In 2001, the Fyke Commission on Medicare recommended “…the creation of a Quality Council with a mandate to improve the quality of health services in the province…In so doing, Saskatchewan will lead the country in the pursuit of a quality culture that will be the next great revolution in health care.”

The Health Quality Council (HQC), an independent agency that opened its doors in 2003, has planted and nurtured an improvement culture in Saskatchewan by measuring and reporting on the quality of care, promoting improvement, and engaging its partners in building a better health system. This document describes the extent to which the HQC has accelerated improvement throughout the province’s health care system and helped build a culture of quality. It is purposefully organized around some of HQC’s core strategies, to show the connection between our activities and our mandate.
Despite the significant amount of public resources spent on health care, we know very little about its quality. One of the key lessons we are learning from high performing health systems elsewhere in the world is that continuous measurement of and feedback on health care quality is essential. Several efforts led by the HQC over the past few years are putting measurement and monitoring front and centre in Saskatchewan’s health care system:

- We have released 14 high-calibre reports that helped identify gaps in the quality of health care in this province. Several of these reports — including those on diabetes, post-heart attack care, patient experience in acute care, use of potentially harmful medications in long-term care, and wait times for breast cancer care — led to quality improvement projects that were collaborations between the Health Quality Council and health care providers and organizations. Further, the reports provided a foundation of solid, locally relevant evidence upon which conversations about the need for quality improvement in Saskatchewan health care could be based. These dialogues ranged from discussions between HQC and primary care practitioners, during recruitment for the Chronic Disease Management Collaborative (described in more detail later), to discussions among MLAs during question period in the Legislature, regarding HQC’s report on wait times for breast cancer care. A couple of more specific examples of the impact of our measuring and reporting work include:
  - HQC’s first report, on the quality of post-heart attack care, showed that in 2001-02 only about one in five heart attack survivors in Saskatchewan were dispensed three key medications proven to save lives and prevent second heart attacks. By 2005-06, 42% of heart attack survivors were receiving these key drugs. During this same time frame, heart attack readmissions declined by 20%.
  - In 2004, the HQC released a report showing that 28% of Saskatchewan seniors living in long-term care regularly received at least one medication with a high risk of adverse side effects. We worked closely with eight nursing homes to see if drug treatment improved if it was managed by interdisciplinary teams that included a consultant pharmacist. Over the course of the project, two-thirds (491) of residents had at least one drug review, and of those, an average of 2.5 drug-related problems were identified for each resident. Forty-three per cent (339) of the recommendations were to stop one or more drugs, 26% (206) to change dosage or interval, and 14% (112) to start a drug. The health professionals involved in the project said they liked the team approach and wanted to see it continue.

- The methods we’ve developed to measure quality for some of our reports have influenced measurement beyond Saskatchewan. For example, our indicators on quality of asthma care were published as a research article in the Canadian Medical Association Journal, and some have been adopted by the Public Health Agency of Canada for their asthma surveillance system and by the Canadian Institute for Health Information as part of their primary care quality indicators set.
• In Fall 2008 we launched a new ongoing measurement and reporting program, Quality Insight, which includes a regular report on the state of quality of health care in Saskatchewan. This work is supported by a provincial collaboration (the Quality Insight Working Group) that brings together representatives of all regional health authorities, the Saskatchewan Cancer Agency, and the Ministry of Health. This group was recently asked by leaders involved in the new Saskatchewan Surgical Initiative to lead development of evaluative measures for tracking its progress.

• In 2004 HQC initiated the first province-wide measurement of patients’ experience of hospital care in Saskatchewan. By continuing to lead and support the ongoing collection of this data, we are helping ensure decision makers and providers have continuous intelligence on the voice of their customer highlighting opportunities for improvement. In just a few short years, we have helped the province progress from having no systematic collection of patient experience feedback, to a point where 33 hospitals across 10 health regions receive feedback information from the patient survey on a monthly basis. We are currently working with our regional health authority (RHA) colleagues to survey individuals about their experience in emergency departments, the results of which we will report publicly in 2010. These patient surveys also support Saskatchewan hospitals in meeting Accreditation Canada’s requirements related to hospital quality. Our patient experience survey was the first in the country to be recognized by Accreditation Canada. This information is also starting to be used by RHAs in their reporting dashboards, and there is broad recognition that these indicators must align with current and future strategic priorities. Health region staff have told us they appreciate our efforts to help satisfy many quality improvement needs through a single data collection process.

- A unit team from Royal University Hospital used this survey information to improve their discharge process, as part of an HQC-sponsored project focused on discharge planning. As a result of a series of small changes related to patient flow and communication, the percentage of patients rating the discharge process as very good or excellent increased from a median value of 42.5% at baseline, to 80% by September 2007.

• Because of the expertise and reputation we’ve built through these and other measurement and reporting activities, HQC continues to be sought out by several external agencies, including:
  - National Accreditation Program Advisory Committee, Accreditation Canada
  - Health System Scorecard Indicator Expert Group, Ontario Ministry of Health and Long-Term Care
  - Long-term Care Quality Measurement Expert Panel, Ontario Health Quality Council
  - National Hospital Report - Clinical Indicators Expert Group, Canadian Institute for Health Information
  - Continuing Care Reporting System Expert Advisory Group, Canadian Institute for Health Information
• In 2009 HQC was granted access to the Canadian Institute for Health Information (CIHI) ePortal, which houses the most up-to-date Hospital Discharge Abstract data available. HQC is the first agency of its kind in Canada (i.e., not a Health Ministry or RHA) to be granted access to this CIHI tool.

- Steering Committee of National Emergency Department Quality Indicators Project, CIHR-funded project based out of Institute for Clinical Evaluative Sciences in Toronto

- Chronic Respiratory Disease Surveillance Methodology Working Group, Public Health Agency of Canada

- Advisory Committee for Report on Chronic Disease in Canada, Health Council of Canada

- Workshop on Public Reporting on Health Care Performance, Canadian Health Services Research Foundation.
Until recently, only a handful of people in Saskatchewan’s health care system were aware of quality improvement (QI). Today, thousands of health professionals not only know what QI is but are becoming increasingly proficient in improvement methodology. By providing hundreds of health care providers and leaders with skills, knowledge, and inspiration for quality improvement, we are helping create an environment in which they can deliver the most patient-centred, effective, and accessible health care possible.

- **Over 200 health system leaders, representing more than 20 organizations, are currently participating in our leadership program** called Quality as a Business Strategy (QBS). It is designed to help leaders integrate management for quality into their organizations. Through their participation in QBS, health organizations are learning how to support front-line managers and teams working to integrate improvement science into planning, testing, and implementing changes to make care better and safer for patients. This series of learning workshops is the first time the entire Saskatchewan health care system (including the ministry, health regions, regulatory bodies, unions, educational institutions and others) has come together to talk about what it truly means to work as a system.

- The number of Saskatchewan health system workers with quality improvement skills and knowledge continues to grow. **Over 1,200 providers have participated in various workshops designed to build QI capability.** In turn, QI departments and leaders have facilitated workshops in their health regions, supported by HQC training, learning materials, or both. Those who have taken HQC’s advanced training are now teaching, consulting, and mentoring others, thereby spreading their learning to hundreds of others in their home organizations.

- In its early years, HQC provided short-term funding to help health regions and the Saskatchewan Cancer Agency create new positions that are responsible for leading quality improvement. RHA leaders have recognized the value this skill set brings to their organizations and have continued to expand the number of positions dedicated to supporting QI initiatives in their organizations. We also established a learning community, called the **Quality Improvement Network (QIN),** to connect these quality improvement leaders and support learning and spread of QI best practices throughout the province. HQC continues to support QIN, which is now run collaboratively by its members from the RHAs, Saskatchewan Cancer Agency, Ministry of Health, and Health Quality Council, with the aim to share and leverage QI efforts across the province.

- HQC has developed and supported close to 150 quality improvement teams across the system and throughout the province. These QI initiatives range from prototypes (single-site initiatives aimed at testing an idea for improvement) to demonstration sites (tests of whether a successful improvement can be repeated elsewhere), and spread initiatives (attempts to spread a proven best practice across the system).
Over the past couple of years, we have exposed more than 550 health professional students to quality improvement curricula through lectures in various health sciences programs at the University of Saskatchewan, including Master of Public Health, Pharmacy, Master of Physiotherapy, Nutrition, and Medicine. This work was recently recognized by the Academy for Healthcare Improvement, an international organization of academics and researchers involved in quality improvement science, and will be made available on their website in 2010. We have also engaged with more than 20 faculty from the University of Saskatchewan (U of S) and Saskatchewan Institute of Applied Science and Technology (SIAST), to build capacity and capability for integrating QI content into their health sciences curricula.
We know from research and from success stories elsewhere that health systems which have transformed themselves have purposefully engaged their clinicians. HQC has intentionally focused a great deal of attention on supporting front-line health care professionals to be actively involved in making our system better and safer for patients:

- In 2005 the HQC launched the Chronic Disease Management (CDM) Collaborative, the largest QI initiative ever undertaken in this province. It involved more than 25% of family physicians, hundreds of other health care providers in all health regions, and approximately 18,000 people living with diabetes and coronary artery disease (CAD), and achieved some impressive results:
  - The number of people living with diabetes in optimal control of their condition rose from one in eight, to close to one in five.
  - The percentage of people living with diabetes who received a recommended screening test for the prevention of kidney disease increased from 48% to 84%.
  - The percentage of people living with CAD who had a healthy lipid ratio < 4.0 increased by 23%.

We have heard, anecdotally, that physicians are increasingly finding value in using flow sheets as a decision-support tool for managing chronic diseases. We will evaluate the first CDM Collaborative in 2010-11, to more fully quantify what improvements were achieved and sustained.

Physician appetite for these types of learning opportunities continues to grow: 54 primary care practices have registered for our recently launched second CDM Collaborative, which will improve care for people with depression and chronic obstructive pulmonary disease (COPD).

- In 2008 HQC launched an improvement strategy called Releasing Time to Care™, which is designed to help increase the amount of time nurses and other providers have for direct patient care, by decreasing waste in processes. Currently 14 units (involving over 1,000 nurses) are implementing this program; the plan is to roll out Releasing Time to Care™ to all medical and surgical units in the province by March 31, 2012. Early results look promising:
  - The equivalent of 1 FTE position was released on the Medical Ward at Moose Jaw Union Hospital by improving shift handover processes. Nurses are now consistently going home on time.
  - An estimated 270 hours of nursing time will be freed up by installing a door between the IV (intravenous) and medication rooms on the surgical ward of Prince Albert's Victoria Hospital.
  - A minimum of 1,900 km of walking will be saved in a year with the installation of a new door release on the admissions unit at Saskatchewan Hospital (North Battleford). Staff say it’s the best thing that’s ever happened on the ward. The change was made three days after staff made the request. Patients love it too.
  - With the Creation of the “Bone Cupboard” on the orthopedics unit at Regina General Hospital, to house in one location all equipment and supplies to set up traction, staff are saving an average of 27.37 hours a year of “travel time” within the hospital. The savings in steps works out to approximately 42 km.
• With the aim of building and supporting physician leadership in quality improvement, HQC has – in partnership with the Saskatchewan Medical Association, College of Physicians and Surgeons of Saskatchewan, and Ministry of Health – **sponsored over 40 physicians to participate in various QI learning opportunities.** These experiences have very quickly led to a significant increase in the involvement of physicians in quality improvement discussions and initiatives (see attached Appendix for more information). One example of the impact of this investment is a story shared by Dr. Mark Wahba (emergency room physician in Saskatoon), who is now enrolled in HQC’s advanced QI capability program, Quality Improvement Consultant (QIC) School:

“We did a PDSA cycle trying to improve how quickly we saw CTAS (Canadian Triage and Acuity Scale) 2 patients. A patient with a CTAS 2 is the second highest rating. They are experiencing chest pain, trauma, overdose, etc. You can see that we hadn’t been making much progress. For over two years we averaged only 39% of patients being seen within the appropriate time frame. After returning from the IHI Forum, I was eager to try something new. I took on the Physician QI lead for emergency and got connected with the right people. We worked out some plans. We tried this new idea out and voila! We went to 48% of our patients being seen within the appropriate time frame. It was a great team effort and it couldn’t have been done without a new way of thinking about an old problem. Although it is a bit early to celebrate, I think we’re moving in the right direction like never before.”

![Percentage of CTAS 2 Patients Seen within Target Timeframe](chart.png)
• These early efforts yielded broader collaboration, which in turn led to the creation of a multi-agency advisory committee (involving the Saskatchewan Medical Association, College of Physicians and Surgeons of Saskatchewan, College of Medicine, and Health Quality Council) called Champions for Quality Improvement, and the development of an online network to engage and support physicians in the province. This level of collaboration across agencies and focus on developing physician leaders for quality improvement is unprecedented in Canada.
INFORMING POLICY

- HQC’s CEO was invited to participate on the steering committee of the Patient First Review. Our organization’s considerable knowledge about high performing health systems and methods for effectively engaging health system stakeholders were seen as helpful to the Commissioner, Tony Dagnone, his consulting teams, and Ministry of Health senior leaders.

- HQC is responsible for bringing some of the best minds from around the world to Saskatchewan, to help our system learn proven improvement methodologies, system transformation techniques, advanced measurement practices, and hear how other systems deal with issues such as transparency and accountability. HQC has played a key role in advancing these discussions. We have frequently heard from senior executives in the Ministry of Health that the shift in thinking that’s taking place across Saskatchewan’s health system (i.e., more focus on quality and patient-centred care) has been significantly influenced by the dialogue and activities initiated by HQC.

- HQC has continued to advance the dialogue in this province, and nationally, about the key role of measuring and public reporting about health system quality/performance in learning and improvement. We reviewed the latest research evidence on effective strategies and promising practices for public reporting as part of a project commissioned by the Canadian Health Services Research Foundation (CHSRF) and Ontario Health Quality Council. We produced a background paper that lists the principles that guide our agency’s reporting and an updated review of the literature on this topic. We also hosted a one-day conference on transparency in June 2008 that attracted close to 200 health system leaders from Saskatchewan and across Canada.

- In addition, HQC has been recognized nationally and internationally for its work related to the spread of quality improvement techniques, applications of best practices, use of advanced measurement techniques, and development and production of quality of care indicators. Through numerous publications, ranging from peer-reviewed research reports to commissioned reviews and discussion documents, HQC has made its mark across Canada and the world and put Saskatchewan on the map as an innovator in health care improvement.

- As part of the first Chronic Disease Management Collaborative, HQC led the deployment of an electronic patient registry and decision support tool (called the Chronic Disease Management Toolkit). We did so to help physicians and other members of the health care team deliver evidence-based care, and with an eye to facilitating physician uptake of an electronic medical record. In September 2009, the Ministry of Health made this tool broadly available to all primary care physicians, and has committed to integrating this tool with electronic medical record (EMR) products soon to be implemented in the province.
WHERE TO FROM HERE?

In response to a formal request from HQC, the provincial government announced in March 2008 it was providing an additional $5 million (above our annual core funding) for activities and initiatives aimed at redesigning and improving health care in Saskatchewan. We noted, in our submission to government, that system-wide transformation of Saskatchewan’s health care system had not yet taken root, and suggested a small investment in focused quality improvement activities in a select few health regions (then subsequently spreading the improvements to all other regions) held the potential to save or avoid $10-15 million in total health spending, by preventing inappropriate and unsafe care, increasing efficiency, and improving access.

To date approximately $1 million of this funding has been invested, primarily in efforts to support health care senior executives and governors in their pursuit of high-quality health care (through the Quality as a Business Strategy initiative) and frontline workers (through Releasing Time to Care™). It is still too early to determine how much money these and other HQC improvement programs have saved. What is evident though is that HQC’s influence and programs have brought about a fundamental change in thinking at all levels of the health system, away from a provider-centric philosophy to one that is focused on the needs of patients.

There have already been some early and notable changes in the behaviour of and degree of collaboration among health regions, the Ministry of Health, and provider groups. RHA board members are now more regularly asking “what does this mean for Esther?” Esther is the name of a fictitious elderly client created by one high-performing health system (Jönköping County Council, Sweden) to inspire and motivate its administrators, governors, and providers to improve patient flow and coordination of care. What were once rigid boundaries between health regions appear to be softening, with RHAs now voluntarily coming together to improve care. For example, regions in southern Saskatchewan have pooled their efforts and resources to improve transitions and patient flow; similarly, RHAs are engaging in a number of Ministry-initiated, system-oriented meetings on health system core purpose, strategic directions, etc. The best example of this new system-oriented, patient-centred focus is the commitment by all partners to work together on the recently announced Saskatchewan Surgical Initiative, which is intended to improve the entire patient experience — including but not limited to reducing surgical wait times to three months within four years. While the precise complement of activities that will be required to achieve this and other aims has yet to be established, what is clear is that this work will require significant resources (both financial and human). With nearly $4 million of the government’s 2008 funding for system transformation yet to be allocated, there are opportunities to invest some of this money to improve care for Saskatchewan residents requiring surgery. HQC will continue to play a key role in supporting this and other emerging health system priorities.

At times, the pace of change seems glacial. Looking back over the past two years though, the shift in the tone and nature of conversations within the health care system is remarkable. The groundwork critical to rapid, system-wide change is forming: There is growing agreement among
those working in the system and the public (expressed in the Patient First Review) that the system needs changing, and increasing commitment – both emotional and professional – to do the work necessary to overhaul the system. The surgical experience priority offers a focused, clearly defined starting point, with specific, measurable goals against which to track progress. It will serve as a solid foundation upon which to base subsequent changes required (e.g., alignment of funding with performance; enhancing team-based care; implementing a comprehensive electronic health record system, creating and supporting environments that facilitate the uptake of ideas, etc).

Transforming health care in Saskatchewan will not be quick or easy. But it is very clear that it will not happen under the status quo. These early behaviour changes and the influence HQC has had in them represent the critical steps in moving towards better health and better care for the people of Saskatchewan.

IN CLOSING

The complement of activities the HQC has engaged in since 2003 has meaningfully and significantly contributed to a growing understanding and expectation across RHAs, health organizations, and the Health Ministry that health care quality is the responsibility of everyone – not just the “quality department.” Trying to reduce to a single measure the extent to which a culture of quality, continuous improvement, and patient-centredness has spread throughout Saskatchewan’s health care system is neither easy nor appropriate. Nor is it straightforward to determine how much of the change and improvement starting to take hold in this province can be directly attributed to HQC’s efforts. That said, we have without question been a key contributor to the greater awareness of and focus on quality now seen among people working in the health system. We have encouraged and supported a growing number of managers and providers to appreciate the importance of quality improvement and be able to apply appropriate approaches and strategies to make care better and safer. There is a palpable shift in the culture, toward putting patients first, collaboration, and working together to improve health care. This is perhaps the truest measure of HQC’s impact in the Saskatchewan health care system.
HIGHLIGHTS

Champions for Quality Improvement advisory committee was struck, and represents a unique partnership between the College of Physicians and Surgeons of Saskatchewan, Saskatchewan Medical Association, College of Medicine, Ministry of Health, the Senior Medical Officer community, and HQC, dedicated to developing and recommending strategies to promote physician engagement and leadership in quality.

Online Physician Engagement Network (oPEN) was developed to connect the physician community around health care improvement. Membership is expanding through word of mouth or involvement in sponsored events. There are now 54 registered users on the oPEN site and use of the site is gaining momentum. Physician colleagues are beginning to use the site to share thoughts or lessons learned from their respective sponsored events.

The following outlines some changes in practice and behaviour resulting from Saskatchewan physicians attending a sponsored event:

- One physician enrolled in HQC’s Quality Improvement Consultant Program (Mark Wahba)
- One physician enrolled in Lean Training (Green Belt) (Mark O’Grady)
- Two physicians moved into “formalized” leadership positions (Leane Bettin, Mark Wahba)
- Three physicians became members of quality/leadership focused committees (Kishore Visvanathan, Susan Shaw, Jeff Hunt)
- One physician is now serving as Clinical Lead for Office Redesign within CDMC II (Kishore Visvanathan)
- Two physicians volunteered to work with HQC to improve their practices as part of an iHI Web in Action Series on office redesign (Shabir Mia, Leane Bettin)
- Two physicians reported their lessons learned at a SMA Representative Assembly meeting and to the Senior Leadership Team of Regina Qu’Appelle Health Region (Phillip Fourie, Stewart McMillan)
- Nine physicians have participated in inaugural meetings of the Surgical Experience Guiding Coalition (Karen Shaw, Susan Shaw, Kishore Visvanathan, Phillip Fourie, Rob Weiler, David Ledding, Joseph Buwembo, Alain Lenferna, Mark O’Grady)
- Two physicians met with their regional IT departments to explore capabilities for quality measurement (Guruswamy Sridhar, Phillip Fourie)
- Five physicians are sitting on their regional/organizational QBS teams (Alain Lenferna, Karen Shaw, Kishore Visvanathan, Guruswamy Sridhar, David Ledding)
- One physician initiated a personal blog focusing on health care and environment and is currently setting up a patient-focused web page showing whether he is on time or running behind schedule (Jason Hosain)
- Five physicians are continuing to implement Office Redesign Principles (Kishore Visvanathan, Mark Brown, Mark O’Grady, Jason Hosain, Guruswamy Sridhar)
- Four physicians enrolled or re-enrolled for CDMC (John Rye, Stan Oleksinski, Melanie Press, Jason Hosain)
- One physician secured funding to develop patient pathways for pregnant women (Tania Diener)

APPENDIX: IMPACT OF PHYSICIAN SPONSORSHIP 2008-09