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Saskatchewan

Patient Centred Community Designed Team Delivered



Primary Health Care
putting the Patient First

***A framework for achieving a
high performing Primary Health Care system***



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What is Primary Health Care?

- Primary health care is the day-to-day care needed to protect, maintain or restore our health.
- At its best, it is delivered by a team of health professionals (physician, pharmacist, dietician, nurse, social worker, etc.) that provide a home base for health care services that meet the needs of a community.





Patient Centred Community Designed Team Delivered

A framework for achieving a
high performing primary health care system in Saskatchewan



Primary Health Care
putting the Patient First



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Saskatchewan's Vision and Aims for PHC

Vision	Primary Health Care is sustainable, offers a superior patient experience and results in an exceptionally healthy Saskatchewan population.			
Major Aims	<u>Access</u> Everyone in Saskatchewan - regardless of location, ethnicity, or 'underserved' status - has an identifiable primary health care team that they can access in a convenient and timely fashion.	<u>Patient & Family Experience</u> A model of patient and family centered care has been implemented to achieve the best possible patient and family experience .	<u>Healthy Population</u> The primary health care system has contributed to achieving an exceptionally healthy population with individuals supported and empowered to take responsibility for their own good health.	<u>Reliable, Predictable & Sustainable</u> We are achieving reliable, predictable and sustainable delivery of primary health care.





Framework Recommendations

- Everyone connected to a PHC Team
- Services designed with patients & community
- Culturally responsive system: First Nations & Métis
- Flexibility: service design & team composition
- Coordinated system: family physicians, RHA services & First Nations system
- Flexible funding, with an accountability framework





The team that delivers service

Each patient/family is a key member of their team.
Each team includes or is linked to a family physician.

Key Functions

- Diagnose, Treat and Prescribe
- Case Management supports self-management
- Navigation and Coordination
- Chronic Disease Prevention and Management
- Continuous Quality Improvement

Attributes of Team

- Multi-skilled Professionals
- Practices evidence-based care
- Practices collaborative care
- Co-location is preferred
- After hours access
- Representative of the community
- Cultural Competence





Service Delivery Models

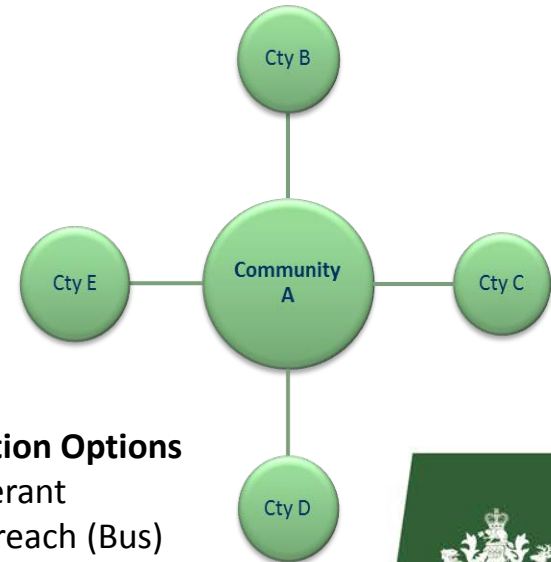
Multi-Community Delivery



Single-Community Delivery



Hub and Spoke Delivery



Connection Options

- Itinerant
- Outreach (Bus)
- Virtual





How will we do this?

- Build Long Term Relationships
- Engage Communities, including First Nations and Métis Communities
- Proactive chronic disease prevention & management / promoting health
- Flexibility: service design & team composition, funding with accountability framework
- Coordinated system: family physicians, RHA services & First Nations system





Learn by Doing

- **Progressing:** Stabilizing Services, Community Engagement, Physician Engagement
- **Innovating:** focus on access and patient experience; role, team, workflow and space redesign and multi-community models; patient and community input; continuous improvement methodologies
- **Approach:** Build, evaluate, spread





Innovation Sites: Snapshot

Meadow Lake – new roles and services

- RN Case Manager, MOA, co-location; integration (public/mental health); empanel patients; CTAS 4/5s; Shared medical visits

Lloydminster – new team development, PHC counsellor; inter-provincial delivery systems; extended hours.

Leader – service and team redesign; technology linking urban/rural, POCT; new roles for EMS; PHC counsellor, RN case manager

Moose Jaw – team design for better integration of services such as public health (leadership; future- immunizations, well-baby clinics).





Innovation Sites cont'd

Regina Meadow – inner city linked to other services
(pharmacy,dental,mental/public health); extended hours; outreach
to rural; POCT(HIV); alternate to episodic care

Regina Multi Community - Balcarres, Lestock and Fort Qu'Appelle;
integration with acute and community First Nations services

Yorkton – team based management of CD – outreach to rural

White Cap Dakota First Nation / Saskatoon RHA – partnership focus
on integration of RHA and FN delivered services
(integrate services, decrease fragmentation; LOU,data sharing
agreements)



Collaborative Emergency Centre

- 24/7 Coverage in rural & Remote
- 0800-2000 PHC team
- 2000-0800 – Nurse/Paramedic after-hours urgent and emergency care with telephone access to physician.



Strategic Deployment

Outcome

- 2017, people with chronic conditions experience better health indicated by 30% decrease in hospital utilization related to Diabetes, CAD, COPD, Depression, Congestive Heart Failure, and Asthma.

Improvement Targets

- 2017, 50% improvement in the number of people who say “I can access my primary health care team for care on my day of choice either in person, on the phone, or via other technology.”
- 2017, 80% of patients receiving care consistent with clinical practice guidelines for Diabetes, CAD, COPD, Depression, Congestive Heart Failure, and Asthma.



PCH 2013-14 Actions

- Shared vision & plan for integration of MH&A into PHC
- Innovation Sites:
 - using Lean as QI tools
 - reporting on standard set of measures
 - have mechanism to connect unattached patients who present in ER
 - gathering & analysing chronic disease data (preferably through EMR)
- Identify innovations to spread & support 'spread' strategy
- Identify key system innovations to link PHC system with the First Nations delivery system
- Design, test and begin to evaluate Model Lines (including CECs), assess readiness for spread
- Toolkit for PHC Teams: for developing & QI, measures, tasks, etc.
- RHAs are stabilizing services & have updated plans



PCH 2013-14 Actions cont'd

- Identify CPGs for 6 chronic diseases (Diabetes, CAD, COPD, Depression, Congestive Heart Failure, and Asthma)
 - Standardized approach
 - EMRs
- Increase supports for self management:
 - *LiveWell™* with Chronic Conditions
 - Increase to First Nations communities
 - “Online” access
 - Support for Health care providers
 - HealthLine/HealthLine Online
 - “Out bound” calls
 - 811





Health Promotion Priorities and Actions

Healthy Weights

Premier's Promise: 5% reduction in the rate of overweight and obesity of children and youth by 2022

Goals:

- Increase Physical Activity
- Improve Access to and Affordability of Nutritious Foods
- Enhance Health and Education Systems and Community Supports





Health Promotion Priorities and Actions cont'd

Tobacco Reduction

- The overall smoking prevalence in Saskatchewan decreased by 3.4% between 2007-08 and 2009-10, which is an all-time low. However, smoking rates in Saskatchewan still remain above the national average (22% compared to 20.4%).

Through the provincial Strategy key action areas continue to be:

- Support for cessation
- Enabling Youth to quit or not begin using tobacco
- Engaging Communities
- Supporting Legislation
- Evaluation





Health Promotion Priorities and Actions cont'd

Dental Screening

- The next provincial dental screening in all regions is scheduled for September 2013 to August 2014.
- Past dental screening data has been used to inform decisions related to oral health standards of practice within the province/health regions.



For more information contact:

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