

Patient Experience Case Studies

Walter's Story:

A Métis man living with chronic health conditions



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Introduction

The Patient First Review was a landmark research study within the Province of Saskatchewan which explored the current health care system from a patient's perspective. The research involved speaking with patients, health care providers, and health system stakeholders in order to understand issues within the system, the potential causes of those issues, and what potential solutions might address them.

While the research provided a wealth of information that will be used by the Ministry of Health and the health care system to guide system planning, the Province was interested in doing a more detailed analysis on some of the key issues within the system in order to validate what was heard in the research. The case study approach was determined to be a useful tool for this analysis.

The purpose of Walter's story is to:

- ▶ Present potential journeys through the health care system for a man with multiple chronic conditions;
- ▶ Engage patients and providers in a deeper discussion on the issues encountered in the system when a patient is living with chronic conditions;
- ▶ Validate the causes of the issues heard in the research.
- ▶ Explore potential solutions to address the issues that might be investigated further by the Ministry, health care providers and system stakeholders.
- ▶ Present the envisioned patient story when improvements have been made in the system.

This case study focuses on the experience of a Métis man in a rural setting, as he moves through the system trying to cope with and manage his disease. The names are fictional; however, the experiences are real. Multiple patients interviewed during the Patient First Review provided an account of their experiences, which were combined to highlight common issues encountered throughout the health care system. Communities named in the studies were used only as reference points. The providers referenced in this case are fictional and are not meant to depict any individuals who work in these communities. Any similarity to real people is purely coincidental.

Walter's Story

Walter is a 53-year old Métis man with multiple chronic conditions. He lives near Cumberland House, approximately two hours from Nipawin and four hours from Prince Albert. Walter suffers from type 2 diabetes, chronic kidney disease and moderate depression. Three times a week, he makes the four-hour trip to Prince Albert for hemodialysis. Walter does not own a car and lives alone. While he has occasionally been able to get a ride to Prince Albert with a friend or relative, he has frequently had to resort to hitchhiking.

Walter has been living with multiple chronic conditions for many years. He was first diagnosed with diabetes approximately 20 years ago. When he was younger, he was physically active and didn't have many problems maintaining healthy blood sugar levels. Several years ago, however, Walter had surgery on his knee, which impeded his mobility. He found it increasingly difficult to remain active and maintain his blood sugar levels.

Walter had always worked in construction, and as his mobility declined, so did his income. Nutritious food, which had always been relatively expensive where he lived, became more and more unaffordable.

Walter's declining physical fitness, along with a decrease in healthy food intake, took their toll. Eventually, he had problems with his kidneys and was diagnosed with chronic kidney failure. The hemodialysis unit in Prince Albert was the only location that had available space for his thrice-weekly treatments.

When Walter was looking for a family physician several years ago, the only physician that was accepting new patients was in Nipawin, two hours from his home. Before this, Walter would travel to the Emergency Department in Nipawin if he felt he needed immediate attention. He often endured long waits and frustrating encounters with health care staff who spoke too quickly, or with terminology he did not understand, despite his repeated reminders that English was not his first language.

Several weeks ago, Walter noticed numbness in his right foot. He had also been experiencing difficulties breathing and slight, periodic chest pains. Arranging transportation for his appointments was difficult and costly, but Walter was anxious about his breathing difficulties and the numbness in his foot, so he made an appointment with his family physician. The soonest his doctor in Nipawin could see him was in three weeks, since her schedule conflicted with his dialysis treatments. In addition, Walter felt that his family doctor never made an effort to understand him as a whole person and focused only on his immediate symptoms.

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After arriving at the physician's office, Walter waited over an hour to see her. When she finally entered the treatment room, she seemed rushed and impatient. As he tried to describe the numbness he was experiencing in his right foot, she frequently asked him questions he did not fully understand, and grew visibly more frustrated every time Walter asked her to repeat herself. Finally, the physician said she would refer him to a podiatrist who would examine his foot and show him how to take care of it. He was handed a form and told the receptionist would help him with the referral on the way out. After talking with the receptionist, Walter remembered that he wanted to discuss his other symptoms and told the receptionist he didn't get a chance to finish with the doctor. She told him he would have to wait until there was an opening in her schedule and that he was welcome to sit in the waiting room. However, Walter's cousin, who had driven him to his appointment, needed to return home. Walter made the trip back to Cumberland House, feeling unsatisfied with his visit.

The following week, after his dialysis treatment, Walter's chest pain worsened. Knowing his cousin was planning to travel to Nipawin for the day to do some shopping, he travelled with her and was dropped off at the Emergency Department in Nipawin. There, he waited four hours to see a doctor, and ate nothing during that time as he was afraid to go to the cafeteria in case his name was called. In the meantime, he saw patients coming and going with what seemed to be less serious conditions. Each time he asked the receptionist how long the wait might be, she responded with "might be a few hours."

Walter was finally brought to an examining room and seen by a doctor. When Walter commented on the long wait, the physician replied gruffly that they were short staffed and he had been on duty for 22 hours. Walter explained why he was there. Upon examination, the doctor told him he would need to have some blood tests done and an ECG. Once the results of those were in, he would come and see him to discuss his condition further. He said he would send a nurse immediately to take his blood so then he could have something to eat.

The doctor returned an hour later and told Walter that he would need a referral to have a stress test done in Saskatoon. The doctor told him he should follow up with his family physician, but that a referral to Saskatoon would be made and he would be called about the appointment. He told Walter that his blood sugar levels and blood pressure were higher than he would like. He said he would retest his blood sugar level after he had eaten and that he wanted to bring his blood sugar levels down before letting him go. An hour later, Walter was told he could go home. Exhausted and feeling badly about delaying his cousin's return to Cumberland House, he left.

After four weeks, Walter hadn't received a call about his appointment and remembered the doctor telling him he should follow up with his family physician. He called to book an appointment with her and was relieved that she could see him in two and a half weeks. During the visit, he told her what the physician in Emergency had said. She told him she would send him for tests to see what the problem was, and also told him to book a follow-up appointment in two weeks as the test results would be ready by then. He was handed a requisition form for the lab tests and an ECG. Walter made sure to book a follow-up appointment on his way out of the doctor's office and was scheduled to come back in two weeks.

He waited four hours to see a doctor, and ate nothing during that time as he was afraid to go to the cafeteria in case his name was called.

Walter found the system difficult to navigate, observed a lack of communication among his providers, and was constantly anxious due to lack of communication and information about his test results and next steps.

During the follow-up visit with his doctor, she told him she would refer him to Saskatoon for further testing. She said her receptionist would fax the referral that day and he should receive a call shortly to book the appointment.

Unfortunately, the circulatory problems that were causing the numbness in Walter's foot continued to worsen. While waiting for calls about his next test or appointment, Walter continued to struggle with depression, spent much of his time watching television, and ate poorly.

In the end, Walter ended up requiring amputation of his right foot because he wasn't able to maintain his health. It is now extremely difficult for him to look after himself. His ill health and frequent travel have contributed to more frequent episodes of depression, and he increasingly relies on family and friends to transport him to Prince Albert or Nipawin.

Walter found the system difficult to navigate, observed a lack of communication among his providers, and was constantly anxious due to lack of communication and information about his test results and next steps. He also felt inadequately served by the system from a cultural perspective, as he frequently encountered language barriers and felt that he was not receiving the same level of care as other non-Aboriginal individuals. It was also difficult and costly for him to arrange travel.

Key Questions

- ▶ How could Walter's family physician have behaved differently to change his outcome?
- ▶ What are some of the incentives or disincentives that contributed to his family physician's behaviour?
- ▶ Are there interventions that could have helped Walter avoid his use of the Emergency Department?
- ▶ What could have been done to ensure Walter's referral for diagnostics wasn't "lost"?
- ▶ What can be done to reduce the amount of travel Walter is required to endure?
- ▶ How can care be shaped to help Walter help himself in achieving his health goals?
- ▶ What can be done to improve cultural sensitivity for Métis and First Nations patients?

Case Discussion

From a high-level perspective, the experience Walter lived through describes that of a Métis man who is seemingly navigating a complex system on his own. To make it worse, the system is not designed to meet his needs in maintaining or improving his health.

Chronic disease rates are growing in Saskatchewan and will continue to increase with the aging of the population, increasing obesity and physical inactivity, and growth in the First Nation and Métis populations, which are susceptible to diabetes (HQC, 2006). In a 2006 study, the Health Quality Council found that only 38 per cent of individuals with diabetes had A1C levels in the optimal range of 7 per cent or less, and fewer than half had their cholesterol levels within an optimum range less than 2.5 mmol/L. This was exemplified in Walter's case.

Walter experienced difficulties accessing the care he required to help him maintain his health. He travelled long distances, relying heavily on family members and friends to access basic care. Walter was a high user of the healthcare system and struggled to receive coordinated care, such as the scheduling of multiple visits in one day. This was a consistent theme across many interviews with patients and providers living in rural or northern areas where access issues are much more prevalent and serious than those heard from patients living in the urban centres.

Walter was frustrated by a lack of communication amongst his providers and while in the Emergency Department. He was also frustrated by the insensitivity of health service providers across the system who didn't appear to make much effort to be understood or to understand him. In the absence of any information or explanations, he sometimes perceived prejudice in his long wait for services. He was also dissatisfied by the referral process. Providers, as well as patients, indicated difficulties in communicating, as formal protocols and processes are not in place, especially when there is a requirement to cross regional boundaries. Additionally, they indicated that the infrastructure and supports are not in place to facilitate this communication.

Walter's referral to Saskatoon was never followed up by the Emergency staff and Walter was unsure whom he should call as a result. In the end, he went back to his family physician, who carried out tests that had already been done. Such duplication was a frequent complaint among those interviewed who were high users of the health care system.

It is possible that Walter's amputation could have been prevented if the system had been more effective and coordinated. Although Walter suffered from depression, which made it increasingly difficult to manage his diabetes, he never discussed his mental-health concerns with his physician, who he felt was there to respond only to his acute care needs. At its core, this is a primary care philosophy that is reactive to illness and injury, rather than one that is proactive in providing patients with the tools to help them manage and maintain their health.

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Key Issues

- ▶ Lack of focus on the patient;
- ▶ Lack of access to primary care;
- ▶ Long travel times for access to care from a northern setting;
- ▶ Long waits in the Emergency Department;
- ▶ Lack of coordinated scheduling for multiple visits;
- ▶ Poor connections among providers in the system (family physicians and specialists / hospitals);
- ▶ Poor communication with patients (aggravated by language barriers) and between providers; and
- ▶ Lack of information for patients upon discharge, (e.g. how to follow up with specialist referrals).

Causes

Discussions with providers and staff throughout Saskatchewan indicated there was a lack of capacity in rural and northern areas across the health care system, including primary services, secondary care and home care. Part of this is being driven by difficulties recruiting and retaining health professionals in rural areas. There is also a difficulty attracting and retaining First Nation and Métis health service providers. While there is some training available to educate providers with respect to culturally sensitive care, the uptake and interest in that training is frequently low.

The Ministry of Health and the Health Quality Council have focused on improving chronic disease management in the province, through the Provincial Diabetes Plan and the Chronic Disease Management Collaborative. These initiatives aim to apply established chronic care frameworks to improve supports for patients to manage their care. While significant progress has been made, these supports are not yet available to all patients. Team-based primary health services, for example, are available to 31.3 per cent of the Saskatchewan population. There is also a lack of formalized infrastructure to support primary care providers to help patients manage their disease through disease registries and electronic health records. This lack of infrastructure creates barriers to the integration of care across the continuum, which is essential for effective chronic disease management.

Research also demonstrates that patients require intermittent supports to help them manage their disease between scheduled appointments with providers. Norris et al (2002) demonstrated that diabetic patients were most effective at managing their HbA1c levels immediately after receiving self management education, but that success waned after one to three months and beyond four months.

In the Emergency Department, providers indicated there were staffing shortages, inefficient patient flow into the hospital, requirements for duplicative and extensive clinical documentation, and over-burdened staff with, at times, minimal supervision. These issues are contributing to poor staff satisfaction, diminished quality of care and a poor patient experience. Providers recognized that the Emergency Department has received increased attention recently, and that the focus on improvements to this important resource varies by region.



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... a lack of formalized infrastructure to support primary care providers to help patients manage their disease through disease registries and electronic health records.

From a systems level perspective, providers indicated there was a lack of a cohesive plan to address Emergency Department issues, issues with leadership, a lack of accountability for quality and the patient experience, and a lack of infrastructure to support improvement initiatives. Staff indicated that many people in the system know the key issues and know how to address them; what is lacking is a cohesive vision and the systematic organization and leadership to drive transformation.

Linking It Back to the Research

Throughout the Patient First Review, patients and providers relayed themes consistent to those presented in this case. The experiences and the causes of these experiences are described below and are consistent with the causes as described by patients and providers interviewed for these in-depth case studies and the data that has been presented to assess them.

The themes and causes as relayed by patients and providers consistent with this case include the following:

Theme – Relationship with family doctor / Quality of interaction between providers and patients

This cause theme is described as low-quality face time with physicians (e.g. lack of two-way communications, inattentiveness in examination, over-prescription).

Patients without a consistent family physician often perceived the following disadvantages:

- ▶ Delay seeking primary care at the onset of a problem due to inconvenience of accessing care;
- ▶ Difficulty connecting to specialized treatments and providers;
- ▶ Over-use of emergency services;
- ▶ Hurried consultations (ER, walk-in) and superficial, less personal care;
- ▶ Lack of advocacy; and
- ▶ Delays in access to treatments and specialists;

Low quality relationships are driven by:

- ▶ Rushed appointments;
- ▶ Dismissive behaviours;
- ▶ Lack of clarity in communications;
- ▶ Over-prescribing;
- ▶ Lack of follow-up;
- ▶ Cultural insensitivity;

Physicians' performance is affected by:

- ▶ Impact of fee-for-service compensation model;
- ▶ Time crunch;
- ▶ Stress; and
- ▶ Uneven adoption of best clinical practices, or strategies to even patient flow such as Advanced Access or office redesign.

... what is lacking is a cohesive vision and the systematic organization and leadership to drive transformation.

Theme – Effectiveness of communication channel between the system and patient

This cause theme is described as poor communication with patients from hospitals, facilities, doctors' offices (e.g., no updates on waits for service, test results, next steps); no one takes responsibility for the patient file.

- ▶ Not being kept apprised of updates and timing;
- ▶ No advocate;
- ▶ Lack of consistent standards for patient-provider communication of test results and diagnosis; and
- ▶ Inadequate sharing of information from providers on what to expect after discharge

Theme – Coordination/organization of care throughout the continuum

- ▶ Poor inter-provider coordination;
- ▶ Duplicate testing; and
- ▶ Frequent travel and associated cost burden that could be reduced.

Theme – Quality of healthcare workforce

This cause theme is described as a healthcare workforce that is perceived to be unstable and delivering care of unreliable quality:

- ▶ Lack of resources, including staff shortages;
- ▶ Difficulties retaining healthcare workers in the province, particularly in rural and remote areas;
- ▶ Healthcare workers that are burnt out;
- ▶ Low staff morale; and
- ▶ Lack of supportive leadership

Theme – Management of health information

This cause can be described as the lack of consistency in managing and sharing patient information among providers:

- ▶ Lack of accessible, centralized means of locating patient health information; and
- ▶ Fragmentation of health information throughout various parts of the system.

Theme – Rural-urban inequities

This cause theme can be described as situations where patients can't access local family health care or routine specialist consultations in rural and remote locations:

- ▶ Perceptions of underuse of local health centres for primary care;
- ▶ Inability to access specialists without significant travel;
- ▶ Shortage of family health care services; and
- ▶ Shortage of rural non-hospital health services (e.g. therapeutics services, mental health care services etc.).

Theme – Cultural sensitivity of the workforce

This cause theme can be described as a lack of sensitivity on the part of health care providers to address the cultural needs of patients. This can lead to feelings of prejudice and feelings of inequity of health service delivery:

- ▶ Poor cross-cultural training;
- ▶ Respect and tolerance among workforce not adequately emphasized;
- ▶ Lack of leadership on cultural issues; and
- ▶ Lack of diversity among staff compared to diversity in the population.

Leading Practices

The following section provides a discussion on practices in other jurisdictions that have demonstrated success in improving the patient experience. In many instances, work is already underway at the Ministry of Health to develop these models for implementation in some form in the Saskatchewan health care system. Most of the initiatives described below are applicable to all population demographics and therefore not specific or targeted towards First Nations or Métis.

Patient-Centered Care

To support any other initiatives that would help Walter's case, there would need to be a reorientation of the healthcare system towards a focus on the patient, sometimes called patient-centered care, or patient-focused care. To begin with, this would require a definition of the patient (typically including the patient's family of choice) and a definition of what patient-centered means. Don Berwick, the CEO of the Institute for Healthcare Improvement, defines patient-centered care as "the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."

Ed Wagner, who developed the Chronic Care Model, indicates that based on a patient-centered definition, a health care system that is patient-centered would respond in the following ways:

- ▶ Explore patient's reason for visit, concerns, and need for information;
- ▶ Seek an integrated understanding of the patient's world – life issues, emotional needs;
- ▶ Find common ground on the problem(s), and mutually agree on management;
- ▶ Enhance prevention and health promotion; and
- ▶ Enhance the continuing relationship with the doctor.

This definition, or one similar, would have to guide all clinical and administrative decisions in the health care system.

From a First Nations and Métis perspective, providing patient-centered care includes being able to communicate and respond to their individual needs. This includes providing services that are culturally competent. Nguyen (2008) identified that poorly handled cross-cultural interactions often resulted in negative clinical consequences including non-compliance, delays in obtaining informed consent, and ordering of unnecessary tests. Educational programs have been effective at cross-cultural training to provide a base level of understanding in addressing the health and cultural needs of First Nations and Métis. Cross cultural training should be an inclusive part of any patient-centered care initiative.

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Addressing the Needs of First Nations and Métis

New Zealand Maori have the highest life expectancy among world aboriginal people. This has been attributed to the growing involvement of Maori peoples in the administration, governance and provision of healthcare services (Sylvain, 2008 and Ellison-Loschmann, L and N Pearce, 2006). Each District Health Board, equivalent to a Regional Health Authority in Saskatchewan, is mandated to have a minimum of 2 Maori board members, and each board member is expected to maintain a minimum level of cultural competence. They are responsible for implementing the government's Maori Health Strategy, developed in 2002, which includes policy to promote Maori health professionals.

Chronic Disease Management

Wagner et al. (1999) suggests a chronic disease management model that focuses on multiple aspects of the health care journey to help support the patient in managing their care. Barr et al (2003) suggested an expanded model that includes a population health promotion approach. The six components of the model include (Barr et al 2003):

Components of Chronic Care Model		Examples
Health System – Organization of Healthcare	Program Planning that includes measurable goals for better care of chronic illness	Visible support of improvements provided by senior leadership Incentives for care providers
Self-Management	Emphasis on the importance of the central role that patients have in managing their own care	Educational resources, skills training and psychosocial support provided to patients to assist them in managing their care
Decision Support	Integration of evidence-based guidelines into daily practice	Wide dissemination of practice guidelines Education with specialist support provided to healthcare teams
Delivery System Design	Focus on teamwork and an expanded scope of practice to support chronic care	Planned visits and sustained follow-up Clearly defined roles of the healthcare team
Clinical Information Systems	Developing information systems based on patient populations to provide relevant client data	Surveillance system that provides alerts, recall and follow-up information Identification of relevant patient subgroups requiring proactive care
Community Resources and Policies	Developing partnerships with community organizations that support and meet patients' needs	Identify effective programs and encourage appropriate participation Referral to relevant community-based services

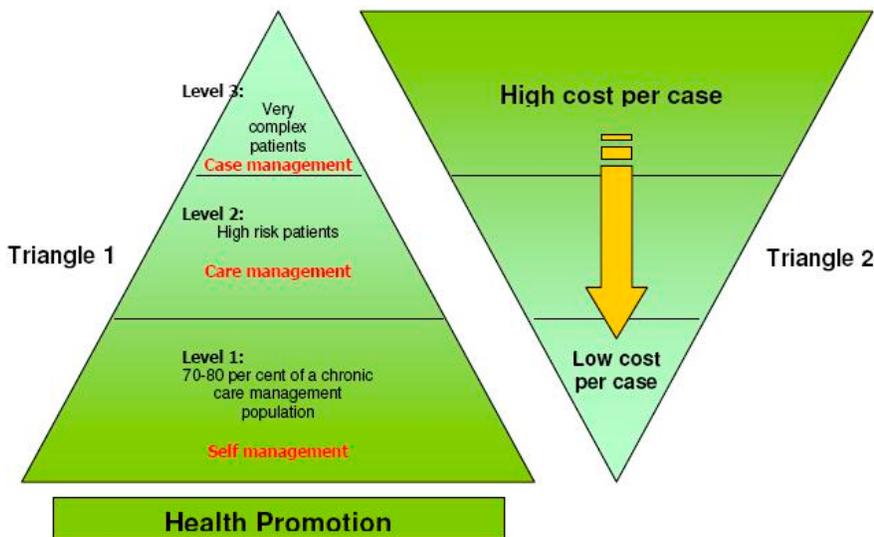
The Ministry of Health has recognized this and made it a key priority by funding the implementation of the Live Well with Chronic Disease program from Stanford University. The Health Quality Council has also completed a second wave implementing the Chronic Disease Management Collaborative. This collaborative is based on an Expanded Chronic Care Model and works with providers to help them reorganize how patients with diabetes and coronary artery disease are cared for and supported throughout their care journey.

While significant progress has been made, it should be a goal that every patient with diabetes and coronary artery disease is cared for in this way. Additionally this year, the HQC will be launching a collaborative to care for patients with chronic obstructive pulmonary disease (COPD) and depression.

Case Management

Kaiser Permanente has implemented a case management model to manage clients with chronic disease. They have put in place a system of case management that creates a team approach to managing and working with clients to help them manage their condition when they are able, recognizing that not all individuals require the same level of care. They have defined three levels of case management based on the intensity of the needs of clients defined as follows (Department of Health, Social Service and Public Safety, 2008). The three levels are illustrated in the following diagram, and then described in more detail:

It should be a goal that every patient with diabetes and coronary artery disease is cared for in this way.



Three levels of case management based on the intensity of the needs of clients.

- ▶ **Supported Self Care** - support of self-management of the 70 per cent of people with chronic conditions whose symptoms are largely stable. Collaboratively helping individuals and their caregivers to develop the knowledge, skills and confidence to care for themselves and their condition effectively.
- ▶ **Disease Management** – Involves providing people who have complex single need or multiple conditions with responsive specialist services, using multidisciplinary teams and disease-specific protocols and pathways.
- ▶ **Intensive Case Management** – Requires the identification of the very high intensity users of unplanned secondary care and the subsequent provision of intensive, personally tailored care to the 3 to 5 per cent of people at greatest risk of hospital admissions.

Through this integrated approach, Kaiser Permanente achieved:

- ▶ Improved quality of life for patients and care givers;
- ▶ Admissions avoidance;
- ▶ Early detection of disease deterioration and proactive interventions;
- ▶ Reduced length of hospital stay;
- ▶ Improved the way medication is given and administered, rationalizing the medication to aid patient concordance;
- ▶ Promoting a seamless service for the patient and improving communication through the patient's journey;
- ▶ Improved awareness of disease progression through avoiding crisis situation through education and advice to patient and care givers;
- ▶ Empowered and informed patients;
- ▶ Improved provision of consistent and integrated care; and
- ▶ More effective use of healthcare resources.

An effective strategy for managing chronic diseases using a case management model is the identification of individuals at high risk of developing chronic diseases. Working in collaboration with these individuals, strategies can be implemented to help them maintain their health and prevent disease. Narayan et al. (2001) demonstrated a 58 per cent reduction in the risk of diabetes through this approach.

Team-based Approach to Care

An important aspect of this care is the use of team-based practices. A significant aspect of helping patients manage their disease is the use of inter-professional care. An example may include a single office practice that employs a dietitian, a nurse practitioner, a physician and a pharmacist who work collaboratively with the patient to educate them and support them in managing their own health. Interactions between providers in these situations must be frequent in order for inter-professional care to be effective. Case conferences are common and incentive structures are in place to support this type of care.

Triple Aim

Saskatchewan will be participating in the Institute for Healthcare Improvement's next wave of health system improvement called "Triple Aim". This improvement initiative brings together many of the improvement aspects discussed in this case. Triple Aim has demonstrated improvements by focusing and optimizing care on the following (IHI, 2009):

- ▶ The health of a defined population;
- ▶ The experience of care for individuals in this population; and,
- ▶ The cost per capita of providing care for this population.

Through this initiative, improvement teams focus on designing patient care processes through the five components listed below:

1. Focus on individuals and families
2. Redesign of primary care services and structures
3. Population health management
4. Cost control platform
5. System integration and execution

These combine to create a more integrated system that responds to the unique needs of the patient while improving the health of the population.

Access in Rural and Remote Areas

Access to care in rural areas is an ongoing issue not only in Saskatchewan but across Canada. In order to improve accessibility, a multi-pronged approach is required that can include the following:

- ▶ Use of Information Technology – Develop patient portals that allow patients to interact directly and share information with providers;
- ▶ Integrated Scheduling – make use of scheduling algorithms that allow for multiple appointments on the same day to optimize the patient's travel time;
- ▶ Expand Use of Telemedicine – Expand the use of Telemedicine that includes specialist consultations, home care telemedicine and patient education;
- ▶ Recruitment and Retention Practices – examine leading practice models that make use of alternate funding models that includes incentives for inter-professional collaboration.

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A successful Australian model has resulted in the implementation of the following physician recruitment practices:

- ▶ Rural Workforce Agencies (Victoria, Australia) that specifically recruit and retain physicians, nurses and allied health staff with the following:
 - ▶ Family support programs – For example, rural medical family network, spouse/partner education and training bursary, career counseling service, telephone counseling service, meet and greet program
 - ▶ Doctor’s Health program – confidential service for doctors and medical students with health concerns including stress and anxiety, etc. Service is available to doctors’ family members, friends, professional colleagues, hospital and clinic staff
 - ▶ Medical Specialist Outreach Assistance Program (MSOAP) – the aim of the program is to increase the access of regional, rural and remote communities to medical specialist services; and to increase and maintain the skills of rural doctors in these areas. This program provides support such as travel expenses, travel time, meals, accommodation, facility fees, and administrative support
 - ▶ Locums – For rural GPs to take leave from practice for professional development, vacation, sick days.
 - ▶ Sustainable models – offering seed grants to communities, rural divisions of General Practice, individual GPs, and local government to support general practice sustainability and increase access to services for rural communities. Supports a range of proposals including feasibility studies into alternative models, trailing after hours support for GP services, role of nurse practitioner, etc
 - ▶ Rural retention program – recognizes long-standing general practitioners in rural communities
 - ▶ Grants for Rural Doctors – such as Individual Clinical Skills Training Grants
- ▶ Shared Service Models that organize physician coverage across a region, typically providing support to rural areas with coverage by urban physicians.

Walter's Story Retold

Walter has been living with multiple chronic conditions for many years. He was first diagnosed with diabetes approximately 20 years ago. When he was younger, he was physically active and didn't have many problems maintaining healthy blood sugar levels. Several years ago, however, Walter had surgery on his knee, which impeded his mobility. He found it increasingly difficult to remain active and maintain his blood sugar levels. Eventually, he had problems with his kidneys and was diagnosed with chronic kidney failure. The hemodialysis unit in Prince Albert, four hours away, was the only location that had available space for his thrice-weekly treatments.

Since Walter didn't have a regular family physician, his kidney specialist recommended he enrol with the Primary Care team in Cumberland House. The team had been working with the Chronic Disease Management Collaborative to develop their chronic disease management practices, including an electronic patient record that would help Walter communicate with his care team. They also had been trained to support the needs of First Nations and Métis patients and in fact employed a Métis physician. The specialist also indicated that through adequate self-management supports, Walter was a candidate for home peritoneal dialysis. Through the insertion of a catheter, proper training, and the support of a care team, he would only be required to travel once or twice a month to the dialysis clinic in Prince Albert.

Walter called the Primary Care Team and made an appointment. Since this would be his first visit, a nurse practitioner came to the phone to explain the concept of the inter-professional care teams and how everyone would work together to help him attain his health goals, including the specialists in the hospitals across the province who had access to his electronic medical record. She asked if he would be ready for an appointment in three days; there he would have the opportunity to meet the care team, discuss his health goals, learn how to manage his own health and how to access the care team at any time. Walter indicated that he would check with the volunteer transportation service, a joint initiative between the community and the Regional Health Authority, and get back to her.

During Walter's visit, he met the care team, which consisted of a physician, a nurse practitioner, a pharmacist, a dietitian, and a social worker who was Métis. The team had attended cross cultural training together and were sensitive to meeting Walter's health and cultural needs. The physiotherapist had an early home visit she had to attend to, but he was told he would be able to meet her on a subsequent visit. They discussed Walter's health goals and how they would work together with him to help him achieve them. They showed him his electronic medical record and how they would track his progress. They also asked him if he had access to a home computer.

A nurse practitioner came to the phone to explain the concept of the inter-professional care teams and how everyone would work together to help him attain his health goals.

During Walter's visit, he met the care team, which consisted of a physician, a nurse practitioner, a pharmacist, a dietitian, and a social worker who was Métis.

Walter left the primary care team feeling very supported and confident that with their help he could manage his health.

If so, he could see his medical record from his home computer and if he wished, he could communicate with the care team through the patient portal linked to his record.

After they established Walter's health goals, he met with the nurse practitioner and the dietitian to learn how to properly manage his health through monitoring his blood glucose levels, and how to remain physically active and practice proper nutrition. They scheduled him for a follow-up visit within a month to assess his progress and to adjust his plan based on this outcome. They provided him with an access number to call for any reason. The providers on the phone were nurses and had access to his medical record, and could connect him with the care team if need be. They told him that if he required a significant amount of help remembering the steps he learned to maintain his health, they would work more closely with this access centre and assign him a case manager until he felt comfortable with his routine.

The team also explained that Walter would be scheduled for regular visits with them and with specialists, depending on his availability. They asked that he work with their scheduler to arrange an appropriate schedule before leaving and that he could expect to receive automated reminders by phone once he logged into the patient portal.

Walter mentioned that his kidney specialist indicated he may be a candidate for peritoneal at-home dialysis. The nurse practitioner indicated that she saw the note on his chart and would call his specialist to discuss his options. She indicated that a member of the care team would call Walter in two weeks and then assess his progress during his follow-up visit in a month. She indicated they could initiate the switch to peritoneal dialysis once Walter and the care team felt he was managing well.

After the visit with the nurse practitioner and the dietitian, Walter met with the physician and the pharmacist, who reviewed his medications and discussed his options for his conditions. Afterwards, the physician conducted a physical exam and asked him how he was coping with his multiple conditions.

Walter told the doctor that he was holding up as well as could be expected for someone in his condition. The doctor asked if he could ask him a series of questions that would help him determine more specifically how Walter was coping, and Walter agreed. In the end, the doctor said it was likely that the burden of these conditions, in addition to other life circumstances, were weighing on him and it appeared that he was suffering from depression. The doctor told him this could also have an impact on his ability to adequately manage his health. He suggested a group therapy session and asked if he could discuss the matter with the team social worker.

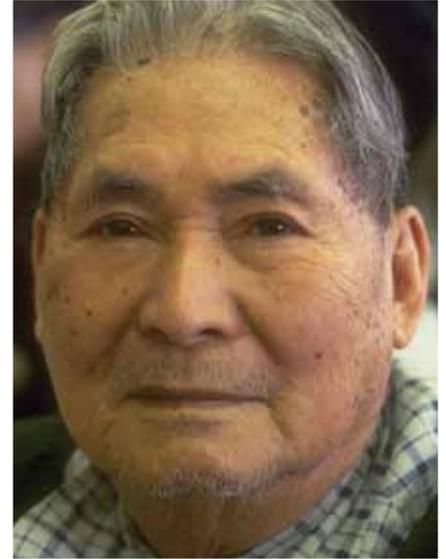
The doctor brought in the social worker and they talked with Walter about the impact his condition was having on his life and his mental health. They discussed several options, which included group therapy, which was available immediately, one-on-one counselling, which had a wait list of three months, and medication. Together they discussed the options and decided they would first try the group therapy session, which was led by a Métis counsellor, before making a referral to one-on-one counselling, and would leave medication as a final option.

Walter left the primary care team feeling very supported and confident that with their help he could manage his health. Walter ended up initially requiring more intensive support, including regular calls to remind him to remain active and to stick to his nutritional plan. He eventually learned to maintain his health and met with his care team twice a year. He made the switch to peritoneal dialysis, which improved his life significantly. He was able to go back to work part time and no longer felt like a burden on his family and friends.

Through the support of his care team, Walter's circulatory conditions were well managed and he kept the full use of his limbs. He also reduced his reliance on the Nipawin Emergency Department and achieved a healthy mental state. Through the integration with a range of specialists, any visits with the podiatrist, cardiologist, nephrologist or other providers were coordinated to suit his schedule and planned on the same day whenever possible.

The story as retold describes a healthcare system that acts in a coordinated manner to support the care needs of individual patients. It is not that far from reality, with many pieces of this picture in place in Saskatchewan. The result of this reorientation of the system has the potential to not only improve the patient experience but to prevent unnecessary health catastrophes such as the loss of a limb, and prevent unnecessary use of the emergency and hospital system.

The table below demonstrates the touch points at each stage in Walter's care journey and the impact on him. The table also provides suggestions for how improvements could be made to each touch point, and links those aims with current/planned initiatives within the Province of Saskatchewan. It is important to reflect on each of the touch points through the case, because it is these touch points that can make or break the overall patient experience.



The story as retold describes a healthcare system that acts in a coordinated manner to support the care needs of individual patients.

Touch Point	Walter's Story	Improvement Aim	Current/Planned MOH Initiative
Accessing Primary Care	Difficulty accessing care close to home	Improve accessibility of primary care providers Improve appointment scheduling	Advanced Access Recruitment and Relocation grant programs for physicians and other health care providers
Describing symptoms with providers	Interactions with providers that are rushed	Improve provider-patient interaction	Advanced Access
Dialysis treatment	Treatment far from home	Care closer to home	
Emergency Department Care	Long waits Lack of communication Over-burdened staff Inefficient care processes	Reduce Emergency Department wait times Improve communication with patient throughout care experience including during wait	Health Human Resource Strategy Lean
Labs and diagnostics	Duplicate testing	Eliminate duplicates	EHR Accelerating Excellence
Referral to specialist	Lost referrals	Lack of provider-provider communication Lack of patient-provider communication Improve communication between providers Improve communication between providers and patients	Lean EHR
Management of chronic diseases	Solo doctor, episodic, lack of patient education Lack of systematic disease management Reliance on Emergency Department	Self-management, goal-oriented care Interdisciplinary Primary Health Care team Reduce reliance on Emergency Department	Primary Health Care Teams HQC CDM Collaborative EHR

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