

## In Conversation with Bonnie Brossart

Ken Tremblay



**In** December 2007, Saskatchewan's Health Quality Council announced Bonnie Brossart's ascendency to the helm. Leading the agency that monitors quality of care in that province and a member of its senior team since its inception, Bonnie is no stranger to the dramatic changes shaping healthcare in Canada. Innovative projects like Saskatchewan's Chronic Disease Collaborative, Clinical Practice Redesign (there's a message in calling it CPR) and public education programs about health system quality and performance are gaining traction and recognition. With degrees in economics from Calgary and McMaster and a dossier of ground-breaking research, Bonnie spoke about her new role, mandate and vision for Saskatchewan's residents, providers and policy makers.

**HQ: Congratulations on your appointment. As CEO of the Saskatchewan Health Quality Council, what projects will top your agenda?**

BB: We recently received \$5,000,000 from the Province of Saskatchewan for a four-year initiative called "Accelerating Excellence." This large initiative will move the system from pockets of excellence, when it comes to quality improvement, to a transformed system. With this new funding, the Health Quality Council will lead, support and initiate large-scale quality measurement and improvement activities that will build skills and knowledge from the boardroom right through to front-line staff. The Health Quality Council will use this money to work with health regions and healthcare delivery organizations to facilitate transformative improvement

throughout the system. In the end, it will mean a different way of doing business in healthcare.

**HQ: Many jurisdictions are beginning to focus on chronic disease management as a means to enhance system performance and to support system integration. How do you see your Chronic Disease Collaborative improving care in Saskatchewan?**

BB: The CDM Collaborative has been far and away the largest quality improvement initiative ever undertaken in this province. To date, about 28% of our family physicians are engaged in this initiative, and close to 600 health providers. The collaborative brings together health professionals who are committed to improving quality of care for people living with chronic diseases. The first iterations focused on diabetes and coronary artery disease.

The collaborative brings physicians and allied health professionals together – nurse practitioners, pharmacists, diabetes educators – with new skills and knowledge to implement evidence-based approaches. We've been extremely successful with a web-based disease registry called "The Chronic Disease Management Tool Kit," which allows health providers to know what quality of care looks like for their patients, so they can monitor in a very proactive way their populations of people living with chronic diseases.

**HQ: Your council's website seems to be designed with the needs of the consumer in mind. How can the Internet advance your agenda of disclosure and transparency in healthcare and help drive the performance improvements you want?**

BB: Over the past few years, the Health Quality Council has engaged in a continuous conversation with our health system providers, as well as Saskatchewan residents, about transparency and public reporting. Through public meetings, discussion forums as well as discussion papers on our website, we create opportunities for public reporting on the quality of healthcare. In June 2008, the Health Quality Council hosted a groundbreaking conference on the topic of transparency.

The conference showcased guest speakers who have been the architects of successful reporting programs where transparency facilitated system learning and improvement. Key objectives for us: bring more intelligence to the people who work in the health system and system performance opportunities that public reporting enables. As a public and provincial agency (committed to quality improvement), we need public disclosure about what quality looks like.

In the fall of 2008, we are releasing our first "Annual Report of Quality of Healthcare in Saskatchewan." This will move us from reporting on individual topics within healthcare to ongoing system measurement and reporting. By shifting to ongoing

measurement, people will see whether healthcare is improving or not and identify opportunities for accelerated improvement.

**HQ: Before joining the Quality Council, you were involved in several significant research studies. How did your experiences in health systems research shape your views about the general public's appetite for information about system performance?**

BB: I was interested in the utilization of healthcare services. That work was invaluable to give people in the system a snapshot of what they were doing through the lens of utilization. Through the efforts of the Health Quality Council, that lens has changed from utilization to quality. That's where there is added value: to provide information about quality of healthcare.

This new perspective is not only critical for people who work in the system but also for people who use healthcare. People do question the quality of their healthcare system and ask about value for money; I wonder why the citizen voice isn't louder about a better, safer healthcare system.

**HQ: How has your advanced training in economics shaped your views about the healthcare system and its challenges for the future?**

BB: One of the fundamental principles in health economics is the concept of scarcity. We have a limited set of resources from which to work, and how do we ensure that that limited use of resources is being used in the best possible way? The second concept is that of opportunity cost. When we make a decision to spend in a certain area, what is the opportunity cost or the forgone benefit that will be missed because of that decision?

About 43% of every tax dollar in Saskatchewan is spent on healthcare, and I can't help but wonder: is this the best use of the next available dollar? Could it be better spent somewhere else? The fundamental principles of scarcity and opportunity cost inform and influence the conversations that I have as a leader in the health system.

**HQ: Many tools are beginning to shape care at the bedside: computerized physician order entry systems with embedded clinical pathways, point of care devices, clinical and patient portals, etc. How might these innovations dovetail with your work with clinical process redesign?**

BB: There's no question that tools in information technology are fundamental to improving quality throughout our healthcare system. In the context of clinical practice redesign, the congruence with that initiative is about understanding the system and processes within it. When we deploy a new technology or tool into an existing work environment, its implementation is often challenged because people have not stepped back to understand how their processes work and how these new approaches will affect them.

Clinical practice redesign facilitates people having the skills and knowledge to understand their workflow so that when we deploy a new process or tool, we can do so as smoothly and as efficiently as possible. The key is understanding your system first in order to smoothly integrate tools such as those that you've mentioned.

**HQ: In the past, discussions about quality in healthcare were driven by the professionals with recent trends shifting to the empowered consumer. What have been your biggest surprises about how the quality debate has entered the public domain?**

BB: The debate could be louder. Certainly the citizen's voice is increasingly coming to the fore, but a fair degree of complacency remains. In Saskatchewan, for instance, the Health Quality Council has a mandate to hold a public meeting each year. Honestly, it has been an ongoing challenge to get the bums in the seats. I would like to see more interest or more urgency from the public regarding the quality of care we deliver. Frankly, I'm surprised that we don't hear a louder cry, that safer care is demanded more loudly, given how much we spend on healthcare.

**HQ: So, what messages would you give to the professionals then?**

BB: When you look at the evidence, when you hear about patients' experiences, particularly when it comes to quality, the constant theme is that by being more transparent and informing the public about what quality in healthcare looks like – including opportunities for improvement – it is a richer and more progressive conversation than where that doesn't happen.

Some say that reporting this information will undermine confidence in the healthcare system. I say it's the contrary. Everything I have read and all my conversations with those who have gone down this path say it facilitates a more constructive conversation about quality between those who provide care and those who receive care. Evidence to suggest that we accelerate opportunities for improvement by withholding this information is quite the contrary.

**HQ: Given all the information and experience your council has collected, where do you see the greatest potential gains for quality improvement in healthcare?**

BB: The greatest gains lie with chronic disease populations. From the statistics, evidence from other jurisdictions and listening to people living with chronic disease, particularly multiple chronic diseases, we see a very small population consuming a significant portion of healthcare resources. A recent report claimed that 1% of the population living with multiple complex chronic diseases can consume anywhere between 20 and 30% of the resources. The opportunity for quality improvement is embedded in both cost

avoidance and efficiency gains by looking at that population and asking, "How do we deliver safer, more effective, efficient quality of care for people living with multiple chronic diseases?"

**HQ: And when you ask that question, what's the best policy advice your council can give to a minister of health?**

BB: The principal mandate of the Health Quality Council is not only to measure and report on quality, but to work with our partners to improve the quality of healthcare. That has meant a large variety of quality improvement initiatives. Our partners include the ministry of health. The best policy advice we can give: "You need to examine and address any policies that may be standing as barriers or obstacles to improving quality and patient safety."

We need to look abroad at policies that have facilitated high-performing healthcare systems and determine how we can adapt these policies to our own setting. Again, the conversation really needs to be: what existing policies can inhibit the delivery of quality care? Are there policies that make it difficult for providers to do the right thing? How do we use evidence, generated locally and from afar, to help inform the policy discussion and development?

**HQ: Would you go out on a limb to give us examples of policies that might need attention?**

BB: I would look at the incentives and barriers linked to good performance associated with chronic disease management. For example, does the current fee-for-service model facilitate high quality care? What different methods of funding/reimbursement can deliver higher quality in chronic disease care?

The other area would be around information technology (IT). It befuddles me that in Canada and Saskatchewan we have such a low uptake on electronic medical records and information technology. I would look to the ministries not only as a source of funding but also for policies that facilitate the uptake of IT. Saskatchewan has a chronic disease registry that is invaluable for managing people with chronic diseases. However, it remains optional when it comes to its use. Similarly, our pharmaceutical information program – a very sophisticated and helpful tool that allows practitioners to see all the drugs prescribed to their patients – has a low uptake among users.

These are some of the policy conundrums the ministry faces. We need to be a bit more assertive when it comes to conversations with our health professionals about what is optional and what should be a standard of practice.

When a provider says that they are not interested in adopting a province-wide initiative, we should ask: "So how does that [stance] help your patients? How does that approach assure better quality of care? How will your individual decision impact not only the people you serve but all people in the health system?"

**HQ: Anything else you would like readers of Healthcare Quarterly to know about Bonnie Brossart?**

BB: I'm a new CEO, brand new to the job and mother of three young boys. With this new incredible opportunity, the work/life balance is a constant challenge. But honestly, it's not that onerous because I am privileged to work with fabulous staff, an incredible board of directors and the many people in this province's health system.

I moved to Saskatchewan in 1990 following the advice of Dr. Greg Stoddard, my mentor at McMaster University. When some colleagues teased me about considering Saskatchewan, he predicted that the experience that I would get in five years would far exceed anything in a larger bureaucracy. Working in Saskatchewan has been such a privilege; it is a little province with a big heart and big ideas. The commitment that people share in this province to improve healthcare quality is truly inspiring. Not only is the work of the Health Quality Council exciting, but the opportunity to lead it is too.

**HQ: Thank you.** 

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### The Five Factors

**Age Category:** The age of a patient

**Comorbidity Level:** The number of illnesses a patient has beyond the primary disease or condition that led to admission

**Flagged Interventions:** The kinds of interventions performed to treat a patient

**Intervention Events:** The number of interventions that are performed in a single hospital visit

**Out-of-Hospital Interventions:** The occurrence of interventions that are performed outside the treating/admitting facility