saskatchewan's current model would be chosen. Should there be remodelling of health care in the province in the future, jurisdictions should be organized on the basis of patient flow, not arbitrarily determined geographical boundaries.

While overall resourcing in the area of general administration is lower than that of other jurisdictions, there appears to be a higher proportion of dollars spent on the boards. This is a function of having numerous regions, each with a board of directors served by a senior management team. Over \$1.7 million is spent annually on per diems and direct board costs to support all of the activities associated with regional governance. This does not include the thousands of hours the regions' management groups spend preparing for monthly board meetings, committee activity and special sessions.

Working within the existing regional governance model, several actions could be taken to reduce the expenditures associated with governance activity. *The Regional Health Services Act* provides for a maximum of 12 board members appointed to each health region board; this maximum number is typically observed. Through attrition, board membership could be reduced to seven directors, meeting a maximum of five times per year. Numerous former board members voiced concern about their role, indicating they were primarily involved in operational decisions rather than policy formulation. Examination of board meeting material supports this observation. Savings from reduced board costs should be reallocated to patient- and family-centred functions.

In order for the governing boards to effectively fulfill their stewardship role, members need skills that equip them for policy development, decision-making and organizational oversight. Effective corporate governance lies in the relationship between directors and in the competence, integrity and participation of individual directors. Formal board evaluation is critical to ensuring effectiveness, providing feedback on performance and creating a culture of "learning leaders" from the top down. A province-wide evaluation model should be adopted and board chairs should engage with appropriate experts in designing this model. An inclusive approach to developing this model provides valuable insights for the participants and fosters a province-wide perspective.

I suggest that all health region and Cancer Agency boards conduct annual performance reviews of their CEOs. The review should follow a template developed by board chairs in consultation with the Ministry which is based on the health system strategic directions, and should at a minimum, consider metrics that reflect quality, safety, and performance of the organization.

*In order for the governing boards to effectively fulfill their stewardship role, members need skills that equip them for policy development, decision-making and organizational oversight.*

### Commissioner's Recommendation:

14. 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.



## Executive staff/medical staff partnership

Ineffective working relationships between physicians and their respective regional leadership are apparent in a number of health regions. This dysfunctionality was described by both patients and providers during interviews and some focus groups.

Unproductive relations between regional leaders and medical staff can adversely affect the workplace and, in turn, the delivery of quality care. Understanding the value of physician involvement when it comes to delivering accessible quality care is a critical factor to the success of meeting community health needs.

Without a solid base of mutuality and clear understanding between medical staff and executive leadership, service consolidations and program alignments may foster a win-lose mentality that damages mutual trust. In these circumstances, executive leadership and medical staff are both responsible for fostering an environment of partnership and collaboration.

For the sake of patients, there cannot be a dividing line between management and regional medical staff. A “we” and “they” philosophy must be superseded by an “us” philosophy that emphasizes working together for the benefit of the patient.

Only when medical staff perceive that regions are genuinely interested in engaging them will there be a constructive dialogue that promotes collaboration and builds mutual trust. Findings from the review indicate that physician leadership roles in non-urban regions are highly variable in terms of time commitment. Increased medical staff leadership is necessary in all regions to support change improvements and accountability requirements.

## Catching up on capital

Saskatchewan's health care infrastructure assets owned by health regions, government, faith-based organizations and affiliated entities represent billions of dollars in investment.

In visiting numerous health care facilities and consulting with system leaders and care providers, it was my observation that capital infrastructure and related technology investments have been deferred for far too long. Years of neglect of building maintenance have resulted in accumulated deficiencies that have a huge price tag for taxpayers. The current physical decay of health care infrastructure will grow exponentially with the passing of time unless major remedies are instituted province-wide.

Saskatchewan's health care infrastructure includes elements that are in significant disrepair and, in some cases, are borderline compliant with current occupational health and safety standards. This leads to compromising the workplace environment and, in turn, the safety of patients and staff. Over the past decade, health care needs have dramatically changed. Regrettably, capital investments have not kept pace. Further, the provincial priorities have not reflected the need to build appropriate capacity to address shifting population and growing volumes of patient care.

All too often in the past, capital funding for health infrastructure has been erratic from year to year. To ensure safe, quality workplaces and patient comfort over the long term, I support a more predictable long-term capital financing plan.



*Alternative financing partnerships present Saskatchewan's health care provider organizations with opportunities to access new sources of capital, expertise and technology.*

In view of the insatiable appetite for replacement of health care infrastructure, and the pent-up technology demands, alternative funding mechanisms should be given serious consideration to refresh both buildings and technologies central to the delivery of quality care. Future major investments in diagnostic/treatment equipment, parking structures, and long-term care facilities are logical candidates for leasing or alternative funding mechanisms. The United Kingdom health care enterprise has led the way in adopting such mechanisms.

Alternative financing partnerships (AFPs) present Saskatchewan's health care provider organizations with opportunities to access new sources of capital, expertise, and technology. When designed properly, AFPs can play important roles in delivering public infrastructure projects on budget and on time while offering value for money to Saskatchewan taxpayers. These opportunities allow health care organizations to address the dual challenges of restricted public funding of the past, and the pent-up demand of years of neglect to refurbish fatigued capital assets. I strongly believe that successful partnerships require a planning framework, provincial strategy, and prudent selection of partners before the province embarks on such arrangements.

Alternative financing partnerships in health care are being pursued across Canada and in numerous countries around the world. Similar partnerships in Saskatchewan can offer new opportunities to facilitate the building of infrastructure such as new parkades or long-term care projects that meet the parameters of an AFP.

A coherent capital plan, which is currently in development with the health regions and the Cancer Agency, will represent progress. The framework for such a plan must be based on a provincial service delivery plan that is agreed to by the regions and under the direction of a dedicated Ministry branch. Planning principles should guide and inform the development of plans for each region and business cases must be prepared for each regional service delivery plan.

*Patients and health care provider organizations look to the Ministry of Health to set out a vision and strategy that will guide the health system.*

### Commissioner's Recommendation:

15. 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.



### A renewed role for the Ministry of Health

Saskatchewan's health care enterprise is complex and diffuse, and is confronted with numerous demands. Patients and health care provider organizations look to the Ministry of Health to set out a vision and strategy that will guide the health system.

The effectiveness of the interface between the Ministry of Health, health regions, the Cancer Agency, and SAHO is critical to delivering timely, quality, and sustainable care to Saskatchewan's one million citizens.

*The Ministry of Health would concentrate on setting strategy, priorities, and standards of performance and monitor outcomes in a transparent manner to achieve public accountability.*

In a preferred health care setting, the Ministry of Health would concentrate on setting strategy, priorities, and standards of performance and monitor outcomes in a transparent manner to achieve public accountability. The ministry's leadership must be receptive to changing its modus operandi and portfolio structure so that all its influence and skills drive "system transformation" that will not only put the patient first, but will achieve improved performance.

Only with this focused ministry direction will health care providers and system leaders regard themselves as true partners and think, plan, and act as a system. This new mode of interaction will result in a positive and productive working relationship. Equally important is achieving clarification on the roles and accountabilities of the regions, Cancer Agency, and the Ministry.

In response to patient and public concerns, it is important that this report offer advice on change improvements within the Ministry. The starting point is to examine the suitability of the current organizational structure relative to the Ministry's role, current challenges in the health system and future needs. The Ministry's organizational structure should be re-aligned to support a transformational change agenda outlined in this report. This will allow the ministry to more effectively serve its stakeholder constituencies by assuming more of a strategist-integrator-steward role for Saskatchewan health care.

Significant concerns have been raised about the mechanisms used to monitor compliance with the Ministry's service delivery and performance expectations. I am encouraged by the work that is under way to streamline the accountability agreements between the Ministry and its service delivery organizations, and urge the partners to continue to work together to arrive at an agreement. A few vital performance measures should be articulated, and consequences of non-compliance should be identified.

Financial metrics that track and record utilization of resources, budget performance against targets, operational efficiencies and workforce-related benchmarks such as sick time, Workers Compensation Board charges/rebates are all important matters that should be publicly and transparently reported.

The current regional model, adopted in 1993 and amended in 2002, presents many challenges for the Ministry as it pursues ways and means to best support each region. Meanwhile, all other provinces have moved on from their original governance models to achieve better performance and improved quality. In the long run, preserving the status quo in Saskatchewan will not yield the quality outcomes and system efficiencies expected by patients and taxpayers alike.

### Commissioner's Recommendation:

16. 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.



### Strong leaders and accountability to the public

I do not underestimate the challenge of leading transformational change in health care. The system is inexperienced in this regard. Aside from the introduction of Medicare and regionalization, health care can be characterized by either status quo increases (more of the same) or incremental, isolated developments focused on specific parts of the system. Often these incremental changes to improve one part of the system have had unintended consequences for another. It will be difficult to advance changes that lead to a patient focused health system and it will require strong resolve and courage on the part of policy makers, health professionals, decision makers and senior leaders.

The challenges ahead require nothing less than a highly skilled and committed leadership that inspire and empower the health care workforce. I heard from frontline providers and patients alike who raised concerns about the lack of visible senior leadership. Leaders and managers were not seen as connected to the “everyday business” of health care and in some instances the roles of managers were unclear and duplicative. The engagement of senior leaders with staff at all levels of the organization is necessary to drive the transformation of the care and caring experience. The engagement of leaders with patients is also important. In addition to natural attrition, it can be expected that a number of people in key positions will retire over the next few years. Health regions, the Cancer Agency and the Ministry need to ensure readiness by engaging in succession planning now.

Accountability is fundamental to effecting change and is closely connected to leadership. Results-oriented organizations require clear accountability relationships, defined performance measures, and well-defined mechanisms for ensuring targets are met.

The public is interested in increased transparency in health care and it is important that information is provided in areas such as health outcomes, patient safety, wound prevalence, infection rates, and adverse patient events, and system performance indicators. More transparent, timely and robust public reporting on system performance would be welcomed by the public.

*The challenge of leading transformational change ... will require strong resolve and courage on the part of policy makers, health professionals, decision makers and senior leaders.*



## Conclusion

From its outset, the mandate of the Patient First Review was to seek out ways to improve patient care and its administration in Saskatchewan. As a result, this report necessarily focuses on some of the gaps that have emerged or widened within the province's health system over time. The concerns we heard from patients and providers alike were real and expressed with an urgency for real change. It was important, then, that those concerns be expressed with a similar urgency in this report.

At the same time, it is worth noting here that every day, thousands of health care providers go to work with the hope and intent of providing excellent care. Yet health care is an incredibly demanding field in which to build a career, and for those who spend their days interacting with people who are ill, injured, and often under great stress, the demands can sometimes be overwhelming, particularly in a workplace that may be cramped, aging, or ill-equipped for today's challenges. I was privileged to meet with some of these unsung heroes and hear them speak with passion and eloquence about their own desire to deliver patient- and family-centred care, and some of the barriers they were experiencing. We now owe it to them to empower them and give them the tools that will enable them to provide the care they were trained to give – and want to give.

While there are obvious challenges associated with the affordability of the latest medical and diagnostic technologies, a great deal can be done to optimize the health care dollars that directly affect and improve patient care. By moving from a piecemeal array of services, service providers, and systems to an integrated provincial network, Saskatchewan can gain significantly greater value for the money its taxpayers contribute to health care.

Saskatchewan people do not appear to be calling for a thorough dismantling or fundamental re-invention of their health system. They recognize the system's relative strengths and are proud of the Medicare legacy. However, they also want to see real "fixes" to those issues that persistently contribute to poor access and a poor health care experience.

Saskatchewan does not lack individuals with tremendous ideas and energy, leaders in patient care and in administration who have the talent and the vision to build a revitalized, patient-centred health system. Nor is there any lack of patient- and family-centred models that have been adopted and adapted in other jurisdictions with great success.

Significant change does not happen, of course, without significant investment of time, effort, and fiscal and human resources. Before embarking on transformational change, the Ministry of Health, with its partners in the Saskatchewan health care enterprise, will need to determine both the relative costs and the relative priorities of the recommendations contained in this report.

With any change to the established and habitual ways of operating, there will be resistance from those more interested in preserving the status quo than responding to the voices of patients and their families. A passion for quality, a willingness to innovate, and the ability to collaborate will be requisites for Saskatchewan's health system leaders.

Saskatchewan has the people and the knowledge necessary to achieve excellence in health care. What is needed is the collective will and vision to bring about real change. The provincial government will not succeed on its own, nor will any one health region, physician, care provider, manager or patient advocate.

Patient First must become more than a mantra. For the sake of patients, it must become a movement that is embraced by all who have a stake in creating healthier communities.

*Saskatchewan people do not appear to be calling for a thorough dismantling or fundamental re-invention of their health system.... However, they also want to see real "fixes" to those issues that persistently contribute to poor access and a poor health care experience.*

# Endnotes

- 1 Canadian Institute for Health Information. *National Health Expenditure Trends 1975-2008*
- 2 McGlynn, E.A., S.M. Asch, J. Adams, J. Keeseey, J. Hicks, A. DeCristofaro, and E.A. Kerr (2003) "The quality of health care delivered to adults in the United States," *New England Journal of Medicine* 348(26):2635-45, found that only 56 per cent of adults with chronic diseases receive guideline-recommended care. Diabetes, a serious problem in Saskatchewan, was the worst managed condition. Consistent with this finding, Saskatchewan's Health Quality Council (HQC) recently reported more than half of people living with diabetes in Saskatchewan do not maintain their blood sugar or cholesterol at optimal levels.
- 3 For example, despite the proven life-saving efficacy of beta-blockers, statins and ACE-inhibitors for preventing further heart attacks in post-acute myocardial infraction patients, the HQC reported that only 42 per cent of Saskatchewan's heart attack patients had filled prescriptions for all three recommended medications within 90 days of leaving hospital (*Quality Insights: Measuring. Learning. Improving Health Care Together*, 2008).
- 4 For example, the HQC recently reported that among community-dwelling seniors who were chronically dispensed benzodiazepines (a medication used to treat anxiety and insomnia), more than 1 in 5 received dosages higher than the recommended maximum for seniors. This rate increased (indicating poorer quality of care) by 3% between 2003/04 and 2005/06 (rising from 20% to 23%) (*Quality Insights: Measuring. Learning. Improving Health Care Together*, 2008).
- 5 Baker GR, Norton PG, Flintoft V, et al. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *CMAJ*,170:1678-86
- 6 K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007
- 7 For the full terms of reference for the Patient First Review, please see Appendix B.
- 8 Transforming Your Practice: What Matters Most, Katherine Gottlieb, MBA, Ileen Sylvester, MBA, and Douglas Eby, MD, MPH, Family Practice Medicine, [www.aafp.org/fpm](http://www.aafp.org/fpm), January 2008, pp. 32 - 38
- 9 Statistics Canada. *Population Projection for Canada, Provinces and Territories 2005-2031*. Cat. 91-520-XIE
- 10 Statistics Canada. *Projection of Aboriginal population, Canada, Provinces and Territories 2001-2017*. Cat. 91-547-XIE
- 11 The impact of unintentional injury in Saskatchewan is significant. Safe Saskatchewan reports the province's injury hospitalization rate is twice the national average and its death rate, at over 300 fatal injuries per year, is 1.4 times higher. Even though Saskatchewan's population is only three per cent of Canada's total, the number of unintentional injuries that occur here are nearly seven per cent of all injuries in Canada.
- 12 In 2004, Saskatchewan Health, in collaboration with other stakeholders, released a population health promotion strategy called *Healthier Places to Live Work and Play*. The strategy builds on work already underway in health promotion and disease and injury prevention, and challenges the health system and community partners to create environments where citizens find it easier to make healthy choices. Four priority issues were identified in the strategy: mental well being; accessible, nutritious food; decreased substance use and abuse; and active communities.
- 13 <http://www.nytimes.com/2009/06/04/health/04chen.html>
- 14 2009 award of excellence for interdisciplinary community services, Tommy Douglas Celebration of Medicare Awards.
- 15 Commitment to Care: Nurse Recruitment and Retention in Saskatchewan

# References

- Berwick, D. (2009). What Patient-Centered Should Mean: Confessions of an Extremist. *Health Affairs*, May 2009.
- Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press; Washington DC.
- Nguyen, Hung The (2008). Patient-centred Care: Cultural Safety in Indigenous Health. *Australian Family Physician*, December 2008.
- Shaller, D (2009). *Patient Centered Care – What Does It Take?* The Commonwealth Fund.
- Shamliyan, T., Duval, S., Du, J., Kane, R. (2008). Just What The Doctor Ordered. Review of the Evidence of the Impact of Computerized Physician Order Entry System on Medication Errors. *Health Services Research*; 43(1).
- Stewart, M. J Brown, A Donner, I McWinney, J Oates, W Weston, J Jordan (2000). The Impact of Patient Centered Care on Outcomes. *The Journal of Family Practice* 49 (9).

# Appendix A

## Consultations / Meetings

Throughout the course of the Patient First Review, many individuals and organizations took the time to contribute their stories and opinions, as well as feedback on the preliminary findings of the research. I appreciate the time and attention given by those who participated in the research focus groups, interviews, and meetings. Your contribution to the Patient First Review is immeasurable. In addition, I want to thank the following with whom I met outside the formal research process:

- Albritton, William M.D. –  
College of Medicine, University of  
Saskatchewan
- Alvarez, Richard – President and Chief Executive  
Officer, Canada Health Infoway
- Antosh, Susan – President & Chief Executive  
Officer, Saskatchewan Association of Health  
Organizations (SAHO)
- Botting, Dale – Chief Executive Officer,  
Enterprise Saskatchewan
- Bourassa, Richard – Saskatoon Surgi Centre
- Bowen, Francis M.D. – Director of  
Emergency Department
- Brossart, Bonnie – Health Quality Council
- Brunskill, Donna – Executive Director,  
Saskatchewan Registered Nurses' Association
- College of Physicians and Surgeons of  
Saskatchewan
- Council of CEOs – Regional Health Authorities
- Cummings, Donald – Emergency Medical  
Services Review
- Davies, Maura – Chief Executive Officer/President,  
Saskatoon Health Region
- Davis, Donna – Patients for Patient Safety Canada
- Davis, Judy – Hospitals of Regina Foundation
- Degelman, Bob and Dianne – City of Melfort
- Dickson, Gary – Information and  
Privacy Commissioner
- Earle, Allan – President, Saskatchewan Urban  
Municipalities Association (SUMA)
- Fenwick, Kevin – Ombudsman Saskatchewan
- Fox, Harvey – Former health sector  
Chief Executive Officer
- Gardiner, Nap – Coordinator,  
Northern Health Strategy
- Gibson, Dave – Director, Continuing Care and  
Seniors Health, Saskatoon Health Region
- Hambly, Barb – VP, Alberta Health
- Health & Social Development Commission,  
Federation of Saskatchewan Indian Nations  
(FSIN)
- Heaton, Gill – Director of Patient Services/Chief  
Nurse, National Health Service, United  
Kingdom
- Higgins, Mike – Vice President Human Resources  
– Regina Qu'Appelle Health Region
- Hope Cancer Centre
- Hornell, Jim – Cypress Regional Health Authority/  
Community Leadership Network
- Hospitals of Regina Foundation
- Hunt, Cecile – Chief Executive Officer,  
Prince Albert Parkland Health Region
- Irwin, Scott – Catholic Health Ministry of  
Saskatchewan (Saskatchewan Catholic  
Health Corporation)
- Junor, Judy – MLA
- Karasin, Keith – Canadian Cancer Society
- Kendel, Dennis M.D. – College of Physicians  
and Surgeons of Saskatchewan
- Kirwan, Joe – Chief Executive Officer,  
Sunrise Health Region

Knelsen, Karen – Provincial Affiliate  
Resource Group

Landry, Shan – VP Home Care and Long-Term Care,  
Saskatoon Health Region

Larrivee, Diane – Vice President Specialty Care  
– Pasqua Hospital

McMillan, Stewart M.D. – Chairperson,  
Saskatchewan Cancer Agency

Métis Nation - Saskatchewan – Métis Nation  
Roundtable

Memorandum of Understanding (MOU) on  
First Nations Health & Well-Being Steering  
Committee

Morrison, Jean – Chief Executive Officer,  
St. Paul's Hospital

Mougeot, Laurent – Chief Executive Officer,  
Saskatchewan Urban Municipalities  
Association (SUMA)

Mycyk, Taras M.D. – Head of Cardiovascular  
Surgery, Royal University Hospital, Saskatoon

Nelson, Dwight – President and Chief Executive  
Officer, Regina Qu'Appelle Health Region

Nilson, John MLA

Ouellet, Robert M.D. – Canadian Medical  
Association

Peterson, Glenn – Saskatoon

Popkin, David M.D. – Vice-President, Care Services  
Clinical, Saskatchewan Cancer Agency

Prince Albert Chamber of Commerce

Quality of Care Coordinators and Patient  
Navigators – Regional Health Authorities

Ross, Laura – MLA, Legislative Secretary for  
Nursing Recruitment and Retention

Ryan, Shirley – Saskatoon Business Association  
Saskatchewan Medical Association  
Board of Directors

Sharma, Nawal M.D.

Shaw, Mike – Ministry of Government Services

Schriemer, Joceline MLA – Legislative Secretary to  
the Premier, At-Risk Youth Initiative (formerly  
Legislative Secretary for Addictions)

Stefiuk, Donald M.D. – Saskatoon Regional  
Medical Association

Stephanson, Randy – Regina Qu'Appelle  
Health Region

Stromberg, Bonnie – Lawyer

Taylor, Len – MLA

Vail, Stephen – Director of Research,  
Canadian Medical Association

Vogel, Martin M.D. – Executive Director,  
Saskatchewan Medical Association

Vuksic, Chris M.D. – Senior Medical Officer,  
Regina Qu'Appelle Health Region

# Appendix B

## Patient First Review: Terms of Reference

### Introduction

Government committed to a Patient First Review of the health care system, that, with input from health care stakeholders would:

- improve front-line care for patients;
- direct dollars away from bureaucracy to front-line care; and,
- create quality work environments for health care professionals.

We want to improve our health care system in ways that are meaningful for patients. It is important that we involve both those that receive and those that deliver health care.

### Who Will Conduct the Review?

Tony Dagnone has been appointed Commissioner and will provide oversight and general management to the review. KPMG LLP and Deloitte Inc. are firms that have experience in working with health care systems and are each conducting parts of this review.

### Mandate of the Commissioner

1. To undertake consultations with patients that are focused on the patient experience with health care. Using a range of mechanisms, the consultations will solicit information on what is and isn't working well in the health care system;
2. To undertake consultations with health care providers and stakeholders, which examine the feedback from the patient consultations and identify opportunities to improve patient experiences across the continuum of care;
3. To provide a report to the Minister that includes findings from the consultations with patients, providers and stakeholders, and makes recommendations on changes needed; and
4. To complete an administrative review of the Regional Health Authorities (RHAs), affiliate organizations, and the Saskatchewan Association of Health Organizations (SAHO) to assist in determining the overall effectiveness of resource use in the health sector, by identifying the current base of administration, operating efficiencies, constraints and opportunities for improvement, and to provide a report to the Minister of Health.



## Principles

The review will be conducted in accordance with the following principles:

**Patient-Centered** – The review will support a system-wide focus on improving patient/public care and experience.

**Open** – The review process will engage the public through multiple avenues and will be open to receiving and considering new information.

**Transparent** – The review process will be open to public scrutiny, and the results of the review will be available to all Saskatchewan residents.

**Innovative** – Ideas for change and innovation will be welcomed from the public, stakeholder groups, and health care experts. Experiences in other jurisdictions will be examined.

**Accountable** – The results of the review will demonstrate responsiveness to input received and a commitment to building a health care system that puts the patient first.



For more information, contact:  
Saskatchewan Ministry of Health

T.C. Douglas Building  
3475 Albert Street  
Regina, Saskatchewan  
S4S 6X6

General Inquiries: (306) 787-0146  
Toll-free: 1-800-667-7766 (Saskatchewan only)  
E-mail: [info@health.gov.sk.ca](mailto:info@health.gov.sk.ca)

[www.health.gov.sk.ca/patient-first-review/](http://www.health.gov.sk.ca/patient-first-review/)



**Saskatchewan  
Ministry of  
Health**