

Optimizing and Integrating Patient-Centred Care



Saskatchewan Advisory Panel on Health System Structure Report

Advisory Panel
Brenda Abrametz, Tyler Bragg & Dr. Dennis Kendel

December 2016

Optimizing and Integrating Patient-Centred Care

Saskatchewan Advisory Panel on Health System Structure Report

Advisory Panel

Brenda Abrametz, Tyler Bragg & Dr. Dennis Kendel

December 2016

Table of Contents

Letter of Transmittal and Acknowledgements	2
Executive Summary	3
Introduction	6
■ Regionalization in Saskatchewan and across Canada	6
■ Current Health System Environment in Saskatchewan	9
■ The Need for Change	10
What we heard	13
Recommendations	15
■ Mandate 1	16
<i>Recommend a structure with fewer Regional Health Authorities to achieve administrative efficiencies as well as improvements to patient care</i>	
■ Mandate 2	22
<i>Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services</i>	
■ Mandate 3	28
<i>Review current legislation and processes to ensure they adequately establish: the roles of health systems Boards; their composition; structure and reporting relationship to achieve appropriate accountability</i>	
■ Mandate 4	29
<i>Identify processes to enhance management information to improve and observe on performance management of the health care system</i>	
Conclusion	32
Appendix A	33

Letter of Transmittal and Acknowledgements

December 2016

To the Honourable Jim Reiter
Minister of Health

On August 18, 2016, the Government of Saskatchewan announced the appointment of an Advisory Panel on Health System Structure tasked with providing advice on the future structure of the health system in this province. Each of us accepted this appointment because we care deeply about the quality of health care delivered to the people of Saskatchewan and are committed to improving the performance of our health care system.

The Advisory Panel was given a four-point mandate; the most prescriptive element being that we provide a recommendation of a future health system with fewer Regional Health Authorities (RHAs). The primary goal of such a consolidation is to achieve improvements to patient care while finding administrative efficiencies. The mandate also included a focus on the composition and accountability of health system Boards, clinical and health system support services that would be better delivered on a provincial basis, and improved capacity for measurement of system performance.

As the Panel met for the first time, we rapidly reached consensus that the overarching purpose of our task be grounded in our health system's current commitment to patient- and family-centred care and the four goals of Better Health, Better Care, Better Value and Better Teams. We were also guided by the commitment of our current RHAs and health agencies to 'think and act as one' in pursuit of continuous quality improvement. The structure of any system only derives meaning to the extent that it either supports or impedes the achievement of the system's objectives. We therefore agreed that 'form should follow function.' With our commitment to patient care through the 'four betters,' we agreed that our goal should be to recommend a structure that best supports those functions and goals.

Based on the input we received, a thorough review of submissions from the public and stakeholders, and our own experiences within the health system, we are pleased to submit our recommendations to the Minister of Health in our report *Optimizing and Integrating Patient-Centred Care: Saskatchewan Advisory Panel on Health System Structure*.



A handwritten signature in black ink that reads "B.A. Abrametz".

Brenda Abrametz



A handwritten signature in black ink that reads "Tyler Bragg".

Tyler Bragg



A handwritten signature in black ink that reads "D. Kendel".

Dr. Dennis Kendel

Executive Summary

The Advisory Panel on Health System Structure was given a four-point mandate to provide independent advice to the Minister of Health to improve the current Regional Health Authority (RHA) structure, specifically through four overarching priorities:

- Recommend a structure with fewer Regional Health Authorities to achieve administrative efficiencies as well as improvements to patient care.
- Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services.
- Review current legislation and processes to ensure they adequately establish: the roles of health systems boards; their composition; structure and reporting relationship to achieve appropriate accountability.
- Identify processes to enhance management information to improve and observe on performance management of the health care system.

The Advisory Panel views the primary element of our mandate as the expectation that we recommend a structure with fewer RHAs, with the primary goal of consolidation being to support improvements to patient care and achieve administrative efficiencies.

To inform our recommendations, our first step was to obtain input from health sector agencies, partners and leaders, and from Saskatchewan citizens. The Advisory Panel held consultations and received input during a formal feedback process that was open to the public from August 29, 2016 through September 26, 2016. During this period, the Advisory Panel held consultations with key health system partners and stakeholders, including RHA leadership, health providers such as physician leaders, provider unions and affiliates, Indigenous leaders and others. The Advisory Panel also received written submissions through an online form and by mail. Over 300 completed written submissions were received from a diverse group of individuals and organizations addressing the four areas within the Advisory Panel's mandate.

The Advisory Panel also reached out to health care leaders in Canada who had experience with the consolidation of health system governance and management. In addition to information shared through the consultation process, we accessed and reviewed the literature on experiences of regionalization of the health system.

The Advisory Panel made a commitment to read, respect and consider every submission made to us, and we honoured that commitment. Based on the input we received, a thorough review of submissions from the public and stakeholders and our own experiences within the health system, the Advisory Panel arrived at the following recommendations within our mandate:

Mandate 1: Recommend a structure with fewer Regional Health Authorities (RHAs) to achieve administrative efficiencies as well as improvements to patient care

Recommendations:

1. **In support of achieving a singular system that is focused on meeting patient needs through seamless, integrated and team-based care, consolidate the 12 existing RHAs into a single Provincial Health Authority with responsibility for all services governed by the existing RHA Boards, with the following considerations:**
 - a) Health care organizations, including affiliates, to be contracted through, and accountable to, the Provincial Health Authority.
 - b) Organize and focus continuous improvement with the objective of reinforcing a culture centred on high quality patient care and improving the patient experience.
2. **To enable effective integration and coordination of care, create four service integration areas.** The ultimate goal is to improve and enhance the patient experience across the continuum of care, including better coordination of patient transitions between service areas.

One of the service integration areas should be unique to the north based on the approximate geography of the existing Keewatin Yatthé and Mamawetan Chur-

chill River health regions. Athabasca Health Authority should remain as currently structured. The remaining three service integration areas should reflect existing and appropriate care seeking patterns, particularly with respect to acute and specialized care.

3. Good primary care is foundational to patient health and successful intervention at other levels of care. **To benefit the patient and the patient experience, one of the first areas of focus of the new Provincial Health Authority and the Ministry of Health should be to fully implement the Primary Health Care Framework (2012) and prioritize enhancement of team-based primary health care across the province.**
4. **Enhance capacity to ensure the needs and interests of residents and communities within each service integration area are identified and advanced through community advisory networks as described in Section 28 of *The Regional Health Services Act*.** The networks will support senior leadership within the service integration areas by informing local health care needs and delivery of services and seeking ways to improve the patient experience, with the goal of achieving a patient- and family-centred health system.
5. **Engage with Indigenous people to help inform how best to address First Nations and Métis health needs in a culturally responsive and respectful manner.** In particular, the following should be examined:
 - a) Appropriate representation in the governance of the Provincial Health Authority;
 - b) Ensuring community advisory networks are reflective of the ethnicity and culture of the community; and
 - c) Establishing a senior administrative role within the Provincial Health Authority with the responsibility for ensuring health care services respect the Indigenous and Métis patient experience.

Mandate 2: Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services

Recommendations:

1. **The Provincial Health Authority should pursue opportunities for consolidation of clinical services within and across the service integration areas, including:**
 - a) Integrating diagnostic services (including laboratory and diagnostic imaging) across the province, including services delivered by the Saskatchewan Disease Control Laboratory (SDCL);
 - b) Optimizing the organization of Emergency Medical Services (EMS) through the consolidation of all planning, dispatch and delivery; and
 - c) Coordinating tertiary acute care services to reduce duplication and variation, and improve consistency and quality of service delivery.
2. **A Provincial Health Authority will allow for a standardized approach to a range of health system support services, including information technology, procurement, supply chain, human resource management, financial services, payroll services and health provider recruitment.**

In recognition of their established expertise, the Provincial Health Authority should pursue ongoing service delivery as follows:

- eHealth for information technology and related services;
- 3sHealth for procurement, supply chain, payroll and other related services;
- Saskatchewan Association of Health Organizations (SAHO) Inc. for labour relations and related services; and
- Physician Recruitment Agency of Saskatchewan (PRAS) for physician and health provider recruitment services.

3. **The Government of Saskatchewan should review the governance arrangements currently in place for eHealth, SAHO, PRAS, and 3sHealth to ensure the most effective and efficient delivery of services, including the potential consolidation of these entities. The Government of Saskatchewan should also review the governance arrangements currently in place for the Saskatchewan Cancer Agency (SCA) to ensure cancer services are appropriately and effectively integrated with services delivered by the Provincial Health Authority. These reviews should occur within two years of the formation of the Provincial Health Authority.**
4. **It is further recommended that the Health Quality Council (HQC) remain as an independent organization to continue its focus on measurement of health system performance, including patient outcomes.**

Mandate 3: Review current legislation and processes to ensure they adequately establish: the roles of health systems Boards; their composition; structure and reporting relationship to achieve appropriate accountability

Recommendations:

1. **Establish a Board to govern the activities of the Provincial Health Authority.**
 - a) The Board to be accountable to the Minister of Health.
 - b) Appointments to the Board to be based on expertise, including the ability to represent patient experience and culture.
2. **Clarify the respective roles and responsibilities of the Provincial Health Authority and the Ministry of Health for strategic planning and operational management.**
 - a) Establish regular meetings between the Minister of Health, Deputy Minister, the Provincial Health Authority Board Chair and Chief Executive Officer to ensure alignment of strategies and policies.

- b) Continue a collaborative forum for senior leaders from the Ministry and the health system to achieve optimal integration of the system.
3. **Ensure physicians play an active role in the planning, management and governance of the health system to achieve shared responsibility and accountability for health system performance.**

Mandate 4: Identify processes to enhance management information to improve and observe on performance management of the health care system

Recommendations:

1. **Create the capacity to standardize data collection and analysis across the health system, in order to understand, monitor, improve and report in a timely manner, on health system performance.** Affiliates and other third party delivery agents, including community-based organizations, should be required to adhere to the same standards and reporting expectations.
2. **Task the Health Quality Council (HQC) to work with the Provincial Health Authority and the Ministry of Health in monitoring and reporting on the experience and outcomes of patient care.**

Introduction



The Advisory Panel on Health System Structure was appointed by the Minister of Health on August 18, 2016 to provide independent advice to the Minister of Health to improve the current Regional Health Authority (RHA) structure in Saskatchewan. The mandate included the following four areas of priority for the Panel to consider:

- Recommend a structure with fewer Regional Health Authorities to achieve administrative efficiencies as well as improvements to patient care.
- Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services.
- Review current legislation and processes to ensure they adequately establish: the roles of health systems boards; their composition; structure and reporting relationship to achieve appropriate accountability.
- Identify processes to enhance management information to improve and observe on performance management of the health care system.

To inform our recommendations, our first step was to define strategies to obtain input from health sector agencies, partners and leaders and from Saskatchewan people. The Advisory Pan-

el also reached out to health care leaders in Canada who had experience with the consolidation of health system governance and management. We created capacity for both agencies and individuals to make online written submissions to the Advisory Panel and we engaged in face-to-face dialogue with key leaders within the health system.

The formal feedback process was open to the public from August 29, 2016 through to September 26, 2016. Over 300 completed written submissions were received and over 30 meetings were held, ensuring feedback from a diverse group of individuals and organizations were received addressing the four areas within the Advisory Panel's mandate. The Advisory Panel made a commitment to read, respect and consider every submission made to us and we honoured that commitment. In addition to information shared through the consultation process, we accessed and reviewed the literature on regionalization of the health system.

We explicitly asked for input focused on our four-point mandate. Many contributors shared with us a perspective that simple reduction in the number of RHAs is unlikely to yield significant system efficiency or effectiveness gains. They encouraged us to think more boldly about system governance and management redesign that might serve as a foundation and springboard for quality improvement. Hundreds of people shared their valuable insights and suggestions informed by their experiences as citizens, patients, health care providers, managers, leaders, researchers and public servants. Most importantly, contributors confirmed the objective of a system structure that promotes and sustains integrated and coordinated patient care.

Regionalization in Saskatchewan and across Canada

Across the country, the landscape of the health care system is characterized by constant change. This change can come in the form of changes to technology that enable improvements to patient care, changing demographics through higher levels of immigration, aging of the population or new diseases that challenge us to predict and support new treatments and drug therapies. Administrative structures are necessary to strategically coordinate investments in human resources, infrastructure, capital and technology required to support the provision of patient care. In recent years across Canada, provinces have

chosen to organize these administrative structures through Regional Health Authorities (RHAs) delegated through legislation to provide direct patient care to the population.

Regionalized health care first materialized in Canada in the 1990s in order to achieve a number of objectives. The goal

was to achieve greater integration and coordination of service, consolidation of hospital services to reduce costs, shift toward greater health promotion and prevention, increase quality and standardization, decentralize decision-making and increase accountability for performance and outcomes.¹ RHAs across Canada are typically governed by a Board of Directors who are

REGIONALIZATION ACROSS CANADA			
Province	2016 Population* (000)	Current Number of RHAs	Governance Evolution
British Columbia	4,751.6	5 Regional+ 1 Provincial Health Authority	2002: From 11 to 5 RHAs 1997: Est. 11 RHAs.
Alberta	4,252.9	1 Provincial Health Service	2008: From 9 to 1 RHA 2003: From 17 to 9 RHAs + 2 Provincial Health Boards and 1 Commission 1997: Est. 17 RHAs
Saskatchewan	1,150.6	12 RHAs (plus Athabasca Health Authority)	2002: From 32 to 12 RHAs 1992: Est. 32 RHAs
Manitoba	1,318.1	5 RHAs	2002: From 12 to 5 1997: Est. 12 (two later merged to create 11 RHAs)
Ontario	13,983.0	14 Local Health Integration Networks (LHINs) created in 2006	2006: Est. 14 LHINs
Quebec	8,326.1	18 RHAs	1992: Est. 18 RHAs (includes Social Service agencies)
New Brunswick	756.8	2 RHAs + 1 Provincial Agency	2008: From 8 to 2 RHAs 1992: Est. 8 RHAs
Nova Scotia	949.5	1 Provincial Health Service + the Izaak Walton Killam (IWK) Hospital	2015: From 9 to 1 RHA 2001: From 4 to 9 RHAs 1996: Est. 36 RHAs
Newfoundland & Labrador	530.1	4 RHAs	2005: Est. 4 RHAs
Prince Edward Island	148.6	1 Provincial Health Service	2010: Ministry devolved to 1 RHA 2005: From 5 RHAs to Ministry 1993: Est. 5 RHAs

* Statistics Canada 2016 Population by province and territory

¹ Marchildon, G. "Regionalization: What Have We Learned?" *Healthcare Papers* Vol. 16 (1): 8-14

accountable to the Minister of Health and have authority over the services provided within their geographic zones.

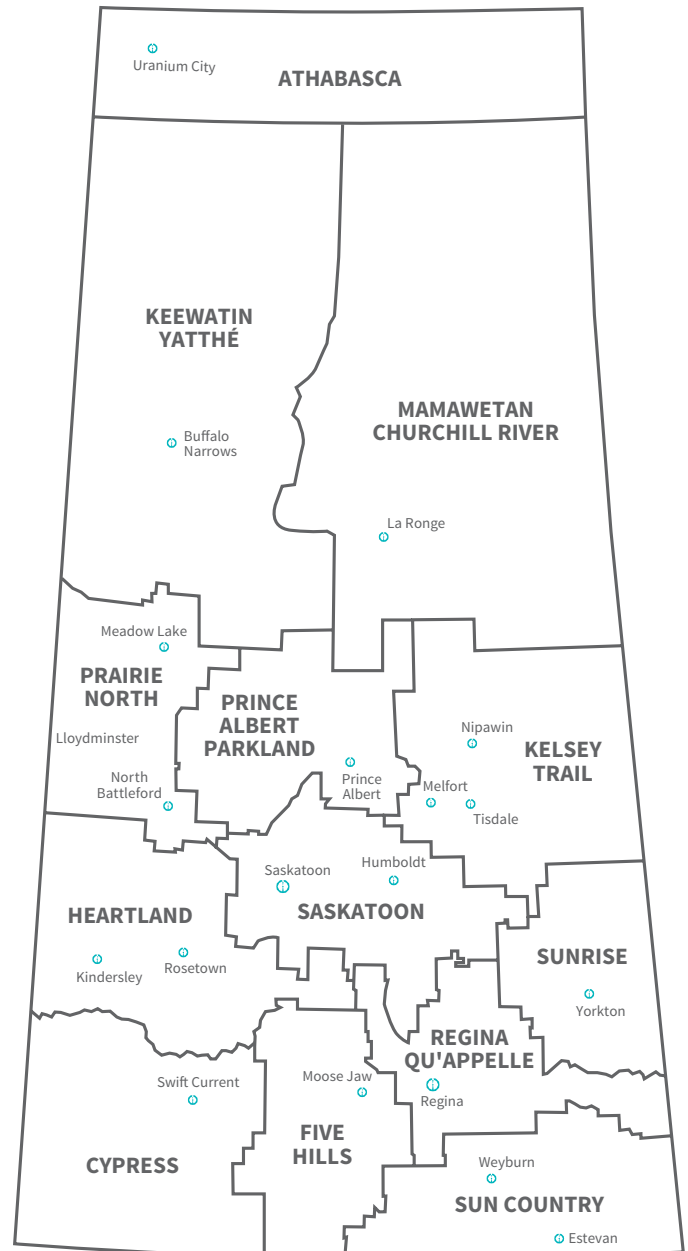
In recent years, RHAs have been going through a system of transformation across the country, as each jurisdiction grapples with the most appropriate and optimal governance and administrative structures. We have seen these changes occurring in every province through amalgamations and service redesign. Saskatchewan faces the same challenges and is one of the last provinces in the country to review health region governance and performance. The regionalization table on the previous page provides a brief summary of the changing health region landscape across the country.

The Saskatchewan experience with regionalization began in the 1990s at the same time as other provinces were beginning to develop similar administrative structures. Saskatchewan first moved toward regionalization after the Murray Commission of 1990 recommended 15 'health service divisions.' This brought together the numerous hospital, nursing home and ambulance Boards to improve the integration and rationalization of services. The Province's response to that recommendation was to create 32 health districts, plus the Athabasca Health Authority. These health districts were formed in 1992 and remained in place until 2002.

In 2000, the Minister of Health commissioned Mr. Kenneth Fyke to lead a review to identify challenges, recommend an action plan for delivery of health services and make recommendations to ensure sustainable long-term stewardship of the Medicare system. At that time, the Commission recommended amalgamation of the 32 health districts to create 9 - 11 health districts. In 2002, the Province established 12 RHAs, plus the Athabasca Health Authority in the North. The Athabasca Health Authority is unique in that it represents a tripartite partnership model between the Saskatchewan provincial government, First Nations and the federal government to both fund and provide health care services to Saskatchewan's most northern population.

In Saskatchewan, the provision of health services is delegated to the RHAs through *The Regional Health Services Act, 2002 (RHSA)*. Through the RHSA, the Minister of Health is responsible for the strategic direction of the health care system. The RHAs are responsible for the planning, organization, delivery and evaluation of health services they provide within their

Saskatchewan Health Region Map



boundaries. Each health region has a Chief Executive Officer (and associated administrative structures) that are accountable through their respective Boards to the Minister of Health.

In addition to the current regional structures, a number of provincial organizations have been established to support various provincial strategic and health system needs. These organizations include Health Quality Council (HQC), eHealth Saskatchewan, the Saskatchewan Association of Health Organizations (SAHO), 3sHealth, the Physician Recruitment Agency of Saskatchewan (PRAS) and the Saskatchewan Cancer Agency (SCA). Each of these organizations fulfills a unique role within the Saskatchewan health care system to support the business operations of the Ministry of Health, RHAs and health providers. In some cases, these organizations provide direct clinical care or service to patients and residents of the province.

The current landscape of health care in Saskatchewan is increasingly complex given the multiple players involved, including health regions, support agencies, health care providers, provider unions, Ministry of Health and other service providers and stakeholder organizations. It can be a challenging environment for patients to navigate and for providers to understand the role and authority of each agency. Decision making by any one organization can have unforeseen impacts on others. It is within this context of multiple agencies coordinating, supporting and providing patient care that the Advisory Panel undertakes our review of the current governance structures and opportunities to enable greater performance management of the system.

Current Health System Environment in Saskatchewan

The Saskatchewan health care system serves a population of almost 1.2 million people with a budget of \$5.1 billion (Ministry of Health 2015-16 budget). Through this budget, the Ministry of Health allocated \$3.6 billion to RHAs to provide direct care and services to Saskatchewan patients. The remaining funds are allocated to physician services (\$900 million), drug plan and extended benefits (\$376 million) and various other provincial and targeted programs.

Saskatchewan's health system relies on partnerships at local, regional, provincial, national and international levels that en-

able Saskatchewan to provide quality health services that meet the needs of our communities. Most services are delivered through the province's RHAs, their affiliated health care organizations and the Saskatchewan Cancer Agency (SCA).

In recent years, Saskatchewan has experienced unprecedented population growth; from 2007 to 2014, our population increased by 134,000 or 13 per cent. Between 2006-07 and 2014-15, the total number of babies delivered in Saskatchewan hospitals increased by almost 25 per cent. This illustrates how a growing population brings additional demand on the health care system.

A number of improvements in patient access to quality care have also come with this growth. For example, in 2015-16 there were over 44,000 workers employed by health regions and SCA, many of whom practice within the 28 regulated health professions in the province. Of these workers, over 15,000 are nurses, a sector that grew by over 1,500 paid full time equivalents (21 per cent increase) between 2007 and 2014. Similarly, the number of physicians practicing in Saskatchewan has grown by nearly 650 doctors (40 per cent increase) since 2007.

There are currently 64 hospitals in the province, 28 of which also include special care home beds. This includes:

- 40 community hospitals;
- 4 northern hospitals;
- 9 district hospitals;
- 6 regional hospitals; and
- 5 provincial hospitals.

Provincial hospitals provide specialized acute care to all Saskatchewan residents, three of these hospitals are located in Saskatoon and two in Regina. In addition, there are six regional hospitals that provide core specialty services and acute care to their local population. District hospitals provide basic inpatient and emergency care, and many also offer additional services such as basic obstetrics and surgical services provided by family physicians with additional training in specialty areas. Community and northern hospitals are focused predominantly on basic emergency services and primary care to meet local population needs. Patients in these centres are typically referred to regional and provincial level facilities for more advanced specialty and acute care.

The Need for Change



The 2009 Patient First Review Commissioner's Report to the Saskatchewan Minister of Health recommended several opportunities for improvement to Saskatchewan's health care system. The Patient First Review was informed through a very broad and intensive public consultation with people across the province to gather patient experiences and input into the health system. During that consultation, Saskatchewan citizens shared accounts describing health care as very fragmented that often seemed to be arranged around the convenience of providers rather than the patients they served. Rural citizens who had to access specialized care outside of their communities spoke of making repetitive long distance trips to see a specialist for consultation, to undergo a variety of diagnostic tests and then to receive the results of those tests. Patients often described the system as being overly complex and difficult to navigate, particularly when under stress in respect to worrisome symptoms, a diagnosis that had not been fully explained, or a compromise in their ability to live independently.

One of the key learnings from the Patient First Review is that patients and their families value seamless care that meets their evolving needs. Their health care journey may necessitate transitions between geographic communities and/or between home and institutions. Patients and families don't want to encounter gaps in such transitions. They want assurance that appropriate services will be available when they need them, but many don't have strong opinions about the system governance and management arrangements that offers such assurance.

The Patient First Review recommended that 'Patient First' be embedded as a core value of the health care system. The Patient First Review articulated two further guiding principles that are directly relevant to the work of the Advisory Panel: health care in Saskatchewan needs to function as a cohesive system, and frontline providers be empowered to deliver patient- and family-centred care. The Advisory Panel was guided and empowered by these core values and guiding principles as we conducted our work.

In response to the Patient First Review, every health sector agency in the province made a commitment to 'put patients first' in the organization and design of health services and programs. Our health system adopted the principles inherent in patient- and family-centred care. A growing cohort of patient advisors were recruited to participate in improvement events and health region Boards committed to hearing directly from patients and families about their experiences within the health system.

The Patient First Review highlighted the need for the health care system to function as a cohesive system and improve coordination and standardization within the administration and leadership of the system. This is admittedly difficult to achieve across 12 RHAs and additional service delivery organizations. The mandate of the Review did not extend to regional health structures, however it did comment on the need for government to consider these changes in future with the aim 'to streamline the integration and effectiveness of services.'

In our current health care system, patients with singular immediate needs are often very well served. As currently designed, our system excels at offering very focused episodic care and emergency response to life-threatening illness. Patients with multiple chronic conditions, complex conditions, and/or sudden inability to live independently are often not well served. The reasons we struggle with multiple chronic conditions and inadequate social supports are diverse, but at the heart of the problem is the simple fact that we have largely failed to deliberately design and organize services tailored to the needs of our patients.

Patients may be told they need to rely on a number of agencies, programs or health care professionals for their care where they encounter communication gaps, hand-offs or conflicting

advice and care plans. Sometimes patients sense that people are working in service silos rather than as a collaborative team focused on meeting their needs. These same challenges can be exacerbated when patients are receiving services from multiple health and social service sectors. Similar communication and coordination gaps exist between health, justice and education sectors.

“Elimination of health regions is not necessarily the solution to any problems the current health system is having. I think the commission has the responsibility to show clearly how this will benefit the people of Saskatchewan through the things they care about, quality service, access to service, effective service and efficient service. Lowering healthcare costs, by a fractional amount at that, will not sit well (sic) with the people of Saskatchewan unless they see improvement in the care they receive.”

Feedback from Respondent

Within our health care system, we organize around primary care, acute care, long-term care and emergency care services. These streams typically plan, design, organize, manage and deliver services in isolation from one another. Patients find themselves falling through the cracks of these internal boundaries. The challenge of navigating between and across these divisions can be daunting or sometimes impossible. Patients with complex needs who encounter these barriers and gaps may understandably question if we truly have a health care ‘system.’

Implicit in any system is the assumption that its parts work synergistically to deliver services. We need to critically consider how synergistically and integrated our health care system actually functions.

- Although we espouse a commitment to shared goals and collaboration, our culture still places emphasis on the independence and autonomy of agencies and health professions.
- Our current system structure defines 12 autonomous RHAs that are individually accountable to the Minister of Health but have no accountability to one another.
- We fail to place appropriate emphasis and value on patient experience of the system as a metric of quality and a key driver to quality improvement.
- We educate, organize and regulate our health care professionals independently from one another.
- We engage and compensate various health care professionals in ways that do not favour capacity for team-based care, and in fact create barriers to collaboration.
- We allocate approximately 20 per cent of the health care budget to affiliate health care organizations who manage services independently from other services in the system.
- We continue to sustain Emergency Medical Services that are delivered by a very large number of vendors with poor service integration.
- We fail to optimally utilize our health care workforce resulting in protectionism and turf wars between and within professions.
- We have not yet fully optimized information technology as an enabler of service integration.

One of the challenges within our current health care system is the autonomy of the medical profession. While we are starting to see a shift across the country in terms of engagement and integration of the medical profession into the health care system, one of the most cherished professional values of physicians is their professional autonomy. The vast majority of physicians in the province practice as ‘independent contractors’ who have no accountability to the system for the impact of their practices on health system resources and cost.

The Advisory Panel engaged in extensive reading on high performing health systems in other jurisdictions. These organizations and health systems take a deliberate approach to hearing and respecting the voice of patients and build their organizational structures and care teams around the needs of patients. A particular example is the National Health Service (NHS) in the United Kingdom.² The NHS has organized care models that seek to integrate services around the needs of patients with the goals of improving the delivery of care. Of specific note are the care models that integrate primary care and the acute care system to reduce and streamline patient hand-offs and bring specialty groups into the community to serve more complex patients outside of the hospital setting. While the Advisory Panel’s mandate did not extend to the direct development of

² National Health Service (2015) <https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/>

care models, we believe a reorganized health system structure would enable service re-design to better reflect the patient experience of care.

Another health care organization that the Advisory Panel explored was the Cleveland Clinic³ in the United States. It is a multidisciplinary academic medical centre in the city of Cleveland that provides services in various cities within the United States and abroad. They seek to deliberately engage patients and the patient experience throughout all levels of care with a specific Office of Patient Experience and an appointed 'Chief Experience Officer' to ensure consistent patient-centred care through partnership with care providers to exceed patient and family needs.

Part of the Patient First Review included an administrative review conducted by Deloitte titled "The Need for Transformation in Health Care Administration."⁴ The Review highlighted the importance of administration in supporting patient care across the province through contributions and leadership in service planning, decision making and delivery, with a corresponding need for a strong management workforce.

The Deloitte review commented on the need to further review the RHA model to achieve greater economies of scale and administrative service quality which has been 'hampered by the distribution of a limited pool of resources.' The report identified that while Saskatchewan is spending less than other Canadian jurisdictions on administration, we are spending more proportionally on Board and executive costs. Further, this leaves fewer resources for general administration. It also noted that the current corporate model with 12 Chief Executive Officers (CEOs) and their associated senior leadership teams is not sustainable given anticipated recruitment and retention challenges of qualified leadership staff.

While shared service models and alignment of the system can create efficiencies, greater gains can be achieved through a re-configuration of RHA structures. The Commissioner of the Patient First Review, Mr. Tony Dagnone, commented:

"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 remodeling of health care in the province in the future, jurisdictions should be organized on the basis of patient flow, not arbitrarily determined geographical boundaries."

The understanding of the need to support change in our current system was evident through the many voices we heard throughout our consultation. This particular quote from the online survey drove home the need for change so that our system is better organized to meet the needs of our patients:

"The health care system is not really a system ... there is an inability to think and act as one system."

This quote does not just apply to RHA structures, but also to the sub-structural elements within and across regions. Through the online feedback mechanism, the Advisory Panel received support for changes that impact patients who want and deserve seamless care within a transparent and accountable care system. The public expressed frustration that there is an evident lack of coordination across the organization of services that support the patient's experience with the health care system. The Patient First Review provided the example of patients making multiple long-distance trips to tertiary centres for testing, specialty consults and exam results that could have been better coordinated around the needs of the patient to minimize disruption and travel.

As one of the respondents to the Advisory Panel on Health System structure recommended:

"Whatever structures are developed, they need to facilitate the organization of services around the patient journey – for particular populations/sub-populations of service users, with a focus on improvement ... in patient outcome and experience."

³ Cleveland Clinical (2016) <http://my.clevelandclinic.org/>

⁴ Deloitte (2009) *The Need for Transformation in Health Care Administration: Report on the administrative component of the Saskatchewan Patient First Review*

What We Heard



As the Patient First Review highlighted, the importance of public engagement and input is paramount to informing any large-scale system changes. Shortly after the appointment of the Advisory Panel, an online feedback form was created to enable members of the public to provide input on health system restructuring, with questions around the four components of our mandate. We received 339 completed surveys from the public. These submissions also included physicians and stakeholder organizations that filled out the form to provide input to our work.

In addition to the online feedback form, many health care organizations and stakeholders took the opportunity to provide additional written submissions to the Advisory Panel. Collectively, the public and organizational input and guidance provided a strong foundation of knowledge, experience and evidence to inform our thoughts and deliberations as we delved into each area of our mandate.

The Advisory Panel also engaged key health care organizations and stakeholders through face-to-face consultation meetings (see Appendix A on page 37). Through these meetings, we were struck by the passion that our health system leaders have shown. They clearly demonstrated that they have the best interests of patients in mind. Our discussions showed

that each individual wants what is best for the system, which means better care and outcomes for those that use the system. Throughout these consultations, we sought input through two key questions:

- What is currently working well in our health system?
- What might make our system even better?

We heard strong concern from stakeholders that, as a system, we have failed to progress team-based primary health care. Several health professions championed a strong desire to play a larger role in team-based care. There was virtually universal agreement among system leaders that a strong primary health care system is a vital foundation to a high-performing health system.

Through our face-to-face consultations, a number of themes also emerged:

- Broad-based willingness to embrace and support system restructuring that supports optimal patient care.
- Excitement about the potential for system restructuring to significantly enhance quality improvement capacity.
- Caution that system restructuring may disrupt relationships between people and organizations that are vital to patient care with a strong desire to mitigate such risks.
- Concerns that rural and remote communities will ‘lose their voice’ in a larger organizational structure.
- Concerns that system restructuring is motivated by fiscal imperatives rather than quality improvement.

Many were also concerned that the current focus on administrative efficiency without attention to clinical efficiency undervalues the important role that administration plays in the organization and functioning of the health system. Without effective and strong administrative leaders and supports, the system cannot function. A structural redesign of the system can assure better service integration for all patients.

Through our online feedback form, we heard many broad and differing opinions and ideas regarding the four components of our mandate. A summary of the survey responses broken into themes related to each of the four mandates is outlined on the following page.

Mandate 1: Recommend a structure with fewer Regional Health Authorities (RHAs) to achieve administrative efficiencies as well as improvements to patient care

Some respondents believed the greatest strength of the current RHA structures is their ability to identify and respond to individual communities and engage those local communities in health care decision making. This theme was echoed in our face-to-face consultation with key health system stakeholders. Related to this was the concern that larger RHAs will lose that community engagement, particularly in rural, remote and northern communities. For this reason, many recommended that we create mechanisms to facilitate local input into decision making such as a ‘hub and spoke’ model, involving municipal leaders in the health system and creating patient and family advisory committees.

While the survey did not generate consensus in terms of a recommended number of RHAs, many believed the current number of 12 RHAs (plus the Athabasca Health Authority) was not appropriate given the size of our population. Options ranged from a single health authority, between two and six RHAs and recommendations to create administrative divisions based on the type of care instead of geographic boundaries. Many also recommended aligning RHA boundaries with those of other human services ministries, such as the ministries of Education and Social Services.

Mandate 2: Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services

Respondents generally believed that consolidation of non-clinical support services had potential to yield efficiency gains, including the areas of finance/payroll, information technology, human resources, scheduling and procurement. Clinical areas recommended for consolidation included Emergency Medical Services (EMS), public health, diagnostic imaging, home care and long term care assessment/placement, and clinical data

collection and reporting. Although there was general support for consolidation in a number of areas, respondents did voice concern for the impact this may have to reduce responsiveness to local issues/disruptions and that it could impact the availability of services in rural and remote communities.

Mandate 3: Review current legislation and processes to ensure they adequately establish: the roles of health systems Boards; their composition; structure and reporting relationship to achieve appropriate accountability

Many respondents favoured a governance model that gave the RHA Boards more autonomy to set priorities and make decisions with reduced political and government involvement. Irrespective of the governance model chosen, respondents urged greater transparency in the system. In terms of the composition of the Boards, many respondents suggested the need to engage Indigenous representatives and ensure the Boards are reflective of the cultural background of the geographic area they represent.

We heard a range of perspectives on the appropriate balance between decision making and authority between the RHA Boards and the Ministry of Health. Some expressed frustration with a lack of authority to make decisions at the Board level.

Mandate 4: Identify processes to enhance management information to improve and observe on performance management of the health care system

While some respondents were not aware of the current information gaps, many pointed to a lack of transparency in how the system operates, how the system communicates and how health care providers and administrators are held accountable to the public. This points to the need for greater information sharing in terms of health system performance as many respondents expressed an ethic that the health system ‘belongs’ to the public. Respondents recommended greater standardization of information sharing and communication, and in particular, information technology systems that ‘talk’ to each other so that information can be more broadly applied to quality improvement.

Recommendations



The mandate of the Advisory Panel was broken into four key and inter-related components. We have based our recommendations in each of these areas on a patient- and family-centred philosophy and with the recommendations and advice from both the members of the public and health system leaders in mind. We believe that our collective advice on health system structure, governance and performance will help set the stage for Better Health, Better Care, Better Value and Better Teams.

We appreciate that the changes we are recommending will cause some short-term disruption within the system. It will change working relationships and require time to create new administrative processes and reporting structures. We strongly encourage the provincial government and senior leaders within the health system to work collegially through this process, to take the time required to ensure a smooth transition and make a commitment to keep the patient as the focus throughout the transition period.

While the changes we are recommending will touch all parts of the system, we have a shared commitment to keep the patient at the center and to support continuous quality improvement. During our consultations, many health system leaders spoke highly of the improvement journey the health system is on. To this end, we would not want to see this improvement work pause while administrative changes are made within the

system. Dr. Susan Shaw, on behalf of Health Quality Council (HQC), offered this recommendation:

“... International literature documents the universal experience of restructuring in health care is it fosters disruption and paralysis that halts progress in improvement and can lead to temporary decline in performance. HQC recommends that the health system take a proactive approach to acknowledging and mitigating this disruption while making a strong commitment to ensure that the period of transition progress on improvement continues on at least the highest shared priority improvement work.”

We have a collective responsibility to ensure the resources provided through our tax dollars are meaningfully invested in the system to achieve the greatest value for our patients. We believe that by implementing a structure as outlined in this report, we will enable enhanced integration of the patient experience, provider participation and administrative leadership to inform ongoing health system improvement, allow a more seamless patient care experience and achieve administrative efficiencies within the system.

Reorganization of the health care system creates a unique opportunity to refocus priorities and align strategic and operational decision making to ensure we improve the patient experience of care. During the Advisory Panel’s consultations and in the formulation of recommendations, the goal of the Advisory Panel has been to optimize the functionality of the system and responsiveness to patient needs. The health care system serves a diverse array of care needs through highly specialized treatments, chronic disease management, and basic everyday health care services that patients expect to be available when and where needed.

It is important to remember that health care requires significant human resources to meet the needs of patients. One cannot assume that a reduction to the number of Regional Health Authorities (RHAs) will result in significant financial savings through staff reductions in areas of management and administration. The health system will retain the same number of health care providers, facilities and services, all of which require administration and management to oversee and coordinate the operations of the system. We must take a thoughtful approach to implementation.

Mandate 1: Recommend a structure with fewer Regional Health Authorities (RHAs) to achieve administrative efficiencies as well as improvements to patient care

Recommendations:

1. **In support of achieving a singular system that is focused on meeting patient needs through seamless, integrated and team-based care, consolidate the 12 existing RHAs into a single Provincial Health Authority with responsibility for all services governed by the existing RHA Boards, with the following considerations:**
 - a) Health care organizations, including affiliates, to be contracted through, and accountable to, the Provincial Health Authority.
 - b) Organize and focus continuous improvement with the objective of reinforcing a culture centred on high quality patient care and improving the patient experience.
2. **To enable effective integration and coordination of care, create four service integration areas.** The ultimate goal is to improve and enhance the patient experience across the continuum of care, including better coordination of patient transitions between service areas.

One of the service integration areas should be unique to the north based on the approximate geography of the existing Keewatin Yatthé and Mamawetan Churchill River health regions. Athabasca Health Authority should remain as currently structured.

The remaining three service integration areas should reflect existing and appropriate care seeking patterns, particularly with respect to acute and specialized care.

3. Good primary care is foundational to patient health and successful intervention at other levels of care. **To benefit the patient and the patient experience, one of the first areas of focus of the new Provincial Health Authority and the Ministry of Health should be to fully implement the Primary Health Care Framework (2012) and prioritize**

enhancement of team-based primary health care across the province.

4. **Enhance capacity to ensure the needs and interests of residents and communities within each service integration area are identified and advanced through community advisory networks as described in Section 28 of *The Regional Health Services Act*.** The networks will support senior leadership within the service integration areas by informing local health care needs and delivery of services and seeking ways to improve the patient experience, with the goal of achieving a patient- and family-centred health system.
5. **Engage with Indigenous people to help inform how best to address First Nations and Métis health needs in a culturally responsive and respectful manner.** In particular, the following should be examined:
 - a) Appropriate representation in the governance of the Provincial Health Authority;
 - b) Ensuring community advisory networks are reflective of the ethnicity and culture of the community; and
 - c) Establishing a senior administrative role within the Provincial Health Authority with the responsibility for ensuring health care services respect the Indigenous and Métis patient experience.

Considerations:

As the Advisory Panel reflected on the wide spectrum of information collected through consultation and research, we carefully considered the roles of governance and management of the system. The primary roles of the Boards are to define the strategic goals of the agencies they govern, engage and evaluate their senior leader, and ensure compliance with the appropriate standards and policies. The primary role of the Chief Executive Officer (CEO) is to execute the Board's strategic plan within the available resources, establish relationships with partners and maintain a skilled workforce to meet the organization's obligations.

Within our current health care system, while each RHA is an autonomous organization, they have jointly collaborated in a shared strategic planning process for several years through a

“The panel should emphasize that form follows function. Although this principle is typically in the architectural industry, it has applications in transformational change where the shape of a building or object should be primarily based upon its intended function or purpose. It should be clear that the structure of the system should achieve certain expectations and that its design should support those goals.”

Feedback from Respondent

Provincial Leadership Team (PLT). The PLT as currently structured, brings together senior health system leaders, including the RHA Board Chairs and CEOs, Ministry of Health, 3sHealth, Health Quality Council (HQC) and eHealth as well as provincial medical leadership. Shared planning identifies high priority provincial goals and the expectation that each RHA works to achieve those common goals. Through the PLT, there is a strong commitment to ‘think and act as one’ in pursuit of these shared goals. Given the positive impact of this strategy, it prompts legitimate questions as to whether we might achieve greater system performance by actually being one organization.

The 2009 Deloitte review of health care administration reported that Saskatchewan spends less relative to its Canadian peers on administration, which results in lower levels of management supports in areas such as strategic planning, quality, corporate project management, medical affairs and physician leadership.

Lower administrative spending is particularly challenging for smaller and non-urban health regions. Equalizing the playing field across the current regional structure would require a significant financial investment and result in duplication of efforts within the province. A single health authority governance model with centralization of key functions will create greater standardization and efficiencies.

From our consultations, a respondent eloquently noted:

“Form follows function. The complexity of a health care system requires acknowledgement that primary, secondary, tertiary and long-term care may require different supporting structures to optimize effectiveness and efficiency.”

There is significant potential benefit from consolidating governance responsibility under a single provincial Board under a single authority. However, there is also strong merit of a distributive approach to system management with clear differentiation between management of clinical and health system support service areas. Consolidation of office functions, such as accounting and data management could yield efficiency gains and achieve standardization. In contrast, clinical care is locally delivered and effective management demands a strategy that includes management capacity closer to where services are delivered. Centralization of governance with a more distributed management model could demonstrate greater alignment with other human service ministries, such as Education and Social Services, which would also support better integration and collaboration of patient- and family-centred needs across the continuum of public services.

ADMINISTRATIVE BENCHMARKING COMPARISON*				
Metric	Sask-wide	Canadian Peers		
		25 th Percentile	Median	75 th Percentile
% of Operating Spend	6.51%	5.80%	6.91%	7.86%
Admin Spend / Health Region (000s)	\$12,308	\$14,480	\$20,940	\$80,739

* Deloitte 2009 The Need for Transformation in Health Care Administration: Report on the administrative component of the Saskatchewan Patient First Review

The Advisory Panel recommends four service integration areas, however further analysis and other considerations may lead to variations ranging from three to six service integration areas. Those considerations should include patient care seeking patterns, presence and geographic distance to a regional hospital facility and correlation to other human services, such as education and social service agencies. Recognizing that there is more work to be done on this, we expect that the Provincial Health Authority and Ministry of Health will require some flexibility to develop the optimal number of service integration areas.

The Advisory Panel believes there are unique population needs in the northern RHAs of Keewatin Yatthé and Mamawetan Churchill River that would best be served by allowing those two RHAs to merge into one service integration area. There is some merit in reconsidering the specific geographic boundary of the northern service integration area. Therefore, we recommend the Provincial Health Authority examine the population needs of communities, such as Cumberland House, that border the northern service integration boundaries. A unique northern service area will provide this population with a stronger voice as one of the four service integration areas and ensure services meet the population's health care needs and recognize the unique geography of northern Saskatchewan. Further, the Advisory Panel believes the Athabasca Health Authority should remain as currently structured given the unique funding and accountability relationship between the federal government, the province and First Nations organizations.



Primary Health Care

Primary health care (PHC) is defined as the day-to-day basic types of care needed to help patients protect, maintain and restore their health. Primary health care should be provided as close to home as possible and meet the majority of the population's health care needs. We commonly equate primary health care as those services provided by family physicians. However, primary health care is most efficient and effective when provided in a team-based care environment, including various health professionals such as nurse practitioners, dietitians, pharmacists, social workers, paramedics, etc. Team-based care is such an important component of our health system that it is included in the four betters referenced earlier, as Better Health, Better Care, Better Value and Better Teams.

To date, PHC has been developed in Saskatchewan through incremental investment and implementation rather than through large-scale system change. For example, between 1995 and 2002, investment and policy development by federal and provincial governments supported the development of 20 'demonstration' PHC teams. This era set the stage for RHA primary health care planning and the development of a model contract for physicians working within these teams. From 2003 to 2012, further investment in PHC supported new leadership positions within the RHAs to take ownership of PHC expansion and new programming for diabetes and HealthLine 811. During that

timeframe, nurse practitioners and midwives were also introduced and pharmacists began to be more integrated into PHC teams. As of May 2012, there were 70 PHC teams within the province.

In 2012, in response to the Patient First Review, the provincial government released a Framework entitled “Patient Centred, Community Designed, Team Delivered: A Framework for Achieving a High Performing Primary Health Care System in Saskatchewan.”⁵ The Framework envisioned high-performing PHC teams and described some key building blocks to those teams. It also called for a patient-focused system that provides timely access and navigation to care. This Framework set the goal to ensure every person in Saskatchewan has access to a PHC team that meets their everyday health needs and that every team would include a family physician.

The Framework did not provide a ‘how-to’ plan, but instead guided system leaders to build new teams and enhance PHC through a greater focus on community and provider engagement and adjusting the team design to meet local needs. The Framework supported a greater inclusion of independent physicians and broadening of the team to include more community-based health providers. The Framework was supported through additional incremental investment in teams, as well as launching innovation models to test new PHC team designs. From 2012 until present, capacity has been increased through forming 25 new PHC teams, bringing the provincial total to 95 PHC teams. Teams are comprised of physicians, nurse practitioners and allied health professionals as determined by a community needs assessment. During this timeframe, RHAs began to focus on patient navigation, chronic disease management, mental health and addictions support and community outreach. Included within the 25 new PHC teams are innovation sites that piloted various PHC service models, including extended hours clinics, collaborative emergency centres, as well as new approaches to clinic management.

Consolidation of responsibility and accountability to a single Provincial Health Authority removes barriers and enhances the opportunity and capacity to spread innovative care models across the province. It supports a systems approach developed locally that could be expanded provincially, such as the recent development of PHC networks in Regina. These networks inte-

grate all providers along a continuum of services, organizing services around patient needs rather than program or provider boundaries.

Consolidation of RHAS will focus leadership and expertise. Instead of 12 senior administrative and clinical leadership teams responsible for smaller geographic zones, it enables leadership to support a provincial view and system vision of PHC service delivery. Further it enables health care providers to take a more global perspective and responsibility for services to the patients throughout the province. Provider support is key to implementing PHC with meaningful integration of providers within collaborative teams.

Our future vision starts with the commitment to primary health care that is sustainable, focused on the patient experience of the system and results in population health improvements. Drawing on the work of a number of national and international sources (Canadian Institute for Health Information (CIHI), World Health Organization and Institute of Health Information), high performing PHC teams include:

- Patient- and family-centred care that involves patients in their care plans with tools that support self-management;
- An engaged leadership with a defined quality improvement strategy;
- Patients have a regular care provider within a team-based care environment which supports coordinated, continuous, seamless and comprehensive service;
- Providers utilizing an electronic medical record to ensure patient information is available to all team members;
- Appropriate and effective care using best practices coupled with health promotion;
- The optimal use of resources, with team members working to the top of their scope of practice to ensure efficiency; and
- Enhanced access, such as extended hours, convenient service locations and reduced wait times.

Spreading team-based PHC as the predominant model requires a large-scale change process including a transformative vision, engagement plan and implementation strategy. Consensus is emerging that a patient- and family-centred PHC system establishes commitment to seamless care along a continuum of

⁵ Patient Centred, Community Designed, Team Delivered: A Framework for Achieving a High Performing Primary Health Care System in Saskatchewan

services provided in the community, outside of the hospital environment. PHC and community-based services also serve a strong role in helping patients navigate the system, thereby reducing barriers and ensuring patients receive care in the most appropriate setting. To strongly demonstrate this commitment, the Provincial Health Authority and the Ministry of Health should work with patients, local communities and health care providers to implement accessible and appropriate PHC. This will be achieved through the enhanced role of community advisory networks, as discussed later in this report, as well as engaging health providers, including the medical profession, at various levels within the system.

Referencing back to the work of the National Health Service (NHS) identified earlier, as well as the activities underway within the Regina Qu'Appelle Health Region to establish care teams and networks that support patients along the continuum of care, there are significant benefits to aligning PHC with acute care services. Currently, the most accessible avenue to receiving care within the health care system is through the emergency department (ED) and hospitals. The use of the ED and acute care system is an inefficient and expensive model of care that most patients would prefer to avoid. Strong community-based care also enables people to live independently in the community, thereby reducing reliance on long-term care and institutional care environments.

Further, acute services have become overcrowded with patients that should be cared for in a community setting, ideally within a team-based primary care environment. Of Canadian provinces, Saskatchewan has the worst rate of patients admitted to hospital for conditions that could have been prevented through appropriate community care.⁶ The Advisory Panel's focus has been on developing a system structure that supports and enables the integration of acute and primary care to best serve patients in the community while enhancing access to team-based PHC. The Provincial Health Authority and the Ministry of Health should prioritize the integration of team-based community and PHC with the acute care system with the explicit goal of better serving patient needs in the community. This will benefit patients by meeting their needs closer to home, prevent admissions to hospital and utilization of the ED and improve the patient's experience of the health care system.

Labour Relations

There are currently five health care unions representing approximately 44,000 health care employees within the province. Two of these unions are provincial in nature. The Saskatchewan Union of Nurses (SUN) represents all registered nurses and registered psychiatric nurses in the province. The Health Sciences Association of Saskatchewan (HSAS) represents approximately 3,700 health professionals across the current 12 RHAs. The Canadian Union of Public Employees (CUPE), the Service Employees International Union West (SEIU-West) and the Saskatchewan Government Employees Union (SGEU) represent health services support employees such as food service workers, housekeeping, maintenance, sterile processing workers and administrative staff, etc.

The Advisory Panel is aware that changes to the RHA structure, and specifically the recommendation for a Provincial Health Authority, will have an impact on health provider labour unions. CUPE, SEIU-West and SGEU represent health care employees within specific regional boundaries. Therefore, further legal and labour relations expertise must be engaged to fully understand and work through a successful transition that seeks to minimize disruption and ensure patient care is not compromised.

Health Care Organizations (Including Affiliates)

There are currently a number of affiliate health care organizations in the province providing a range of acute and long-term care services to Saskatchewan residents through funding arrangements with the RHA in which they reside. These affiliate organizations are owned and operated by non-governmental organizations such as religious or community groups or agencies and are operated and run as non-profit societies. In terms of long-term care facilities, affiliates comprise 33 different facilities accounting for 2,533 beds and represent 20 per cent of such facilities and 28 per cent of the total long-term care beds in the province. Affiliates also provide acute care services through a faith-based organization operating six acute-care facilities in the province. These six facilities are comprised of three community hospitals, two district hospitals and one of the provincial tertiary hospitals. They represent approximately 15 per cent of acute care beds in Saskatchewan and provided

⁶ Canadian Institute for Health Information, 2014. Your Health System

11 per cent of inpatient separations in 2014-15. They serve a significant component of the health system and provide valuable service to the residents of the province.

During the Advisory Panel's consultations, a common theme emerged echoing the need for greater consistency in the relationships between the current RHAs and affiliates. The presence of a single Provincial Health Authority will enable greater consistency in relationship because it allows a single organization to work with the affiliate organizations and their representative organizations, thereby removing variation across the previous regional boundaries. While a Provincial Health Authority will hold the accountability for standardizing contractual relationships with affiliate organizations, there is also a need at a more local level to have effective working relationships to meet local population needs. To achieve local cooperation, service integration areas should engage at a more local level with affiliates to ensure local population needs are met and cooperation and collaboration occur across the two systems.

Community Advisory Networks

One of the caveats we face with consolidation to a single Provincial Health Authority is the risk of the loss of engagement between the health system and the patients and populations we serve. This was a common element of the feedback we received through consultations and written submissions, and was flagged as one of the strengths of our current regional model. *The Regional Health Services Act (RHSA)* currently requires RHAs to have community advisory networks to provide "advice respecting the provision of health services in the health region or any portion of the health region." Within the current system, the functionality, composition and role of these networks is highly variable across the province. Within the current system, there are some well-established patient and family advisory committees that provide meaningful and important input to the health care system. These committees should continue to support and inform the health system within the Provincial Health Authority.

Under the Provincial Health Authority, the community advisory networks will play an increasingly important role to maintain connectivity between the Authority and local populations. Borrowing on the work of Nova Scotia⁷, the Advisory Panel sees

a broader role for these networks than what is currently envisioned under the RHSA. The Provincial Health Authority should be tasked with enhancing the role of these networks through standard terms of reference, staff support and a defined role in local health system planning. These networks should not be narrowly defined within local community boundaries, but larger geographic catchment areas based on patient patterns of care seeking.

"Ensuring local and regional needs is more of a mindset than a geographical setup and requires people who are willing to listen carefully to the people they serve. If administrators are willing to look objectively at each facility and the services they provide I have confidence they can be successful."

Feedback from Respondent

In terms of the specific role of the community advisory networks, the Advisory Panel recommends that the networks should be charged with active involvement in community needs assessment and developing multi-year community health plans based on consultation with local leaders, residents and community organizations. Ideally these plans could support a larger systems view of community and population health through the lens of the determinants of health. These plans should then be utilized by senior leadership within the service integration areas to inform strategic and operational planning. There are examples of groups that have been formally developed by RHAs in partnership with communities, to create a forum for communication, creative problem solving and collaborative visioning for the development of PHC. These committees should be integrated into the new community advisory networks.

Representation on these networks should be reflective of local culture and ethnicity and include local leadership. When the population of a community shows a high level of ethnicity, the community advisory network must ensure that ethnic and cultural participation occurs in a substantive way. This recognizes that, while all residents should expect the same standard of care across the province, the way care is delivered will be influenced by the community with their culture, customs and focus.

⁷ <http://www.nshealth.ca/get-involved/community-health-boards>

Indigenous Engagement

According to the 2011 National Household Survey, there are 103,205 self-identified First Nations people and 54,450 Métis people living in Saskatchewan, which represents 16.4 per cent of the total Saskatchewan population. Of those First Nations people, 53.2 per cent lived on reserve. The cities of Saskatoon and Regina each had a population comprised of approximately 10 per cent First Nations and Métis while Prince Albert's population was comprised of 23.5 per cent First Nations and Métis people. The median age of self-identified Indigenous people living in Saskatchewan was 22.6 years compared to 40.9 years for non-Indigenous people.

There are significant examples of poorer health outcomes of Indigenous people compared to the non-Indigenous population, such as higher rates of kidney disease, diabetes, obesity and communicable diseases. Tragically, Indigenous people have higher rates of suicide and infant mortality. The health care system must be responsive and respectful of Indigenous culture, and we must create space for Indigenous voices to be heard at all levels. Through the Advisory Panel's consultations and our previous experience within the health care system, we believe the Provincial Health Authority and the Ministry of Health can better establish partnerships with Indigenous people to improve health outcomes. That is why the Advisory Panel believes there should be an expectation through the governance of the system, the administration of the system and through local engagement mechanisms that the Indigenous voice and health care needs are prioritized and respected. This is especially true in northern Saskatchewan where Indigenous people represent a significant proportion of the population.

Some of the current RHAs are taking steps to improve engagement of Indigenous patients and their families. The Provincial Health Authority should learn from these local efforts to spread innovative engagement that improves access to culturally appropriate care. Here are some examples:

Native Health Services (NHS) – Based in the Regina Qu'Appelle Health Region (RQHR) and operating out of centres within the Regina General and Pasqua Hospitals, NHS has been providing liaison and cultural services and supports to Indigenous patients and families, and regional health employees since the 1990s. NHS services include Elder support, advocacy and liai-

son, counseling, education, assessment and referral and medical transportation.



Photo by Regina Qu'Appelle Health Region

First Nations and Métis Health Services – Established in 2013, and operating out of the St. Paul's and Royal University hospitals, the goal of First Nations and Métis Health Services is to provide an integrated and culturally respectful approach to care for First Nations and Métis people coming into the Saskatoon Health Region for treatment and other services.

Mandate 2: Consider opportunities to consolidate clinical or health system support services currently delivered by Regional Health Authorities or other health care agencies that may be more efficiently delivered on a province-wide basis and the mechanism(s) to best organize and deliver such services

Recommendations:

1. **The Provincial Health Authority should pursue opportunities for consolidation of clinical services within and across the service integration areas, including:**
 - a) Integrating diagnostic services (including laboratory and diagnostic imaging) across the province, including services delivered by the Saskatchewan Disease Control Laboratory (SDCL);

- b) Optimizing the organization of Emergency Medical Services (EMS) through the consolidation of all planning, dispatch and delivery; and
- c) Coordinating tertiary acute care services to reduce duplication and variation, and improve consistency and quality of service delivery.

2. **A Provincial Health Authority will allow for a standardized approach to a range of health system support services, including information technology, procurement, supply chain, human resource management, financial services, payroll services and health provider recruitment.**

In recognition of their established expertise, the Provincial Health Authority should pursue ongoing service delivery as follows:

- eHealth for information technology and related services;
- 3sHealth for procurement, supply chain, payroll and other related services;
- Saskatchewan Association of Health Organizations (SAHO) Inc. for labour relations and related services; and
- Physician Recruitment Agency of Saskatchewan (PRAS) for physician and health provider recruitment services.

3. **The Government of Saskatchewan should review the governance arrangements currently in place for eHealth, SAHO, PRAS, and 3sHealth to ensure the most effective and efficient delivery of services, including the potential consolidation of these entities. The Government of Saskatchewan should also review the governance arrangements currently in place for the Saskatchewan Cancer Agency (SCA) to ensure cancer services are appropriately and effectively integrated with services delivered by the Provincial Health Authority.** These reviews should occur within two years of the formation of the Provincial Health Authority.

4. **It is further recommended that the Health Quality Council (HQC) remain as an independent organization to continue its focus on measurement of health system performance, including patient outcomes.**

Considerations:



Distribution of Clinical Services

The Advisory Panel believes a more in-depth review should be undertaken by the Provincial Health Authority and Ministry of Health to pursue opportunities for consolidation of clinical services. The engagement of physicians in health system planning and enhanced roles of community advisory networks will improve clinical service delivery plans. Further, by intentionally seeking the voice of patients and patient experience within the health system, there will be a stronger ability to organize services in a manner that better reflects patient needs.

The safety and quality of very highly specialized clinical services may be enhanced by consolidating such services in centres where service volumes and the patient case-mix enable highly skilled personnel to sustain their skills. In respect to the most highly specialized services, it may be most appropriate to consolidate such services in a single centre that serves the entire population of Saskatchewan. However, general specialty services can be safely offered in a broader spectrum of communities, typically offered within the current regional hospitals. A more distributed service delivery model is particularly helpful to patients who have access to specialized services frequently and/or over extended periods of time. Hemodialysis is an excellent example of such services. The opportunity for patients to access hemodialysis services closer to home has an enor-

mously positive impact on the care experience and daily lives of patients.

In some instances, it makes more sense to have medical specialists travel to communities rather than having many patients make the long journey to see a specialist. Northern Medical Services has provided visiting specialist services to northern communities for decades. Some itinerant specialized consultation and therapeutic services are provided to communities across the province on an ad hoc basis. A Provincial Health Authority governance model provides opportunity to coordinate a provincial model of service delivery, including visiting services. Saskatchewan has not implemented evidence-based policies for proactive planning and delivery of specialized services in the province. The lack of such policies impairs our capacity to ensure patients have access to predictable and consistent levels of care throughout the province. Explicitly defining the scope of specialized medical care that should be sustained at each of our six regional hospitals would enhance our effectiveness in recruiting and retaining specialist physicians and other highly skilled staff. Such a plan would also support rational acquisition of technologies that may be essential to delivery of specialized services at regional hospitals. Due to its unique role in providing specialized services to northern Saskatchewan, the role of Victoria Hospital in Prince Albert warrants particular attention.

Currently, diagnostic services, including laboratory and diagnostic imaging, are offered in locations throughout the province. For example, there are over 400 labs licensed in the province to provide various levels of laboratory testing, these laboratory services are not coordinated or integrated within the system. There is also a lack of coordination and integration of diagnostic imaging services within the province. Through the use of technology, there are significant opportunities to coordinate and integrate these services to improve the patient experience. The Saskatchewan Disease Control Laboratory (SDCL) is responsible for various laboratory testing, disease surveillance, laboratory standards and serves as a centre for integrated disease and data management. The SDCL is a key diagnostic support to clinicians throughout the province. As a clinical service, transferring SDCL to the umbrella of the Provincial Health Authority ensures that the SDCL aligns clinical service delivery with the appropriate governance and administrative structure.



Emergency Medical Services (EMS)

The Ministry of Health provides funding to the RHAs to cover a substantial portion of the costs for ambulance services, with the balance of the costs recovered through fees billed to patients and/or their insurers (private insurers, other federal and provincial programs, workers' compensation, Saskatchewan Government Insurance (SGI), etc.). In 2015-16, the RHAs spent \$83.9 million on provision of ground EMS. Ambulance services are not an insured benefit under *The Canada Health Act*. Provision of EMS in Saskatchewan is governed by *The Ambulance Act*, proclaimed in 1989.

Currently in the province, ground ambulance services are provided by a mix of RHA owned and operated, private ownership, non-profit services and First Nations communities. There were 104 provincially registered ground ambulance services in Saskatchewan in fiscal 2015-16, handling a total call volume of 122,714 calls. Regina and Saskatoon are the two largest urban ambulance services, handling 70 and 81 calls per day respectively, accounting for 45 per cent of the total provincial call volume. Many (54.8 per cent) of the services in smaller rural communities handle less than one call per day. Nine of these only handle less than one call per week.

In addition to ground ambulance, air ambulance services are provided through Saskatchewan Air Ambulance fixed-wing service and the Shock Trauma Air Rescue Society (STARS) ro-

tary wing program. Air Ambulance service also includes the fixed-wing service that transports basic and intermediate level patients in northern Saskatchewan to the appropriate nearest hospital to ensure they have access to the appropriate levels of care.

The Ambulance Act has had limited substantive changes that would improve the delivery of service. When health districts were established in 1994, they replaced the previous 108 district ambulance Boards and the various health and long-term care Boards. Little has changed in the delivery of EMS since that time, with 104 providers still in existence.

With the large number of ground ambulance providers and substantial variation in service volumes, comes variation in service delivery, staffing models and availability of EMS. The following map highlights the location of ground EMS and the variation of staffing models from Advanced Life Support (ALS) to Basic Life Support (BLS) providers.

Through our consultations with senior leaders in the health system, there was a request to take steps to achieve greater standardization of EMS services. We heard many concerns that the current delivery of EMS is not well coordinated across the current system and would benefit from a larger provincial approach to service provision and governance. Saskatchewan is falling behind other jurisdictions in Canada in providing efficient and patient-focused ambulance services.

Maintaining EMS staff where the call volumes are low is a significant challenge. Many of the smaller ambulance services do not offer full-time positions. These services often rely on recruiting local residents in the community to take the basic level of training at the emergency medical responder (EMR) level to staff the local ambulance as an on-call or casual employee. The inability of smaller rural ambulance services to maintain full-time staff directly affects the time it takes that ambulance operator to respond to a call and the level of care that is able to respond to the patient. Volunteer medical first responders providing support bridges that gap until an ambulance arrives.

With 12 separate RHAs each managing and monitoring their own EMS providers, there is significant room for variation and gaps in terms of performance and delivery of service. Consolidation to a Provincial Health Authority with oversight over the

system allows for standardization and more consistent performance management. This will ensure patients across the province, regardless of location, are assured of consistent, responsive and quality care.

The Advisory Panel strongly recommends the Ministry of Health and the Provincial Health Authority make modernization and standardization of EMS a priority in the short term. To achieve this, *The Ambulance Act* must be modernized to allow for greater efficiencies, a re-organization of the service and a more patient-focused EMS system. Further, the Advisory Panel recommends that governance, management and delivery of EMS services be assumed by the Provincial Health Authority.

Consolidation and Centralization of Non-Clinical/Administrative Services

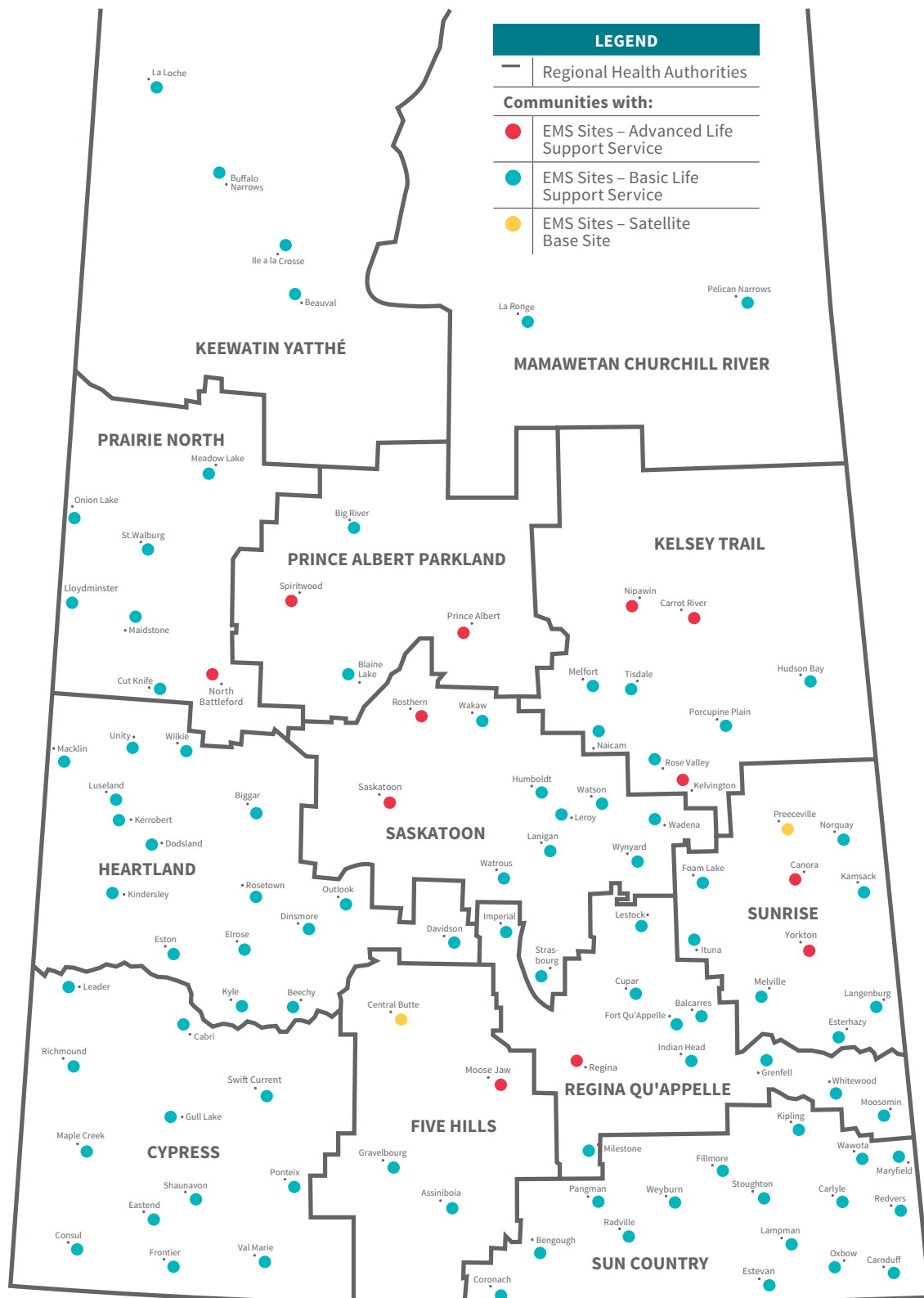
The 2009 Deloitte review of health system administration articulated the resource capacity challenges (workforce and fiscal sustainability, particularly in non-urban RHAs) in maintaining corporate management, particularly in areas such as finance, human resources and information technology. A consolidation of these functions would serve to achieve economies of scale, but would also improve the quality and sustainability of these services within a new provincial structure. Centralization of these services not only supports better outcomes in terms of the second component of our mandate, it also supports our fourth mandate through greater data quality, standardization and comparability within a single organization's control.

In terms of consolidation of non-clinical services, we recommend centralization of administration under a single provincial governance structure to enable greater coordination, standardization and higher quality service. There are potentially many more examples of opportunities and efficiencies that the Provincial Health Authority could implement as the organization matures.

Impact to Health Care Organizations

eHealth, SAHO Inc., PRAS, 3sHealth, SCA and HQC are currently all separate entities which have a role in delivering some facet of services to the health care system. As part of the Advisory Panel's mandate to explore the consolidation of health system supports, the Advisory Panel reviewed the purposes and gov-

Saskatchewan Health Regions and EMS Sites



ernance structures of these entities to determine whether they should remain as separate organizations or be consolidated within the Provincial Health Authority.

The HQC was established as a result of the Fyke Commission's⁸ recommendations to establish an independent organization responsible for monitoring and reporting on the quality of care being provided within the Saskatchewan health care system. As Fyke recommended, "the Council should be an evidence-based organization, arm's length from government." The benefit of an external organization having the mandate to research and comment on the quality of care is that it is removed from any organizational bias and serves as an independent voice to champion quality and patient-focused care. As the Advisory Panel will recommend later in this report, we believe the HQC has the capacity and should play a larger role in driving quality improvement of the system as an independent voice, separate and apart from the Provincial Health Authority.

eHealth, SAHO Inc., PRAS, and 3sHealth exist to serve a provincial focus to provide support services to the 12 existing RHAs. Once consolidation occurs into a Provincial Health Authority, it reduces the need for arm's length agencies to serve multiple and diverse organizations. That said, there can be value in maintaining some specific organizations outside of the Provincial Health Authority to ensure greater flexibility and responsiveness to the system while maintaining their distinct identities. A review of each organization's purpose follows.

3sHealth was established in response to a recommendation of the Patient First Review to achieve greater value "by establishing a provincial shared-services organization that would gain buying power and realize significant savings." 3sHealth supports the health system by providing province-wide shared services to the current RHAs, SCA and affiliates through services such as payroll, transcription and shared purchasing.

PRAS serves a coordination and marketing function to recruit physicians and health professionals to the province. It was originally established in 2010 as part of the province's Physician Recruitment Strategy to recruit and retain physicians. PRAS more recently assumed responsibility for Health Careers in Saskatchewan (HCIS) from the Ministry of Health. The mandate of PRAS is to work with system partners to optimize the

health workforce in Saskatchewan. Over the last number of years PRAS has built a strong image and identity both within the province as well as through external marketing within Canada and abroad.

SAHO Inc. is statutorily designated to be the representative employers bargaining agent in the health care sector, specifically for the 12 RHAs, SCA and approximately 30 affiliate organizations. It also serves a broader function as labour relations consultants for these employers, providing labour relations advice and expertise, resource planning, job classifications, costing and market research.

eHealth Saskatchewan is a treasury board Crown corporation best known for its role in the provision of IT services to patients, health care providers, the Ministry of Health and RHAs. It provides key leadership in the development and operation of the Electronic Health Record (EHR), in procurement, implementation, ownership and operation of various IT systems that directly and indirectly support patient care. In addition, eHealth is statutorily designated to operate the provincial beneficiary registry on behalf of the Ministry of Health and is statutorily listed as the Crown corporation through which the Minister of Health will exercise his/her functions under *The Vital Statistics Act*.

While the Advisory Panel envisions potential benefits to bringing these entities within one governance model, it recognizes that each organization has some unique elements that require further consideration before a final determination is made. Considering that the transformation being proposed is already significant and challenging, the Advisory Panel is concerned that adding the intricacies of these organizations into the initial transfer may hamper transition. The transition of the current RHAs to a Provincial Health Authority will create some disruption within the health care system and the services provided by these agencies must continue to be provided during the transition. Accordingly, the Advisory Panel recommends these entities remain during the transition period. Once the transition period has been completed, further thought and analysis should occur to determine the most appropriate configuration of these health service support organizations. It is possible that they may be combined into one service agency that delivers specific services to the Provincial Health Authority. It is also

⁸ Fyke, Kenneth J. (2001) *Caring for Medicare: Sustaining A Quality System*

possible that some or all would be best combined into the Provincial Health Authority.

The SCA is a statutory corporation responsible for the delivery of cancer services in Saskatchewan. The Advisory Panel takes note of the fact that the SCA delivers highly integrated cancer care services to all patients with a cancer diagnosis and does so effectively. However, the Advisory Panel recognizes that it is somewhat inefficient to have a stand-alone agency dedicated to the treatment of a single disease and which may impact the seamless transfer of patients between care centres. The processes required to provide pan-provincial integration of all health care services will need to be developed by the Provincial Health Authority. As those processes are developed, cancer care should be considered for inclusion within the governance of the Provincial Health Authority. However, in the Advisory Panel's view it is premature to consider that transition to the Provincial Health Authority until greater care integration within the Authority has been demonstrated.

Mandate 3: Review current legislation and processes to ensure they adequately establish: the roles of health systems Boards; their composition; structure and reporting relationship to achieve appropriate accountability

Recommendations:

1. **Establish a Board to govern the activities of the Provincial Health Authority.**
 - a) The Board to be accountable to the Minister of Health.
 - b) Appointments to the Board to be based on expertise, including the ability to represent patient experience and culture.
2. **Clarify the respective roles and responsibilities of the Provincial Health Authority and the Ministry of Health for strategic planning and operational management.**
 - a) Establish regular meetings between the Minister of Health, Deputy Minister, the Provincial Health Authority Board Chair and Chief Executive Officer to ensure alignment of strategies and policies and the delivery of patient care.

- b) Continue a collaborative forum for senior leaders from the Ministry and the health system to achieve optimal integration of the system.

3. **Ensure physicians play an active role in the planning, management and governance of the health system to achieve shared responsibility and accountability for health system performance.**

Considerations:

The Advisory Panel believes that a singular Provincial Health Authority governed by an expert Board will achieve greater health system integration, coordination and have the greatest capacity to achieve more seamless patient care. With the creation of a Provincial Health Authority comes a much larger span of control and operations and a significantly larger budget, approximately \$3.6 billion, with over 40,000 unionized employees. Such an organization requires expert governance to monitor and address the performance and financial management of the Provincial Health Authority. Governance and oversight of the operations of the Provincial Health Authority will be particularly important during the period of transition.

Moving toward an expert provincial Board replaces the current Board model where Board members are representatives of local communities and interests. One of the strengths of the current RHA model is that Board members were local and these Boards were often better positioned to address local community needs. This supports the earlier recommendation to enhance the role of community advisory networks to serve as local engagement mechanisms to ensure the Provincial Health Authority continues to hear local voices in the organization and delivery of health care services.

During the Advisory Panel's consultation with key health system leaders, one of the consistent strengths identified was that all RHA senior leaders and Board chairs participated in joint strategic planning with the Ministry of Health through a mechanism called the Provincial Leadership Team (PLT). This meeting format enables provincial planning and has been a key enabler to achieve the goal to 'think and act as one.' The Advisory Panel recommends a similar format, albeit with a much smaller group of senior leaders, continues to engage in shared health system planning across the various organizations involved in the health system.

In addition to provincial strategic planning, regular meetings between the Ministry of Health and Provincial Health Authority senior leaders will be necessary to ensure alignment between the Authority and the government in terms of both strategic decision making and patient care. This will be particularly important during the transition period when key decisions and organizational structure are finalized.

Medical Leadership and Integration

In the course of our consultation, many stakeholders shared the importance of building stronger relationships and greater integration of physicians within the health care system. The ability to achieve this greater integration has the potential to positively impact the future management of clinical services in our health care system. Clinical decisions made by physicians have implications for the health system budget and the delivery of health care services.

Physicians exit their medical training with expertise beyond clinical decision making, they are taught communication, advocacy and leadership skills. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada set the standards for medical education and continuing professional development of all physicians in the country. They define medical leadership as an integral part of the role of physicians to contribute to a high quality health care system and take responsibility for their use of finite health care resources. Medical residents and new graduates enter the health workforce with the expectation that they will have opportunities to exercise these skills.

In high performing health systems, physicians are typically responsible and held accountable for delivering services within an allocated annual budget for their services. In part, they achieve this goal by ensuring their services are delivered in accordance with evidence-based care pathways developed by the medical team. In the future, it may be helpful for the Ministry of Health to consider bringing the budget for physician services under the governance and management of the Provincial Health Authority to better align care models and accountability for resource management.

The University of Saskatchewan, College of Medicine has made recent significant gains to position themselves as key partners

in the health system and have become champions of medical leadership and health system research to support improved quality of care and access to services for Saskatchewan patients. At the same time, the Saskatchewan Medical Association has begun to envision a different working relationship between physicians and the health care system. These developments position the health system to achieve greater integration, better health care outcomes for our patients and a more sustainable future.

We strongly believe in the value medical leadership brings to the administrative table, for this reason we would urge the new Provincial Health Authority and Ministry of Health to embed medical leadership throughout the organization of the health system. Further, we encourage the health system to fully appreciate the benefits of embedding academics and research into the mandate of the health care system.

Mandate 4: Identify processes to enhance management information to improve and observe on performance management of the health care system

Recommendations:

1. **Create the capacity to standardize data collection and analysis across the health system, in order to understand, monitor, improve and report in a timely manner, on health system performance.** Affiliates and other third party delivery agents, including community-based organizations, should be required to adhere to the same standards and reporting expectations.
2. **Task the Health Quality Council (HQC) to work with the Provincial Health Authority and the Ministry of Health in monitoring and reporting on the experience and outcomes of patient care.**

Considerations:

The administrative component of the Saskatchewan Patient First Review (2009) undertaken by Deloitte identified a lack of consistency and reliability of data in and across health regions, creating challenges in making comparisons of relative region performance. While, for example, there are common reports

generated and used in all regions, there is variation in the application of accounting policies and data definitions which result in the need for manual adjustments in order to make the data usable for comparison purposes. Additionally, health regions are not making full use of the capability of the Canadian management information system (MIS) database (contains financial and statistical operations information for hospitals and health regions across Canada) and data standards that support assessment of, and response to, operational performance, variance analysis and overall health system performance and results. Data and information gaps such as these limit our collective capacity for taking informed, timely and effective management action and for making sound public policy decisions.

“Information should be available in some form to everyone who lives in Saskatchewan and uses the services. The public should be able to see where the strengths and weaknesses lie, there should be transparency. Clear information makes the health services less of a political tool and more of the public service it is supposed to be.”

Feedback from Respondent

There has been a considerable amount of research and reporting on the consolidation of health system support services in the province. One of the most promising initiatives initially sought to replace a 40- year-old provincial health payroll system that is clearly due for an upgrade. The initiative provided an opportunity to explore consolidation of ‘back office’ systems in order to generate considerable financial savings and standardize processes to achieve provincial consistency and accountability. We would encourage the government to consider these proposals to enable real-time accurate and integrated information for effective data driven decision making.

Consolidating the administration of human resource and labour relations could improve provincial consistency and more effective management. While consolidation would centralize this function, local management is still required within the service integration areas to maintain effective relationships between management and employees. For this reason, local labour relations and human resource personnel should remain in service areas to represent local perspectives, which would

provide a more effective information conduit to the provincial administration.

Through the Advisory Panel’s consultation and our own experiences within the health care system, we appreciate the complexity of working across multiple organizations to develop standards and processes to ensure consistency in reporting and effective use of data. The existing regional structure necessitates a high degree of collaboration across organizations, not yet achieved, in order to ensure consistent, high quality, timely data and information on which to base provincial decision making. In the absence of such information, the administration of a complex system becomes extremely challenging, if not impossible.

As such, we recommend the following:

Consolidation and Standardization

- Province-wide consolidation of the clinical and administrative desktop computing environment while retaining service area/local support capability and improving efficiency.
- Provincial consolidation and approach respecting the hosting and management of all clinical and administrative applications with the goal of improving systems integration (thereby reducing the number of standalone/siloed systems and applications).
- Standardization and ease of the provider experience as it relates to technology (how they log-on, systems they access, support, for example) regardless of the service area or facility.
- Consolidation of Information Technologies (IT) Security Services across the health system in support of a singular approach to security that includes trusted connections between health service organizations.
- Joint procurement of IT hardware and software.
- Consolidated/provincial approach to systems/technology use and deployment, including, but not limited to, telephone (VoIP) systems, email, SharePoint services and other network systems. This could result in significant licensing savings and reduction of waste and duplication.
- Consolidated health system data warehousing in order to reduce duplication across the system, ensure data security and redundancy, and reduce costs.

- Provincial approach to data analytics, ensuring the right data is collected, analyzed and available for improved health system management and results.

During our consultations, a consistent theme arose respecting current limitations in the health system’s ability to leverage information and data to support decision making within the system. The system has hundreds of independent information systems collecting data. This data has been traditionally analyzed in silos, if at all, resulting in a limited and often incomplete representation of health system problems and solutions. A more consolidated information system that integrates data in timely manner would enable the health system to:

- access and analyze the data needed to effectively predict, plan, deliver and manage health services;
- solve and identify problems with real time data;
- understand the results achieved;
- understand where improvements are needed;
- innovate successfully; and
- to make better decisions in service of meeting the needs of our patients.

We believe leveraging the investments made by eHealth and its health system partners in the development of the foundational supports to deliver on a provincial data and analytics strategy will lead to supporting evidence informed decision-making by administration, policy makers and health care providers. In order to capitalize on the improvements to information systems, analytic capacity within the HQC, the Provincial Health Authority and the Ministry of Health will need to be enhanced and coordinated.

Health Quality Council (HQC)

We strongly believe that HQC should continue to play an important supporting role in the health system by providing assistance and stability to the health system throughout the reorganization period and beyond. Ensuring continued progress on province-wide improvement work and the mitigation of disruption will be key to our success.

As HQC shared within their submission to the panel:

“Successful design and use of measurement to understand and improve performance is not a widespread capability in Saskatchewan health care; to achieve it will require development of capabilities in people and information systems.”

We believe the HQC should be meaningfully engaged to further assist in the development of capability to produce information on the value delivered by health services and on variations in processes. To that end, there is a need to develop capability for measurement of system processes, as well as system and patient outcomes. We believe HQC is well positioned to advise on the design and deployment of measurement systems that fit into the daily workflow of health care, and provide information that is valued by providers, patients/families, and administrators while not becoming burdensome and getting in the way of care.

Collaboration across the Human Services Sector

Patients and clients, particularly those with complex needs, are best served when the human services sector works in collaboration and not in their traditional silos. Sharing of data, within a context of privacy risk assessment and reasonable mitigations, should become the standard. Legislative and regulatory changes may be required to support system-wide data flow within the health system and other human services.

Conclusion

We strongly encourage the provincial government to take a thoughtful approach to implementation that seeks to minimize adverse impacts to patient care and that respects those who work within the administration of the system. There is considerable concern within the health system that change will impact our ability to serve our patients, as well as anxiety regarding what the work environment will look like in the future. In the short term, we appreciate the transitions required to develop the structure we have recommended will cause some disruption within the health system that can be mitigated by a strategic implementation plan. We firmly believe that, in the long term, unified governance and administration of the system will improve patient care and enable the system to more sharply focus on the patient and patient experience.

To that end, as an Advisory Panel tasked with such a significant task, we have appreciated the candor and honesty of the members of the public, senior leaders and representatives of the various organizations who met with us or submitted input. Every individual and organization demonstrated their passion and support of the health care system, their desire to do what is best for patients and a willingness to continue to work together to improve the health system. For this, we thank those who contributed their time, their knowledge and their experience to inform our work.

Appendix A

List of Advisory Panel Consultations

1. 3sHealth
2. College of Medicine University of Saskatchewan
3. eHealth Saskatchewan
4. Federation of Sovereign Indigenous Nations
5. Government officials from Alberta, Manitoba and Nova Scotia
6. Health Quality Council
7. Minister of Health and Minister of Rural and Remote Health
8. Physician Recruitment Agency of Saskatchewan
9. Provincial Affiliate Resource Group (PARG)
10. Provincial Government – Ministries of Health, Education, Social Services, Justice and Corrections and Policing
11. Regional Health Authorities – CEOs and Board Chairs
12. Saskatchewan Association of Health Organizations, Incorporated
13. Saskatchewan Association of Rural Municipalities
14. Saskatchewan Cancer Agency
15. Saskatchewan Emergency Medical Services Association
16. Saskatchewan Medical Association
17. Unions – CUPE, SGEU, SEIU-West, HSAS, SUN

For more information, visit saskatchewan.ca