Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Addictions

Thinking about the addictions treatment services available in Saskatchewan, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• One CU – adequate medically induced protocols for sedation • Peds/acute care – good protocol to manage weaning off of narcotics • Several facilities available with trained staff for addiction • Methadone programs • NARCAN availability • Stricter regulations for narcotic prescriptions • Needle exchange program • Methadone program • Treatment programs • Many access point available for cancelling treatment • Urban mobile treatment/access options • More detox centres • Concurrent disorders program in Saskatoon • Naloxone kits	• Teens fall through the cracks • Harm reduction with safe needle drop offs and needle exchange program • Naloxone kits – police etc., available • Addicted individual admitted for health issues – do not have adequate medication to manage their addiction while hospitalized – withdrawal • Gap in legislation for addictions. (cannot order adequate treatment to manage their additions) • Not enough recovery support programs in community (AA, etc.) • Cause of additions – no • Prescribing practices lenient with some physicians • Not enough capacity in the facilities • Minimal emergency addictions facility/services; i.e., to deal with ACUTE withdrawal	• Change in perspective to medication addiction • Educate in schools younger • Increase hospital care – holistic clinics for pain – www.saskpain.ca • Increase monitoring of physicians ? Medical Association • More detox beds – in-home detox programs (done in B.C.) • More education in schools re: addictions • Availability of testing equipment for police officers for testing of influence of marijuana levels • Information sharing between hospitals/clinics/pharmacies for continuity of care for patients • Education for doctors/pharmacists/nurses regarding prescribing and alternate options to treat pain • Create a mandatory counselling program for methadone clients – mandatory testing, etc.

• Access to addiction counsellors • Access youth counsellor • Hospitals have ondex sets – detox/alcohol – addressing low/high (also addiction specific) • Offer smoking cessation • Methadone program • Trying to combat drinking and driving – extended campaigns • Narcan to general population • Compassion during addiction and pregnancy = increased compliance = decreased addition rates	• Access to Public Rehab services • Not enough health care professionals involved in Methadone program • More education for caregivers dealing with clients involved in addiction programs • Wait times for treatment • Limited options for access – pharmacy • Lack of counselling availability • No safe injection sites • Limited times for needle exchange clients – 0900-1600 – Yorkton site • Self referral to detox – limited beds available • Lack of long-term support following treatment • Health care professionals are waiting for patients with addictions to come to us – we are not taking the services/help to them • Staff fear for their own safety – i.e., pharmacist denying a client medication due to warning signs – double doctoring, etc., "I have to walk to my car alone after work and this person is high and upset with me" • Lack of treatment beds, detox beds • Lack of addiction treatment in rural areas • Lack of immediate crisis interventions • Lack of concurrent disorder treatment in rural areas • Child and youth addiction services • Over medication of pain meds, lack of alternatives to pain management leading to addiction • Lack of education to professional with addictions • Zero access for aboriginals to services • Not timely access to counsellors	• Longer residential treatment services • Acute pain services in hospital (multidisciplinary to prevent addictions) • Provide education in school systems on addictions early on – preventatively • Concurrent management of pain and addictions • Increase NA and AA programs, more structured psycho ed groups • Recognition of co-morbidity • Increase harm reduction, safe injection sites • More medical detox beds • Education for families to help their family member to self-refer • Addiction treatments in jail • More education and access to counsellors • Getting into preventative health in school systems • Front-line education to all employees – nursing/physicians • Support families – access to Alonon • Increase staffing, more follow-up • Naloxone training from all staff • Physician education on addictions vs pain – management and follow-up • Need a provincial plan in place for HIV • Safe injection sites • Education • Other options beside always turning to narcotics • Invest services into communities • Equitable investments • Strong leadership • Alcohol consumption sites

	• Not enough and not replaced addiction counsellors • Standardized provincial order sets for all addictions (including Youth/pediatric) • Healthy alternatives (health concerns vaping) • Strict guidelines/more support/specialized nursing physician support • HIV rates • Methadone needs to be more streamlined • Opiate policy's need to be followed better	

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café

Theme: Communication

In terms of communication –between practitioners, to the patient/family, etc – within the Saskatchewan healthcare system, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Identifying shortcomings and trying to address them • Global email • Telehealth • E-health • Telehealth • Regular family meetings • Standard discharge process (pharmacy) • Development of SBAR • Video calling with families in LTC • Safety huddles • We communicate well within our own environment • Wall walks/board/huddles • PIP – provides a current list of medications prescribed meds • Interdisciplinary rounds • Emergency – Chart on SCM	• Silo's – middlemen giving 2nd hand information, which leaves room for interpretation and error • No outdated technology • Knowing who is on your team and who needs to know pertinent information (navigation) • Access to consistent policies, education, procedures, equipment and supplies • Increase telehealth • Utilizing technology better • EHR viewer • Citizen health portal (not built into workflow that makes sense for a practitioner) • Sharing discharge instruction with all healthcare providers • Unable to access the provider (as a pharmacist) of the patient	• Multi-disciplinary rounds • Family case conferences • Use of technology to join all parties (stakeholders) and use as education tools • Families identifying a single point of contact (spokesperson) • EMR – Single • Ability to text healthcare professionals/team members in safe manner • Electronic health record (comprehensive) that's accessible to all health care providers • Physicians have set times for rounds on the floors and enough time to spend with patients and families • Discharge planning could be better communicated if we worked in the same systems • Everyone have access to E-Health

	• Better communication on when physicians will do rounds and having the time to speak with patients and their families • We don’t always know what resources are available to assist inpatient care when they are discharged • Lack of cohesiveness amongst regions • PIP Doesn’t cover all medications • Role clarity • Same questions have to be asked on different units when it would be easier to just add current complaints	• Have each professional association work collaboratively and define specific roles and utilize additional authorized practice (AAP)

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café

Theme: Safe & Compassionate Care

Thinking about the delivery of, and ensuring, safe and compassionate care in Saskatchewan, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Best effort to provide best possible care • Previous mentorship programs • Safety is on the radar • Reporting of incidents and improvement opportunities • Most staff are willing to participate and learn • Double checks for high alert medications and pediatrics • Smart Pumps • Religious services accessible • Translators available • Nurses spending time with patients and family • We strive for it but I don't think we are meeting it yet • Most urgent needs get the required care • EHR Viewer • Circle of care from one facility to another • One complaint per MD visit? • Safety and compassion are 2 different entities • Medication – double checking high alert meds	• Patient Ratios • Rushed Care • Mentorship and orientation standardized for new staff • Satisfactorily working conditions and work life balance • Managing workplace and staff • Employee engagement lacking • Hidden harassment and workplace violence • Palliative and hospice care for rural area • Nurse to patient ratios (safety) • Software with smart pumps (specifically pediatrics) • Phone majority (translators) • Discharge process different on units • How do you provide confidentiality with bedside report • Having the whole team for report/notes written poorly • Are we over testing	• Re-establish mentorship programs • Establish patient ratios • Build strong teams of care providers • Opportunities for stress reduction activities and work life balance • Communication between team members • Ability for team members to feel safe and heard by leaders • Team building activities • Improving access for community for palliative and hospice care • Translators (skype or facetime) • Discharge planning standardized • "One Stop Shop" BW/X-Ray, SW, CNE, Dietician etc.) • Encourage team approach including nurses, whiteboards successful on some units • Navigation tool to help patients navigate where to go • Broader view of provincial tests done

• Falls risk • Safety telephone # to call • Compassionate care (pain management) • TLR • Palliative Care • Non-punitive reporting of near misses and safety issues • I am with ACU team and its really working • Experience in rural and remote access and services • Front line workers have to wait hours to be seen in ER • From an RN – short stay – opening a short stay unit to full capacity to address the surgical bed situation, alleviate the surgical wait times and help that one patient waiting in ER • Access to PYXIS Medication system - safer medication delivery • Have safety line to report concerns and safety issues • Palliative Care, care for patients once there • My voice form done by patients • Offering palliative care at home for terminal patients and home care for chronic patients, involving family and other disciplines • Most professionals respect their clients and are accountable for their care • Involve family in all levels of care • Policies and procedures for safe patient care • Goal increase quality care safely • PIP has helped communication • Accessing computers • Compassionate action (mandatory course) • Gentle persuasion • Mandatory Education • Decrease errors	• We need to expand most urgent needs get the care to the community • EHR – More info from other standardized testing • Portal for patients to view their own • More timely access to MD's • Trunk line service for patients and staff • Nurse and physician communication • Judgemental and drug abusers • 24/7 – 365 days out-patient treatment centre • The on-line reporting needs to be more flexible, it's geared mostly to in-patient falls and med errors, the software rarely applies to community • Improvement is on going • So much to improve on like transformation, access to OT & patient services, mental health, suicide education and prevention • Is it possible to have occupational health clinics for hospital staff • Full staffing for safe patient care • Pharmacy to send pharmacist to check on medication concerns • Need more palliative beds in hospitals in our province • Need to utilize hospice • Long wait list for long-term care even for palliation • Need to start end of life conversation earlier • Time is a major factor, too busy, more mistakes, more abrupt, less teaching and reassurance • Not enough hands on patient time • Streamline technology requirements so more time is spent on the patient • Too much time spent on computer data and not enough time for patient care • Role Clarity • Collaboration between different bodies	• More MD's/NP's availability for time & questions from patients and families • Education for patients (stop being judgemental) • Homecare should manage and coordinate an out-patient treatment centre including blood transfusions and catheter changes • More versatile software for on-line reporting • Community centres and hospitals must start doing some very important nursing skills like blood transfusions etc. to shorten city hospital stays • Manager to advocate for care to be available • Charge nurse to communicate to pharmacy at start of shift and medication concerns • Raising awareness and making case for presenting to government, if there is help people can continue to work • Research and data collection by family or doctor or transferring hospital • Less procedures on palliative than medical ward • Doctors and nurses need to speak to families about end of life care • Need to review forms with patients and families every time they come in • Proper staffing for needs; true accountability for errors • Right profession for the right task with the right knowledge base • SRNA • Lack of Admin • Outdated information • Lack of computers and access • Provincial wide policy and procedures • Remove obsolete documentation • Upon admission printing stickers to decrease errors

	• Too task orientated • Lack of policies • Under staffed – stressed, unsafe • Correct nurse patient ratio • Less wait times • Inadequate orientation • Lack of mentorship	

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café
Theme: Culturally Safe Care

Thinking about providing culturally safe care in Saskatchewan, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Expansion of the role of Social Worker(s) on peak time(s) • Flow of the patients in acute care facilities (Emergency, Critical Care) • Development of Community based organized programs (Health & Wellness, Chair Yoga, Health Topics, Cooking & Nutrition) • Access to more Interpreters/Translators • More community support available • Database providing up to date and accurate information • We talk about it • In some places access to resources that support specific culture • There is an awareness • Some assess to translators • Offer First Nations liaisons • Offer smudging in some settings • Interpreters available • Access to Elders/Spiritual Care/Priests/Pastors • We try to accommodate family and involve them in care	• Schools/Systems • Public Health Nurses from grade K-8 • Build a child clinic, inclusive of NP support and immunization programs • More training • Culturally specific (Healthcare & Restrictions information • Patients of families need to verbalize care needs • More patient navigators to help patients through the system • Persons in their homes needing support and do not know how to ask or who to ask for assistance • Community Interpreters (Have knowledge of who is in your building to use for translation & communications • Not easy to access resources that support culture • Generalizing response to care as culture making assumptions	• Social Issues • Determinants to Health (Housing, Food & Nutrition) • Education – build on community supports and create new • Build on technology • Build trusting relationships • Blanket exercise & Turtle Island education in colleges • Education about diversity • Bring back spiritual care • Use online/over the phone interpretation • More cultural education • More appropriate spaces for cultural care opportunities to engage with community/family for care • Engage the community

• Access to space for spiritual and cultural care • Modified diets (i.e. vegan, halal etc). to respect beliefs	• Not a lot of background education on the diverse cultures & languages of the people we work with • Education re: variety of demographics not offered to all staff • We don't know what we don't know, we think we are providing culturally competent care • Needing to educate peers making racist comments in staff room • Cuts to spiritual Care • Make interpreters available 24/7 • Not enough space at saskatoon City Hospital and Royal University Hospital for family/community/patient involvement • Not recognizing the importance of culture in health outcomes	

Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Emergency Departments

Thinking about the emergency services available in Saskatchewan, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Triage Well • Consults between team members to set the patient seen appropriately • Computer charting • True traumas get excellent care • Health line/poison control centre – great in theory • In Rural – Dr.'s keep open spots for clients to access emergency for clinic type situations • Have reduced some wait times • There are some smaller communities that do have an ED • Triage well. Always keep a spot for next ML or trauma possible to come • Good patient care with time allotted	• Communication between staff in ER and the Ward. LD Standardize • Advocating for being seen in the appropriate route of care and providing the education for our patients • Changing the heath line to make more applicable • Public still believe 1st come 1st serve in ER. More education needed • Waiting a long time to get admitted • Sitting in hallways • Patient education – Health line • Costs of an emergency visit – inform the public • A lot of non-emergent cases • No privacy for anything, no confidentiality • Some EDs don't have ED Mental Health physically there – you're waiting • Poor communication with family and departments • Better hand tools to wards	• Code Silver – this is a great ideal. (for violent ppl with a weapon) • Privacy • Physician dedicated to minor assessment and care • Nurse triage to decide if it is a true emergency. If it is, the patient goes into the emergency department. If it is not an emergency, there would be an urgent care center attached to the hospital for non-emergent situations. • Triage system where you go the ED or you go to a walk-in type of department staffed with an NP and/or MD or you go to mental health team • Better check lists standardized forms eg stabbings; stoke; MI, etc. • Need two mediclinics eg Saskatoon. One east side and one west side with lab and xray

	• Triage to medi clinic? As same don't need to be there	

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café

Theme: Home Care/Community Health

Thinking about the services available in Saskatchewan which focus on the maintenance, protection and improvement of the health status of the people in the community (community health), including home care, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Services to help people stay in their homes – out of hospital/LTC • Provide respite to families • Decreasing risk of hospital acquired/infection • Mobility decline • Social interaction for clients • Clients more comfortable getting care in their home • Close monitoring of ER accessing of clients (some places, Prairie North) • Cross Provincial monitoring ER usage of Home Care clients • Good number of referrals from acute to community • Keep people in their homes longer • Palliative at home • Developed and adapted to cover changing community demand	• Access to services to rural (maybe only 1-2 visits per week) • Some areas have reduced hours (Example: after hour care) • Need more services = reduced load on acute and LTC; reduced hospital acquired infections • Intake for counselling is too long • Communication gaps in referrals from acute to community • Difficult communication between community pharmacies and home care and physicians – can lead to medication errors • Infrastructure: support for a consistent approach to diabetes management • Too many silos – communication breakdown between all the resources	• Home Care Nurses/Aides within each community • Continuity • Get the buy-in from Provincial Health Authority for SRNA Specialty Practice and SRNA AAP – to initiate programs such as, example, community worker in management to reduce med errors, etc. • Improve access to community services on weekends – walk-ins, home care, social workers, pharmacies • Home visits from physicians • "CIS" priority for provincial health information system • Electronic Health records • Interdisciplinary environment • Education – preventative Health Care

• Broader range of services provided • Infections Disease work HIV/HEP C strongly improved • Saskatoon has 24 hour Home Care • Trying to collaborate with other health regions (Example: Regina local and Saskatoon mtg) • Home Care clinic for: dressings, IV • Access is easy (Example: referral process, timely fashion) • RQHR doing a good job understanding how "prophylactic" home care/primary care work can keep especially seniors out of acute care system • Advanced Speciality Nursing Practice (vascular assessments, PICC, PORTs, VAC wound care, footcare prevention) • Fall prevention • Post acute follow up • Referral to multi disciplinary team • Working to keep people in their homes • Teaching	• Dealing with the whole person not just the "leg" or whatever the inquiry initially took them to seek out Home Care • Public Health seems to still remain silo'ed • Home Care also could be more integrated into the broader system • Recognition of the complexity of client demand and a broader scope of inter-collaborative providers (Example Hosp in the Home) • Working closer with Social Services – building both front line and corporate relationships • Rural Home Care: providers – distance travelled • Inequality of care • Not standardized in all regions (3 days/week, 1 day/week, 7 days/week)) – not consistent • Regina and rural does not have 24 hour care • Recruit and retain? • Supplies need to be standard as well • Staffing issues • Food care needs to be included • Include physiotherapy in community • Teams: include NPs, Pt, Drs, etc. • Community mental health access to service and getting appointments in timely fashion • Pain management services • Communication between homecare nurses/staff and mental health patients • Staff: patient ratio to increase • Access to physio, OT very poor, huge wait times • Cost for home based service, private physio • Lack of access to youth for dental, audiology, mental health • Nutrition /Dietician access • Gaps in discharge planning and information • Nursing in Rural areas is not consistent. May only be 3 days/week	• Nurses back in schools along with Dental Nurses! • Transformation and development of Network teams in the New Health Authority. Health leaders working with front line to develop • Integration of NP into our community housing (serving specific populations) for Mobile/Hub type of service • Have a provincial policy for HC – standardize • Mentorship program – education, clinical placement • Make a broader criteria for patients to access foot care • More access to universal health care • Nurse practitioner able to manage pain for patients • Have a health directory website/app/phone number to allow easier access/increase knowledge for who to contact • "Work standard" for patients, what they should expect, when to expect it, follow-up contacts • Build "211" app – increase technology with regards to healthcare • Sooner d/c planning city to rural • National Home Care program • Access to services, more continuity • Education • Need 7-day care • Evening care • Checklist • Increase access to Nursing services 7 days/week • Quick response services to facilitate earlier d/c home from hospital or if having acute episode

	• Nursing needs to be available 7 days/week as clients have complex needs and not appropriate that clients unable to receive that service • Discharge from urban to rural (different services)	

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café
Theme: Indigenous Health

Thinking about the Indigenous health in Saskatchewan, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Aboriginal Awareness now initiated • Truth and Reconciliation is now being brought to the table • Traditional healing, acknowledging utility of Elders (example: Eagle Moon Health Office) • We have improved on education of health care providers (example: Indigenous health issues, initiatives such as aboriginal training, etc.) • Mandatory Aboriginal Awareness training • Aboriginal Education/Elders visiting schools • Aboriginal lessons – in schools/hospitals • Supporting public health on reserves • Offering traditional practise/culture within wards/hospitals • Have a medicine wheel approach to health care • Traditional practices very important	• Racist co-workers • Lack of resources in Northern Remote Services • Social issues/clean water/physiological/housing • English-centric system • Access to logistics/transportation • Culture dependence/independence/transition • Need to improve communication/education between Health Care and Aboriginal issues • We need to improve cultural awareness further; need to find ways to have the resources to adapt and accommodate aboriginal families in the health care system (example: palliative care) • Cultural differences when it comes to death and dying • Care for Aboriginal funded Federally but provided provincially • Access to certain services in rural/northern reserves • Stereotypes/racism and generalization affecting care • Social determinants affecting access to health	• There are other ways to do care • Use more holistic means • Advocate for solid social determinants of health (funding) • Open dialogue with diverse stakeholders/jurisdictions • Cultural safety • Support of cultural practices • Support for independence • Language based care – delivered in patient preferred/traditional • Leaders of Aboriginal communities/health care providers/ political parties • Federal versus provincial system; gaps in system, continuity of care • Coordination of Social Services and health care • Intersect provincial/federal programs to provide better care • Labs on reserves • More access to primary care

• Great respect for Elders		• Need better pre-natal services on reserves • Educate new health care workers/international workers on Indigenous people – make aware of racism • Can use things like Telehealth to access hard to reach reserves and northern communities • Address social determinants (example: milk – expensive groceries) • Having community participating solutions • First Nations leaders need to be accountable to their reserve and people

Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Long-Term Care

Thinking about the long-term care services available in Saskatchewan, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Fostering relationships • Pharmacare – review elderly meds • Advocate with elderly care • Amalgamate3d care respite/long term care • Discipline – Doctor, Nurse Practitioner • Acknowledging problems • More acknowledgement of home like atmosphere/importance • Incorporating a more holistic approach – providing care • Have been receiving more specialized training • Taking patient centred approach • Trying to do better • Palliative care • Great holistic use • Home! Not Home-Like! • Build GREAT family/patient relationships • Great relationships with our community • Build community with other LTC sites • Advocacy!	• Staff levels • Continuity of care • Consistent care/treatment • Acuity increasing • Connected to hospital for easy care access • Nurse Practitioner at each long-term care • Keep elderly closer to family if possible • In smaller community baseline not met, is being replaced with another provider • Medical complexity is up, staffing is not • Need to have staff educated when they start work • Disjointed medical records/history • Lots of potential for error and miscommunication • More licensed staff working – lower patient to licensed staff ratio • Need to recognize case for whole person including spiritual care • Recognize we are not an acute care service – accepting patients from ICU, with multiple	• Need RNs 24/7 • Nurse to patient ratios per residents • Respite and convalescent improvement • Remove unnecessary meds • Every 3 month Conference/patient review • Support elderly in their own home as long as possible • Family support paramount to well-being • Communication • Education for unregistered staff before starting work and ongoing • EMR – increase communication • Accountable Care Units or some type along this line • More resources – highly acute patients but same resources as 1995! • More specialized LTC areas: 1) behaviour (ABI); 2) young; 3) behaviour assessments (short-term) • Look at different funding models for spouse/levels of care/assisted living on site

• Utilize all types of nurses NOT just RNs and RPNs – we ALL have a role! • Some units are very patient-focused • NPs being hired as part of the team; less hospital visits for patients • Bringing services to the center (Example: Foot care or buses to take clients to services) • Supportive of a "home like" environment • Some respite beds helpful for care providers • Transition into LTC smoothly, rapidly • Hospital, home care and LTC provider communicating well • Good respite connection • Do good with medication with review • Offer support groups (Example: monthly dementia group, caregiver support) • Good quality care with a limited budget • Offer good diets and food • Rec staff is good – activities are well involved with community engagement	interventions, tubes, IVs, etc. and current staffing risks good client care • More NPs and other specialties on-site • LTC & A/C collaboration is very poor. LTC residents sent "home" to LTC to die (if seen/accessed by ER) BECAUSE ageism and LTC status • Technology! We need EMR too! It's not just for A/C!! • Not enough care homes to keep clients in home community • Care needs to be more individualized (Example: right care at the right time) • Not adequate staffing to meet client needs • Support the person for what they need – custodial care versus rehabilitation • System is not seamless • System is broken if it needs navigation support then the system doesn't work • Patient may not get their preferred locations due to bed shortage • Not communicating well with kindness and care of need for LTC • Patient and family and patient resistance • Concern re High burden of UTI • Perhaps some patients need antipsychotics are not getting • Higher ability for people to live independently especially in rural areas (day programs, respite) and need for telemedicine and use of resources outside community • Less consistency from one facility to another • Access to acute nursing care • Access to rec/OT in rural • Consistency	with LTC – we are the same community but cause divide when we separate spouse/families when different locations in different places • Global assessment of the service • More support for independent living • Staffing levels adequate • The right providers in the setting to meet the needs of clients • More advocacy for "seniors" • Incorporating other practitioners for support (Example: "Elderly doulas") • Develop a "pathway"/support network for seniors • Strong health maintenance programs (Example: OT) • Very hard to solve this situation (patients not getting their preferred locations due to bed shortages) • More family conferences around need for changes (need for LTC, need for deprescribing) and education to public (Example: transitioning to LTC and stigma of LTC – it can be positive for those not doing well at home) • Education to public about need for availability for quality care • Who: health regions (SHA), private facilities • HC administrators need to ensure HC professionals have the support so staff can do what patients need (care, expertise) • Develop a provincial standard for staffing/service to LTC facilities • Eden Alternative Philosophy – with appropriate education and staffing • Increase staffing – RNs for assessment and coordination, LPNs for medical tasks, CCAs for ADLs

		• More respite beds – decrease caregiver burnout • More homecare services and palliative supports

Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Mental Health

Thinking about the mental health services available in Saskatchewan, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• ECT Program successful • Mental Health programs available • Community Education • Counselling • Acute care needs • Crisis management team • Geriatric psychiatrist • Connect to specific support groups at addiction • Hospital Daycare program • RPN on duty 24/7 in RUH & RGH • Dubé center in Saskatoon • Advocate for our patients • Wonderful mental health staff, who are trained and skilled in mental health • Physch Triage Nurse in the large center ER department • Dubé Center in Saskatoon • Direct admissions to inpatient mental health from community	• Suicide rate education • Emergency department used inappropriately • Involve family throughout care • Post partum depression rates increasing • Navigate and access services • Well being (mental) quality of life • Stigma • Screening process • Where do patients with schizophrenia go when becomes elderly • Patient flow • Need to be able to go straight to mental health rather than wait in ER • Community referrals are really difficult • Availability of different services, not knowing what is available • Lack of timely access to out patient services • Waitlist • Access to group services poor • Ø community supports	• Connect people to services and programs • Information/educate public • Screening at immunization clinics • Communication • Better parent education workshops • Need access to psychiatrists • Need links to provide supports • Crisis management team • Outreach prevention program • Timely access to care • Education • Provide psychiatric nurse assessment in all institutions in order to access Tx in a timely manner • Shared access of patient information provincially • Free access to all services • Increase crisis units, mobile crisis, housing, funding, LTC for mental health

• Improvements have been made to recognize need to increase awareness an mental health	• Coordination of services is poor i.e.: homecare and mental health nurses • Breakdown of communication between services, ER, homecare, mental health in patient • Provision in care for people in crisis • Community liaison i.e.: RCMP • Lack of LTC for mental health patient • People/funnel into ER for care decrease ability for timely assessment • Increase agitation slow triage • Difficulty referring from small centres to larger 'Psych Centers" • Urgent access long • Specialized school programs have been cut • Decrease addiction rehab services • Suicide crisis interventions • Decrease stigma of mental health issues • Mental health units are so full and in demand that patients not ready for discharge to make room acute admissions • Rural communities have Ø info received from last inpatient admissions in urban – need better communication in chart • Lack of psychiatrists • One of lowest funded business lines across Canada • Inpatient psychiatry unit is used as a detox center/homeless centre shelter • Monday-Friday 0800-1700 psychiatrists available in hospital/clinic only • Need early intervention and increase CBT therapy • Street nursing • Medication focus-lack of therapy • Not using all the mental health's ward in the province (ex: Swift Current not always full where as Regina is always full) • Language barriers/communication	• Mental health professionals (RPNs) in places like ER, maternity, ICU, palliative care • Education re: stigma • 811 have a RPN available • More psych nursing seats • Provide Psych assessment in all areas • Dust off Psych Plan Framework • Use technology (RX) Telehealth appointments for psych from rural areas • Improved access to rehab facilities • Improved communication to what resources are available • Education on hot to access resources • Standardize exceptional services across the province • Mental health needs to be addressed as a crisis – marginalized people count too - stigma needs to be addressed • Funding • HIPA makes sharing info among health care team extremely difficult – need to lean back towards mental health act for patient's best interest • Need increase community services addictions/homeless/social worker • SCM to be made provincewide to allow rural health care facilitators from major centres • Med access/one database for all electronic charts to access • ACAL system used by physicians in Sask. – psychiatrists could use but when on certificate only good in the city admitted – this needs to be changed • Mental health emergency centers • Better process regarding involuntary admits • Streamline a process to transfer acute mental health from ER to appropriate acute inpatient unit

	• Mental health clients sitting in emergency • Not enough security available on ward to keep staff/patients safe • Increase demand on community health nurses but Ø support • Not using research appropriately/enough • Lack of resources • Accessibility: RPN's in ER and better transfer protocols • Instances of youth/others committing crimes to get incarcerated to have access to mental health/addictions services • Treatments that do address addictions and mental health together • Intake process – calling a number and speaking to a person which then determines the client's level of urgency. Some people won't call a number – they may be assessed urgent/less urgent – this is not a reliable intake process • Public awareness • 24/7 Services	• Strengthen collaborative addiction/mental health services – have access to services from many points of care ex: the ability to refer to mental health programs from ER/homecare/acute care/primary health clinic/EMS • Increase education re: mental health/addictions for healthcare providers in ER/EMS • Initiate a "Psychiatric response team" for urban ER's – like a code blue team

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café

Theme: Navigating the System

Thinking about entering and/or navigating the healthcare system to receive the appropriate information and/or care, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Navigating the System – colorectal, breast screening programs • Current screening programs • There are a few highly functioning PHC/family practice teams who help people navigate the system • Surgical Care Network – as tool on who to refer to • Nurse Navigators -colon/rectal • Cancer/prostate career • Navigator/nurse navigator • Renal unit – few positions work well • Anticoagulation clinic • Diabetes nurse educators • Once services are initiated, we do well • Accountable care unit – patient advocacy • Preceptors/mentors for nurses are valuable • Good services but poor coordination • PIP discharge med summary	• Having to sign off is a barrier, should be patient driven • Need more screening programs • Need more highly functioning PHC/family practice teams who help people navigate the system • General navigator for system in general • Knowing where to access services • Online resources for services • Limited number of specialized practitioners, SLP, OT, physio and how to access • Education to public regarding what each discipline can do for them, most appropriate care provider • Discharge care, communication transition between areas • Stigma against MH wit ADS patients • Senior care complex, multiple disciplines required	• Patient driven – patient should be able to allow • Navigator to connect to next step • Provide clients with timely access to their results • Expand surgical care network to include internists, cardiologist, endocrinology, etc. • Expand the common referral forms to other specialists e.g.: hip/knee pathway, polled Gynecologist referral, cardiac care centre (Moose Jaw) • Increase public awareness of current "navigators" #811 and #211 • Better integration of public with now public services – companies that offer additional services • Saskatchewan Health Region should be in charge of accurate list of resources, but links

• More standardization with meds • VH viewer (labs, immunizations) • Provide good care once seen – in the system	• Missed care (mobilization, psychological, hydration) • Communication between nursing staff – doctors-patients-families • GP's are gatekeepers – have to refer to specialists serially for complicated patients – no case conference or collaborative care • Dismissive attitudes • Information flow • Culture of only examining current episode care don't consider experience before or after • Multidisciplinary D/C care planning • No navigation support for complex/chronic patients or patients with challenging backgrounds • Inter-hospital transitions • Information lost • Different EMR's being used across the board • We are still repeating our story to every person as you make your way through it • We need standardized approaches ex: palliative care, pain management, comfort care • Communication of what happened to clients in acute care when they return to LTC. Electronic records could improve this • Not every place is doing: PIP discharge med summary, standardization with meds, VH viewer (labs, immunizations) • Lack of services in some areas i.e.: OT services, PT. maternal • Patients need to drive for services (no provincial transit) • Lack of communication between discharge hospital to what to do at home	accessible through city websites, school board websites • Instead of 811, a _11 number for info regarding health care services • Patients are continuously asked the same question, gets frustration • No wrong door • Education to follow nurses on stigma against MH wit ADS patients • Go back to the educational institutions on Senior care complex, multiple disciplines required • Staff, direct patient care more thorough reporting pertinent care • Mentoring new nurses to ensure continuity of patient care • Nurses need to value the patients experience and adapt to patient needs • Effective communication between care providers • Primary multidisciplinary health care clinics solve navigation issues for some patients • Time • Electronic health record – self populating – diagnosis-medications • Using progressive charting where each discipline adds onto the story – maybe we should summarize back to the patient what we understand • Standardized order sets – that can continue into LTC • Electronic records, digital ECG's, X-Rays to be read in real time no matter where you are • Provincial policies and procedures for standard practices • Recruitment? Retention? • Charge process or change communication tool to list indication on drug discharge sheet

	– don't know plan – patient asking local pharmacist what their plan is • Coordination of services • Able to contact right service/provider, etc. • Seen quicker specialist for serious illnesses	so patient knows why on drug disability to reach care providers (doctors) • Centralized system to guide the patient • Test results easily accessible (instead of blood work each time seen for same c/o)

Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Palliative Care

Thinking about the palliative care services available in Saskatchewan, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Only in Sunrise Health Region has 3 Regional Palliative Care Care Coord RNs (with CHPCN(c) credentials) to support nurses, physicians, and all care providers. Follow the patient through system whenever they are LTC hours and home. So all pain symptom/mang review and support • Address bereavement of families & bereavement followup • Family support to keep at home • General Hosp had good access to Palliative Care (quick response) and Pall Care Team in Regina • We acknowledge not only client but family • Focus on whole picture – holistic care • ADL/bedside care • Some facilities have "nicer" private rooms designated to palliative (end of life) for patient and families • Long term care – recognizes early on • Involve multidisciplinary to all be involved	• Pediatric palliative care • Standardize palliative care service • Need early access to palliative care • Clearer definition not only End Stage • More hospice facilities in province • Pain management quidelines • Bottleneck at urban centre, back to rural • Foreign physicians have no to limits education to pain management • No prov education due to funding • Prov access to bereavement resources and support • Not access in rural to teams • Most rural sites are palliative care off set • Education • Lack to pain specialists/doctors • Not all regions have palliative care nurse • Spiritual interference • Lack of palliative care beds and units • Lack of support to keep family at home	• Education for pediatric and Prov Guidelines order set • Prov standardizes – order sets for all physicians • Prov Palliative Coordinator RN • Prov education to all caregivers on all aspects of palliative care • Mandatory education for physicians Can/foreign from palliative care & pain/symptom management • Bereavement coordinators and support on Prov level • Team approach is Prov, not just urban – ensure dispensal of expertise and support • Better access to TeleHealth, to specialists/physio/OT • Have access to pain clinics • Needs to be more focused as a treatment on a whole • Support/education to families/medical staff • More access to alternative support therapy

<table>
<tr>
<td>• Palliative care with more care – family support, pain control
• Access rural area
• Team approach – pharmacy, physician
• A lot of passion in province
• Family based approach in palliative care units
• Pain control – innovations, oil, alternative
•</td>
<td>• Should be recognized as all “systems” palliative (COPD/Cancer, etc.)
• What is the definition of “Palliative Care”? Who does it apply to?
• Support adult patients vs children patients. More support for adult to adult; not adult to sick kids
• Provide more options for palliative care in all settings – community, acute care
• Start discussion/awareness of palliative care early on
• Lack of education, fear of dying process
• Medicalization of care – spiritual, emotional, psychosocial
• Consistent definition of palliative care
• Few beds – not get access; family released before palliative care ends
• Staff support to help family stay at home. More help required at home
• Equitable access
• Rural SK palliative care beds but staff not trained in palliative care
• Not enough integration with other end of life option
• No palliative care strategy access to all available options
•</td>
<td>• More support of I.T. (keep technology/virtual reunions)
• Psychologist access to support patient and family
• Increased education to medical staff and have the appropriate care giver
• More teamwork or team that specifically focuses on palliative care
• Standard specific guidelines province wide
• Education!
• Cultural approaches to individualize palliative care
• Funding to organizations who provide palliative care when patients “deemed” palliative and non-paying
• More resources – hospice or partnership
• Draw plan of ideal palliative care
• Equitable care for all regions based on resources
• Solid infrastructure of legislation to support care
•</td>
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Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Primary Healthcare

Thinking about the primary healthcare services available in Saskatchewan, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Providing Primary Health Care Services; rural areas • What does it mean? • Is it affordable? • Do we have to go to professionals or not registered people? • Do we pay for Primary Healthcare? • Is this be backup system for the hospitals? • Rural area/city • Primary Educators: diabetic education, COPD • Primary Care Advisory Networks – involves community • Telehealth – help connect patients with physicians and resources they can't access where they live • There are some stellar multi-disciplinary PHC teams	• Having more services consistently OT, physio in rural areas • How do we access it? • Who gives permission to see Primary Health? • New to Canada people don't have 100% access from arrival and should be front line users/guests • Why is Dentistry not part of Primary Healthcare? • Is preventative better/cheaper than pay for service Dentistry? • Limited hours • Increase technology access in all locations i.e.: pictures from a NP to MID for diagnosis. HIPA regulations • Clarification around regulations in the province	• Money, politics are barriers • Advocacy • Team Advocation • Who leads this crazy group? What does the title mean? • What is primary about PHC? • We need to advertise who to talk to, even the public advocates can't access easily • Need to increase 24/7 access • Educate people on the right place to access appropriate health services/providers • Sustainability – finding a way to keep providers in smaller areas with adequate coverage (would help decrease the strain on ER's) • We need alternative funding model(s) for nurse practitioners (SK health) • More team building support for family practices

• Immunizations by Public Health • Every dollar spent on children in PH saves $80.00 in health care • Primary Health Care Access – seems to be more services within the region to help with things like chronic diseases, (COPD, Diabetes) • In Rural right track – good inter-collaborative teams started (NPs, Drs., Midwives, Navigators, Pharmacists) • One EMR in our area – promotes people's ability to access information • Some places most appropriate provider sees the clients • Family Practice – shared care with Psychiatric in urban • Mentorship from specialist – "Link Program" to establish a plan of care • Salaried Physicians in Rural promotes team environment	• Patient flow overcapacity – community growth increase need but no increase to accommodate – patients acute – Ø convalescence in acute care setting – strive for positive outcomes • Not enough PHC teams • No funding models to allow NP's to work other than health authority employees • Physicians are asking how an NP can join their practices • There are under employed NP's • Public Health nurse cut backs have eliminated nursing presence and teaching, etc. in schools • Even well baby checks are trimmed to only needles • Lack of quality physicians to provide care • Lack of services in rural • Decrease pain management services • Difficult to access services in P.C people use ER • Some communities in rural have lacking of access to health information • People don't identify with a team • Transient clients who move around the community • Patients prefer to respond to a small team or Dr • The team is spread over the city not in one area • Transportation issues getting to different services • Decrease social services, decrease mental health access in rural • ER physicians in rural not getting support from referral physician • Support for rural physicians in orientation for work	• More openness to varying team composition as fits the community needs • Increase PH $, services, school presence, parenting support, baby checks and ECIP and addressing the determinants of health • Increase the use of NP's in all areas, ER, Clinics, etc. • Primary Care service for Chronic Pain with mentorship • Go to Patient First model • More social workers/mental health • Create "HUB" were teams are • More full scope of practice for providers

World Café

Theme: Patient & Family Inclusion/Education

Thinking about the inclusion and education of the patient and family members regarding patient care (type of care required, delivery, health maintenance, prevention, support/needs/education prior to entering the system, learning needs, etc), from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Family meetings • Discharge meetings • No visiting hours • Patient rounds • Report in room in front of patient • Family-centred care • Pediatrics – good team approach (i.e. rounds) • Good discharge planning (i.e. careplans & safe discharge planning) • Scheduled rounds on Accountable Care Unit • Invalue family & resident in the care • We are more geared towards family-centred care, such as: no restricted visiting hours; pets allowed; family can room in • Do it everyday in the accountable care unit • Lots of community groups acting as advisors • Skype/technology advances	• Staff not wanting family there and asking them to leave • Attitude of past expectations is new expectations (i.e. visiting hours) • Requiring consent from patient to talk to family (i.e. paranoid, no insight) • Patient who do not have capacity – staff should be able to make sure they need a family (i.e. elderly who think, able to make all decisions, and they may have poor memory) • Awareness – need to involve family more • Physician & nurse home visits should be available • Lack of family involvements • Long term care • Education families in palliative/end of life care • Long term care – lack of multidisciplinary care • Patients not having family/social supports	• Manage clear guidelines what is appropriate (when guidelines already there & not respected need reminders from co-workers) • Discussion between management/staff in wall walks • Consent forms should be part of admission bundles or should be able to give info unless patient specifically states otherwise • Third person communication cannot be allowed (such as laboring mom will only allow doula to talk to nurse) • Educate families, patient need encouragement/Dr. need intervene • Translators (women for women only) • Database for discharge planning instructions – educator?

• Expended visiting hours • Identifying family members • Health Line • Tech • Daily rounding at bedside with patient and family • Family inclusion • Consistency/inconsistency across the system – depending on where in system – units have different focuses • The My Voice document province wide distribution • Recent change in visiting/being with family members 24 hours per day rather than just during “set” visiting hours • Family can aid and help with patients care • Nurse educates patient/family – educates public – becomes systemic (continuum of HIC) •	• Educate family being their own advocate • We can’t all access e-health from patient (vital) information • With that, there is a delay in treatment & often repeat test have needed to be done at an increase cost to our health care system • More knowledge of available resources for patients • More engagement needed by family and patients • Patients having access to their own information • Signage and directions aid in patient comfort • Is it working • Standardized resources for patients to look up • Some key members missing • Room for improvement • The time for the conversion • Difficult to be “specialized” as focus of being generalist • Disconnect between patient and family members (family dynamics) • Staff and professionals need to be educated and respective of choices they decide • Different re: restraint policies • Patients and families have no idea what care is like until they need it (i.e. surgery, mental health, long term care) • How to address patient needs around the patient and family if in a pay for service • Increase RN scope of practice – make “house calls” like physicians did year ago • Security for staff/patents in small town health care facilities r/t a risk for violence & harassment • Time/place for patient education • No such thing as over-educating • Google their systems •	• Short staffing needs to be addressed. Two nurses for 60-65 residents. Family education will not be met properly if we are short staffed. • Can we have a patient-nurse ratio for LTC? • Nurses more task-driven rather then sitting with residents and having meaningful conversations because of short staffing • It would be beneficial if patients could have access to their own health information and teaching/education start prior to them coming into the hospital • Invite family to be involved right from the beginning, have them engage in care and give them the resources to feel that their concerns are valid • Continue with patient access to own information • Can it be improved • Home visit use • Appreciate credible current information • My Voice document • Education to all • 24/7 security staff/implement a security stop upon entering the health care facility • Be aware of type of communication and avoid medical jargon; have patient paraphrase information to ensure understanding • Giving a list of evidence-based apps that co-relate with doctor/nurse care, instead of patients coming in with WebMD or apps that are not scientifically supported •

World Café

Theme: Quality Improvement Initiatives

Thinking about the delivery of, and ensuring, safe and compassionate care in Saskatchewan, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Pharmacy – right meds, right time, right patient, right route – good communication and access • Experience charge nurse with knowledge to all charge nurse duties (RN) • Narcotics • Physician • Lots of projects are started; we have good ideas and we recognize the concern • Good working relationship/communication within the daily working groups • Trying to standardize care in each unit/area • New positions for ET nurses •	• Computer – some meds fall off mark • Pre-printed orders – but change in patient condition warrants review • Handover reports – need better and clear, precise patient history and pertinent information to be shared • Patient rounds with whole team • Family physician not notified in timely matter of patient admission • Not accepting change and not committed to the projects • Dissemination gap between RN/managers • Unmanaged staff conflict – need a way of managing conflicts and creating solutions • Immediate access to policy – on units and on Home Care • Standardizing care across the board/province • Gaps in ET RN care •	• Knowledge • Experience • Healthcare professional • Communication paramount • Need to know roles/assignment of patient care • Committee with members who are involved with project and supported by disciples • Commitment to Action, and follow through • Needs planning before implementation • Needs to follow nursing process • Take ownership and workshops on soft skills and critical conversation • Debriefing after critical events • We need to support each other • Mentorship: LD for new nurses; LD new nurses within the unit • Apps, handheld devices, in-services, easy intervention sheets which include key policy points

		• More ET nurses – each area needs an ET RN so that ET RN have a smaller referral area •

Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Quality Healthcare Workplaces

In terms of creating and sustaining quality healthcare workplaces in Saskatchewan, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*

• Support systems in the workplace (i.e. Educators)
• OH&S legislation
  ○ TLR
  ○ WAVE/PART
• Unionized – collective bargaining units followed
• Quality improvement offices
• Initiatives projects (i.e. Med Reconciliation)
• Union support in the workplace
• Open communication between union & management
• In-house education
• Electronic occurrence reporting
• Inter-disciplinary rounds
• Diversity of view points
• Non-threatening, everybody's role is valued
• Have access to supplies
• Trust as a care provider
	• Equal input from workers for problem solving
	• Lack of resources in rural
	  ○ Education, supplies/resources, staffing
	• Communication from Senior level to Front-line
	• Taking ownership of preventative practices for our clients to prevent injury and poor outcomes
	• Not enough representation from Front-line staff on committees
	• Role clarity
	• Follow through of incident reports
	• High staff turnover/senior/junior staff mix
	• Lack of communication/listening by management
	• Retention, recruiting, retention in the workplace
	• Opportunities for education & development
	• Funding for professional development
	• More focus on individual needs of staff
	• More meetings & communication
		• Travelling resource teams to support rural areas
		• Staffing – more access to NPs
		• Equity in resources available to rural/urban staff
		• Regular "Team Huddles" to make issues clear to Senior Level leadership for both immediate issues & long-term issues
		• Provide ownership to changes in workplaces which gives pride in workplace
		• Strategic, clinical networks?
		• Follow evidence based practice
		• Increased communication/information sharing
		• Scope of practice clarity & respect of same
		• Improving & using telehealth
		• Improve legislative framework to improve role clarity
		• Equitability of services (i.e. Respiratory Tech)
		• Allow workplaces to keep savings that they have incurred in the year

• Every position has a role to play and every position is equally important • Have opportunities for meetings to discuss and communicate needs	• Embrace change • Enough staff • More recognition	• Mentorship to identify roles allowing people to see a different side of you

Health Innovation Summit
Inspiring Tomorrow's Healthcare

World Café

Theme: Rural & Remote Access & Services

Thinking about the services available, and access to these services, in rural and remote Saskatchewan communities, including our northern communities, from your perspective.....

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• HC in community is going well • Nurse practitioners in rural locations • Telehealth • Interdisciplinary rounds – scheduled 5X/week in some locations • Team-based approach and work well together • Used to being problem solvers with limited access to resources • More connected with providers • We have free health care • Telehealth	• Lack of services • No physician • Request for NP to HR with no response • Sometimes share physician with other community • Have a LTC facility • Long wait times to family physicians • Integration within physician-based offices for some day appointments • Continuity of care • Delayed review of results; i.e., patient has x-ray/CT/MRI and not read until the next day • Courier system reduced for specimen and blood transport d/t closure of STC • More availability and locations needed • Scheduled in other • Resources - To recruit and retain staff in remote areas	• Hire NP – even if shared with other community • Additional authorized practice for NPs • Lack of services available, or different agencies/locations • Medical courier especially for blood transport • More flexible funding to ensure the right care provider can be employed (N.P. in community – no funding – but funds available for physician) • Access to acute care social workers – bridge between acute care and community services • Ability to consider staffing with multi-community lens. (shared positions between communities to encourage full-time positions and recruit) • Mobile visiting units

	• No relief staff – no guaranteed hours • Budgetary constraints • Mental health transfers – not able to care for acute psychological patients • Lack of some services • Lack of communication; patient, providers, facilities • Lack of access • Seniors and transporting to get access • Duplication of diagnostics • Surgical wait times still long • Increased EMR and PIPP - ? universal Canadian PIPP • Team approaches • Need more education on telehealth	• Telehealth should be everywhere • Home visits by teams • Universal forms and charts across Saskatchewan and Canada • Abolish John Black-Kaizen – waste of time and $$$ • Mayo clinic model • Integrated system ?new health authority • In-house pharmacy for long-term care

Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Social Determinants of Health

Thinking about the services available in Saskatchewan to address the social determinants of health, from your perspective…..

(The social determinants of health include income and social status; social support networks; education; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; gender; and culture)

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• Free K-12 educations • Dealing with crisis situation (24 hr on call crisis services) • Everybody, regardless of sex, race have basic free health care • Universal Health System!++ • Follow-up/through in community Public Health • Programs (free) • Cessation programs available • NP travelling on-site/clinic Reserves • Mental Health Access program • Vaccination(s) • Free health care • MVP • Primary Health Care Centres • Public Health	• Lack of accessibility of education (particularly health) in rural locations • Look at having health education in high school, perhaps by a public health nurse. (They can talk about identifying mental health, healthy sexual habits.) • Rural/Northern mobility access i.e., EMS; STARS; Air Ambulance • Minimum wage • No incentive to work • Cuts in education • Transportation issues – no STC Bus, medical taxis etc., etc. • Consequences – return trips?? • Housing • Access to health care • Seeing appropriate health care providers • Health education in schools	• Use of technology to improve education in rural locations • Having a course to explain basic finances (i.e., how to do taxes) • Needs to be more awareness about how to access services • Implementing E-Health to provide access to health care providers • Increase accessibility to people living below the poverty line • Volunteer services – re: transportation • Government programs in place • Two-way transportation – recourse • Increase numbers of PHC Centres, especially in Northern Communities • Bring back school nurses • Find funding for patients who have these extra expenses

<table>
<tr>
<td>Clearly defined social determinants of health for the educated
Good policies
Immunizations/public health nurses in schools with access to community services
Education
Most people have portable water
Most people have access to food
Human rights generally respected
Services that go out to the clients; i.e., health bus
Food Bank programming; i.e., life skills</td>
<td>Rural patients have to come to Regina or Saskatoon for Chemo, surgeries, etc - $, limited resources
Education for people that don’t have as much formal education
Housing
Poor health literacy
Poor health education for seniors and on-English speaking people
Focus more attention to rural and northern areas
Have a list of community services available for acute care services
Education is not integrated with public health and primary health and social services!
Portable water – many communities don’t
Food – many have inconsistent access to quality nutrition
Human rights – except discrimination against many visible minorities
Need more high functioning primary health teams who go back to the basics of 20% of members’ time is towards community development, programs and determinants of health
Daycare
Integrating services; i.e., diabetes care
Coverage for supplies; i.e., testing
Education and health curriculum
Proactive programs; i.e., foot care, parent mentoring
Access in rural areas
Gap in community services – day care</td>
<td>Upstream thinking
Better access to community services
Better education for seniors and non-English speaking people
Mesh health education with public school education
Communicate successes between agencies, health regions/wards, nurses
Listen to suggestions from front line workers
Take more risks/try new methods
Research based
Put public health nurses back in schools
Resume screening well – baby and child checks during immunization appointments
Put more money in public health and primary health to control and decrease the demands on acute care and care homes
Expand home care and treatment clinic hours and services
High functioning primary health teams – Health Authority direct this, prioritize this and provide resources towards to PHC teams
Team-based options for accessing care
Coverage for supplies
Hubs that monitor school attendance
? technology solutions</td>
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Health Innovation Summit

Inspiring Tomorrow's Healthcare

World Café

Theme: Practitioner Access to Technology

In terms of providing practitioners with access to technology with the goal of providing safe and efficient patient care, from your perspective…..

Successes: What do we do well within the current system?	*Room for Improvement: What gaps do you see?*	*Solutions: What actions/innovations need to be taken, and by whom, to address these gaps?*
• E-Health systems (EMR, PACs) • E-Health • Virtual Pressure Systems	• Health Innovative Officer in Government Interconnected System	