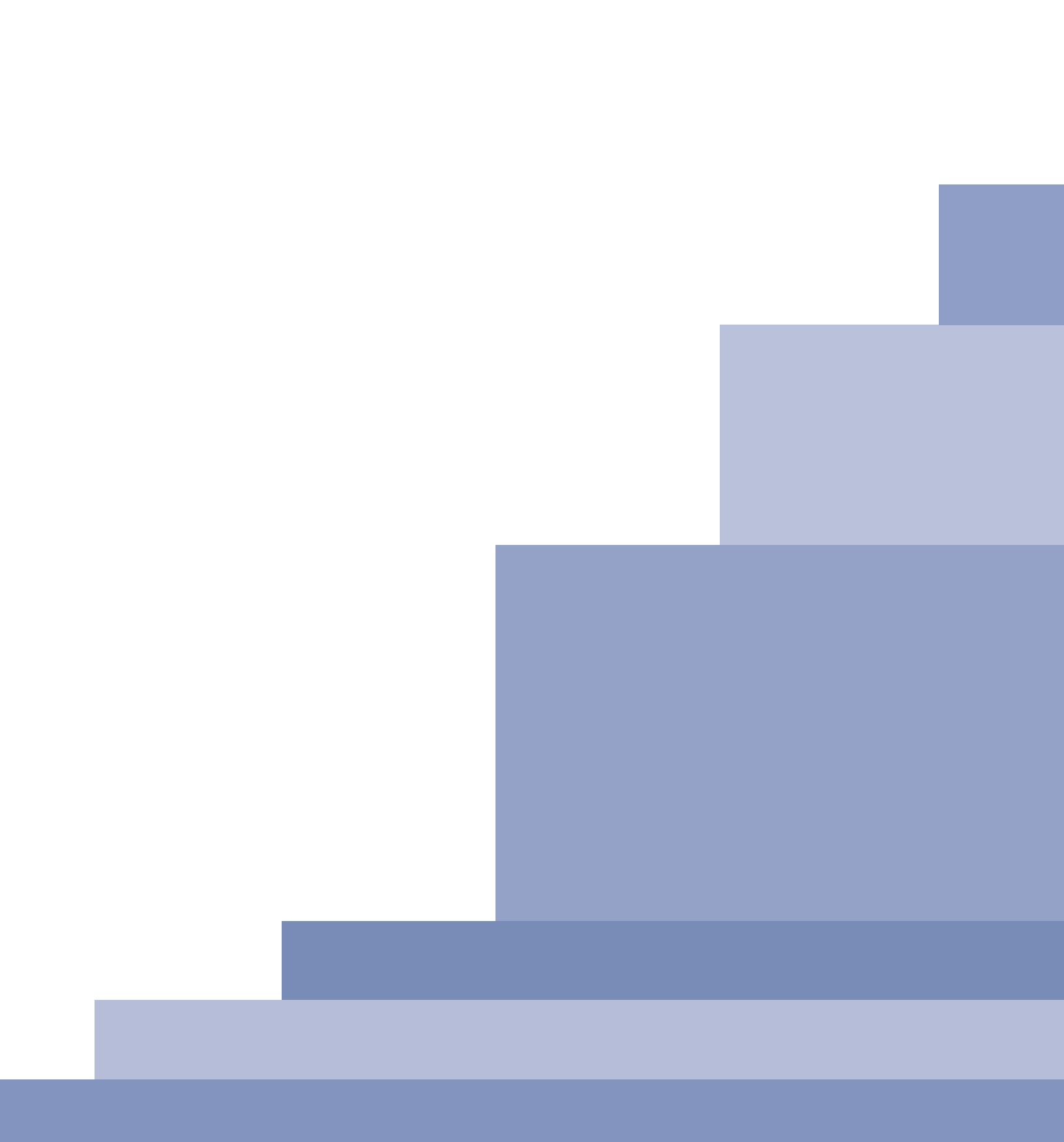


Patient Centred Community Designed Team Delivered

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



Primary Health Care
putting the Patient First



Thanks to the Regina Qu'Appelle, Saskatoon and Sun Country health regions; SWITCH at Westside Clinic, Saskatoon Community Clinic; Crestline Coach Ltd., 2012; and Studio 10 for generously sharing their photos.

Executive Summary	6
Preface	17
Primary Health Care Today: A Snapshot	19
What is “Primary Health Care?”	19
How is Primary Health Care Currently Delivered in Saskatchewan?	20
Primary Health Care Tomorrow: Our Vision	21
Our Vision and Aims	22
Areas to Strengthen to Ensure Success	22
Patients and Families at the Centre	22
Communities as Essential Partners	23
Physician Engagement in Team-Based Care	24
The Building-Blocks of Saskatchewan’s High Performing Primary Health Care System	26
Relationships as the Foundation	27
Increase Patient and Family Self-Reliance	27
Engage Communities in Service Model Design	28
Engage with First Nations Communities and Métis Communities	30
Enable Primary Health Care Teams to Flourish	31
Be Proactive in Preventing and Managing Chronic Disease	32
Engage in Building Models That Work	33
Policy and Accountability	35
Support Each Other Through the Transition	36
Next Steps: Our Planned Approach	37
Measuring Our Progress	39
A Long-Term Commitment	42
Appendix A: Physician Initiatives	44
Appendix B: Other Enabling Strategies	45
Appendix C: Contributors to the Primary Health Care Framework	48

Every day in Saskatchewan, thousands of people experience primary health care. They visit their family doctor for a physical. They call HealthLine about their sick child. They manage their diabetes, arthritis, or other chronic conditions. They get advice about quitting smoking from a pharmacist or a nurse practitioner, talk to a mental health counselor about their depression, a dietician about nutrition, or receive an exercise program from an exercise therapist.

These are every day encounters that help to protect and promote the health of Saskatchewan's citizens. When the *Patient First Review* was released in 2009 it recommended more be done to meet the health care needs from the point-of-view of patients and families.

This Framework – *Patient Centred, Community Designed, Team Delivered: a Framework for Achieving a High Performing Primary Health Care System in Saskatchewan* – outlines a road map for strengthening primary health care in Saskatchewan so that everyone has access to the care they need when they need it, so that the experience of care is exceptional, so that people stay or become healthy, and so that the system is reliable for patients and communities and sustainable into the future.

This Framework is the road map for a **patient-centred** primary health care system that ensures timely access to appropriate care with assistance to navigate services and supports for maintaining good health. In our **community designed** primary health care system, communities have a voice in the design and delivery of health services and supports needed to best address local needs. Our **team delivered** primary health care system makes better use of a full range of health professionals, working to full scope of practice, with a physician as a key team member.

The Framework for Achieving a High Performing Primary Health Care system in Saskatchewan was built by many hands and I would like to thank everyone who contributed their experience, wisdom and time. Patients, community leaders, health care providers and health system leaders worked together to develop this Framework. In addition, several agencies and organizations participated in the development of the Framework including: Saskatchewan Association of Rural Municipalities (SARM), Saskatchewan Urban Municipalities Association (SUMA), Saskatchewan Medical Association (SMA), Saskatchewan Registered Nurses Association (SRNA), Saskatchewan Association of Nurse Practitioners (SANP), Regional Health Authorities (RHAs), Health Quality Council (HQC), and First Nations and Métis organizations.

The success of this Framework's implementation depends on everyone continuing to work together and I am confident that we will continue to see positive results!



Honourable Don McMorris
Minister of Health



4

This Framework is the road map for a patient-centred primary health care system that will ensure timely access to appropriate care with assistance to navigate services and supports for maintaining good health.

“ Our vision is a primary health care system that is **sustainable, offers a **superior patient experience** and results in an **exceptionally healthy Saskatchewan population.** ,”**



Executive Summary

Purpose

This framework synthesizes the perspectives of more than 400 people – community leaders, patients, providers, policy-makers and managers. It outlines their shared vision for a sustainable primary health care system that will provide a superior patient experience and result in an exceptionally healthy Saskatchewan population.

The framework has been developed for communities, patients and providers, Regional Health Authorities and other service delivery partners.

It is the beginning of a province-wide effort to achieve a high performing primary health care system. It is an invitation to work together, designing a system that works best for patients, families, communities, physicians and other health care providers. As such, it serves as a “where to” rather than a “how to.” The “how to” will be developed at the community and regional level by partners working together to decide how to best implement this vision.

6

*This framework . . .
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Primary health care has often been described as the “everyday care” that a person needs to protect, maintain, or restore health.

7

Primary Health Care Today: A Snapshot

What is “Primary Health Care?”

Primary health care has often been described as the “everyday care” that a person needs to protect, maintain, or restore health. It is often a person’s first point of contact with the health system. This may come in the form of a visit with a family physician or nurse practitioner, advice from a pharmacist, information on managing a chronic disease, or numerous other interactions between patients, families and providers.

At its best, primary health care provides a home-base for health services, and improved access to those services, for patients. It is also the link to other parts of the health system and serves the patients by helping them to navigate the complexities and services of the health system.

What patients said they wanted:

Following the Patient First Review of 2009, subsequent consultations confirmed that primary health care in Saskatchewan must:

- Be more accessible and provide better access to after-hours care;
- Better meet the challenges of rising chronic disease rates; and
- Focus more on illness/injury prevention and management at the local, regional and provincial levels.

Patients, providers, and community leaders also noted:

- While there are pockets of success in Saskatchewan, primary health care needs to be more comprehensively established throughout the entire province;
- Patients want to be more informed and involved with their own health care;
- Navigating the health system is complex and often confusing – patients and families want assistance accessing the providers and services they need;
- Communities want to be engaged in the design of their health care services and share in the decision-making;
- First Nations communities and Métis communities want a provincial health system that is culturally responsive and seamlessly linked to the federal system.
- Family physicians are dedicated to caring for their patients, but want work/life balance and flexibility in funding options.
- Health care providers want improved team work, maximizing their knowledge, skills and abilities and collaborating with others to provide the best possible patient care.

In response to these concerns, primary health care in Saskatchewan should:

- Offer every person in Saskatchewan access to a **Primary Health Care Team** that meets their everyday health needs and helps them **navigate** the rest of the system. Every team will include or be connected to a family physician;
- Be **rooted in community** and designed in collaboration with patients and communities;
- **Reflect the communities** it serves, with specific attention to First Nations communities and Métis communities;
- Be **flexible** in designing teams and service delivery, in order to match community needs with resources and assets;
- **Include** independent family physician practices, primary health care services managed by Regional Health Authorities, and the First Nations primary health care delivery system;
- Use a flexible funding approach, with **decision-making located closest to the patient** and community and Regional Health Authorities;
- Have **clear aims, accountabilities, and expectations** for providers and Regional Health Authorities; and
- Use a **continuous improvement** approach to ensure progress towards aims related to patient and family experience, health outcomes and sustainability.

While there are pockets of success in Saskatchewan, primary health care needs to be more comprehensively established throughout the entire province.

Primary Health Care Tomorrow: Our Vision

Our Vision, Aims and Measures of Success

Our vision is a primary health care system that is **sustainable**, offers a **superior patient experience** and results in an **exceptionally healthy Saskatchewan population**.

To accomplish this vision, we need to achieve these four aims:

1. **Everyone in Saskatchewan – regardless of location, ethnicity, or ‘underserved’ status – has an identifiable primary health care team they can access in a convenient and timely fashion.**

Measures of success for improving access will be refined and tested, and could include:

- In two years:
 - 75% of Saskatchewan residents are aware of what primary health care services are available to them.
- In five years:
 - All Saskatchewan residents who choose to be are connected to a primary health care team and recognize the importance of a consistent team as their home base for health care services;
 - 50% of primary health care teams have undertaken Clinical Practice Redesign;

First Nations communities and Métis communities want a provincial health system that is culturally responsive and seamlessly linked to the federal system.



- Primary health care teams, broadly defined, are seen as the model of choice for patients, communities and providers, and are in place throughout the province of Saskatchewan;
- 50% of primary health care teams are accepting new patients; and
- All Regional Health Authorities have a process in place for referring patients who are without a regular primary health care provider to an available primary health care team.

2. A model of patient- and family-centred care has been implemented to achieve the best possible patient and family experience.

Measures of success for patient- and family-centredness will be refined and tested, and could include:

- In five years:
 - 75% of Saskatchewan residents rate their primary health care experience as exceptional;
 - Saskatchewan residents show an increase in self-rating their health;
 - All Saskatchewan patients and families, including First Nations and Métis, are meaningfully involved with and engaged in decision making at all levels (shared decision making and advisory processes);
 - 75% of patients with chronic disease report an increase in confidence to self-manage their disease;
 - All patient navigation is culturally sensitive and appropriate to the patient population; and
 - 100% of primary health care teams assume responsibility for the coordination and navigation of their patients' journeys.

3. 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.

Measures of success for a healthier population will be refined and tested, and could include:

- In two years:
 - Every Regional Health Authority recognizes the burden of chronic disease on the health of their population and has identified resources to address it;
 - The Ministry of Health, in conjunction with other key Ministries, has developed and implemented policies relating to social determinants of health and promoting good health;
 - Regional Health Authorities are collaborating with communities and have community needs assessments either underway or completed in 50% of communities that are ready; and
 - Based on community needs assessments, all Regional Health Authorities have a plan for primary health care and an accompanying health human resources plan.

- In five years:
 - There are an increased number of outreach programs to vulnerable populations served by primary health care teams;
 - There is a reduction in risk factors that result in chronic diseases;
 - The Ambulatory Care Sensitive Admission rates are reduced by 50%; and
 - The primary health care system has demonstrated measurable improvement in clinical indicators for selected chronic diseases prevalent within Saskatchewan's population.

4. We are achieving reliable, predictable and sustainable delivery of primary health care.

Measures of success for knowing we have healthier provider teams will be refined and tested, and could include:

- In two years:
 - 50% of primary health care teams have agreements in place that outline their commitments to members of their team;
 - Incremental team supports (facilitation, change management, etc) are in place to support primary health care teams; and
 - There is dedicated, appropriate and flexible funding.
- In five years:
 - Agreements articulating mutual commitments are part of the primary health care culture;
 - 100% of primary health care teams have targets that speak to promoting healthy lifestyles;
 - Health care provider turnover rates are reduced by 50% through improved team stability; and
 - 50% of health care providers report improvement in work-life balance and job satisfaction.

10

Measures of success for contributing to training future primary health care providers will be refined and tested, and could include:

- In five years:
 - The primary health care system is providing a range of high functioning primary health care practice settings for all health science students.

Measures of success for knowing we are committed to improvement will be refined and tested, and could include:

- In five years:
 - 100% of primary health care teams measure, monitor and make changes to practice based on results; and
 - Ongoing quality improvement is integral for all primary health care teams.

Primary health care is about helping patients and families to manage and maintain their own health to the greatest extent possible.

Primary health care development in every community must begin with the community's involvement in assessing its needs and planning how to meet those needs.

Areas to Strengthen to Ensure Success

Three crucial areas to strengthen in order for Saskatchewan to develop a truly high performing health system are noted below.

Patients and Families at the Centre

Patients and families are viewed as essential allies and treated as true partners. Providers encourage patients and families to ask questions and participate in their care and decision-making at the level they choose.

In addition to treating illness and injury, *primary health care is about helping patients and families to manage and maintain their own health to the greatest extent possible.* It *supports and empowers patients living with or at risk of chronic disease to manage their conditions,* providing timely, accessible care whenever needed. With information, support, and resources provided close to or in their own homes, patients can enjoy the improved quality of life and freedom that comes with less day-to-day dependence on the health system. The more effective our health system becomes at managing and preventing chronic illness, the less strain there will be on acute care services.

Patients *choose* their primary health care team and understand and appreciate the benefits of being *connected to* a team that is their home base for health services, and improves access to those services.

Communities as Essential Partners

Primary health care development in every community must begin with the community's involvement in assessing its needs and planning how to meet those needs. Community engagement is essential to building the trust and relationships required to successfully implement and evaluate effective primary health care.

True engagement means information and ideas will flow in multiple directions as health care leaders, providers and planners learn from community members about the community's strengths, assets, and needs.

In addition, in order to ensure that First Nations communities and Métis communities have effective input in the design and delivery of health care services, specific attention needs to go to supporting partnerships between Regional Health Authorities, provider groups, including the First Nations primary health care delivery system and First Nations and Métis community-based organizations, and community leaders. Successful partnership models are in place and need to be learned from and replicated, with Provincial and Federal Governments acting to remove barriers and enable success.

Physician Engagement in Team-Based Care

In addition to improved outcomes for patients, evidence also suggests that team-based, interdisciplinary care is beneficial for practitioners. Studies demonstrate that interprofessional collaborative practice is associated with higher provider satisfaction and increased sharing of information among physicians and other providers. In Saskatchewan, all primary health care teams will include or be connected to a family physician and family practices will be more effectively connected with Regional Health Authorities and their services. The definition and membership of the rest of the team should not be defined in policy, but is broadly defined and flexible, based on community needs and assets.

The team acts as the patient's health care home base, providing a range of health care services in a seamless and integrated fashion, with enhanced access through extended hours and use of new technology. The team also facilitates the patient's link to other parts of the health system, including referrals to specialists, navigation through the system and hospital care.

Studies demonstrate that interprofessional collaborative practice is associated with higher provider satisfaction and increased sharing of information among physicians and other providers.

The Building-Blocks of Saskatchewan's High Performing Primary Health Care System

Relationships as the Foundation

Long-term relationships at the patient and healthcare provider level have been shown to provide numerous benefits, including more coordinated and comprehensive care, reduced usage of hospitals and emergency rooms, and better engagement of vulnerable populations. Relationships between communities and Regional Health Authorities, Regional Health Authorities and providers, and communities with each other are also critical to the success of primary health care in Saskatchewan.

12

Increased Patient and Family Self-Reliance

Equipped with information and the right supports and tools, patients and families can do a great deal to manage their own health. Patients should always come away from an appointment with a clear plan of action for managing, maintaining, and protecting their health.

Long-term relationships at the patient and healthcare provider level have been shown to provide numerous benefits.

Engage Communities In Service Model Design

Community engagement is a process in which members of the community participate in assessing, planning, implementing, and evaluating responses to community needs, interests or problems. Community engagement is essential in building the relationships and trust required to assess needs, plan solutions, implement solutions, and evaluate effectiveness of any new primary health care models. Anything developed for the community must begin by involving the community.

Engage First Nations Communities and Métis Communities

Primary health care . . . represents a tremendous opportunity to engage with Saskatchewan's First Nations communities and Métis communities to build a system that provides the best possible care, access and patient and family experience.

Primary health care also represents a tremendous opportunity to engage with Saskatchewan's First Nations communities and Métis communities to build a system that provides the best possible care, access and patient and family experience. Any such system must build on the assets and strengths of First Nations peoples and Métis peoples and must also incorporate cultural awareness and respect in its very architecture. It also must better coordinate with the First Nations delivered primary health care system.

Enable Primary Health Care Teams to Flourish

Team-based health care has huge untapped potential, but there are numerous factors that contribute to – or sabotage – a team's success. If primary health care teams are to flourish in Saskatchewan, we must:

- Enable teams to design their practices and measure their own results in achieving primary health care's major aims;
- Achieve quality of life and job satisfaction for all team members;
- Measure how well teams work together;
- Provide education on areas of importance for primary health care providers;
- Clarify responsibilities and commitments through agreements that delineate each team member's role and responsibilities (legislated or non-legislated) and enable team members to work collaboratively at the top of their scope of practice;
- Use community working groups to bring all the stakeholders together periodically – Regional Health Authority, community, physicians and other team members, patients and families -- to ensure they are all on the same page; and
- Ensure funding is fair, transparent, flexible, and encourages team-based care that meets the needs of patients and families.

A Proactive Approach to Chronic Disease Prevention and Management

Many chronic diseases are preventable, and can be managed to reduce, delay, or avoid debilitating or harmful impacts on patients and families. In Saskatchewan, primary health care needs to fully engage with population health programs and other inter-sectoral partners in a coordinated effort to prevent, reduce, and manage chronic disease. By developing a province-wide vision, setting measurable goals, and focusing on modifiable risk factors and the social determinants of health, Saskatchewan's health and social sector can contribute to an unprecedentedly healthy Saskatchewan population.

Collaboration to Building Models That Work

The perspectives of patients and families are integral to the design and ongoing delivery of primary health care services. A formalized patient and family advisor role, supported financially and through policies and training for providers and advisors, will ensure that patient experience remains a central focus.

High-functioning primary health care services are the result of successful collaboration between communities, family physicians and other health care providers, First Nations delivery systems, Regional Health Authorities and the Ministry of Health. If each of these partners understands, embraces, and successfully fulfils their role, the resulting services have the best possible chance of meeting the community's needs in a reliable, sustainable, predictable manner.

Policy and Accountability

To date, our health care system has focused much of its attention and funding on providing services for people after they get sick or injured. While these services are important, health care policies and funding need to reflect a shift to health promotion, chronic disease management, team development, and innovative programming that reflects patient- and family-centred care.

In exchange for moving decisions around team composition and models of delivery to Regional Health Authorities, communities and primary health care teams, accountability for improved health care and health must be strengthened. It must be made clear what outcomes Regional Health Authorities and health care providers are responsible for achieving and to whom they are accountable.

Opportunities for input and joint problem solving should be created at all levels of the primary health care system – the team, Regional Health Authority, and provincial levels. These mechanisms should include patients and families, community leaders, First Nations peoples, Métis peoples, and health care providers.

Support Through the Transition

Changing how we deliver primary health care will mean significant change for everyone, from patient to provider. United by our shared desire for a patient- and family-centred health system and healthier population, we can and must work together and support each other through the transition. Deep listening to patients, community and providers is a key first step in identifying changes required to achieve the aims identified. Collective problem solving to identify sustainable solutions, build teams and measure progress must be supported at the regional and provincial level.

High-functioning primary health care services are the result of successful collaboration between communities, family physicians and other health care providers, First Nations delivery systems, Regional Health Authorities and the Ministry of Health.

Our Plan of Action

Phase 1 – The Framework

The approaches and building-blocks described in this document will serve as the basis for progressing primary health care in Saskatchewan.

This document represents completion of Phase 1: it provides a high-level framework for a primary health care system that is sustainable, offers a superior patient experience and results in an exceptionally healthy Saskatchewan population. The framework was developed by the contributors listed in Appendix C, with input and advice from many others. The proposed direction was then affirmed with health care providers and their associations, patients, communities and their leaders, and other health care stakeholders.

Phase 2 – Learn By Doing

The approaches and building-blocks described in this document will serve as the basis for progressing primary health care in Saskatchewan.

A number of sites will be selected for the testing of new concepts in primary health care service delivery. These sites will test elements of the framework, combined with attributes of high performing health care systems, adapted to the Saskatchewan context.

The new concepts and delivery systems will be continually evaluated and modified with the input of providers, patients, administrators, and communities. As new learnings are confirmed, they will be expanded to other sites and communities. Even as this work is taking place, Regional Health Authorities throughout the province will promote and strengthen existing primary health care services by building on their own successes and those of other Regional Health Authorities or provider groups. A continuous improvement approach will ensure progress towards the aims: access, patient and family experience, health outcomes and sustainability.

All stakeholders will have vital roles to play in the implementation of primary health care. In addition to the Ministry of Health and provincial government, Regional Health Authorities, communities, individual health care providers, agencies and associations such as the Saskatchewan Medical Association, the Health Quality Council, and community-based organizations will be critically important in fulfilling the vision reflected in this document.

In Summary...

Strengthening primary health care in Saskatchewan will require a constant commitment to change and innovation. The challenge that we must collectively overcome is ensuring that there is consistent vision, communication, team work, and leadership throughout this process. Everyone has a stake in this change; patients, communities, practitioners, or governing bodies must commit to a shared vision of change and support it by providing our own unique contributions and voices.

By their very nature, patient- and family-centred health systems will always be evolving and adapting to meet the ever-changing needs of their communities. There is no “ultimate model” or end point for designing how primary health care is delivered. In fact, one of the strengths will be its flexibility and responsiveness to changes in communities. Primary health care in Saskatchewan may look very different in 2025 than it does in 2012. What should remain stable, however, is a commitment to our four aims: access, patient- and family-centred care, healthy populations, and reliable, predictable, sustainable, community-driven services.

Primary health care is the foundation of the health care system, and the stronger and more vital it is in Saskatchewan, the better we will be able to adapt to the challenges and opportunities brought to us in the years to come.

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17

Preface

"A fundamental re-design of primary health services is urgently required in this province to serve patients better."

*For Patients' Sake: Patient First Review
Commissioner's Report to the Minister of Health¹*

The focus on strengthening primary health care is only one facet of a fundamental and province-wide effort to build a patient and family-centred health system in Saskatchewan.

Since the findings of the *Patient First Review* in 2009, health care providers, patients, Regional Health Authorities, the Saskatchewan Cancer Agency and the Health Quality Council have been working with the Ministry of Health to lead Saskatchewan's health system in a new, patient- and family-centred direction. When patients and families are understood to be the centre of the system, their priorities, values, and wishes become the driving force for excellence, value, safety, and positive outcomes.

The focus on strengthening primary health care is only one facet of a fundamental and province-wide effort to build a patient- and family-centred health system in Saskatchewan. The Saskatchewan Surgical Initiative, working to eliminate long surgical waitlists and create a safer and more positive care experience for surgical patients, is another example of patients, providers, and

¹ www.health.gov.sk.ca/patient-first-commissioners-report

other health system leaders working together to improve care. Additional health care strategies underway in Saskatchewan are listed and described in Appendices A: Physician Initiatives and B: Other Enabling Strategies.

A Framework Built By Many Hands

This framework document incorporates the perspectives of hundreds of individuals who collaborated on its creation. Patients, providers, administrators, community leaders, First Nations and Métis providers and patients, and other important partners have participated in numerous working groups and consultations, all leading to this framework for primary health care re-design.²

This framework serves as a proposed vision for the primary health care system of the future. As such, it is intended as a launch pad for detailed, implementation-level discussions with community leaders, patients, health care providers and administrators, and all who have a stake in the design of Saskatchewan's health care services. The document sets out a framework to guide our efforts. It serves as a "where to" rather than a "how to." The "how to" will be developed at the community and regional level by partners working together to decide how to best implement this vision.

The literature states that a high-performing primary health care system can improve the general health of the population, as well as increase patient and health practitioner satisfaction levels. Strengthening primary health care in Saskatchewan will require a constant commitment to change and innovation, which in itself presents a unique set of challenges. Thus, the challenge that we must collectively overcome is ensuring that there is consistent vision, communication, team work, and leadership throughout this process. Everyone has a stake in this change; we as patients, communities, practitioners, or governing bodies must commit to a shared vision of change and support it by providing our own unique contributions and voices.

A high-performing primary health care system can improve the general health of the population, as well as increase patient and health practitioner satisfaction levels.

² See Appendix B for a complete list of working groups and participants.



Primary Health Care Today: A Snapshot

What is “Primary Health Care”?

A strong primary health care system provides access to high quality care delivered by a team of health professionals that meets the needs of patients and their families of all ages, in any health care setting.

Primary health care is the foundation of the health care system; it has often been described as the “everyday care” that a person needs to protect, maintain, or restore health. It is often the first point of contact people have with a health care provider when they have a health concern. It may be a family physician/nurse practitioner visit, advice from the pharmacist, or information on chronic disease management.

A strong primary health care system provides access to high quality care delivered by a team of health professionals that meets the needs of patients and their families of all ages, in any health care setting. A primary health care team provides a health care home base for patients, and assists them in navigating the rest of the health care system. Primary health care is a holistic approach to health and recognizes that health is influenced by many factors outside the traditional health system.

Primary health care can look very different from one community or region to the next, because individuals, families, and communities will have different requirements for meeting their health care needs. Despite these differences, however, readiness of access is a fundamental characteristic to all primary

health care; it is accessible, available and responsive to needs identified by patients.

According to the Saskatchewan Medical Association (SMA), primary health care “must encompass harmonious coexistence of health care providers working in a collaborative, flexible and adaptable partnership with the patient-family centre to achieve the common goal of better outcomes for all.”³

How is Primary Health Care Currently Delivered in Saskatchewan?

Every day, thousands of community-based physicians, nurses, pharmacists, therapists, and other health care providers make a positive difference in the lives of patients and families. Private physician/medical clinics, community health centers, community clinics, First Nation community health clinics, and several northern nursing stations provide everyday health services.

There are many more contributors to the delivery of primary health care services in Saskatchewan, including HealthLine⁴ and HealthLine Online⁵, community-based pharmacies, private chiropractic, dental and therapy clinics, and organizations such as the Saskatchewan Lung Association, the Alzheimer’s Society of Saskatchewan, and the Canadian Diabetes Association.

In Saskatchewan, Regional Health Authorities are responsible for the delivery of health care services on behalf of the province and are a major employer of health care providers.

Over the past ten years, significant investment has been made in expanding and enhancing primary health care services by establishing Regional Health Authority-managed primary health care teams throughout the province. The focus of this investment has included significant changes in service delivery, the introduction of Registered Nurses (Nurse Practitioners) [RN(NP)s] to work in an expanded role, the recent engagement of pharmacists with some primary health care teams, and professionals learning to share roles and responsibilities, with a new focus of meeting individual, family, and community needs.

Saskatchewan has a diverse delivery system with numerous examples of high performing teams and a rich heritage of success on which to build and achieve a world-class primary health care system, but there is more to be done. For example, many family physicians work outside of the formal Regional Health Authority system, with limited access to supports for providing better primary health care. They are keen to better serve their patients while improving their own work life. Similarly, the First Nations health delivery system and the provincial health system could be better connected to meet the needs and improve the experience of First Nations peoples.

³ SMA Primary Health Care Framework, April 2011. p. 2

⁴ Toll-free telephone information and medical decision-making support tool available to all Saskatchewan residents at any hour of the day, every day of the year.

⁵ Provides medically approved health advice to anyone in Saskatchewan with Internet access.

Primary health care is a holistic approach to health and recognizes that health is influenced by many factors outside the traditional health system.

Over the past ten years, significant investment has been made in expanding and enhancing primary health care services by establishing Regional Health Authority-managed primary health care teams throughout the province.



21

Primary Health Care Tomorrow: Our Vision

What are the core functions of a primary health care team in Saskatchewan? How do we ensure those functions are carried out?

The following section guides us toward answers to some critical questions:

- What would Saskatchewan's high performing primary health care system look like?
- What is the common experience it should offer patients, providers, and communities?
- What are the core functions of a primary health care team in Saskatchewan? How do we ensure those functions are carried out?

To help address these questions, the following pages outline a proposed vision for Saskatchewan's primary health care of the future and some of its critical components.

Our Vision and Aims

As patients, providers, administrators, community leaders and other partners debated and discussed primary health care, a vision and four aims emerged:

Our vision is a primary health care system that is sustainable, offers a superior patient experience, and results in an exceptionally healthy Saskatchewan population.

To accomplish our vision, we need to achieve these four major aims:

- 1. 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.
- 2. A model of patient- and family-centred care has been implemented** to achieve the best possible patient and family experience.
- 3. The primary healthcare system contributes to Saskatchewan having an exceptionally healthy population**, with individuals supported and empowered to take responsibility for their own good health.
- 4. We are achieving reliable, predictable, and sustainable delivery** of primary health care.

Patient- and family-centred providers share complete, unbiased information on patients' illness, diagnosis, treatment options and procedures in a way patients and families can understand.

Areas to Strengthen to Ensure Success

From this vision and aims, three areas that need to be strengthened to ensure the success of primary health care across Saskatchewan emerged: putting patients at the centre, enhancing the role of community, and broadening and strengthening primary health care teams.

22

Patients and Families at the Centre

Patient- and family-centred care (PFCC) demonstrates:

- Respect and dignity to patients and families;
- Sharing of information so that patients and families have a full understanding of health issues and the choices available to them;
- Participation by patients and families in the consultations and decisions that affect them; and
- Collaboration among health providers and between providers, patients, and families.

Patient- and family-centred providers share complete, unbiased information on patients' illness, diagnosis, treatment options and procedures in a way patients and families can understand. They encourage patients and families to ask questions and they take patients' cultural backgrounds and beliefs, health literacy skills, and education levels into account when developing their treatment plans or providing treatment options. Patients and families are also encouraged to participate in their care and decision-making at the level they choose. Overall, patients and families are viewed as essential allies and treated as true partners.

The more effective our health system becomes at managing and preventing chronic illness, the less strain there will be on acute care services.

In addition to treating illness and injury, primary health care is about helping patients and families to manage and maintain their own health to the greatest extent possible. With information, support, and resources provided close to or in their own homes, patients can enjoy the improved quality of life and freedom that comes with less day-to-day dependence on the health system. Patients choose their primary health care team and understand and appreciate the benefits of being connected to a team as their home base for health services, and improved access to those services.

The more effective our health system becomes at managing and preventing chronic illness, the less strain there will be on acute care services. Effective primary health care services will support and empower patients living with or at risk of chronic disease, helping them to manage their conditions and providing timely, accessible care whenever needed. This will require more integration between health services, and improved collaboration and communication between health professionals.

Communities as Essential Partners

At its best, primary health care arises directly out of the needs identified by those it serves. Patients, families, and communities should be engaged in determining their needs and how those needs can most effectively be met in a reliable, predictable, stable manner. Primary health care providers, in turn, should have a sound knowledge of their patients and community and a focus on improving the community and meeting its residents' needs.

Communities can be defined by geography, as in Biggar or Yorkton, by need, as in the frail elderly or those with a one or more chronic condition, or by culture, such as a First Nations community or an immigrant community.

It is not enough for communities to be "informed" about changes in their health care; community members need to be involved and engaged in assessing their needs and strengths, planning and implementing health care services, and evaluating those services. As noted by the Saskatchewan Medical Association, "it will be the community, the health care team, and the patient and their families' ability to pick the right (primary health care) components for their particular circumstances/needs that will help ensure success."⁶ Communities should participate with health regions and providers, in making decisions about primary health care service configuration and delivery, within the parameters of federal or provincial regulations, policy and budgets.

Primary health care development in every community must begin with the community's involvement in assessing its needs and planning how to meet those needs. Community engagement is essential to building the trust and relationships required to successfully implement and evaluate a new primary health care model. True engagement means information and ideas will flow in multiple directions as health care leaders, providers, and planners learn about a community's strengths, assets and needs.

⁶ SMA Primary Health Care Framework, p. 2

The benefits of successful community engagement are numerous and profound. The resulting health services will have genuine and lasting roots in the community, strengthened by greater mutual trust and understanding between providers and community members.

PARTNERSHIPS WITH FIRST NATIONS COMMUNITIES AND MÉTIS COMMUNITIES

In addition, in order to ensure that First Nations communities and Métis communities have effective input in the design and delivery of health care services, specific attention needs to go to supporting partnerships between Regional Health Authorities, provider groups, including the First Nations primary health care delivery system and First Nations and Métis community based organizations, and community leaders. Successful partnership models are in place and need to be learned from and replicated, with Provincial and Federal Governments acting to remove barriers and enable success.

Collaborative practice not only facilitates more comprehensive and coordinated care, it also encourages professionals to work to their full scope of practice while enjoying a better work-life balance.

Physician Engagement in Team-Based Care

One of primary health care's most distinguishing characteristics is its emphasis on interdisciplinary, team-based care to provide integrated, holistic health services. Collaborative practice not only facilitates more comprehensive and coordinated care, it also encourages professionals to work to their full scope of practice while enjoying a better work-life balance.

Scholarly evidence supports a team-based approach as the most effective model of primary health care. Collaborative practice has been associated with improved quality of care in the treatment of depression, type-2 Diabetes, hypertension, Alzheimer's disease, obesity, and heart disease.

In addition to better outcomes for patients, evidence also suggests team-based care is beneficial for practitioners. Studies demonstrate that interprofessional collaborative practice is associated with benefits for providers such as improved provider satisfaction and increased information-sharing between physicians and other providers.

The specific services delivered by primary health care teams will vary from community to community, but nearly all of the essential functions can be placed in one of the following categories:

- Timely access to primary health care services
- Diagnosis, treatment, and prescription
- Case management
- Navigation and coordination
- Prevention and management of chronic disease

The configuration of practitioners, providers and others who fulfil these roles will be based primarily on the locally defined needs of the community and the assets and resources already in place. However, all teams will include, or be connected to, family physicians, and could also include nurses and

Scholarly evidence supports a team-based approach as the most effective model of primary health care.

In order to strengthen primary health care services, family practices need to be more effectively connected with Regional Health Authorities and their services to facilitate access to supports, ensure communication and coordination, and strengthen networks.

nurse practitioners, pharmacists, traditional healers, emergency medical technicians, mental health professionals, addictions workers, social workers, dieticians, home care workers, midwives, community outreach workers, specialist physicians and others. In order to strengthen primary health care services, family practices need to be more effectively connected with Regional Health Authorities and their services to facilitate access to supports, ensure communication and coordination, and strengthen networks.

Primary health care teams provide a health care home base for their patients. They are multi-skilled, with all members working to the top of their scope. They collaborate with each other and with patients and families while providing care. They can be co-located, are reflective of the community they serve, and provide after-hours service for their patients. They also:

- Establish long-term relationships with their patients, communities, and all other interested stakeholders;
- Demonstrate cultural competence;
- Have a common vision and goals;
- Work in collaborative practice models;
- Engage with their community;
- Design services to ensure increased cultural, functional, and geographic accessibility as well as continuity of care;
- Utilize technology to improve communication (e.g. electronic medical records, skype, e-mail);
- Have mechanisms for on-going improvement (e.g. patient feedback, plan/do/study/act cycles); and
- Use evidence to inform their quality of care.



The Building-Blocks of Saskatchewan's High Performing Primary Health Care System

26

After considering the present state of primary health care services in Saskatchewan and envisioning the desired future state, the inevitable questions arise:

- How do we get from here to there?
- How and where do we begin the journey?
- What tangible changes must be our focus if we are to begin moving in the direction we wish to go?

Two assumptions guide this section:

1. We must be strategic in our approach, always keeping our desired end in mind and focusing on those changes that have the best potential to lead us to our goals.
2. We must proceed boldly, testing new service delivery models and ensuring their success in specific sites while continuing to make progress in primary health care across the entire province, learning and adapting as we go.

What tangible changes must be our focus if we are to begin moving in the direction we wish to go?

What follows are the building blocks for Saskatchewan’s primary health care system.

Relationships as the Foundation

Relationships are at the core of successful community engagement; without an appropriate level of understanding, trust, transparency, and communication, success is limited.

Relationships, at all stakeholder levels, are the foundation of effective primary health care. These relationships are critical to ensure that patients’ needs are met and providers are able to work collaboratively.

Long-term relationships at the patient and provider level have been shown to create numerous benefits, including more coordinated and comprehensive care, reduced usage of hospitals and emergency rooms, improved engagement of vulnerable populations, and increased satisfaction for people working in the health care system.

Relationships are at the core of successful community engagement; without an appropriate level of understanding, trust, transparency, and communication, success is limited. Relationships occur at various levels; between patients and physicians, between health providers and communities, between communities (including First Nations communities and Métis communities) and health regions, between regions and various government agencies, and between all levels of government. A truly engaged relationship is based on partnership and ownership; the parties are actively ‘at the table’; and are empowered to make a difference at their local level; these relationships are catalysts for future change. Relationships may change over time, but are consistent and enduring.

Increase Patient and Family Self-Reliance

Equipped with information and the right supports and tools, patients and families can do a great deal to manage their own health. When patients and families are at the centre of care, the primary health care team becomes a resource for them, providing information, counsel, and clinical/medical assistance as needed. Patients should always come away from an appointment with a clear plan of action for managing, maintaining, and protecting their health.

It is not enough for health services to be “in place;” patients and families must be aware of their existence and function and must also know how to access and navigate the services. Communities, patients, and families should be engaged in assessing their needs around access and the requirements for a formal navigation function.

Any development of primary health care services should be accompanied by an education/communication strategy designed to introduce team members to the community and ensure community members are aware of available health services and resources and know how to access them.

A formal navigation function, incorporated as part of the primary health care team’s work, would help to ensure that no patient is denied the information and support they need to access services.

It is not enough for health services to be “in place;” patients and families must be aware of their existence and function and must also know how to access and navigate the services.

Engage Communities in Service Model Design

Community engagement is an active process that demands purposefully established opportunities for members of the community to participate in assessing their needs, then planning, implementing, and evaluating responses to their needs, interests, and problems. Community engagement is essential in building the relationships and trust required for effective primary health care. Anything developed for the community must begin by involving the community. Community engagement, when performed successfully, goes well beyond merely making information available to community members, or gathering opinions and attitudes from community members. It entails the active exchange of information, viewpoints, and expectations.

Successful community engagement produces health care decisions that reflect the needs, values, and culture of the community, and makes decision-making more accountable to the community. Local resources are used more effectively due to better access and increased support for programs and services. The increased networking between providers and community members enhances community awareness of health issues and fosters an enhanced sense of control and empowerment in the community, while providing an opportunity for different perspectives, pooling of resources, and creative problem solving.

For the purposes of primary health care, communities can be defined by geographic location – neighbourhood, suburb, village, town or city; by culture, such as an ethnic or religious group; or by need, such as the frail elderly or those with chronic conditions.

Community members continue to play an essential role long after primary health care delivery models are designed and established. They play a key role in educating and informing other community members about available services. They can help clear up confusion and misinformation that may arise when “traditional” health services are re-designed. Most importantly, they help to keep primary health services connected to the community.

Community needs assessments are an essential step in enabling communities to determine:

- The types of care required in the community;
- Services that currently exist, and the gaps within them; and
- The assets and strengths of the community.

Once the specific needs of the community are clear, communities can work with health care providers and Regional Health Authorities to determine how best to meet those needs. This is a critical step in determining the composition of the team and the overall service delivery model.

It will be important for communities to understand the specific functions of the various health care providers. The majority of Saskatchewan residents are familiar with the services provided by a physician, as they are able to diagnose,

Successful community engagement produces health care decisions that reflect the needs, values, and culture of the community, and makes decision-making more accountable to the community.

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prescribe medications and make referrals to specialists. Nurse practitioners are also able to provide these services for common health concerns and in managing chronic conditions. For this reason, these providers are often seen as the “core” of the team.

Although the physician is the most familiar provider of primary health care, and is always a member of a team, there are many other providers that can work as part of the team to meet the specific needs of the community. These can include:

- Traditional healers
- Pharmacists
- Emergency medical technicians/First responders
- Social workers
- Psychologists and other mental health professionals
- Midwives
- Home care providers
- Community developers
- Addictions counsellors
- Specialists/specialized family practitioners, and others.

Team composition will vary by community type; the availability and location of provider resources will drive the service delivery model for a particular community, based on a localized set of needs.

Service delivery models also emerge as a result of local needs, innovation, and strong partnerships between communities, providers, and Regional Health Authorities. The three delivery models outlined below are examples of how primary health care has been and can be adapted and delivered throughout the province.

- **Single community delivery**

With this model, the primary health care team serves patients and families within one urban, rural, or remote community.

- **Multi-community delivery**

In this model, a primary health care team can be made of providers in communities close to each other working together to serve their collective populations.

- **Hub-and-spoke delivery**

With the hub-and-spoke model, a central health care site provides support to ‘satellite’ sites that are distributed throughout an area in response to community needs.

Engage with First Nations Communities and Métis Communities

Strengthening primary health care represents a tremendous opportunity to engage with Saskatchewan's First Nations communities and Métis communities to build a system to provide the best possible care, access, and patient and family experience. Any such system must build on the assets and strengths of First Nations peoples and communities and Métis peoples and communities and must also incorporate cultural awareness and respect in its very architecture. Recognizing this, First Nations peoples and Métis peoples identified the following as important guiding principles:

- Effective primary health care services will support and empower First Nations and Métis individuals and communities to take ownership and drive change for their people through greater input into health care policy and system design.
- Primary health care planning and decision-making tables must have First Nations participation and Métis participation.
- Primary health care must be based on strong relationships built over time between all stakeholders – especially the health care providers and the communities they serve.
- Primary health care must include traditional medicine practices. Traditional practices must be carried out by First Nations people and Métis people.
- Programs and services for First Nations people and Métis people must be built by or with First Nations and Métis people and ideally delivered by First Nations and Métis people or those with the appropriate cultural training. They must be sustainable and holistic.
- Partnerships with Regional Health Authorities should support and build upon existing First Nations health delivery models and the capacity in place. Aligning the Health Canada-funded First Nations primary health care system with provincial Regional Health Authority-delivered services will ensure better coordination of care and more effective service delivery for First Nations peoples.
- First Nations communities and Métis communities deal with distinctive challenges, but also offer distinctive strengths that can be integral to successful new models of delivering care. Primary health care for these communities must put power into the hands of patients and families, enabling and supporting them in their quest for good health, and must align with and enable existing services.

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30

First Nations communities and Métis communities deal with distinctive challenges, but also offer distinctive strengths that can be integral to successful new models of delivering care.

Enable Primary Health Care Teams to Flourish

Team-based health care is an exciting concept with great untapped potential, but there are numerous factors that contribute to – or sabotage – a team’s success.

Team-based health care is an exciting concept with great untapped potential, but there are numerous factors that contribute to – or sabotage – a team’s success. If primary health care teams are to flourish in Saskatchewan, we must:

- **Enable teams to redesign their practices and measure their results in achieving primary health care’s major aims.** This can mean:
 - Making the Health Quality Council’s Clinical Practice Redesign program available to all teams;
 - Providing tools, supports, and resources to primary health care team members who wish to measure “how they’re doing” and use the information as a learning tool for continuous improvement;
 - Moving forward with “virtual practice” tools such as Skype, telehealth, etc.; and
 - Implementing electronic medical records as an aid to continuity of care and bringing team members together.
- **Enable teams to measure their success in achieving quality of life and job satisfaction for team members.** This can mean:
 - Developing a validated measurement for work-life balance and job satisfaction, one that all team members can use to establish a baseline and track improvement;
 - Conducting exit interviews with departing team members;
 - Using tools such as the Team Effectiveness tool to ensure that teams are working together optimally; and
 - Providing education on areas of importance for primary health care providers, including team-based care. This education can begin with an orientation package that outlines the benefits of team-based care for patient and provider. Inspirational speakers and other resources can be employed periodically to support continued collaboration and effective teamwork.
- **Clarify roles through agreements that delineate each team member’s role and limitations (legislated or non-legislated) and enable team members to work collaboratively at the top of their scope.**
- **Ensure there are mechanisms in place to help the team engage with the community.** This could include:
 - Regional Health Authorities conducting community needs assessments so team members are kept apprised of the needs of the population they serve; and
 - Using community working groups to bring stakeholders together periodically – Regional Health Authority, community, physicians and other team members, and patients and families, to ensure they are all ‘on the same page.’
- **Ensure that funding is flexible, and encourages team-based care that meets the needs of patients and families.**

Be Proactive in Preventing and Managing Chronic Disease

Good nutrition, physical fitness, immunization, mental wellness, and a safe environment are among the factors contributing to individual and community health. Primary health care focuses not only on treating illness and injury, but on maintaining good health and reducing the likelihood of illness and injury.

Chronic diseases are prolonged conditions that normally do not improve with time and are rarely cured. In 2005, 35% of Saskatchewan residents were living with at least one chronic health condition. In Canada, chronic diseases account for 80% of visits to a family physician, 70% of all deaths, and more than 60% of health care costs.

Around the world, chronic conditions are the leading cause of death and disability; in Canada, chronic diseases represent an estimated annual cost of \$80 billion.⁷ As our understanding of the significance of chronic illness has grown, health systems are trying to do a better job of working with patients to manage these conditions. By emphasizing collaborative, interdisciplinary care and the relationship between patient and provider, primary health care encourages better ongoing management of chronic disease.

Many chronic diseases are preventable, and many that aren't prevented can be managed so as to reduce, delay, or avoid debilitating or harmful impacts on patients. In Saskatchewan, primary health care needs to engage with population health programs and other inter-sectoral partners in a coordinated strategy to prevent, reduce, and manage chronic disease. By developing a province-wide vision, setting measurable goals, and focusing on modifiable risk factors and the social determinants of health, Saskatchewan's health and social sectors can contribute to an exceptionally healthy Saskatchewan population.

Communities and their primary health care teams should partner with local social and health organizations to identify their priorities for chronic disease prevention and management and develop plans for focusing on those priorities. Province-wide data and information from Regional Health Authorities can help to inform these plans.

There are other ways communities and their primary health care teams can be proactive in managing and preventing chronic disease, including:

- Educational sessions for providers on supporting patients living with chronic disease;
- Educational sessions that empower patients to advocate for themselves and access the tools and supports they need to manage their conditions;
- Doubling the number of "Live Well With Chronic Conditions" sessions currently offered within health regions, with a special focus on the North, where the chronic disease burden is disproportionately high;

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32

By emphasizing collaborative, interdisciplinary care and the relationship between patient and provider, primary health care encourages better ongoing management of chronic disease.

⁷ Chronic conditions include communicable diseases such as HIV/AIDS, non-communicable diseases such as diabetes, cardiovascular disease and chronic obstructive pulmonary disease, and severe and persistent mental disorders.

- Encouraging increased participation in healthy activities, through partnerships with local recreation centres and other programs; and
- Establishing a referral program whereby emergency room providers can automatically refer patients with chronic disease to a primary health care team.

In working with First Nations communities and Métis communities, it is essential to work with all partners . . . to develop a unified, cohesive vision for primary health care.

Engage in Building Models That Work

Patients' and families' perspectives must be incorporated into the design and ongoing delivery of primary health care services. A formalized patient/family advisor role, supported financially and through policies and training for providers and advisors, will ensure that patient experience remains a central focus.

While communities will share many common health care needs, their distinctive demographics, geographies and other characteristics call for a primary health care model based on engagement and input from community leaders, organizations, and residents. No primary health care team or service should be established without extensive direction and input from the community it serves. This engagement process can begin with awareness campaigns that educate and inform communities about the vision for primary health care. Subsequent dialogue with communities can take place with local service clubs, churches, and other community organizations. Primary health care teams should establish agreements outlining mutual commitments with the communities they serve, and those communities should receive regular reports on community health indicators.

In working with First Nations communities and Métis communities, it is essential to work with all partners – including non-profit organizations, First Nations health services, Health Canada, the Ministry of Health, and Regional Health Authorities – to develop a unified, cohesive vision for primary health care. Dialogue with communities should focus on building trust, identifying barriers to primary health care development, and working together to remove those barriers. Opportunities also must exist to ensure First Nations peoples and Métis peoples are represented in the workforce throughout the health care system, and to educate all health care providers on the philosophy of First Nations cultures and Métis cultures.

Physicians and health care providers, both new graduates and established practitioners, must be educated on primary health care and engaged in its development. The relationship between physicians and Regional Health Authorities must be strengthened, with physicians serving a recognized advisory role.

One of the benefits of strengthening primary health care will be increased engagement between physicians and other stakeholder groups: physicians will play a leadership role in designing and implementing the evolving primary health care system. Also, primary health care will be flexible in its design, with physicians able to choose the components that are a good fit for their practices and the needs of their community.

One of the benefits of strengthening primary health care will be increased engagement between physicians and other stakeholder groups.

Regional Health Authorities, supported by communities, professional associations, and the Ministry of Health, should present primary health care to all providers as the preferred option for practice.

The Ministry of Health must create the conditions necessary for a coordinated and integrated delivery system. Every effort should be made at the local service delivery level to connect community-based physicians, Regional Health Authority delivered primary health care services, and the First Nations primary health care delivery system.

High-functioning primary health care services are the result of successful collaboration between the Ministry of Health, Regional Health Authorities, the First Nations health delivery system, family physicians, other health care providers and communities. If each of these partners understands, embraces, and successfully fulfils its role, the resulting services have the best possible chance of meeting the community's needs in a reliable, sustainable, predictable manner.

The Roles of Communities, Regional Health Authorities, and the Ministry of Health

Communities and their leaders are responsible for assessing and continually communicating their health care needs and the success of existing services in meeting those needs. By fully engaging in discussions and meetings with the Regional Health Authority, community leaders can represent the interests of patients and families and also gather important information about local health services – information that should be shared throughout the community so that all are aware of how best to locate and access services.

Regional Health Authorities oversee the design and delivery of health services, in response to community needs. Working with communities, providers, and the Ministry of Health, Regional Health Authorities play a leadership role, setting standards and accountabilities for health care, ensuring every patient and family has an identified primary health care team as close to home as possible, and providing support for primary health care teams. That support can include facilitation and coaching, information infrastructures, staffing, and allocation of resources. Also, Regional Health Authorities should engage with community-based physicians to ensure they are fully integrated with primary health care services.

The **Ministry of Health** collaborates with Regional Health Authorities, communities, providers, and other stakeholders to set the strategic direction for Saskatchewan's health system – its overall values, goals, objectives, and priorities. By providing funding, setting and reviewing legislation, and leading in the development of province-wide tools, supports, and standards, the Ministry can help remove barriers and facilitate a continued path of quality improvement and patient- and family-centred health care.



Policy and Accountability

Policy That Enables

The goal . . . is to ensure that all stakeholders can effectively respond to patients' needs and create an environment where the barriers to an exceptionally healthy population are removed.

To date, our health care system has focused much of its attention and funding on providing services for people after they get sick or injured. While these services are important, health care policies and funding need to reflect a shift to health promotion, chronic disease management, team development, and innovative programming that reflects patient-centred care.

To address this dilemma, the Ministry of Health must create a new, forward-looking, flexible primary health care funding approach and supportive policies. The goal of this approach is to ensure that all stakeholders can effectively respond to patients' needs and create an environment where the barriers to an exceptionally healthy population are removed.

The Ministry must also create the conditions necessary for a coordinated and integrated delivery system. Regional Health Authorities, at the local service delivery level, will make every effort to connect community-based physicians, Regional Health Authority-delivered primary health care services, and the First Nations primary health care delivery system. In addition, the Ministry will support continuity in the planning and policy actions of Regional Health Authorities, other provincial ministries, and the federal government; the end goal of this collaborative form of governance is to ensure that programming and policies strive for the optimal health of the Saskatchewan population.

Accountability Framework

In exchange for flexible primary health care funding . . . accountability for improved health and health care must be strengthened.

In exchange for flexible primary health care funding, which would move funding and spending decisions to Regional Health Authorities, communities and providers, accountability for improved health and health care must be strengthened. It must be made clear what outcomes Regional Health Authorities and health care providers are responsible for achieving and to whom they are accountable: their patients, their primary health care team members, their communities, Regional Health Authorities, and/or the Government of Saskatchewan. The “Measuring Our Success” section of this document outlines some proposed success measures which could form the basis of these accountabilities.

Opportunities for input and joint problem solving should be created at all levels of the primary health care system – the team, Regional Health Authority, and provincial levels. These mechanisms should include patients and families, community leaders, First Nations peoples, Métis peoples, and health care providers.

Agreements to Bring Clarity

To help ensure all parties have a clear understanding of what is expected of them and what they can expect in turn, written agreements will be set in place. These agreements are the commitments of the parties to each other – the respective ethical accountabilities among involved parties. They outline mutual “gives and gets” for each participant – their obligations, and the benefits they will enjoy as a result of contributing as agreed to in the arrangement. Such agreements have been effective in supporting health system change by creating a new dialogue and set of expectations between parties. For example, a community may agree to a new model of care, utilizing a nurse practitioner in collaboration with a physician and an emergency services technician working part-time as an extended member of the team. In return, that primary health care team agrees to provide timely and convenient care, such as scheduling appointments on the patients’ day of choice and after hours access arrangements.

When developing primary health care services for a community, agreements could be developed to support mutual understanding of expectations in the following circumstances:

- Between the patient/family and primary health care team;
- Among members of the primary health care team;
- Between the primary health care team and the community;
- Between the physician and the Regional Health Authority;
- Between the community and the Regional Health Authority; and
- Between communities served by a primary health care team.

Although such agreements are not legally binding in the manner of contracts, they can be linked to a legally binding arrangement such as employment contracts or contracts for services.

When developing primary health care services for a community, agreements could be developed to support mutual understanding of expectations.

36

Support Each Other Through the Transition

Progressing primary health care will mean significant change for everyone, from patient to provider. United by our shared desire for a patient- and family-centred health system and healthier population, we can and must work together and support each other through the transition. Deep listening to patients, community and providers as a key first step in identifying changes required to achieve the aims identified. Collective problem solving to identify sustainable solutions, build teams and measure progress must be supported at the regional and provincial level.

In practical terms, this could mean the development of transition teams that support patients and providers as primary health care models are tested in a community. Models to support physicians will also need to be developed, providing assistance with team set-up, infrastructure, and resources as they redesign their business and clinical practices to better integrate with the primary health care system.



37

Next Steps: Our Planned Approach

How will we move this vision, the aims and building blocks off the page and into a revitalized network of primary health care services and a fully functioning primary health care system for Saskatchewan people?

The following is our plan of action.

Phase 1 – The Framework

This document represents completion of Phase 1: it provides a high-level framework for a primary health care system that is sustainable, offers a superior patient experience and results in an exceptionally healthy Saskatchewan population.

The framework was developed by the contributors listed in Appendix C, with input and advice from many others. The proposed direction was then affirmed with health care providers and their associations, patients, communities and their leaders, and other health care stakeholders.

All stakeholders will have vital roles to play in the implementation of primary health care in Saskatchewan.

Phase 2 – Learn By Doing

The approaches and building-blocks described in this document will serve as the basis for progressing primary health care in Saskatchewan.

A number of sites will be selected for the testing of new concepts in primary health care service delivery. These sites will test elements of the framework, combined with attributes of high performing health care systems, adapted to the Saskatchewan context.

The new concepts and delivery systems will be continually evaluated and modified based on the input of providers, patients, administrators, and communities. As new learnings are confirmed, they will be expanded to other sites and communities. Even as this work is taking place, Regional Health Authorities throughout the province will promote and strengthen existing primary health care services by building on their own successes and those of other Regional Health Authorities or provider groups. A continuous improvement approach will be used to ensure progress towards the aims: access, patient and family experience, health outcomes and sustainability.

All stakeholders will have vital roles to play in the implementation of primary health care. In addition to the Ministry of Health and provincial government, Regional Health Authorities, communities, individual health care providers, agencies and associations such as the Saskatchewan Medical Association, the Health Quality Council, and community-based organizations will be critically important in fulfilling the vision reflected in this document.

The new concepts and delivery systems will be continually evaluated and modified based on the input of providers, patients, administrators, and communities.



39

To help us measure progress towards our vision and aims . . . we will focus on two-year and five-year success measures.

Measuring Our Progress

To help us measure progress towards our vision and aims, our community of advisors told us we should focus on two-year and five-year success measures. A number of measures were identified and will be further researched, tested and refined through the Learn by Doing process:

1. **Everyone in Saskatchewan – regardless of location, ethnicity, or ‘underserved’ status – has an identifiable primary health care team they can access in a convenient and timely fashion.**

Measures of success for improving access will be refined and tested, and could include:

- In two years:
 - 75% of Saskatchewan residents are aware of what primary health care services are available to them.
- In five years:
 - All Saskatchewan residents who choose to be are connected to a primary health care team and recognize the importance of a consistent team as their home base for health care services;
 - 50% of primary health care teams have undertaken Clinical Practice Redesign;

- Primary health care teams, broadly defined, are seen as the model of choice for patients, communities and providers, and are in place throughout the province of Saskatchewan;
- 50% of primary health care teams are accepting new patients; and
- All Regional Health Authorities have a process in place for referring patients who are without a regular primary health care provider to an available primary health care team.

2. A model of patient- and family-centred care has been implemented to achieve the best possible patient and family experience.

Measures of success for patient- and family-centredness will be refined and tested, and could include:

- In five years:
 - 75% of Saskatchewan residents rate their primary health care experience as exceptional;
 - Saskatchewan residents show an increase in self-rating their health;
 - All Saskatchewan patients and families, including First Nations and Métis, are meaningfully involved with and engaged in decision making at all levels (shared decision making and advisory processes);
 - 75% of patients with chronic disease report an increase in confidence to self-manage their disease;
 - All patient navigation is culturally sensitive and appropriate to the patient population; and
 - 100% of primary health care teams assume responsibility for the coordination and navigation of their patients' journeys.

3. 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.

Measures of success for a healthier population will be refined and tested, and could include:

- In two years:
 - Every Regional Health Authority recognizes the burden of chronic disease on the health of their population and has identified resources to address it;
 - The Ministry of Health, in conjunction with other key Ministries, has developed and implemented policies relating to social determinants of health and promoting good health;
 - Regional Health Authorities are collaborating with communities and have community needs assessments either underway or completed in 50% of communities that are ready; and
 - Based on community needs assessments, all Regional Health Authorities have a plan for primary health care and an accompanying health human resources plan.



41

- In five years:
 - There are an increased number of outreach programs to vulnerable populations served by primary health care teams;
 - There is a reduction in risk factors that result in chronic diseases;
 - The Ambulatory Care Sensitive Admission rates are reduced by 50%; and
 - The primary health care system has demonstrated measurable improvement in clinical indicators for selected chronic diseases prevalent within Saskatchewan's population.

4. We are achieving reliable, predictable and sustainable delivery of primary health care.

Measures of success for knowing we have healthier provider teams will be refined and tested, and could include:

- In two years:
 - 50% of primary health care teams have agreements in place that outline their commitments to members of their team;
 - Incremental team supports (facilitation, change management, etc) are in place to support primary health care teams; and
 - There is dedicated, appropriate and flexible funding.
- In five years:
 - Agreements articulating mutual commitments are part of the primary health care culture;
 - 100% of primary health care teams have targets that speak to promoting healthy lifestyles;
 - Health care provider turnover rates are reduced by 50% through improved team stability; and
 - 50% of health care providers report improvement in work-life balance and job satisfaction.

Measures of success for contributing to training future primary health care providers will be refined and tested, and could include:

- In five years:
 - The primary health care system is providing a range of high functioning primary health care practice settings for all health science students.

Measures of success for knowing we are committed to improvement will be refined and tested, and could include:

- In five years:
 - 100% of primary health care teams measure, monitor and make changes to practice based on results; and
 - Ongoing quality improvement is integral for all primary health care teams.



A Long-Term Commitment

42

"A passion for quality, a willingness to innovate, and the ability to collaborate will be requisites for Saskatchewan's health system leaders."

- For Patients' Sake: Patient First Review Commissioner's Report

Creating a high performing primary health care system will not happen overnight, but with sustained focus and coordinated effort, it is reasonable to expect that within the next ten years, all Saskatchewan residents – no matter their age, gender, ethnicity, or place of residence – will have ready access to the right health care provider, in the right place, at the right time. As we pursue that vision, we are committed to putting patients and families first and adhering to the values and principles outlined in this framework.

By their very nature, patient- and family-centred health systems will always be evolving and adapting to meet the ever-changing needs of their communities. There is no "ultimate model" or end point for designing how primary health care is delivered. In fact, one of the strengths will be its flexibility and responsiveness to changes in communities.

By their very nature, patient- and family-centred health systems will always be evolving and adapting to meet the ever-changing needs of their communities.

The 21st century will bring many changes to Saskatchewan, including demographic shifts that will challenge the responsiveness and resourcefulness of health care services.

Primary health care in Saskatchewan may look very different in 2025 than it does in 2012. What should remain stable, however, is a commitment to our four aims: access, patient- and family-centred care, healthy populations, and reliable, predictable, sustainable, community-driven services.

For patients and families, the benefits of these aims are obvious. At the same time, physicians and all health professionals delivering primary health care can enjoy the benefits of improved work-life balance, teamwork, and working to the top of their scope – to say nothing of the fulfilment that comes with improved patient satisfaction and outcomes.

The 21st century will bring many changes to Saskatchewan, including demographic shifts that will challenge the responsiveness and resourcefulness of health care services. The greatest preparation we can make for a bright future is to ensure a strong foundation for our health care system. Primary health care is that foundation, and the stronger and more vital it is in Saskatchewan, the better we will be able to adapt to the challenges and opportunities brought to us in the years to come.

Appendix A: Physician Initiatives

Physicians in Saskatchewan play a critical role in primary health care, and will remain, for many Saskatchewan residents, the first point of contact with the health system. Physician leadership, at the local, regional, and provincial levels, will be essential if re-designed primary health care is to achieve its aims.

Clinical Practice Redesign

With the support of the Health Quality Council and Ministry of Health, a growing number of specialists and family physician practices are adopting tools and methodologies to improve access to care, office efficiency and communication between health care providers. When these facets of a physician's practice are operating effectively, patients are seen sooner and physicians feel they are making the best use of their time helping patients and families.

Physician Recruitment Agency

Saskatchewan's new Physician Recruitment Agency will coordinate the many facets of physician recruitment and will be responsible for:

- Coordinating recruitment and retention efforts between health regions, communities and physician practices and acting as a central point of contact for physicians seeking to practise in Saskatchewan;
- Improving communication between health regions and communities with graduates from the College of Medicine at the University of Saskatchewan;
- Reducing competition for physicians between communities and health regions;
- Providing recruitment expertise to communities, physician practices and health agencies, especially those with less experience in this area; and
- Collaborating with key stakeholders with respect to recruitment and retention programs and services for physicians.

44

Contract Support

The Ministry of Health is currently in discussions with the **Saskatchewan Medical Association** regarding a **model contract** for physicians engaging with primary health care teams.

Appendix B: Other Enabling Strategies

Achieving a high performing primary health care system is only one facet of a fundamental and province-wide effort to build a patient- and family-centred health system in Saskatchewan. As we move forward with improvements to primary health care, it is important to be aware of the changes and system improvement strategies under way elsewhere in our complex, interdependent health system. Primary health care service delivery will be supported by these strategies and should support them in turn.

Health Human Resources Strategy

Saskatchewan's 10-year Health Human Resources Strategy, released December 2011, outlines the provincial vision for a health workforce with the right mix of providers and progressive, collaborative approaches to patient care. It also provides a comprehensive, long-term assessment of Saskatchewan's health care human resource needs. The plan provides a framework for Saskatchewan health care educators and employers responsible for educating, training, recruiting, and retaining health care providers.

Patient- and Family-Centred Care

The Ministry of Health has developed a provincial policy framework that makes patient- and family-centred care an expectation and point of accountability for health regions and health care providers. Using this framework as their guide, each Regional Health Authority, the Saskatchewan Cancer Agency, the Athabasca health Authority, and affiliate organizations will develop a specific plan as to how they will adopt patient- and family-centred care over the next ten years.

Continuous Improvement

(RELEASING TIME TO CARE AND LEAN INITIATIVES)

Releasing Time to Care was developed by the National Health Services Institute for Innovation and Improvement. It is a patient-centred approach to improving the quality of care on acute care nursing units by freeing up caregivers' time for more direct patient care. Supported by the Health Quality Council and funding from the province, 52 facilities and hospital wards in Saskatchewan are implementing the Releasing Time to Care modules.

Information Technology

The Primary Health Care Information Technology (PHC IT) Solution is an electronic medical record software application designed specifically for teams of health professionals working in primary health care. The PHC IT solution is a collaborative effort between the Ministry of Health and E-Health Saskatchewan and is being implemented in primary health care teams across the province.

An Electronic Medical Record (EMR) replaces paper-based health charts with an automated system that contains office visit and other health-related information. It can facilitate scheduling, alerts, management of medications and allergies, referrals, immunizations, orders and laboratory results, care planning, maintenance of patient profiles, and can also provide reporting functions. Because there is a common patient chart across the clinic, patient information is more readily available. This results in a reduction in test and procedure duplication as the care team has access to the full patient chart.

First Nations Health and Wellness Plan

The Government of Canada, the Government of Saskatchewan and the Federation of Saskatchewan Indian Nations (FSIN) have worked together to develop a draft First Nations Health and Wellness Plan. The goal is to improve coordination of the delivery of health programs and services to ensure more efficient and effective health systems that provide seamless and continued care for Saskatchewan First Nations. The plan has eight priority areas: Health Human Resources, Mental Health and Addictions, Chronic Disease Prevention and Management, Improving the Health Care System Experience, Long-Term Care, E-Health, Intake and Discharge Planning and Relationships and Partnerships in the Delivery of Health Services for First Nations.

Population Health Improvements

The Ministry of Health is committed to strengthening its efforts to promote health and well-being and strives to create communities that will best support Saskatchewan children and youth to reach their full potential and enjoy a high quality of life now and in the future. Saskatchewan Population Health Council (SPHC) guides the strategic directions adopted for population health. They have identified four theme areas to guide their work: Healthy Communities, Healthy Environments, Communicable Disease and Public Health Infrastructure.

The Healthy Communities Initiatives include the following:

- A Healthy Weights Framework to provide direction for future action to promote healthy weights in Saskatchewan;
- An Enhanced Preventative Dental Services Initiative aimed at reducing dental decay and contributing to the healthy development of prenatal mothers, infants and preschool-aged children within populations at risk;
- *Building a Healthier Saskatchewan – a strategy to reduce tobacco use was released on October 25, 2010. Implementation is under way with the engagement of several partners; and*
- Finalizing the Senior Falls Prevention Resource Suite to be posted by Spring 2012.

Strategies to reduce communicable disease include:

- A 4 year HIV Strategy 2010 – 2014 developed in response to recent increases in provincial HIV infection rates. The strategy focuses on increasing capacity on the front lines, enhancing capability through training, and engaging our communities to address HIV and AIDS through prevention, education, treatment and awareness; and

- A tuberculosis (TB) strategy is being developed to address Saskatchewan's high TB rate, which is one of Canada's highest. The strategy, to be developed jointly by the Ministry of Health, Regional Health Authorities, First Nation and Inuit Health (Health Canada) and the Northern Inter-Tribal Health Authority, will begin with a detailed profile report to describe the situation in Saskatchewan by drawing on historical data about TB and its management.

Multisector Initiatives

The work of many provincial Ministries contributes to strong primary health care. For example, the Ministry of Education supports *KidsFirst* and the Ministry of Education leads the provincial Child and Youth Agenda.

KidsFirst

KidsFirst helps vulnerable families to become the best parents they can be and to have the healthiest children possible. The program enhances knowledge, provides support and builds on family strengths.

KidsFirst families receive:

- Support from a home visitor who provides assistance regarding child development, parenting and connecting to the community;
- Help to access services such as childcare and parent support groups;
- Early learning opportunities for children; and
- Help regarding literacy, nutrition, transportation and specialized counselling services.

47

Children and Youth Agenda

The Government of Saskatchewan has developed a Children and Youth Agenda to address issues identified in the Saskatchewan Child Welfare Review Panel's report. The agenda spans across government ministries and links together a number of important strategies together in an effort to address complex issues facing Saskatchewan children, youth, and families. The Child and Youth Agenda has four basic pillars with different ministries taking the lead in each:

- Child Welfare Review Investments, responding directly to the recommendations of the Child Welfare Review panel (Social Services);
- Provincial Autism and Fetal Alcohol Spectrum Disorder Strategies, supporting the needs of people with ASD/FASD and preventing FASD (Health);
- First Nations and Métis Education and Employment Strategy, eliminating gaps in education and employment for First Nations and Métis people (AEEI, Education); and
- Saskatchewan Police and Partners Strategy to Reduce Crime and Violence, creating safer communities by reducing crime and violence (CPS; Justice).

Appendix C:

Contributors to the Primary Health Care Framework

Community Engagement Working Group

*Achilles, Sheila – Saskatoon Health Region
Anderson, Richard – Heartland Health Region
*Butt, Peter M.D., **Co-chair** – University of Saskatchewan
Ferguson, Dianne – Five Hills Health Region
Hunt, Cecile – Prince Albert Parkland Health Region
Isbister, Shirley – Central Urban Métis Federation
Linner, Tony – Patient Representative
Miller, Wanda – Sun Country Health Region
Mueller, Harold – Community Representative
Perrins, Dan – Johnson-Shoyama Graduate School of Public Policy, University of Regina
Senecal, Darryl – Saskatchewan Association of Rural Municipalities
Tootoosis, Janet M.D. – Saskatchewan Medical Association
Topola, Paul – Saskatchewan Urban Municipalities Association
*Vachon, Beth, **Co-chair** – Cypress Health Region

Chronic Disease Prevention & Management through Interdisciplinary Teams Working Group

Bathgate, Debbie – Saskatoon Health Region
Frey, Leslie – College of Physicians and Surgeons of Saskatchewan
Gibbons, Karen – Patient Representative
Graham, Brian – Saskatchewan Lung Association
*Joubert, Ray, **Co-chair** – Saskatchewan College of Pharmacists
Livingstone, Scott – Saskatchewan Cancer Agency
Markentin, Morris M.D. – Family Physician
Milbrandt, Donna – Sunrise Health Region
Quinlan, Colleen – Regina Qu'Appelle Health Region
Sandomirsky, Larry M.D. – Saskatchewan Medical Association
*Smadu, Marlene, **Co-chair** – University of Saskatchewan, College of Nursing
Stueck, Gord – Community Pharmacist
Tant, Heather – Sun Country Health Region
Uzelman, Glenys – Prairie North Health Region
Whiteman, Lesley – File Hills Qu'Appelle Tribal Council

Physician Engagement Working Group	Others who contributed through consultation sessions
Bevis, Carol – Patient Representative	
*Brossart, Bonnie – Health Quality Council	Barlow, Linda – Kelsey Trail Health Region
Cutts, Danielle M.D. – Family Physician	Barr, Grace – Patient Representative
Dickson, Michael M.D. – Family Physician	Barr, Paul – Patient Representative
*Fan, David, Co-chair – Prairie North Health Region	Bedard, Kathy – Kelsey Trail Health Region
Fourie, Phillip M.D. – Saskatchewan Medical Association	Bishop, Bernie – Community Representative
*Laursen, Brian M.D., Co-chair – Family Physician	Breitkreuz, Lorna – All Nations Healing Hospital
Lawrence, Kathy M.D. – Family Physician	Brooks, Leslie – Northern Inter-Tribal Health Authority
Lee, Connie – Prince Albert Parkland Health Region	Bruce, Joyce – Regina Qu'Appelle Health Region
Mantler, Ed – Physician Recruitment Agency	Cameron, Mark M.D. – Family Physician
McKinney, Veronica M.D. – Northern Medical Services	Conley, Jennifer – Prince Albert Grand Council
Meili, Ryan M.D. – Family Physician	Docking, Jill – Patient Representative
Pickering, Betty – Patient Representative	Erman, Arden – Community Representative
Poulin, David M.D. – Saskatoon Health Region	Favel-Rewarts, Sandra – Battlefords Tribal Council
Redenbach, Michael – Regina Qu'Appelle Health Region	Filipowich, Kathy – Five Hills Health Region
Van der Merwe, Shaulk M.D. – Family Physician	Flett, Barb – Keetwaten Yatthé Health Region
White, Gill M.D. – University of Saskatchewan, College of Medicine	Gardner, Nap – Community Representative
Wright, Debra-Jane – Health Quality Council	Geller, Brian M.D. – Saskatchewan Medical Association
Zimmer, Roland – Saskatchewan Urban Municipalities Association	Goodtrack, Rhonda – University of Saskatchewan, College of Nursing
	Gwillim, Peggy – Saskatoon Health Region
	Hampton, Eber – University of Regina
	Highway, Florence – Patient Representative

- Ibrahim, Rizqi M.D. – Saskatchewan Medical Association
- Johnson, Lynn – Saskatoon Tribal Council
- Klenk, Maureen – Nurse Practitioner
- Knudson, Lorna – Regina Community Clinic
- Lafond, Diane – Federation of Saskatchewan Indian Nations
- Landry, Shan – Saskatoon Health Region
- Larson, Ingrid – Saskatoon Community Clinic
- Lewis, Terrance – Patient Representative
- Marit, David – Saskatchewan Association of Rural Municipalities
- Maurice, Jacquie – University of Saskatchewan, College of Medicine
- McKay, Shirley – Saskatchewan Registered Nurses' Association
- Neckoway, Ramona – Patient Representative
- Nippi-Albright, Betty – Saskatoon Health Region
- Nolin, Gary – Prairie North Health Region
- O'Byrne, Greg M.D. – Family Physician
- Oberholzer, Werner M.D. – Family Physician
- Oleksinski, Stan M.D. – Family Physician
- Panter, Doug – Community Representative
- Pebane, Motlobeng M.D. – Family Physician
- Peel, Bev – Federation of Saskatchewan Indian Nations
- Philippon, Don – Saskatchewan Academic Health Sciences Network
- Porter, Richard – Saskatchewan Association of Rural Municipalities
- Press, Melanie M.D. – Family Physician
- Prettyshield, Kyle – Federation of Saskatchewan Indian Nations
- Rewarts, Sandra – Battlefords Tribal Council
- Robinson, Judy – Patient Representative
- Sanderson, Keith – Patient Representative
- Steel, Doug – Saskatchewan Association of Rural Municipalities
- Thomas, Marlene – Federation of Saskatchewan Indian Nations
- Thomson, Patsy – Yorkton Tribal Council
- Tootoosis, Leona – Elder
- Troupe, Cheryl – Métis Nation of Saskatchewan
- Turner, Tara – Métis Nation of Saskatchewan
- Vogel, Martin M.D. – Saskatchewan Medical Association
- Wapple, June – Patient Representative
- Ward, Corrine – Regina Qu'Appelle Health Region
- Whitehawk, Bev – Federation of Saskatchewan Indian Nations
- And many more who contributed through on-line consultations, through Association meetings and with formal and informal advice and feedback.*

* Denotes members of the Core Team

For more information, contact:

The Saskatchewan Ministry of Health

T.C. Douglas Building

3475 Albert Street

Regina, Saskatchewan S4S 6X6

General Inquiries: (306) 787-0146

Toll-free: 1-800-667-7766 (Saskatchewan only)

www.health.gov.sk.ca/primary-health-care



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