Ministry of Health




Annual Report for 2014-15

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Government of Saskatchewan

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Letters of Transmittal

Honourable Dustin Duncan
Minister of Health

Honourable Greg Ottenbreit
Minister Responsible for
Rural and Remote Health

July 29, 2015

Her Honour, the Honourable Vaughn Solomon Schofield,
Lieutenant Governor of Saskatchewan

May it Please Your Honour:

Our government's health care priorities are based on meeting the needs of patients and their families. Government invested $5 billion in health care in 2014-15, a three per cent increase ($144 million) over 2013-14. These funds were used to improve health care outcomes, support the 'patient first' transformation, and increase our growing population's access to high quality care.

Government is committed to increased accountability, honouring its commitments, and taking responsibility for managing expenditures. Healthcare spending in 2014-15 supported better access to services, improved quality of care, and shorter wait times. Resources were focused in areas which will make the greatest difference in improving the quality of life for Saskatchewan people.

This annual report describes the health system's progress this year in the key areas of primary health care, seniors, mental health and addictions, the Saskatchewan Child and Family Agenda, referrals to specialists and diagnostics, emergency department waits and patient flow, appropriateness/best practice, bending the cost curve, strategic investment in infrastructure, creating a culture of safety, and improving the rural family physician supply.

We respectfully submit the Annual Report of the Ministry of Health for the fiscal year ending March 31st, 2015.

Dustin Duncan

Minister of Health

Greg Ottenbreit

Minister Responsible for
Rural and Remote Health

Government of Saskatchewan

Max Hendricks
Deputy Minister of Health

July 29, 2015

His Honour, the Honourable Dustin Duncan, Minister of Health and His Honour, the Honourable Greg Ottenbreit, Minister Responsible for Rural and Remote Health

May it Please Your Honours:

I have the honour of submitting the Annual Report of the Ministry of Health for the fiscal year ending March 31, 2015.

Saskatchewan is working towards being the best place in Canada to live, work, raise a family, and build a life. The 2014-15 Health Plan helped focus the health system to achieve the best possible health outcomes for communities and the best possible care for patients. It also contributed to a financially sustainable system and helped ensure the professionals working in the system have the tools they need to do their best work. Every page of our 2014-15 Health Plan demonstrated our unwavering commitment to patients and families. This fundamental aspect of our work, coupled with safety and improvement goals, was behind our successes across the province.

In 2014-15, we focused on emergency department waits and improving patient flow. We know emergency departments are often the first stop for those who need treatment outside of regular office hours. Improvement efforts in this area will continue in 2015-16.

Health costs increased in 2014-15, and the Ministry and health regions collaborated on efforts to bend the cost curve. Now, more than ever before, we are using what we've learned through Lean to ensure health care is safe, compassionate, and patient- and family centred. We will continue to seek alternative, cost-saving, and value adding ways of doing our work to ensure the health system is sustainable into the future, while putting the patient first.

As the Deputy Minister of Health, I am responsible for the financial administration and management of the Ministry of Health. As such, I have made every effort to ensure the information and content of the Ministry of Health 2014-15 Annual Report is meaningful, complete, and accurate.

Max Hendricks

Deputy Minister of Health

Government of Saskatchewan

Introduction

This annual report for the Ministry of Health presents the Ministry's results on activities and outcomes for the fiscal year ending March 31, 2015. It reports to the public and elected officials on public commitments made and other key accomplishments of the Ministry.

Results are provided on publicly committed strategies, actions and performance measures identified in the 2014-15 Plan. The report also demonstrates progress made on Government commitments in the *Government Direction for 2014-15: Steady Growth, the Saskatchewan Plan for Growth – Vision 2020 and Beyond*, throne speeches, and other commitments and activities of the Ministry.

The annual report demonstrates the Ministry's commitment to effective public performance reporting, transparency, and accountability to the public. Throughout this report you will see evidence of the Ministry of Health and the health system's commitment to contribute to a better quality of life for all Saskatchewan people, deliver responsive and responsible government, meet the challenges of growth, and sustain growth and opportunities for Saskatchewan people.

Alignment with Government's Direction

The Ministry's activities in 2014-15 align with Government's vision and four goals:

Our Government's Vision

To be the best place in Canada – to live, to work, to start a business, to get an education, to raise a family, and to build a life.

Government's Goals

- Sustaining growth and opportunities for Saskatchewan people.
- Securing a better quality of life for Saskatchewan people.
- Meeting the challenges of growth.
- Delivering responsive and responsible government.

Together, all ministries and agencies support the achievement of Government's four goals.

The Saskatchewan Plan for Growth

Saskatchewan's rate of growth is producing many new opportunities and many new challenges. The Saskatchewan Plan for Growth, released on October 15, 2012, addresses these opportunities and challenges with strategies designed to support Government's vision that our province is the best place in Canada to live, work, start a business, get an education, raise a family, and build a life.

Saskatchewan will meet the challenges of growth, as well as sustain growth and opportunities for Saskatchewan people by:

- Investing in the infrastructure required for growth.
- Educating, training and developing a skilled workforce.
- Ensuring the ongoing competitiveness of Saskatchewan's economy.
- Supporting increased trade, investment, and exports through international engagement.
- Advancing Saskatchewan's natural resource strengths, particularly through innovation, to build the next economy.
- Ensuring fiscal responsibility through balanced budgets, lower debt, and smaller more effective government.

A key result of the Plan for Growth was transformation of the surgical care experience. One year after the Surgical Initiative, Saskatchewan patients now have much better access to surgery. The combined efforts of thousands of health system staff and physicians have transformed the surgical care experience so patients spend less time waiting and are able to recover sooner.

The dramatic reductions in surgical wait times that began during the four-year Saskatchewan Surgical Initiative have continued, with even more patients receiving sooner, safer, smarter surgical care. The number of patients waiting more than three months for surgery is down 89 per cent, with 13,613 fewer patients waiting that long for surgery on March 31, 2015 than in March 2010.

Of the 10 health regions offering surgery, seven had zero patients waiting longer than three months for surgery as of March 31, 2015.

Regina Qu'Appelle Health Region made big gains in 2014-15 and reduced the number of its patients waiting more than three months to 443 (down from 2,314 a year ago). Prince Albert Parkland Health Region had just 20. Saskatoon Health Region experienced a surge in demand for surgeries during 2014-15, but was still able to reduce its number of patients waiting more than three months to 1,215 (down slightly from 1,469 in March 2014, but an 84 per cent reduction from the more than 7,719 patients waiting that long in 2010). Saskatoon provided 39,348 surgeries in 2014-15, nearly 2,000 more than the previous year and close to half of the 89,420 surgeries provided by Saskatchewan's health system.

For the period January 1 to March 31, 2015, 89.2 per cent of Saskatchewan surgical patients received surgery or an offer of surgery within three months, up from 80.8 per cent during the same period a year ago. Monthly wait time updates for each health region are posted on www.sasksurgery.ca.

Many improvement projects that began under the Surgical Initiative are continuing:

- An online Specialist Directory helps patients identify surgical options. The number of visitors using the page has increased steadily, with over 4800 unique visits per month in 2014-15.
- The number of specialist groups who pool referrals continues to grow, allowing patients the option to see the first appropriate specialist, or wait for a specific specialist;
- Timely and appropriate care through clinical pathways continues, with work underway on acute stroke care and lower-extremity wounds;
- A focus on reducing the use of MRIs for lower back pain except when symptoms indicate that an MRI exam is appropriate; and,
- Expanded capacity through third-party surgical and diagnostic services.

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Ministry Overview

The Ministry strives to improve the quality and accessibility of publicly-funded and publicly-administered health care in Saskatchewan. Through leadership and partnership, Saskatchewan Health is dedicated to achieving a responsive, integrated, and efficient health system that puts the patient first, and enables people to achieve their best possible health by promoting healthy choices and responsible self-care.

We strive to explore innovative approaches and set bold targets for the health system in four areas: better health, better care, better value, and better teams. Our system-wide focus on Lean puts the needs and values of patients and families at the forefront of both our planning and the delivery of care.

The strategic work of the Ministry detailed in this report is organized into four areas called *the Betters* in the 2014-15 Health Plan. Each of the "betters" as well as the health system's vision, mission, and values are reflected in figure 1 below. *The Betters* are:

Better Health - Improve population health through health promotion, protection, and disease management/prevention, and collaborating with communities and other provincial and federal government organizations to close the health disparity gap.

Better Care - In partnership with patients and families, improve the individual's experience, achieve timely access, and continuously improve healthcare safety.

Figure 1: Health System Strategic Direction

Government of Saskatchewan

Better Value - Achieve best value for money, improve transparency and accountability, and strategically invest in facilities, equipment and information infrastructure.

Better Teams - Build safe, supportive workplaces where providers are focused on patient- and family-centred care and collaborative practices, and develop a highly skilled, professional, and diverse workforce that has a sufficient number and mix of service providers.

Ministry activities include:

- Providing leadership on strategic policy;
- Setting goals and objectives for the provision of health services;
- Allocating funding and leading financial planning for the health system;
- Providing provincial oversight for programs and services, including acute and emergency care, community services, and long term care;
- Monitoring and enforcing standards in privately delivered programs such as personal care homes;
- Administering public health insurance programs such as the Saskatchewan Medical Care Insurance Plan;
- Providing eligible residents with prescription drug plan benefits and extended health benefits, including:
    - Supplementary Health, Family Health Benefits, and Saskatchewan Aids to Independent Living (SAIL).
    - Providing communicable disease surveillance, prevention, and control through the Saskatchewan Disease Control Laboratory and Population Health Branch to identify, respond to, and prevent illness and disease in our province.
    - Providing leadership on health human resource issues.
    - Leadership on and responsibility for approximately 50 different pieces of legislation. (See Appendix IV on page 64).

The health care system in Saskatchewan is multi-faceted and complex. There are 26 self-regulated health professions in the province and the health system as a whole employs more than 42,000 people who provide a broad range of services. The Ministry oversees a health care system that includes 12 health regions, the Saskatchewan Cancer Agency, the Athabasca Health Authority, affiliated health care organizations, and a diverse group of professionals, many of whom are in private practice. It also provides governance training, including effective strategic oversight, for the Boards of Directors of health regions and the Saskatchewan Cancer Agency.

The Ministry assists health regions, the Saskatchewan Cancer Agency, and other stakeholders to recruit and retain health care providers, including nurses and physicians. The Ministry also works in partnership with organizations at local, regional, provincial, national, and international levels to provide Saskatchewan residents with access to quality health care.

The Ministry supports the *Saskatchewan Plan for Growth* and is helping to ensure an estimated 1.2 million provincial residents in the year 2020 enjoy a better quality of life by:

- Undertaking continuous quality improvements in the delivery of programs and services through the use of Lean and other methods and tools.
- Managing a multi-year program review as part of an ongoing process to ensure the programs and services delivered by government are being delivered as efficiently and effectively as possible, as well as being aligned to government's priorities.
- Requiring third parties that receive significant provincial funding such as health regions, to demonstrate financial efficiencies through, for example, joint supply purchasing, shared services, and Lean initiatives.
- Increased funding of $107.5 million to regional health authorities in 2014-15 includes $24 million to address the increased usage of health care services because of Saskatchewan's growing population. (Saskatchewan Plan for Growth)

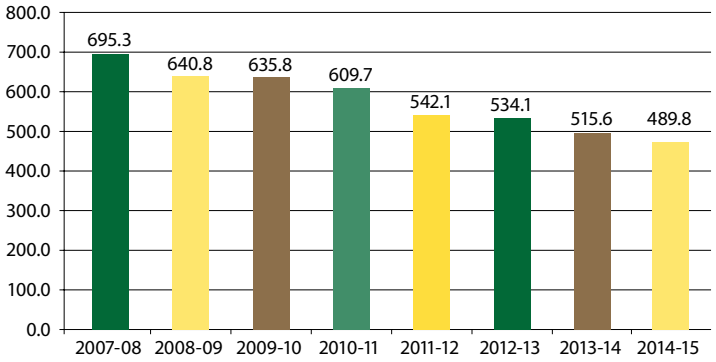
In Canada, the federal and provincial governments both play a role in the provision of health care. The federal government provides funding to support health through the Canada Health Transfer. The federal government also provides health services to certain segments of the population (e.g. veterans, military personnel, and First Nations people living on reserve). Provincial governments are responsible for most other aspects of health care delivery.

Ministry of Health Employees

In the 2010-11 Budget, the Government of Saskatchewan announced a plan to reduce the size of the public service by 15 per cent. (Saskatchewan Plan for Growth) To date across government, more than 1,900 positions have been eliminated or identified or elimination, resulting in cumulative annual savings of more than $198 million over the four year period, and allowing government to redirect savings to address new service demands in priority areas.

As shown in figure 2, the Ministry of Health has reduced the total number of full-time employees or equivalents (FTEs) over the last eight years. The variance is primarily the result of vacancy management.

Figure 2: Ministry of Health Full Time Equivalents 2007-08 to Present



The Public Interest Disclosure Act

The Government of Saskatchewan and the Ministry of Health are committed to accountability, trust, and protecting the public interest as well as maintaining high standards of professional values and ethics in the Public Service.

The *Public Interest Disclosure Act* was proclaimed in 2011 to support these commitments. The Act helps to maintain the integrity of government and the Public Service, and supports accountability and fairness. The Act also sets up a structure under which public servants can report allegations of wrongdoing within the Public Service and protects those who make reports.

Progress in 2014-15 on Ministry obligations under *The Public Interest Disclosure Act* (PIDA):

- The Ministry has designated Tracey L. Smith, Assistant Deputy Minister of Health as the Public Interest Disclosure Officer.
- The Ministry has established procedures for its employees on who to approach and how to report or disclose a wrongdoing. These processes are outlined on our Ministry Intranet including the Employee Fact Sheet, the Disclosure of Wrongdoing Form, and a Complaint of Reprisal Form.
- The Ministry's Disclosure Officer communicated to all Ministry staff via email. This communication provided information about PIDA and a link to the Ministry's intranet site to access additional information and forms.
- The Ministry did not receive any disclosures in 2014-15.

Progress in 2014-15

Better Health

Primary Health Care

Primary Health Care (PHC) has often been described as the "everyday care" a person needs to protect, maintain or restore health. It is often a person's first point of contact with the health system and involves providing services, through teams of health professionals, to individuals, families, and communities. It also involves a proactive approach to preventing health problems while ensuring better management and follow-up once a health problem has occurred.

The vision for PHC in Saskatchewan is that PHC is sustainable, offers a superior patient experience, and results in an exceptionally healthy Saskatchewan population. Strengthening PHC is a key priority for our health system leaders and providers, and the framework *"Patient Centred, Community Designed, Team Delivered: A Framework for Achieving a High Performing Primary Health Care System in Saskatchewan"* released in May 2012 is guiding this work.

All primary health care teams include, or are supported by, a family physician. This team-based approach ensures patients receive the primary health care they need, when they need it, particularly in rural areas where recruitment and retention of family physicians is a challenge. Improved access to PHC and the provision of care consistent with best practice guidelines will result in better health for people living with chronic conditions, fewer visits to emergency departments, and fewer hospitalizations.

The 2014-15 Budget provided $13.15 million (an increase of $3.4 million compared to 2013-14) for the operation of five Collaborative Emergency Centres, as well as to enhance primary health care sites. In 2014-15, efforts were focused on expanding new models of care to improve access, as well as chronic disease prevention and management. By the end of the fiscal year, eight innovation sites, announced in 2012, were fully implemented and using new models of team-based care focused on:

- Increasing patient case management i.e. Registered Nurse Case Manager roles and using proven methods to create continuity for both patients and providers;
- Integrating mental health and addictions services into PHC settings (i.e. PHC Counsellors, screening tools);
- Expanding hours of service to better meet community needs;
- Linking with First Nations health delivery systems;
- Implementing new chronic disease management approaches (i.e. shared medical visits); and,
- Connecting patients who present in emergency departments to a PHC provider (known as unattached patients).

Four new PHC teams (two of these are still in development) were established in 2014-15 to enhance "closer-to-home" access to PHC services within patients' communities. These four new PHC teams and the eight innovation sites are part of a network of 95 PHC teams throughout the province. New Collaborative Emergency Centres (CECs) were implemented, tools to promote adoption of best practice guidelines for chronic conditions were developed, and support was provided to two regions to develop "Connecting to Care" hotspotting pilots to better support individuals with complex health care needs. A number of health promotion and disease prevention initiatives were also supported in 2014-15.

For more information on primary health care in Saskatchewan, visit the Ministry of Health website at: https://www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/primary-health-care.

Results

Implement Collaborative Emergency Centres (CECs) in Spiritwood, Wakaw, and Canora.

- The Canora Collaborative Emergency Centre (CEC) was launched in July 2014; the province now has three fully implemented CECs (Maidstone, Shaunovan and Canora). Two more CECs (Spiritwood and Wakaw) are in development using a phased-in approach. As of May 2014, Wakaw began offering extended access to PHC services and in September 2014, urgent/emergent care until midnight daily was re-established outside of PHC

clinic hours. In Spiritwood, a plan was finalized in 2014-15 to support CEC implementation in 2015-16. Results from the first three CECs have been positive – over 1,437 people were helped by the end of March 2015; the majority of these individuals (78 per cent) were treated in the community, rather than being transferred to another hospital. Service disruptions were common in these sites prior to implementation of CECs; there were no service disruptions in the communities where CECs have been fully implemented in 2014-15.

Identify best practice guidelines for two more chronic conditions (heart failure and chronic obstructive pulmonary disease) as well as develop and deploy tools (flow sheets, how-to guides) to support implementation.

Under the Chronic Disease Management-Quality Improvement Program (CDM-QIP), best practice guidelines for Chronic Obstructive Pulmonary Disease (COPD) and heart failure, as well as indicators for both chronic conditions, have been identified. Paper and electronic medical record (EMR) versions of standardized, evidence-based flow sheets have been developed. These flow sheets assist physicians in using current best practice guidelines to provide optimal care. They allow physicians to track the treatment and management of a patient's chronic condition. The paper version of the heart failure and chronic obstructive pulmonary disease (COPD) flow sheets are available, and the EMR versions will be available by July 2015. Work has continued to deploy/support adoption of previously launched flow sheets for diabetes and coronary artery disease. (See the related work towards 2020 goals on page 11.)

Pilot a "hotspotting" program that will help connect high-risk, high-use patients, who are repeatedly hospitalized and not well served by the current system, with alternative and more customized/personalized services.

The health system struggles to meet the needs of patients with complex and varied issues – sometimes related to mental health. These patients are frequently hospitalized and repeatedly seek services in the emergency department.

One per cent of hospital patients account for 21 per cent of all hospital costs in the province. This does not serve the best interests of these patients, nor is it an effective use of resources.

In 2014-15, the planning and launch of two Hotspotting pilots, each assisting approximately 30 targeted patients with needs that can be better met in the community rather than the hospital environment. $1.5 million was budgeted to support two 12-month 'Connecting to Care' Hotspotting Initiative pilots – one in both Saskatoon and Regina. The Regina pilot launched in January 2015 and the Saskatoon pilot began at fiscal year-end.

Pilot care teams are developing targeted, high-impact supports to better meet patients' needs. The result is less reliance on the emergency department for care. Examples include providing better co-ordinated, customized, and more holistic care from teams of health providers.

Emerging patient stories from the Regina pilot revealed gaps that are being addressed, including connection to community-based services, navigation to appropriate services and more holistic care, resulting in avoidance of emergency department visits, and the prevention of hospitalizations.

Additional Primary Health Care Enhancements in 2014-15

Improve population health through health promotion, protection and disease prevention, and collaborating with communities and different government organizations to close the health disparity gap.

Smoker's Helpline

In 2014-15, the province provided additional financial support to the Canadian Cancer Society – Saskatchewan Division to fund interpretation services, including Cree and Dene, through Smoker's Helpline.

Prevention of Smoking by Youth

In January 2014 an innovative classroom-based information program called View and Vote gave students in grades 6-12 an opportunity to view 12 of the best international anti-tobacco television ads. Teachers guided students as

they watched the ads and encouraged them to engage in discussion about the effects of tobacco use and to think critically about many different aspects of tobacco use. Students then voted for the ad they felt would keep them from starting to use tobacco or, if they already use tobacco, the ad that made them think about quitting. The ad voted most effective was Terrie's Tips. It was shown in movie theatres and available online throughout Saskatchewan during June 2014.

Comprehensive School Community Health Framework

Cross-Ministry work by the Ministries of Education and Health resulted in the creation and adoption of the *Comprehensive School Community Health Framework* (CSCH) to guide and coordinate government actions in support of student learning and well-being. The CSCH framework was updated in 2014 with the importance of engaging family, a focus on First Nations and Metis perspectives, and the significance of policy and procedures in creating safe and healthy learning environments.

Poverty Reduction

The Ministry is part of a cross-Ministry Advisory Group for Poverty Reduction. The group has been meeting, consulting with community groups, and planning a round table discussion in order to get the feedback required to put forth recommendations in 2015-16.

Performance Measures

By March 31, 2017, people living with chronic conditions will experience better health as indicated by a 30 per cent decrease in hospital utilization related to six common chronic conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, depression, heart failure, and asthma).

Progress toward the 2017 target is being made and is measured against a baseline of 173 hospitalizations per 100,000 population aged less than 75 years of age. A 30 percent reduction by 2017 would be a rate of 121 hospitalizations per 100,000 population.

At the end of March 2014 (the last quarter for which data is available at this time) this measure indicated 158 hospitalizations/100,000 population aged less than 75 years – this represents a reduction of 9 per cent (i.e. 15 hospitalizations/100,000) compared to baseline. This reduction is attributable to progress on all six chronic conditions, especially mood disorders, asthma, and coronary artery disease.

While this reduction shows significant progress, it was short of the goal for an 11.4 per cent decrease by March 2014 supporting the 2017 target. To better support progress towards the target, the Ministry and its partners are enhancing engagement efforts and supports for health provider utilization of best practice tools for chronic disease management.

By March 31, 2017, there will be a 50 per cent improvement in the number of people who say, "I can access my Primary Health Care Team for care on my day of choice either in person, on the phone or via other technology."

The baseline (established in 2013-14) is a positive response from 85.2 per cent of respondents. A 50 per cent improvement by 2017 would equate to a response rate of 92.6 per cent positive responses.

At the end of February 2015 (the last month where complete data is available) 89 per cent of people surveyed reported they received an appointment on their day of choice. Compared to the baseline, progress in 2014-15 equates to a 25.68 per cent improvement – on track to achieving the 2017 target. To better support progress toward this target, the Ministry and partners are working to enhance patient experience surveying and to increase access to primary healthcare services.

Note: The value of this measure is limited. Because this survey is only administered to patients once they are at their provider's clinic, it reflects data for people who have successfully booked an appointment. It does not provide a way to measure patients' experience trying to access care if they do not have a provider, or if they have not been able to book an appointment with their provider of choice.

A new patient experience survey was implemented in 2013 and has been introduced to an increasing number of clinics. In 2014-15, more work will occur to expand the use of this clinic-based survey, such as potentially implementing a province-wide phone-survey to learn from a sample of patients across Saskatchewan, to understand if their experience accessing care differs from those patients surveyed once in their providers' practices.

By March 31, 2020, 80 per cent of patients with six common chronic conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, heart failure, depression, and asthma) are receiving best practice care as evidenced by the completion of provincial flow sheets available through approved electronic medical records (EMR) and the EMR viewer.

As of March 31, 2015, 594 general practitioners and 95 nurse practitioners (115 per cent of target) were enrolled in the program and were using the CDM-QIP optimal care flow sheets to help provide care to 25,174 Saskatchewan residents (125 per cent of target) living with a chronic condition: 17,958 patients with diabetes; 4,024 patients with coronary artery disease (CAD); and 3,192 patients with both diabetes and CAD.

Efforts continued to encourage providers to use best practice flow sheets developed by the CDM-QIP (Chronic Disease Management – Quality Improvement Program) for diabetes and coronary artery disease. Standardized, evidence-based flow sheets in both paper and electronic medical record (EMR) versions have been developed. These flow sheets are tools that assist physicians in using current best practice guidelines to provide optimal care. They allow physicians to track the treatment and management of a patient's chronic condition. The paper version of the heart failure and chronic obstructive pulmonary disease (COPD) flow sheets are available, and the EMR versions will be available by the end of 2015.

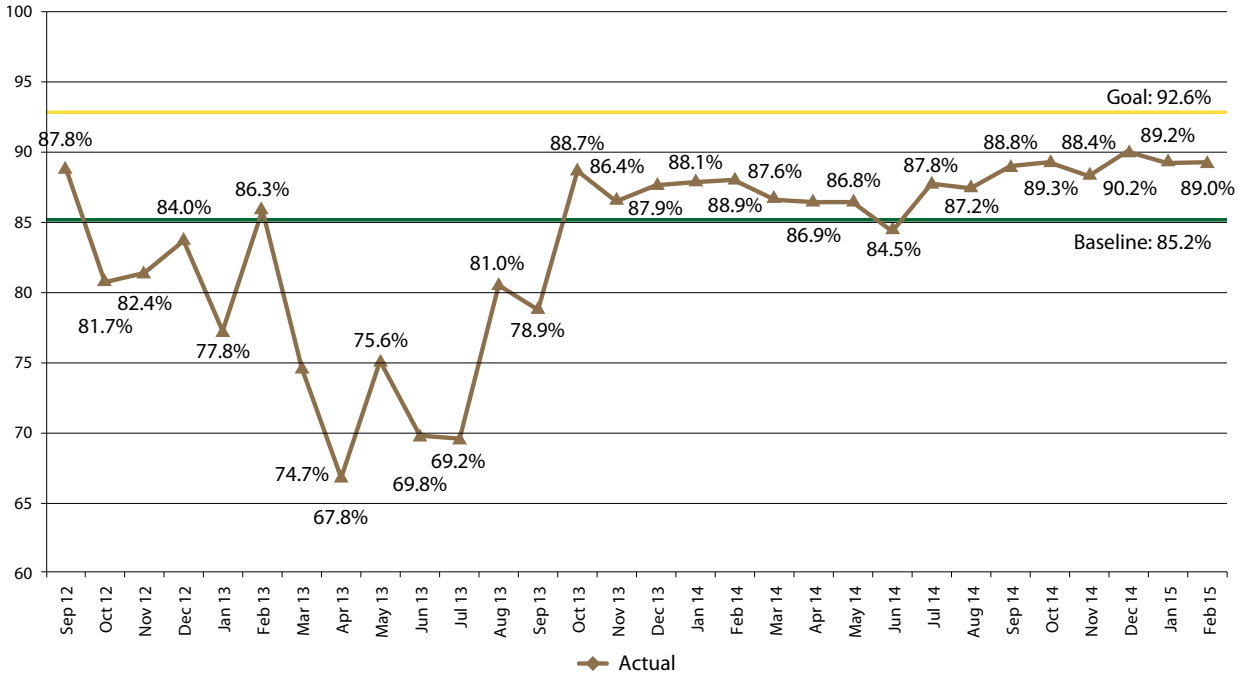


Figure 3: The percentage of patients who responded "yes, they were able to get an appointment on their day of choice."

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Percentage of Saskatchewan residents who are connected to a family physician or primary health care team as their usual provider of care.

The usual provider continuity (UPC) index, measures a patient's level of attachment to their most common provider, assumed to be the regular provider of PHC, within a given timeframe. See figure 4.

Increasing the UPC index is an indicator of success. This measure has increased from 68.7 per cent in 2010-11 to 69.6 per cent 2014-15. UPC index increases were seen in every region and for every chronic condition in 2014-15.

This change can be attributed to the following limitation: Providers have six months after the patient's date of service to submit their claims to Medical Services Branch (MSB) for processing and/or payment. In order to provide the most current information on patient connectedness, the latest available Medical Services Branch Billing Claims data are used in the analysis. This may result in an underestimation of current service reporting for the most recent two quarters (6 months). As new claims data are submitted, results for past quarters may change in future reports as providers complete their claims submissions.

Figure 4: Usual Provider Continuity Index for Saskatchewan patients.

Fiscal Year	Percentage of Saskatchewan residents who are connected to a family physician or primary health care team as their usual provider of care.
2014-15	69.6
2013-14	69.5
2012-13	69.4
2011-12	68.4
2010-11	68.7

Percentage of emergency department visits that are scored as Level 4 or 5 on the Canadian Triage Acuity Scale (CTAS).

One goal of primary health care is to increase access to primary health care without increasing pressure on emergency departments. A significant number of CTAS 4 and 5 patients (with less urgent and non-urgent concerns) represent patients who may have been safely managed in a primary care option that did not require ED visits. (Find more information about CTAS scores including the criteria for each level and related actions on page 28.)

The higher the percentage of patients visiting emergency department as CTAS 4 and 5 the more emergency department resources are utilized to provide care.

As primary care investments such as increased numbers of primary providers available to provide services for previously unattached patients, extended hour access to existing family providers, and urgent care after hour facilities expand, the number of CTAS 4 and 5 patients visiting the emergency department should go down.

From July 2011 to August 2014 (the last month for which complete data was available), this measure shows between 46.5 -51 per cent of hospital visits in Regina, Saskatoon, and Prince Albert (added only after April 2014) have been CTAS 4 or 5.

Seniors

The growing population of senior citizens and their families have a desire to see a shift away from institutional care to more community-based supports that will allow them to live in their homes for as long as possible. With better supports in place for seniors, we expect to see improved health status and a reduced need for emergency department visits, admission to hospital, long-term care, and/or personal care homes. As we strive to enhance community support, improving the quality of long-term care is Saskatchewan is also a priority.

Strengthening the collaborative services for seniors with primary health care will also improve the effective management of chronic diseases in the senior population.

Results

Complete year two of the Home First/Quick Response Home Care pilot projects.

$4.5 million was provided for the HomeFirst/Quick Response Homecare program, an increase of $2.5 million over last year. At the close of year two, Saskatoon, Prince Albert Parkland, Regina Qu'Appelle, and Prairie North health regions have all implemented Home First/Quick Response Home Care projects and have seen success in keeping individuals at home longer.

Undertake an evaluation (including mid-pilot report) of the Home First/Quick Response Home Care pilot projects.

The Ministry received the final evaluation information from the Regina Qu'Appelle Health Region regarding their Home First/Quick Response Home Care pilot. The region's targets of five per cent increases in both home care clients and units of service were met.

Quality improvements in long-term care include:

In Spring 2014, Regional Health Authority CEOs completed the second annual tour of long-term care facilities to identify and review the progress made with addressing care issues.

The Long-Term Care Urgent Issues Action Fund of $10.04M was directed toward the most urgent issues in long-term care. An additional $3.76M was provided for ongoing pressures. Heath regions used the funds for new equipment, staff training, enhanced recreational programming, and improving the quality of care in long-term care facilities.

The Ministry of Health distributes an annual quality of care survey to the Resident and Family Councils in each long-term care facility. Resident and Family Councils provide an opportunity to bring concerns forward and to receive feedback about the actions taken to address concerns. The survey is one way to provide feedback to the Ministry of Health and the Minister regarding what is working well, what is not working well, and provide suggestions for improvement.

In order to further improve resident care, a target was set to spread Lean in long-term care, aimed at identifying efficiencies that maximize staff time spent on direct resident care.

The Ministry of Health is monitoring quality indicators in long-term care and has implemented a process which identifies facilities that are above the national average, in terms of seven key quality indicators. The Ministry asked health regions to submit improvement plans for those long-term care facilities that were outside the norm. The improvements plans were reviewed and responded to by the Ministry of Health. Monitoring of quality indicators in long-term care were as follows:

- The 2014-15 target for residents in daily physical restraints was to achieve the Canadian Institute for Health Information CIHI reported national average of 11.1 per cent and at the end of 2014-15 Saskatchewan was at 12.3 per cent. CIHI produces timely, relevant data that Canadian decision-makers can use to help inform their decisions
- The 2014-15 target for taking antipsychotics without a diagnosis of psychosis was the CIHI reported national average of 30.8 per cent and at the end of 2014-15 Saskatchewan was 30.5 per cent.
- The 2014-15 target for falls among long-term care residents was to achieve the CIHI reported national

average of 13.3 per cent and at the end of 2014-15 Saskatchewan was at 9.2 per cent.

- The 2014-15 target for pain worsening was the CIHI reported national average of 10.9 per cent and at the end of 2014-15 Saskatchewan was at 10.5 per cent.
- The 2014-15 target for bladder continence worsening was the CIHI reported national average of 18.8 per cent and at the end of 2014-15 Saskatchewan was at 17.5 per cent.
- The 2014-15 target for stage 2 to 4 pressure ulcers worsening was to achieve the CIHI reported national average of 2.9 per cent and at the end of 2014-15 Saskatchewan was at 1.9 per cent.
- The 2014-15 target for newly occurring pressure ulcers was to achieve the CIHI reported national average of 2.7 per cent and at the end of 2014-15 Saskatchewan was at 1.8 per cent.

Exploring the development of benchmark targets for long-term care quality indicators.

Benchmark targets have been established to determine areas for quality improvement efforts in long-term care. Targets were set against the 2014-15 national averages for these two areas, and will be based on provincial trend analyses over the next three years (until 2017-18).

- The 2015-16 target for residents in daily physical restraints will be 10.73 per cent and the target for antipsychotics usage without a diagnosis of psychosis will be 29.00 per cent.

Performance Measures

By March 31, 2020, seniors who require community support can remain at home as long as possible, enabling them to safely progress into other care options as needs change.

The 2014-15 Budget provided $800,000 to develop a new Seniors' House Calls program for seniors with complex issues. A pilot "seniors' house calls" program has been developed for the Saskatoon and Regina-Qu'Appelle Health Regions. The program will support some senior citizens with complex issues with a mobile team including physicians, nurse practitioners, and other health care providers, by providing home-based visits and other health services in their homes.

These targets will guide improvement work to the end of 2015-16. Given programming started in March 2015, program evaluation and reporting on the below measures will occur starting in the last half of the fiscal year 2015-16.

- Decreased number of emergency department visits by 50 per cent over baseline (prior year usage) for the cohort group.
- Decreased rate of hospital admissions by 50 per cent over baseline for the cohort group.
- Decreased rate of readmissions by 50 per cent over baseline for the cohort group.
- Administer qualitative client, family and provider surveys related to service provision and satisfaction with services.

By March 31, 2017, the number of clients with a Method of Assigning Priority Levels (MAPLe) score of three to five living in the community supported by home care will increase by two per cent.

Components of the Home First/Quick Response Home Care pilot projects targeted enhancing and improving home care for intensive short term needs to sustain seniors in their homes; facilitate appropriate discharge from acute care to the community; prevent unnecessary admissions to emergency rooms; and engage service providers in the system to support seniors in their own homes.

Evidence from other jurisdictions indicates the model can help reduce the demand on long-term care beds, improve access and flow by reducing the number of patients in acute care beds, and decrease the number of seniors presenting to the emergency departments.

The MAPLe score is an indicator of the level of care required by a home care client and is used to classify clients into five priority-level groups, yielding a score from 1 to 5. Typically people with a high priority level (i.e. higher score) have a higher relative need for care and risk of adverse outcomes.

If community supports are in place, such as those provided by the Home First/Quick Response Home Care pilot projects, it is

likely individuals with higher MAPLe scores can remain in the community rather than being admitted to long-term care.

- The MAPLe score increased 4.8 per cent from 2013-14 Q4 to 2014-15 Q4. Progress of development and implementation for establishing provincial standards for MAPLe data definitions, collection, and reporting.
- Provincial standards for the MAPLe were confirmed. The data is regularly monitored and reported on.

By March 31, 2015, increase home care utilization and clients in the three pilot health regions by five per cent; and by March 31, 2015, increase home care utilization and clients in the three Home First/Quick Response Home Care pilot regions by five per cent.

- Percentage of acute care beds occupied by individuals assessed for long-term care who are awaiting placement.
    - The provincial average of acute care beds occupied by individuals assessed for long-term care who are awaiting placement was 4.3 per cent in March 2015 (which is above the target of 3.5 per cent). However, this will be impacted in future years by the work being undertaken in the areas of emergency department waits and patient flow. Find more information about emergency department waits and patient flow on page 25 of this report.
- Number of Home Care Clients
    - As of March 31, 2015, the Regina, Saskatoon, and Prince Albert Health Regions reported meeting the target of a 5 per cent increase in the number of home care clients and a 5 per cent increase in the number of units of service to home care clients.

Additional Supports for Seniors in 2014-15

Personal Care Home Inspections

In January 2014, the Ministry of Health procured a single software solution to automate personal care home inspections and reporting. The new system enables inspectors to perform inspections on electronic handheld devices (i.e. tablets) while providing greatly expanded capabilities in terms of data collection, analysis, reporting, and public disclosure. Work proceeded on the new data management system early in 2014.

The new system:

- Allows inspectors to enter inspection information directly into a tablet as it is collected, replacing the 'pen and paper' system and eliminating the need for manual data entry from paper forms after the fact, saving significant time and reducing errors.
- Enables a more efficient mechanism for tracking personal care home inspections, findings, and public reporting.

Ombudsman Saskatchewan

In November 2014, the Minister of Health requested the Saskatchewan Ombudsman to conduct an investigation into care at the Santa Maria Senior Citizens Home. The Minister asked that the circumstances surrounding the care of Mrs. Margaret Warholm while she was a resident at Santa Maria Senior Citizens Home be investigated. The Ombudsman notified Santa Maria, the Regina Qu'Appelle Health Region, and the Ministry of Health of the intention to conduct an independent investigation.

The Ombudsman released her findings in May 2015. Minister Dustin Duncan reinforced government's commitment to placing the needs of long-term care residents first, accepting the Saskatchewan's Ombudsman's report, and committing to begin work immediately to address the recommendations.

Four recommendations were focused more broadly on improvements to the long-term care system in Saskatchewan. The Ministry of Health has begun work with health system partners to:

- Ensure all health regions develop and implement policies and procedures to operationalize the standards of care in the *Program Guidelines for Special-Care Homes*, and identify specific, measurable indicators or outcomes that will be tracked and reported;
- Implement a process to publicly report on how long-term care facilities are meeting the standards in the Program Guidelines;

- Set out detailed steps for handling of concerns and the appeal process within the Program Guidelines; and,
- Develop and implement a long-term care strategy to meet the needs of long-term care residents and to address the factors affecting the quality of long-term care in Saskatchewan.

The government has also taken steps to address concerns at Santa Maria, including establishing a quality oversight committee focused on ensuring residents at Santa Maria are provided with safe, high quality care. The Quality Oversight Committee will continue to play a role at Santa Maria moving forward.

Mental Health and Addictions

Mental health is a Government priority and it is committed to improving the response to the needs of individuals with mental health and addictions issues. Addressing mental health and addictions issues across many service sectors is complex, and will require the efforts of many Ministries and organizations collaborating together.

Work is underway in the provincial health system to reduce wait times for outpatient mental health and addictions services. Work also continues in the area of suicide prevention, with the spread of newly developed protocols for healthcare providers to ensure there is consistent practice for the assessment and management of persons at risk of suicide in mental health and addiction services. In 2014-15 the health regions and Ministry used tools from the Lean Management System and best practices to reduce wait times and work together to implement a suicide prevention protocol plan in other parts of the health system.

Results

Health regions, in cooperation with the Ministry, will:

Develop and implement strategies to ensure triage benchmark targets for outpatient mental health and addictions services are met [monthly data regarding wait times for outpatient mental health and addiction services. Monitor all triage levels (one to four)].

In preparation to develop and implement strategies, mental health and addiction outpatient wait times for all triage levels have been monitored and reported on throughout 2014-15.

Monitor 30 day re-admission rates and develop strategies to reduce the number of individuals re-admitted within 30 days. Monitor the number of individuals with long stays on inpatient psychiatry and develop strategies to reduce the number.

These rates were monitored and reporting processes have been established for individuals readmitted within 30 days as well as for the number of individuals with long stays on inpatient psychiatry.

Collect data and establish a baseline for wait times for contract and salaried psychiatrists.

Baseline wait time data has been collected for contract and salaried psychiatrists in 2014-15 and 2015-16 benchmarks have been established.

Participate in the development and implementation of an integrated mental health and addictions information system.

As steps toward an integrated mental health and addictions information system, a Privacy Impact Assessment was completed and LOCUS (an electronic system for care needs of individuals) was implemented in three test sites.

Develop a defined plan for spread of the suicide prevention protocols to other areas of the health system.

Prairie North, Prince Albert Parkland, Sunrise, Cypress, and Mamawetan Churchill River Health Regions were assisted with implementing suicide prevention protocols in ED and/or long-term care settings.

Work on "Connecting to Care" - A Hotspotting Initiative will contribute to improvements in the area of mental health and addictions.

Find more on pages 9 and 29 of this report.

Performance Measures

By March 31, 2019, there will be increased access to quality mental health and addiction services and reduced wait time for outpatient and psychiatry services.

By March 31, 2017, wait time benchmarks for mental health and addictions will be met 100 per cent of the time. (Target for all triage levels is 70 per cent in 2014-15, 85 per cent in 2015-16, and 100 per cent in 2016-17).

Mental health and addiction outpatient wait times for all triage levels have been monitored and reported on throughout 2014-15. The target of 70 per cent for 2014-15 was met.

Provincial data for 2014-15 shows, on average, that mental health and addiction outpatient wait times for all four triage (severity) levels were above the 70 per cent benchmark threshold.

Percentage of mental health and addiction clients meeting the wait time benchmarks based on triage level

This measure relates to the five-year health outcome: By March 31, 2019, there will be increased access to quality mental health and addiction services, which includes residential and community support for individuals with complex mental health needs, and decreased wait times for outpatient and psychiatry services.

In the past, some health regions had long waits for mental health and addiction services. This can result in decreased client functioning, increasing severity in mental health and addiction issues, leading to hospitalization and emergency department presentation. Improvements are already being realized. This is a multi-year project focusing on the reduction of wait times for outpatient mental health and addiction services. In 2014-15, the target is to meet the wait time benchmark for 70 per cent of clients at all urgency levels, 85 per cent meeting targets in 2015-16 and 100 per cent by 2016-17.

Collectively the health regions are meeting the benchmarks in adult and child outpatient services, but there are exceptions in some health regions that require corrective action plans.

Strategic measures that have assisted the wait time reduction include the introduction of a number of standardized processes, lean efficiency measures and stepped care measures (have the right provider and the right time with the right intensity of services). In 2014-15, the data showed mental health services outpatient services are collectively above the 70 per cent threshold.

Additional Mental Health and Addictions Supports in 2014-15

The Mental Health and Addictions Action Plan

In 2013, the Minister of Health appointed a Commissioner to develop a 10-year inter-ministerial action plan to address the

complex and often connected issues of mental health and addictions. Lead by the Ministry of Health, partner Ministries included Social Services, Education, Justice (Corrections and Policing).

Public consultations began in August 2013 and concluded in April 2014. The Commissioner and team travelled the province learning from clients and stakeholders in more than 150 meetings, and heard from more than 4,000 individuals through a variety of ways, including an online questionnaire.

The Commissioner's public consultations guided the development of a *Mental Health and Addictions Action Plan* which was delivered in December 2014. (Speech from the Throne 2014) Government endorsed the Commissioner's report, *Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan*. Government also acknowledged the report's recommendations are a guide for the next 10 years.

The *Mental Health and Addictions Action Plan* outlined 16 recommendations which fall into seven categories:

- Enhance access and capacity and support recovery in the community;
- Focus on prevention and early intervention;
- Create person and family-centred coordinated services;
- Respond to diversities;
- Partner with First Nations and Métis Peoples;
- Reduce stigma and increase awareness; and,
- Transform the system and sustain the change.

Addressing mental health and addictions issues is complex. Improvement will require the efforts of several Ministries and many organizations working together. To that end, the Ministry of Health is leading a multi-Ministry implementation of the action plan.

Many improvements are currently underway across government to address areas the Commissioner noted. Examples include:

- reducing wait times for mental health and addictions services;
- improving responses in emergency departments for individuals with mental health and addictions issues;
- the Anti-Bullying Strategy;
- Early Learning Strategy;
- work with Hubs/COR for at risk people;
- Police and Crisis Teams (PACT); and,
- initiatives under the Saskatchewan Child and Family Agenda.

The Ministry of Health, with funding received from Health Canada under the Drug Treatment Funding Program, is working to improve Saskatchewan's addictions and mental health treatment systems. Current efforts are focused on the creation of a health regions-based implementation team to advise on implementation strategies and to effectively introduce, implement and maintain evidence-based practices in the regions. Key project activities include increasing collaboration between mental health, addiction and other health services, and delivery of Mental Health First Aid training within the health sector and other human services' Ministries.

Additionally, plans are moving ahead to build a new hospital to replace the Saskatchewan Hospital North Battleford and an integrated correctional facility. The replacement of Saskatchewan Hospital North Battleford is in line with government's commitment to provide improved mental health services to Saskatchewan citizens. The new complex will include a 188-bed replacement for the existing 156-bed Saskatchewan Hospital North Battleford and an adjoining 96-room correction facility that will house both male and female inmates.

Work in the spring of 2014-15 was focused on establishing governance structures and work processes, with new measures and reporting to start in 2015-16

Saskatchewan Child and Family Agenda

The aim of the Saskatchewan Child and Family Agenda is to better support the well-being of all children and youth and achieve improved outcomes for vulnerable children and youth; and to maximize the strategic impact of investments through integrated, coordinated programs.

The goals of the Saskatchewan Child and Family Agenda are:

- Children get a good start in life,
- Youth are prepared for their future,
- Families are strong, and
- Communities are safe.

The Ministry of Health, as a member of the Saskatchewan Child and Family Agenda, works toward more co-ordinated, cross-government approach to helping Saskatchewan children, youth and families with the complex issues they face.

Families with Complex Needs

The Ministry of Health has committed to assist the Complex Family Unit, based at the Ministry of Justice, with the development of an innovative intervention model to assist Saskatchewan's most complex families: The goals of this initiative are to challenge the way we currently serve Saskatchewan's most complex families by introducing a more cohesive intervention model that will improve the well-being of the families, while reducing long-term costs across multiple Ministry programs.

Fetal Alcohol Spectrum Disorder

The Government of Saskatchewan recognizes the prevention of Fetal Alcohol Spectrum Disorder (FASD) requires a multi-pronged approach to ensure effective and sustainable progress towards reducing the incidence of FASD. Government works in collaboration with other levels of government and nongovernmental organizations so our combined efforts will enhance positive outcomes for residents.

A key action for the Ministry of Health in 2014-15 will be finalizing a Fetal Alcohol Spectrum Disorder (FASD) prevention strategy.

Work was completed in 2014 on the development of *The FASD Prevention Framework* aimed at supporting women to have alcohol-free pregnancies in Saskatchewan. The framework was developed by the Ministry of Health and the Provincial FASD Coordinating Committee, chaired by the Saskatchewan Prevention Institute, and included input from Ministries and organizations across human service sectors. The Framework will guide the development and implementation of FASD prevention initiatives across human service sectors throughout the province. *The FASD Prevention Framework* was electronically released to stakeholders In December 2014 and posted to the Ministry of Health website.

Standardization of Information Sharing Among Provider Groups

The Ministry committed Lean resources to work collaboratively with the Ministry of Social Services and sector partners to develop a value stream map of the of the "Two Tragedies" to consider opportunities for improvements in addition to those identified in the Saskatchewan Advocate for Children and Youth's report.

The multi-Ministry/sectoral value stream mapping improvement event resulted in the drafting of an implementation plan to support the standardization of information requirements and actions among human service provider organizations when handing-off information and responsibility or disclosing information to enable other service providers to provide appropriate client service.

Population and Public Health

Communicable Diseases

- *The Disease Control Amendment Regulations, 2014* were approved in August 2014 and are in effect. They allow for improved disease surveillance, investigation, and control in Saskatchewan; and align with similar regulations in other jurisdictions. They are used in conjunction with *The Public Health Act, 1994* and regulations. This legislation lays out processes for reporting, investigating, and controlling outbreaks of Communicable diseases to protect the health of the public.

Human Immunodeficiency Virus (HIV)

Resources provided through the Saskatchewan HIV Strategy 2010-14 have helped create increased supports for those living with HIV. Provincial efforts to address HIV are making a difference and the number of new cases continues to drop. See figure 5.

Key components of HIV/AIDS prevention and control include timely HIV diagnosis, entry, and retention in HIV care/ supportive services, initiation of antiretroviral treatment (ART) and adherence to treatment to ensure viral suppression (Public Health Agency of Canada, 2013).

In Regina Qu'Appelle Health Region initial data analysis shows that since 2009 there has been an increase in the number of clients who are engaged and retained in care, prescribed antiretrovirals, and who are virally suppressed, which means treatment has been effective and risk of HIV transmission is reduced.

More clients are receiving support to address social issues such as housing, transportation, mental health/addictions, and other stressors, leading them to more successful treatment outcomes.

Figure 5: Rates of HIV cases for the years 2009 to 2013 for Saskatchewan and Canada.

Year	HIV Rates in Saskatchewan (crude rate per 100,000)	HIV Rates in Canada (crude rate per 100,000)
2013	11.5	n/a at printing
2012	16.2	5.9
2011	17.2	6.4
2010	16.3	6.8
2009	19.2	7.2

In 2014-15

- The *HIV Strategy Final Evaluation Report* was finalized, and is expected to be released in 2015. The evaluation reports on the system improvements and resources that have had an impact on patient care and outcomes.
- Saskatchewan HIV and hepatitis C rates remain at approximately twice the national rate, so continued work is needed.
- A YouTube video, titled "It's Different Now" was released, describing how HIV testing, treatment and prognosis have advanced, and that HIV is a manageable disease.

  The revised Routine HIV Testing Policy and Resources for implementation were released in order to increase the number of providers offering testing as part of routine health care.

- Efforts to disseminate information to health care providers, as well as expand opportunities for risk-based (HIV Point of Care) testing in non-traditional settings continue.
- Provincial training opportunities continued to build the capacity of health care and allied professionals. Examples included provincial HIV Rounds which are offered twice per month via Telehealth and an annual e-learning event in partnership with the College of Nursing, University of Saskatchewan.
- Peer to peer programming was expanded to Sunrise and Mamawetan Churchill River Health Regions in 2014-15. Programming is now available in six health regions in the province.

- Consultations were initiated within the Ministry to complete the Perinatal HIV Prevention Protocol. Dissemination of the resources is expected to occur in 2015.
- Planning occurred with Prince Albert Parkland Health Region for the expansion of the Infectious Disease Clinic electronic medical record for HIV patients. Implementation will be completed in 2015.
- Multidisciplinary HIV/hepatatis C/Sexually Transmitted Infections (STIs) outreach clinics continue to be offered in remote, northern and First Nations communities. Clinics were expanded to rural areas in Regina Qu'Appelle and Sunrise Health Regions.
- Remote technology, such as the "Doc In the Box" is providing opportunities for access to specialists in remote areas of the province.
- Mentorship opportunities continued for physicians, pharmacists, and nurses. Funding was provided for the Saskatchewan Infectious Disease Capacity Augmentation Project which is a webinar series aimed at improving capacity of primary care teams to provide HIV care.

Tuberculosis

The Ministry of Health in partnership with Tuberculosis Prevention and Control Saskatchewan and the provincial Quality Improvement Office (Kaizen Promotion Office) conducted a visioning session for Tuberculosis (TB) in Saskatchewan. The purpose of the visioning session was to build upon the work of the Saskatchewan TB Strategy, which was released in 2013. The visioning session worked towards an agreed upon future state for TB prevention and control that is coordinated, efficient, patient focused and actionable.

- A broad range of participants contributed to the vision for TB prevention and control.
- Patients presented their stories of their personal experience with TB in Saskatchewan. These stories formed the foundation for the discussion that followed. The stories represented northern, southern, and newcomer perspectives.
- There is strong congruency with the elements in the TB Strategy (2013).

Work continues in the targeted high incidence communities to improve early identification, to enhance follow-up for individuals who have previously been treated for the latent form of TB (Latent TB Infection [LTBI]), and to reduce stigma of TB within communities through community engagement.

TB Prevention and Control Saskatchewan continues to develop updates for *TB Prevention and Control Saskatchewan Clinical Guidelines*. Highlights in 2014-15 include revisions to Home Isolation Policies.

A report of Phase 1 of the implementation of the TB Strategy evaluation framework was finalized.

Sexually Transmitted Infections

The Ministry continued to work with health regions and other partners to improve prevention and treatment for, and reduce the incidence of, sexually transmitted infections (STIs). Saskatchewan developed tools to help physicians appropriately diagnose and treat gonorrhea, and increased efforts to detect the emergence of gonorrhea strains that are resistant to traditional medications.

The Ministry responded to a medication shortage by adding another suitable medication to the centrally accessed supply. The Ministry provides public access to drugs for the treatment of STIs by public health in health regions and First Nations jurisdictions in order to provide point of care access to treatment for their patients.

Additional Population Health Enhancements in 2014-15

Panorama (Public Health Information System)

Panorama is a comprehensive, integrated public health information system that replaced the current aging Saskatchewan Immunization Management System (SIMS). Five program modules support public health programming: vaccine inventory, immunizations, family health, communicable disease investigations, and outbreak management. Co-led by the Ministry of Health and eHealth Saskatchewan, Panorama is funded in large part by Canada Health Infoway.

The vaccine inventory module was implemented in March 2014. The vaccine inventory module tracks vaccine use and availability. This feature ensures vaccine supplies are ordered in a timely manner and facilitates the management of outbreaks, allowing the province to move vaccines quickly to areas of need.

In February 2015, the immunization module was implemented, which involved the transferring of over seven million immunization events from the Saskatchewan Immunization Management System in partnership with 12 health regions and 12 First Nations communities. The immunizations module in Panorama provides the ability to record all immunizations administered by Public Health in the province, forecasts or provides a recommended immunization schedule, and enhances the ability to invite or remind families and individuals who are due for an immunization. The ability to track immunization coverage by region and province wide will be improved and regions will be better able to plan and target programs. This is a tremendous support for patients and families who will no longer have to contact their health region, or rely on memory or paper records to track their immunizations. It will reduce missed and duplicate immunizations, especially among groups who move frequently.

Immunization

In October and November 2014, the Ministry launched the "Arm Yourself" campaign to encourage people to get immunized for influenza to protect or "arm" themselves. The campaign included television closed-captioning, online ads, and posters. It targeted parents or others who are often responsible for the most vulnerable - such as children and aging parents.

During the 2014 – 2015 flu season, health regions continued to expand delivery of immunization services in community settings typically frequented by adults, children and families including sports facilities, schools and community halls.

A variety of other options for accessing influenza vaccine were available including:

- upon discharge of clients/patients from hospital;
- in outpatient community clinics;
- through obstetricians and pediatricians (in addition to family physicians and primary care centers); and,
- in hospital or regional facility lobbies.

During 2014 – 2015, the varicella (chickenpox) vaccine became publicly funded for non-immune health care workers and women of the child-bearing age group.

Data Management System for Public Health Inspectors

In January 2014, the Ministry of Health procured a single software solution to replace an aging database program for the Public Health Inspection program. The new system enables inspectors to perform inspections on electronic handheld devices (i.e. tablets) while providing greatly expanded capabilities in terms of data collection, analysis, reporting, and public disclosure. This new data management system was implemented in March 2015. The new system:

- Helps the Ministry meet the Provincial Auditor's December 2012 recommendations for improvement by overseeing the enforcement of regulations that address the safety of meat products;
- Allows inspectors to enter inspection information directly into a tablet as it is collected, replacing the 'pen and paper' system and eliminating the need for manual data entry from paper forms after the fact, saving significant time and reducing errors.
- Includes a public website component, to be implemented in 2015-16, with enhancements over the current online restaurant inspection information website.

Ebola Provincial Contingency Planning

In August 2014, the World Health Organization (WHO) declared a public health emergency of international concern related to an outbreak of Ebola Virus Disease in West Africa. In response, the Ministry of Health convened an Ebola Provincial Contingency Planning Committee to develop provincial and regional Ebola contingency plans, and address operational issues in the event of a possible Ebola case in Saskatchewan. Ministry officials collaborated with federal, provincial, and territorial counterparts to develop plans and protocols to

ensure health care workers, patients, and the public remained safe and patients had ready access to care should a case of Ebola be confirmed in the province. Key elements developed as part of the Provincial Ebola Contingency Plan included:

- Documents and tools to assist in the assessment of suspected Ebola cases;
- Designation of treatment centres located at the Regina General Hospital in Regina and St Paul's Hospital in Saskatoon;
- Protocols for ambulance providers and guidelines for moving patients to designated treatment sites;
- Protocols and procedures for personal protective equipment and decontamination products;
- Protocols for management of laboratory specimens to ensure safe testing, care, and handling;
- Training plans and simulation exercises for health care workers; and,
- Protocols for health care workers and/or travelers returning from affected countries.

There were no Ebola cases in Canada between April 1, 2014 and March 31, 2015. However, the knowledge and experience gained in developing Ebola contingency plans at the health region, provincial/territorial, and federal levels will be useful in addressing future public health challenges related to Level 4 pathogen diseases such as Ebola.

Healthy Beaches

Over the 2014 summer season, the Ministry of Health and health regions monitored health risks at 65 public beaches. When water sample results exceeded guidelines, do not swim notices were posted. The Ministry is targeting 2017 for full implementation of the program. When implemented, the program will enable users of beaches and lakes to access water quality information via a "Healthy Beach Website" to assist in making informed decisions when selecting swimming areas at our lakes.

West Nile Virus

West Nile Virus (WNV) has become endemic in Saskatchewan since first identified in 2002 and is no longer considered an emergent human disease in the province. In 2014, public health officials altered their response to focus more on messaging of level of risk, prevention activities, and public education. The focus shifted from reporting human cases to communicating the environmental risk indicators (e.g. mosquito species, positive pools, weather conditions) to better indicate actual risk.

The WNV web content on the government website was redesigned to better describe the risk of WNV transmission to humans by ecological area (e.g. mixed grass prairie, boreal transition, boreal forest) through weekly reporting of environmental indicators (e.g. mosquito numbers and infection rates, temperatures).

Figure 6: Human WNV Neuroinvasive Cases in Saskatchewan 2003-2014

Year	Neuroinvasive Cases	Deaths
2003	63	7
2004	0	0
2005	6	3
2006	2	0
2007	75	6
2008	1	0
2009	0	0
2010	0	0
2011	0	0
2012	0	0
2013	7	1
2014	1	0
Total	155	17

Better Care

Referral to Specialists and Diagnostics

Building on the success of the Saskatchewan Surgical Initiative which significantly reduced patient wait times for surgery, the health system is working to strengthen coordination, communication, and referral guidelines to better coordinate services to ensure patients have timely access to the most appropriate specialist and diagnostic services. By reducing the wait time for a consult with a specialist or diagnostic services (such as MRI and CTs), patients will be able to access treatment sooner.

Develop and publish baseline wait time measures for all Saskatchewan specialists.

Calculating how long patients are waiting to be seen by a specialist has been an issue for Saskatchewan and other Canadian jurisdictions. The Ministry enlisted wait time measurement experts at the University of Western Ontario (UWO) to find a means of calculating this wait time for all specialists before baselines can be determined. An algorithm has been developed to measure this wait time and is now being tested.

Hold consultations with Saskatchewan physicians to discuss Future State Plan to reduce the wait time to see a specialist.

Over 200 physicians across the province were consulted about the plan to improve the province's referral system. Twenty six physicians contributed to the development of the plan at a provincial lean visioning session; others offered feedback at regional meetings. There was strong support to proceed with the plan developed by the participants at the visioning session.

Develop and test a provincial model for an appropriate referral to specialists in two clinical areas.

An improved referral model using pooled referrals has been implemented in one clinical area. Pooled referrals offer patients the option of choosing to be seen by the next available orthopedic surgeon. Patients will continue to be able to choose a particular specialist however this may result in a longer wait time.

The orthopedics area in the Regina Qu'Appelle Health Region adopted pooled referrals and launched the new Hip and Knee Treatment and Research Centre. The new treatment centre was designed around the patient with a focus on delivering a variety of care and support options to hip and knee patients in an easy to access facility. Patients are served by a multi-disciplinary team of physiotherapists, orthopedic surgeons, and nurse educators who work as a team to help patients understand all of their treatment options. The staff at the centre help patients prepare for treatment by explaining their options, what to expect, and prepare for surgery (if required) with techniques research has demonstrated may achieve better outcomes.

Patients who have received hip or knee treatment prior to the improved referral process and again through the new process were interviewed and their responses have been overwhelmingly positive. They were particularly impressed with the follow-up they received from their care team and the support they received in the group physiotherapy sessions where they were able to meet other patients who have had the same treatment. The new centre has seen nine month wait times reduced to one month or less. Orthopedic wait times will be used as the balancing measure for the Regina orthopedic surgeons to ensure reduced wait times for an office appointment is not causing surgical wait times to increase.

Work is now underway to replicate these improvement strategies with the province's rheumatologists to assess how well the new referral model works in a non-surgical service line like rheumatology. A balancing measure for the province's rheumatologists will be developed as the new referral model is implemented.

Develop multi-year improvement targets to reduce patient wait times to see a specialist by March 31, 2019.

The project was on track to achieve its multi-year improvement targets based on the successful replication of the provincial referral model in other specialty areas. The goal is to replicate a model that has demonstrated it can reduce

wait times and improve the quality of the referral process. The multi-year targets include using the electronic health record and other technology to replicate the new model to all specialty areas by March 31, 2019.

Develop a physician engagement and communications strategy for the Future State Plan.

This project has developed a physician engagement strategy and communication plan, and continues to meet with both family practitioners and specialists to review new ideas. New ideas are vetted with patients and physicians prior to being implemented to not only ensure the changes have the desired effect but also to minimize any unintended consequences. The steering committee overseeing this project includes four patients, eight physicians, and a nurse practitioner.

Identify barriers that prevent the expanded use of technology for physicians to communicate with patients electronically.

A policy review has been conducted to identify potential barriers to using technology such as email, video conferencing, and text messages when communicating with patients. The results will inform discussions regarding policy areas that require development or revision.

Efforts are underway to increase patient access to their personal health information and their health care providers through an electronic patient portal. Over time the portal will allow patients to view their electronic health record, track referrals, and receive notification of test results.

Patient and provider feedback is collected from satisfaction surveys.

The goal is to conduct patient and physician satisfaction surveys with each clinical pilot group several times a year. The surveys will measure the satisfaction of each stakeholder in the referral process to ensure wait time reductions are not creating an unintended negative impact.

In 2014-15, patient and provider satisfaction surveys were collected at the Regina Hip and Knee Treatment and Research Centre, and with provincial rheumatologists.

Emergency Department Waits and Patient Flow

In October 2012, the Saskatchewan Plan for Growth identified a challenge for the provincial health care system to eliminate waits for emergency department (ED) treatment by 2017. It is known that long waits in the ED are a symptom of multiple issues affecting patient flow across the continuum of care, and in order to reduce ED waits the root causes must be identified and addressed. It is widely recognized ED waits are driven by many internal (hospital) and external (community) factors. The literature suggests both hospital and hospital based strategies must work together to address this systemic problem.

Achieving "zero waits" in emergency departments by 2017 may not be feasible due to the magnitude and complexity of the patient flow challenge. New targets and action plans are being developed in 2015-16 to better tackle this complexity and support the successful implementation of the plan.

The goal for 2014-15 was at least 85 per cent of patients requiring admission from the ED would be admitted to an appropriate bed within five hours. This improvement target was very aggressive and was not realized in 2014-15. In order to achieve the five hour target, significant improvements will be required across the continuum of care.

Improvement work in this area seeks to improve emergency department procedures in addition to addressing related processes and pressures outside the emergency department.

Saskatchewan is taking a system-wide approach to significantly reduce wait times in EDs. The goal is to improve patient emergency department experiences by minimizing waits to see a care provider, and to ensure there are no unreasonable delays through the entire care experience. The Ministry of Health established a project team and advisory group to lead this effort, including patient and family advisors, members of the Health Quality Council, clinical experts in geriatrics and emergency medicine, and representatives from health regions.

Establish viable options for less urgent and non-urgent care outside emergency departments in Prince Albert, Saskatoon, and Regina.

Bottlenecks in patient flow in acute care and community settings must be addressed in order to successfully reduce and eventually eliminate wait times. Early work to support the provision of less urgent and non-urgent care outside EDs has begun in Saskatoon and Regina with the implementation of programs like senior's house calls, Police and Crisis Team (PACT) and hot spotting.

Establish alternative models of care for emergency department patients in Prince Albert, Saskatoon, and Regina.

This year, various programs and processes were introduced to better address the needs of patients seeking care in EDs. Since problems affecting wait times differ by health region, the solutions to those problems took different approaches. These efforts were undertaken in Regina, Saskatoon, and Prince Albert:

Saskatoon Health Region

- Implementation of Police and Crisis Team (PACT). PACT is an example of how police, health and the community can work together to support police calls involving a mental health crises. Each unit consists of a member of the Saskatoon Police Service and a mental health worker from the Saskatoon Crisis Intervention Service who work in partnership to respond to mental health crises in the community. PACT's goal is to reduce risks to community safety and ensure people experiencing mental health crises receive appropriate medical assistance. Corrections and Policing through the Ministry of Justice provided $220,000 for PACT's two police officer positions as part of its Municipal Police Grants program. The Ministry of Health provided $250,000 funding for the two mental health worker positions through its Emergency Department Waits and Patient Flow Initiative.
- Support for an inpatient model of care redesign (including therapies coverage on weekends and after hours).
- The Saskatoon Health Region's 14 Day Challenge empowered frontline staff to tackle persistent overcapacity. The result of the challenge was fewer patients waiting for beds and the need for fewer temporary beds.

Regina Qu'Appelle Health Region

- Regina Qu'Appelle Health Region has been leading a trial for a new model of Physician Treatment Assessment (PTA). This pilot changes the way physicians are scheduled in EDs. Early work in the summer of 2014 showed that this resulted in a 27 per cent decrease in the time patients waited for a non-urgent assessment. The region continues to refine this scheduling process.
- A nurse practitioner (NP) began working at the Regina Pioneer Village Long Term Care Facility to help avoid transfers to EDs by performing assessments in facilities and increasing preventative care.
- Assessor coordinator weekend coverage was established in community hospitals to ensure patients' care plans are carried out seven days per week to support seven day a week discharges.
- Building on the success of the Saskatoon pilot of PACT, Regina Qu'Appelle Health Region plans to implement PACT programming as well. This program is scheduled to begin in Regina in spring 2015.

Prince Albert Parkland Health Region

- In Prince Albert, an increase in physician coverage during peak hours at the Victoria Hospital ED resulted in improved times for a patient's initial assessment in the ED. This work began November 1, 2014, and early results suggest patient wait times for physician initial assessment have decreased.

Emergency Department and Patient Flow Kaizen Team

In addition to work that began in the three largest health regions to address ED wait times and patient flow issues, the Emergency Department Provincial Kaizen Operations Team also committed to supporting wait time improvements in 2014-15 throughout the system. Some of the work supported by the provincial team included:

- Development of an evaluation framework for future program investments;
- Development of a provincial plan for health system modeling;
- Creation of a memorandum of understanding to be endorsed by all health regions that develops provincial standards for all inter and intra-regional transfers of care. This includes a tool kit which supports health regions in implementing the required processes for safe transfers of care.
- Geriatric core competencies training for paramedicine. Watch a video of a paramedicine visit in Wakaw.
- The Ministry announced plans to add a geriatrician in the Regina Qu'Appelle health region in the 2015 budget.

Establish protocols for linking 'unattached' patients to Primary Health Care Team or General Practitioner during ED visit.

Linking patients who do not have a primary health care provider to a Primary Health Care Team is another strategy to address patient volumes in the ED. This work will be advanced in future years of the initiative.

Establish protocols for safe and timely transfers of care across continuum.

Regina Qu'Appelle Health Region and Sunrise Health Region developed standardized processes for transfers of care to home hospital and home region from tertiary care. Saskatoon Health Region has worked with Prairie North Health Region in replicating and implementing similar processes. This standardized process for patient transfers will expand to include all transfers of care and ensure the resources and capacity of the provincial health system are efficiently and maximally utilized. This work will be replicated across the rest of province in 2015-16.

Establish protocols for safe and timely transfers of care across continuum.

Battlefords Union Hospital added a nurse practitioner to their emergency department to assist with patient flow. This added resource allows low acuity patients to be seen and cared for in a more timely fashion.

The Patient Treatment Assessment process at the Regina General Hospital leverages a team model of care delivery to improve physician initial assessment wait times for non-urgent presentations to EDs.

St. Paul's Hospital in Saskatoon has added Physical Therapy services to their emergency department team. The addition of a Physical Therapist in the ED allows for mobility and equipment issues to be identified and managed right in the department, often avoiding unnecessary delays or acute care admissions.

Build capacity by developing geriatric core competencies.

The 14 Day Challenge and subsequent 90 day Hoshin in the Saskatoon Health Region has advanced the training of geriatric core competencies for paramedic teams operating in the community. This enhances the team's ability to safely care for frail elderly patients on-site, avoiding unnecessary transfers to the ED and admissions to hospital. This will be replicated in the Regina Qu'Appelle Health Region in 2015-16 to help advance the development of a Geriatric Evaluation and Management team in the region.

Optimize triage protocols within the Emergency Department.

By reviewing the practices in other high performing jurisdictions, the Regina Qu'Appelle Health Region learned that by optimizing the team compliment and aligning the work during an ED shift, patient care could be delivered in a more efficient way. The new practice of Patient Treatment Assessment (PTA), allows an ED physician to stay in contact with patients as they move from their initial assessment through their care, relocation, or discharge. This practice improves patient safety and the care experience by reducing patient handoffs and optimizing ED resources.

Fully implement medication reconciliation at transfer or discharge from acute care, and admission and transfer from long term care.

The Emergency Department Provincial Kaizen Operations Team will include medication reconciliation work standards into their inter and intra-regional transfers of care toolkit (to be developed in 2015-16).

Establish a patient navigation strategy to improve patient outcomes and reduce Emergency Department re-visits and acute care readmissions.

As an initial component of this work, Saskatoon Health Region has established a First Nation and Métis Health Educator/Navigator role at St. Paul's Hospital. These staff act as the primary resource for complex cases where communication problems or the inability to access services are a barrier for patients receiving the right care at the right time in the right setting.

Monitoring improvements in emergency departments using the Canadian triage and acuity scale

Process improvements within provincial emergency departments have been monitored using measures defined by the Canadian Association of Emergency Physicians (CAEP). The Canadian Triage and Acuity Scale (CTAS) measures used to evaluate this initiative are:

- Time to physician initial assessment in emergency department for CTAS 3-5 patients;
- Time to physician initial assessment for CTAS 1 and CTAS 2;
- Length of time from the decision to admit from the emergency department until the patient is in an appropriate bed;
- Length of time from when an in-patient bed is assigned until the patient arrives in that bed; and,
- Length of stay in the emergency department for CTAS 4-5 patients.

Figure 7: Canadian Triage Acuity Scale (CTAS)

Canadian Triage Acuity Scale (CTAS)	
Category Level	**Acuity level**
I	Resuscitation
II	Emergent
III	Urgent
IV	Less Urgent
V	Non-Urgent

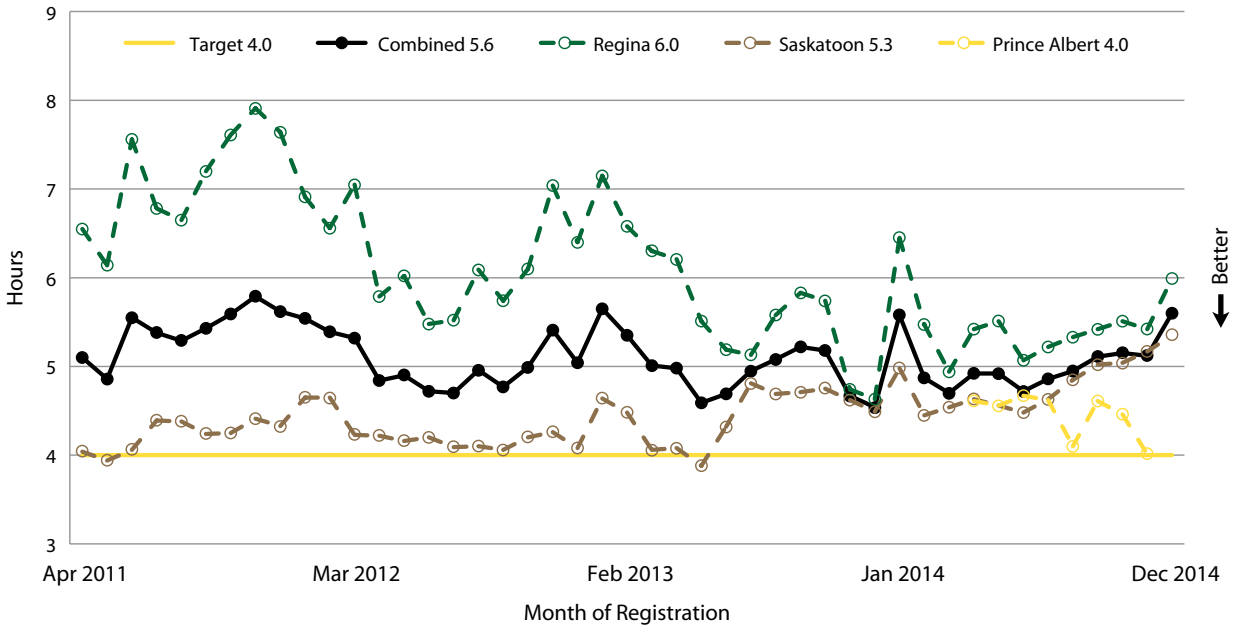


Figure 8: Average Length of Stay for Patients at CTAS Levels 3, 4, and 5 in the Emergency Department. Target: Less than Four Hours

To insure that process change does not alter care negatively the initiative tracks the balancing measures of:

- The number of patients who left the emergency department without being seen;
- The acute 30 and 60 day readmission rates.

Percentage of patients responding 10 to the question: "Overall, I would rate my Emergency Room visit as …" where 1=worst and 10=best.

Patients were surveyed to determine satisfaction baseline values for the percentage of patients that would rate their ED visit as 10 out of 10. 2014-15 was the first year this measure was collected. This baseline data will allow for future reviews of patient satisfaction with their emergency room experience.

Physician initial assessment

This is the wait interval from registration or triage to the time to be assessed by a physician in the emergency department. Regina, Saskatoon, and Prince Albert ED results are stable over time. Although stability does not mean improvement, it does signify to the system that the problem is not getting worse in the short-term while a system wide approach is established. Saskatoon has the shortest wait time. Regina is improving but still has a longer wait time than Saskatoon. Prince Albert wait times improved in November 2014 with additional ED physician coverage and are now similar to Saskatoon's.

Figure 8 shows the average length of stay in EDs for Canadian Triage and Acuity Scale (CTAS) 3-5 patients and is related to this measure.

Time waiting for an in-patient bed

Time waiting for an inpatient bed represents the interval from when the decision is made to admit a patient to an inpatient bed until a patient departs to the ward. The target in 2014-15 is 85 per cent of patients waiting less than five hours for an in-patient bed. Outside of the cities of Regina, Saskatoon, and Lloydminster - all other hospitals meet the target of 85 per cent of patients waiting less than five hours for an in-patient bed.

Length of emergency department stay

This measure is defined as the time from when a patient registers at ED until they are discharged from ED. Regina has improved compared to the 2011-12 base but lengths of stay are longer than Saskatoon. Saskatoon has improved below their 2011-12 baseline.

Regina and Saskatoon have stable emergency department length of stay rates. Prince Albert improved in October and November 2014, as such their November 2014 rates are similar to Regina and Saskatoon.

Number of patients who left the emergency department without being seen.

This measure is tracked using data gathered at patient registration and referencing that data against completed ED visit data. In the Regina Qu'Appelle Health Region five per cent of patients left the ED without being seen by a physician. In Saskatoon that number was 4.4 per cent and in Prince Albert it was 11.2 per cent. (This data is does not represent a full fiscal year)

Acute care 30 and 60 day readmission rates.

Readmission rates are a long used measure of care quality. There are national values tracked for all jurisdictions by the Canadian Institute for Health Information. These rates may alter when change occurs within a health system. Both 30 and 60 day readmission rates are stable across the province. Work related to "hotspotting", seniors house calls, and the Home First Program will be part of, or contribute to, improvements in the area of emergency department waits and patient flow. These are presented on page 8 of this report.

Performance Measures

By March 31, 2017, no patient will wait for care in the emergency department. (Saskatchewan Plan for Growth)

Saskatchewan is taking a system-wide approach to significantly reduce wait times in emergency departments. The goal is to improve patient emergency department experiences by minimizing waits to see a care provider, and

to ensure there are no unreasonable delays through the entire care experience.

Eliminating wait times by March 2017, will be challenging due to the complexity of the problem, the substantial investments required, and the system capacity for transformational change. Revised targets are being developed in 2015-16 to better tackle this complexity and support successful implementation of the plan.

The ED Waits and Patient Flow team has completed extensive literature review and environmental scan over the past year. It is clear wait times in the ED are a symptom of poor patient flow through the entire continuum of care. The issues causing delays and bottlenecks across the system are complex. The solutions to successfully address them are equally complex. The team continues to work with system stakeholders in implementing strategies and improvment to aggressively address the issues causing delays.

By March 31, 2015, 50 per cent reduction in emergency department waits.

Wait times to see a physician have improved in the Prince Albert Parkland Health Region and wait times for an inpatient bed has improved in the Regina Qu'Appelle Health Region. Other wait times across the province have shown small improvements in part due to the complexity of the problem; the need for substantial investments to make large improvements; and the system's capacity for transformational change.

Establish baseline for number of alternate level of care days (Canadian institute for health information definition) as a proportion of total acute care bed days. Maintain the number of alternate level of care days (waiting placement) across the province and in each region at no more than 3.5 per cent of total.

The work for 2014-15 has focussed on adopting a consistent definition for alternate level of care (ALC) that will be applied across the province in all regions. There was also a focus on improving work flow processes to more accurately collect data from the point-of-care, in order to establish an accurate baseline and patient profile for ALC in 2015-16. Given the small amount of consistent data, the measure of those assessed for long-term care and awaiting placement in acute care was used as a measure. See figure 9.

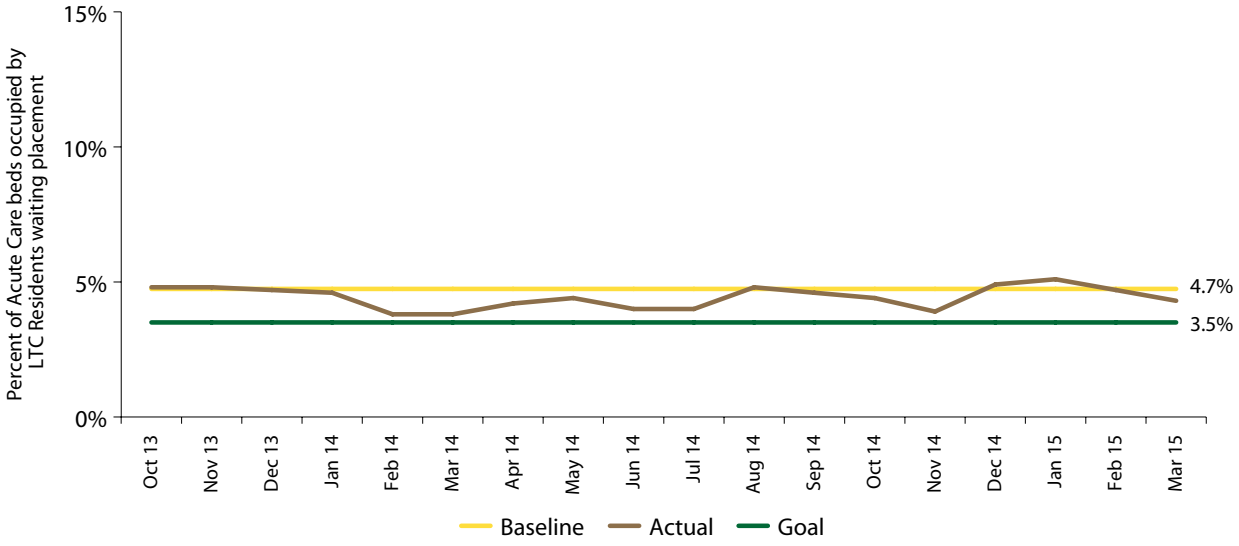


Figure 9: Percentage of acute care beds occupied by individuals assessed for Long Term Care (LTC) who are awaiting placement

Data Source: Manual bed count submitted by regional health authorities to Ministry of Health

Determine the number of Alternate Level of Care days as a proportion of total Acute Care bed days.

The total number of ALC days as a proportion was not able to be calculated, however, the calculation of those assessed for LTC and awaiting placement in acute care, which is a subset of ALC, was measured in 2014-15. The provincial average of acute care beds occupied by individuals assessed for LTC who are awaiting placement was 4.3 per cent in March 2015 (which is above the target of 3.5 per cent). See figure 9.

Appropriateness/Best Practice

Evidence shows there is variation in the use of health services. Patients with similar conditions frequently experience differences in diagnostic testing and treatment options resulting in varied experiences and outcomes. This is in part due to the complex factors to consider when diagnostic tests and treatment options are offered to patients resulting in some variation.

Work in this area aims to ensure patients receive consistent, evidence-based, and safe diagnostic and treatment options, receive high-quality care experiences, and achieve the intended outcomes. To accomplish this, a working group of Saskatchewan physicians, other health care providers and health system leaders are learning from the experiences of high-performing health systems. The working group will collaborate with various specialties to look at data that shows the extent of variation in frequently performed procedures, then explore why the variation occurs. As front line providers learn more, they will understand better where services are both over-used and under-used. The next step will be for clinicians to build consensus around common service guidelines that will help to reduce the practice variation.

Read more about appropriateness and watch a video about appropriateness and clinical variation in surgical care at www.sasksurgery.ca/provider/appropriatenessclinicalvariation.html.

Results

Develop a project charter to include project governance, stakeholder identification, accountability and authority structures, scope, and replication strategy.

The Appropriateness of Care project charter was developed. It provides an overview of the project, including governance, accountability, project scope and deliverable, and is a living document that will evolve over time.

The key components of the governance structure include a steering committee and a strategic project team. The steering committee is comprised of patients, health system leaders (i.e. CEOs of health regions, eHealth, and 3sHealth), and senior

medical officers who will provide overall strategic direction and oversight. The strategic project team, comprised of the physician co-leads, the appropriateness of care program lead, representatives from the Ministry of Health, 3sHealth, eHealth and the Health Quality Council (HCQ), will provide front-line and clinical expertise to inform decision making.

Identify and pursue early opportunities in laboratory and diagnostic imaging to start to achieve efficiencies for patients and the health system.

Magnetic Resonance Imaging (MRI) of the lower spine has been selected as the clinical area of focus to test the Appropriateness of Care framework in 2015-16. The number of MRIs performed in Canada has increased dramatically in recent years; however, studies are showing some MRIs, particularly of the lower spine, may have minimal impact on patient treatment or outcomes. According to a recent Canadian study, 29 per cent of MRI requests of the lower spine studied were considered "inappropriate" and another 27 per cent were found to be of "uncertain appropriateness", which means MRIs for some patients may not be necessary for diagnosis and treatment. Inappropriate MRI testing contributes to increased wait times for those patients who truly need an MRI for diagnosis and treatment, and may put some patients at risk for further testing and invasive procedures.

Overuse of Magnetic Resonance Imaging JAMA Internal Medicine March, 2013; Derek J. Emery, MD, FRCPC; Kaveh G. Shojania, MD, FRCPC; Alan J. Forster, MD, FRCPC; Naghmeh Mojaverian, MD; Thomas E. Feasby, MD, FRCPC

Develop a strategy and plan to ensure that appropriate data capture and reporting tools, including data analysis and reporting mechanisms, are in place to support clinical quality (variation and appropriateness) improvement initiatives.

A methodology for data collection, analysis and reporting at the point of care has been developed and is undergoing review and final approval. It is part of the overall Appropriateness of Care Framework and will be implemented in the MRI project. A limitation exists in the ability to report clinical outcome data. A broad plan for improving data infrastructure (i.e. data warehouse, data sharing agreements, etc.) is under development. The Ministry of Health will continue to work with eHealth to support development of this plan.

Develop and initiate a broad physician appropriateness engagement and communication plan.

A broad stakeholder engagement plan has been drafted as part of the overall Appropriateness of Care Framework, and is expected to be finalized in 2015-16. The plan includes specific actions for engaging physicians, health system leaders and providers, patients, and the public in improving Appropriateness of Care.

Physician involvement is one of the key elements for improving quality of care and appropriateness. To ensure physicians are engaged in this work, two physicians have been recruited to lead the development of the framework and a group of physicians has been recruited to guide the MRI of lower spine project.

Develop a specific Physician Engagement Plan for each of the components of the Appropriateness Initiative, including discussion and adoption of a physician compact (and/or contract, and/or Medical Staff Rule, or policy) which includes participation in quality improvement. (The words including discussion and adoption of a physician compact were removed from this target.)

The physician/clinician engagement strategy will focus on:

- Raising awareness of appropriateness of care issues and the work that is underway;
- Providing education and training to increase knowledge and understanding of Appropriateness of Care methodologies to help clinicians implement them in their own practice; and,
- Creating an environment where physicians are encouraged and supported to be part of the effort to improve quality of care and appropriateness.

Multi-year targets and actions for each of these individual components have been developed and will be implemented over the next three to five years.

Continue with Variation and Appropriateness Working Group work already underway with a defined and resourced data/ measurement system and an evaluation plan, to inform and address the variation in vascular, lower spine procedures, breast and prostate cancer surgery.

The Variation and Appropriateness Working Group (VAWG), established in 2012 under the Saskatchewan Surgical Initiative, has continued to work on the following projects to standardize reporting for breast cancer and vascular surgery:

- An electronic synoptic template to capture operative information for patients with breast cancer has been adopted for use in Saskatchewan and is being implemented in a phased-in approach in the province. The synoptic template was developed by surgeons from across Canada, working with the Canadian Partnership Against Cancer. Once implemented, the synoptic operative report will provide a standardized report with consistent information that will be used for quality improvement purposes.
- A vascular surgery database has been developed by the vascular surgeons in SK to compile clinical outcome information on patients with peripheral arterial disease. The database was initially designed as a series of paper-based data collection tools and is currently being converted to an electronic synoptic reporting system.

A synoptic surgical report replaces the traditional surgeon-dictated operative reports, and captures standard information about surgery at the point of care. Surgeons, administrators and quality improvement personnel can use this information to improve quality and safety of patient care. Find out more in these bulletins on the sasksurgery.ca website here and here.

Clinical pathways development/improvement for 2014-15 is aligned to support the appropriateness strategy.

Clinical pathways are an approach to improving quality of patient care that includes the full range of interventions from the primary care to acute care and rehabilitation. Four clinical pathways have been developed in Hip and Knee, Prostate Cancer, Pelvic Floor, and Spine, and two pathways including Lower Extremity Wound and Acute Stroke are currently under development.

Performance Measures

By March 31, 2018, there will be a 50 per cent reduction in inappropriate services.

The outcome target is currently under review and will be revised due to challenges associated with measuring appropriate services.

By March 31, 2015, develop a provincial appropriateness framework strategy, implementation plan and accountability mechanisms, and indicate the level of development reached, by quarter, for establishment of an Appropriateness Framework for Saskatchewan.

The Appropriateness of Care project team, led by two physicians and supported by the Ministry of Health and the Health Quality Council, has been established. The team has developed a provincial framework for Appropriateness of Care, as well as an Engagement Plan. This work is currently pending final approval and is expected to be finalized in 2015-16. The framework will provide shared understanding of what Appropriateness of Care means, vision and goals, as well as a methodology to improve appropriateness of care at the clinical practice level, and the key system support structures that are critical to embedding Appropriateness of Care culture into the system.

The framework will be tested in MRI of lower spine in 2015-16. A development team including orthopedic surgeons, neurosurgeons, radiologists, and family physicians, as well as patients has been established to lead the MRI project. Once the pilot is completed, it will be replicated in other clinical areas. Key learnings from this group will be applied to the framework.

The team will be working with the Strategy for Patient-Oriented Research (SPOR) group to identify research opportunities from the MRI of the lumbar spine as it has been identified as SPOR's clinical focus for 2015-16.

For accountability, the progress of implementing the Appropriateness of Care framework will be monitored and reported to the Provincial Leadership Team (PLT) on a quarterly basis and to the Ministry of Health Senior Leadership Team on a monthly basis.

By March 31, 2015, data analysis and reporting mechanisms are in place to capture and analyze baseline data that flows back to point of care; indicate the level of development of mechanism(s) [e.g. compact] that support physician involvement and the level of development, by project/model line, of measurement mechanisms for data capture at point of care, analysis and reporting back to point of care.

A methodology for data collection, analysis and reporting has been developed and is currently pending final approval. The methodology provides detailed processes for identifying existing data, key metrics, and how to collect, analyze and report data when implementing the framework in a particular clinical area.

This data framework will be tested in the MRI of lumbar spine project. The measurement mechanisms for the MRI project (i.e. data capture, analysis and reporting) will be developed and embedded in the clinical workflow by the development team.

The primary data as well as findings from literature review are currently being collected and will be presented to the development team in 2015.

Additional Work to Promote Better Care in 2014-15

Capital Investments

Capital investments in 2014-15 totaled $95 million. Funding for ongoing projects included $16.0 million to complete the new hospital in Moose Jaw and $27 million to continue construction of long-term care facilities in Biggar, Kelvington, Kipling, Maple Creek, and Prince Albert. The 2014-15 Budget committed new funding of $3.5 million for facility planning including renewal of Prince Albert's Victoria Hospital, replacement of long-term care facilities in Regina Qu'Appelle Health Region, and planning for more long-term care beds in La Ronge. (2014 Budget)

Saskatchewan Children's Hospital

The new Saskatchewan Children's Hospital in Saskatoon will be a state-of-the-art maternal and children's hospital that will support high quality health care for our province's children and families. The 176 bed facility will be located next to the Royal University Hospital on the University of Saskatchewan campus in Saskatoon.

With the support of the government's $235.5 million investment, the facility design is now finalized and the construction phase has begun. Children, their families, and project partners celebrated a major milestone for the Children's Hospital of Saskatchewan with a ground-breaking ceremony at the construction site in September 2014. Phase 1 of construction, initial piling and foundation, was completed in March.

Capital Investments

The new hospital in Moose Jaw will be the first healthcare facility complete in the province to fully integrate Lean Methodology into the design, function, and culture of the facility. The hospital is designed and based on a cellular model of care which will significantly reduce patient movements and handoffs between staff and departments. The result is care that is much more efficient and patient focused. The hospital design will help care givers provide "the right care in the right place by the right provider" and reflects the efforts of over 200 people who have been involved in its design including patients and their family members, doctors, nurses, therapists, dietary workers, maintenance workers, and housekeepers. Bringing the provider to the patient will allow healthcare professionals to provide better care for patients and make the hospital much more efficient. Read more about the facility in this Five Hills Health Region factsheet.

The opening of the new Moose Jaw Hospital has been delayed, but the project remains on budget and construction is still on schedule. The facility will open in Fall 2015, instead of the original target of late August.

Replacement of the Saskatchewan Hospital North Battleford

Read more on page 40 of this report.

New Long-Term Care Centre

Construction on the new long-term care centre in Swift Current is moving forward on-time and on-budget to meet its planned opening in spring 2016. A total investment of $108.5 million is being made the facility including the cost of design,

construction, finance, and maintenance in 2014 dollars. The 225-bed centre will replace three aged facilities: Swift Current Care Centre, Prairie Pioneers Lodge and Palliser Regional Care Centre and is expected to save taxpayers $16 million dollars by using the P3 approach compared to a traditional model. (Speech from the Throne 2014) These savings include P3-related costs, such as private financing. A construction camera is capturing each step of the facility's progress with the option to view a time lapse feature, click http://www.cypresshealth.ca/scltc to view the photos.

Urgent Issues Action Fund

The Urgent Issues Action Fund was created in October 2013 to provide $10.04 million to address priority issues identified by health regions stemming from CEO tours of long-term care facilities. As of March 31, 2015, health regions have spent $8.6 million of the $10.04 million to purchase new medical equipment like mechanical lifts and electric beds, make capital improvements like new nurse call systems and food preparation equipment, and train staff in Gentle Persuasive Approaches which helps them provide better care for residents with difficult behaviours and/or dementia. (Speech from the Throne 2014)

Amendments to Three Pieces of Legislation

- ***The Health Information Protection Act*** was strengthened to protect patient privacy. This includes stronger measures to prevent the unauthorized viewing of patient records and a provision authorizing the Minister of Health to appoint a person or body to take control of abandoned patient records. (Speech from the Throne 2014)
- ***The Human Tissue Gift Act*** modernizes Saskatchewan's organ donation and transplantation processes to reduce wait times for people who need organ transplants. Among those who will benefit are 100 people who have waited up to two years for a cornea transplant. (Speech from the Throne 2014)
- ***The Pharmacy Act*** enhances the scope of practice for pharmacists by giving them the authority to administer vaccinations and other drugs as well as ordering, accessing and using lab tests. (Speech from the Throne 2014)

Better Value

Bending the Cost Curve

Health costs continue to increase and as a result a focused effort is required to ensure the health system is sustainable into the future. Part of the solution is to undertake initiatives to achieve the best value for money, improve transparency and accountability, and strategically invest in facilities, equipment and information infrastructure. In 2014-15, health regions and the Saskatchewan Cancer Agency worked to collectively identify $51.9 million in savings through sharing of services, attendance management, and reduction of lost time due to injuries, premium pay and sick time.

Our health system partners are focused on finding efficiencies to provide the best possible health services at the lowest possible cost. We are on track to achieve better care, better health, and better value for the people of our province. The goal for the health system is to bend the cost curve by lowering status quo growth rate of costs by 1.5 per cent per year by 2017.

Utilization of Lean Management Tools to Enhance Quality and Effectiveness.

The Government of Saskatchewan encourages productivity enhancement within government through techniques such as Lean to eliminate unnecessary non-value adding activities and focus on the needs of our patients. (Saskatchewan Plan for Growth)

Lean is a patient-focused approach to managing and delivering care that continuously improves how we work, and improves the quality of care and safety for the patient – from the patient's perspective. Lean processes empower patients and health care providers to collaboratively generate and implement value-added innovative solutions to problems. These improvements are monitored, and improvement data is examined and re-examined continuously.

There are many processes involved in health care. Lean is about finding and eliminating waste in these processes.

Waste is defined as anything that does not add value from the patient's perspective.

Lean makes health care better in several ways:

- It increases safety, by eliminating defects and errors;
- Patients are more satisfied with their care;
- The staff doing the work are the ones who look for waste and find better ways to deliver care;
- It reduces cost, by getting rid of waste; and,
- Patients have better health outcomes.

Creating improvements that make the system more effective and efficient is also allowing us to make the most of our health care dollars. Lean has improved patient care in Saskatchewan while achieving more than $125 million in projected financial benefits through significant one-time savings, capacity increases, productivity gains, and avoided future costs.

The financial savings are due to quality improvements across the healthcare system from 2008 through January 2015, realized through improvements to quality of processes and products, and business cases that identify shared service opportunities will improve the system.

Organizations will continue to pursue Lean efficiencies.

To date, more than 1,000 Lean projects have been launched in Saskatchewan's health system. These efforts are improving patient experiences and outcomes, enhancing staff morale and engagement, increasing system productivity, and freeing-up provider time for patient care and improved service delivery.

Read stories and watch videos of how Lean is being used to make health care better and safer in Saskatchewan at BetterHealthcare.ca, the provincial Lean website. In the 2014-2015 fiscal year, nearly 60 articles about how health regions and other health organizations are using Lean methods were published on the website.

Performance Measures

By March 31, 2017, as part of a multi-year budget strategy, the health system will bend the cost curve by lowering status quo growth rate by 1.5 per cent per year.

By March 31, 2015, shared services will achieve measurable improvements in quality while achieving the $100M in cumulative savings.

Together with the system, 3sHealth has saved a total of $110 million as of February 2015 ($10 million over its five year target).

Combined purchasing (joint contracting) has resulted in $98M in cumulative savings.

Additional savings of $12.3 million have also been found through the Provincial Linen and other payroll services savings initiatives.

Organizations will continue to pursue shared services initiatives that improve quality and reduce cost. By March 31, 2015, the 2014-15 approved business cases for shared services will be presented for feedback and implemented once a final decision is made and an implementation plan is in place.

Business cases are being developed for shared services that have the potential to transform health service delivery. In 2013-14, 3sHealth began the planning for seven business cases to achieve innovation and integration in the health system. In 2014-15, these areas were targeted for improvement: transcription services, environmental services, supply chain services, and enterprise risk management. Work in these areas is being led by 3S Health with the cooperation of the health system and the Ministry.

Organizations will reduce salary costs by focusing on staffing at straight time. By March 31, 2015, we will have spent one per cent less on straight time worked hours and premium hours than in 2013-14, resulting in approximately $20M savings to the system.

The following increases and decreases reflect results in the health system at March 31, 2015:

- Premium shift compensation costs increased by $7.6 million (8.5 per cent) for a total cost of $96.8 million from 2009-10 to 2014-15. This increase is the result of collective bargaining increases.
- Wage Driven Premium hours per fulltime equivalent (FTE) have decreased by 6.23 hours per FTE (12.4 per cent) for a total of 43.84 hours per FTE from 2009-10 to 2014-15.
- Sick Time Compensation costs increased by $12.8 million (19 per cent) for a total cost of $79.8M from 2009-10 to 2014-15. This increase is also a result of collective bargaining increases.
- Sick Time Hours per FTE decreased by 7.56 hours per FTE (8.7 per cent) for a total of 79.86 hours per FTE from 2009-10 to 2014-15

Additional Work to Bend the Cost Curve

Saskatchewan's provincial generic drug pricing strategy, and collaboration with other provinces and territories through the pan-Canadian Pharmaceutical Alliance, has resulted in significantly lower generic drug prices in Saskatchewan since 2011.

Pursuant to Premiers' direction to the Health Care Innovation Working Group in 2012, Canadian provinces and territories continue to secure better prices for generic drugs. The province combined purchasing power with our provincial and territorial partners to establish a price point for 14 of the highest cost, highest utilization generic drugs to 18 per cent of the brand price.

Through a phased-in approach, generic drug prices decreased from a range of 50 per cent to 70 per cent of brand name prices to 35 per cent of brand for most generic drugs as of April 1, 2014. In 2014-15, the Drug Plan completed a price confirmation process with manufacturers to reduce the price to 25 per cent of the brand drug effective April 1, 2015.

In addition, Saskatchewan and Nova Scotia led discussions to establish a framework which was implemented in 2014-15 to provide consistent pricing of newly listed generic drugs across participating provinces and territories (all excluding Quebec at this time).

Starting in February 2015, and until this process is transitioned to the office of the pan Canadian Pharmaceutical Alliance in Ontario, Saskatchewan is serving as the single point of entry for a coordinated price tier confirmation process. This coordinated process is reducing duplication and streamlining the price confirmation process for manufacturers and participating provinces and territories.

Through these domestic and pan-Canadian initiatives to improve value for generic drugs, the Government of Saskatchewan has achieved $60.8 million in savings since 2011.

Strategic Investment in Infrastructure

Maintaining needed health system infrastructure (information technology, facilities, and equipment) is essential to ensuring continuity of health services for our patients. We are taking a strategic provincial approach to ensure standardization, coordination, and integration of investments across the system.

Explore options to improve asset management across system.

During 2014-15, a Hoshin business case proposal for strategic investment in infrastructure (IT, facilities, and equipment) was completed and submitted for review and approval.

Work has begun on the development of a capital asset plan for health facilities in the province.

eHealth has developed an integrated multi-year provincial roadmap for Information technology / information management (IT/IM) which is focused on alignment with healthcare priorities

3S Health completed work with health regions to review current asset management systems for equipment needs.

Redesign and streamline the capital development (new and replacement) process.

A proposal to redesign the current 18 step capital process has been completed. Approval to proceed is pending.

Streamline and consolidate provincial equipment prioritization and funding process.

Work is underway with health regions to review equipment asset management systems and to establish an inventory of health equipment in the province. For example, 3S Health worked with health regions to begin establishing an inventory of health equipment in the province and a review of asset management systems. They are currently identifying and pursuing group purchasing opportunities that may be available for future equipment purchases.

Draft provincial information technology strategic planning process in place, including approved structure and decision making process.

Progress includes:

- An integrated multi-year provincial roadmap for IT/IM focused on alignment with 2015-16 healthcare priorities was completed.
- The criteria for provincial prioritization of projects was defined.
- A portfolio management approach for projects and new initiatives was completed.
- An inventory of IT/IM services across the province was compiled.
- Standard-setting processes and conducted an inventory of current standards were developed. (e.g. enterprise architecture, single identity management solution for providers).

Receive approval for and begin implementation of provincial information technology/information management strategy.

Planning is complete and health region CEO approval will be sought in 2015-16.

Performance Measures

By March 31 2017, all infrastructure (information technology, equipment and facilities) will integrate with provincial strategic priorities, be delivered within a provincial plan and adhere to provincial strategic work.

Progress includes:

- Developed an integrated multi-year provincial roadmap for IT/IM.
- Defined criteria for provincial prioritization of projects.
- Developed a portfolio management approach for projects and new initiatives.
- Conducted an inventory of IT/IM services across the province.
- Developed standard-setting processes and conducted an inventory of current standards. (e.g. enterprise architecture, single identity management solution for providers).

By March 31, 2015, equipment and facility renewal planning processes will be developed to ensure a coordinated and integrated provincial approach.

Facilities - Ministry of Health

Work began on the development of a Capital Asset Plan for health facilities in the province. Work completed in 2014-15 included:

- Scoping of the deliverables.
- Data analysis on facilities (facility condition and operational measures).
- Consultation with affected branches internal to the Ministry.
- Drafting of a working copy to serve as the basis for more detailed work in 2015-16. (The Saskatchewan Plan for Growth).

Information Technology / Information Management – eHealth (The Saskatchewan Plan for Growth)

Progress includes:

- Developed an integrated multi-year provincial roadmap for IT/IM, focused on alignment with 2015-16 healthcare priorities.
- Defined criteria for provincial prioritization of projects.
- Developed a portfolio management approach for projects and new initiatives.
- Conducted an inventory of IT/IM services across the province.
- Developed standard-setting processes and conducted an inventory of current standards. (e.g. enterprise architecture, single identity management solution for providers).

Additional Better Value Health Care Enhancements in 2014-15

The province is committed to the renewal of health care facilities in the province for the benefit of Saskatchewan people. The Saskatchewan Hospital North Battleford and the Swift Current Long-Term Care Facility projects are excellent examples of how government is investing resources to ensure residents are receiving quality care.

Saskatchewan Hospital North Battleford

The Prairie North Health Region has completed its Lean 3P (Production, Preparation, and Process) work where patients, families, and staff were directly involved in the design process. The design for the new facility uses Lean principles of care delivery which will improve patient satisfaction, enhance the flow of services to patients, and increase facility flexibility in the future.

SaskBuilds, the Ministry of Health and the Ministry of Justice (Corrections and Policing) are working together as the new hospital project proceeds as a public-private partnership, with construction targeted to begin in summer 2015. The new complex will include a 188-bed replacement for the existing 156-bed Saskatchewan Hospital North Battleford, and an adjoining 96-room correctional facility that will house both male and female offenders. Programming and treatment for the two populations will be separate. (2014 Speech from the Throne and the Saskatchewan Plan for Growth)

Swift Current Long-Term Care Facility

Construction began in the fall on the new 225-bed Swift Current long-term care facility. Construction is scheduled to be completed by spring 2016. Read more on page 34 of this report.

Better Teams

Efforts in this area help build safe, supportive, and quality workplaces that support patient- and family-centred care and collaborative practices, and help to develop a highly skilled, professional and diverse workforce with a sufficient number and mix of service providers.

Culture of Safety

Improving the safety of patients and healthcare workers is a top priority in Saskatchewan. The provincial focus is to eliminate harm to both the patients we serve and those providing care, and place safety at the heart of the organization's activities.

To ensure better protection of Saskatchewan workers on the job, the Government of Saskatchewan will reduce workplace injuries, promote the importance of workplace safety, and ensure workplaces are in compliance with health and safety regulations. (Saskatchewan Plan for Growth)

Harm can occur in all healthcare settings; however, many of these harms are preventable when safe practices are embedded in daily work. One step towards establishing a culture of safety is to design a safety alert process that empowers patients, families, and healthcare workers to "stop the line" when they spot a potentially dangerous situation and trigger a process to stop the harm before it occurs.

Results

Begin implementation of a provincial Safety Alert and Stop the Line process with the development of a "model line" in the Saskatoon Health Region and coordinate replication in stages, when new processes are working well, and health regions are ready.

A Safety Alert and Stop the Line process "model line" was implemented in April 2014 at St. Paul's Hospital in Saskatoon Health Region. Standard work for reporting events has been developed which identifies response times and expectations for leaders and managers. Performance measures have been collected to determine reliability of processes.

Introduce an awareness campaign, "Who's got your back?" aimed at reducing shoulder and back injuries in the workplace.

The "Who's got your back?" campaign was a collaboration between Saskatchewan Association For Safe Workplaces In Health, WorkSafe Saskatchewan and *Mission:Zero*, and was well-received by the healthcare industry. The campaign promotes proper body mechanics when handling patients or when lifting or maneuvering heavy or awkward objects. Posters and educational materials with "a safe work environment translates into better patient care and injury prevention is within everyone's control" messaging have been circulated throughout healthcare facilities and additional materials can be ordered from WorkSafe Saskatchewan at no cost.

Fully implement at a minimum, Elements 1-2-3 of the Safety Management System:
1. Leadership and Commitment.
2. Hazard Identification and Control.
3. Training and Communication.

The Safety Management System (SMS) provides an organizational framework and standards for safe workplaces and practices. Implementation of the SMS in all health regions establishes a foundation that ensures healthcare environments are using standardized safety practices and responses that work for patients, staff, and families. All health regions have identified a facility of focus and have identified timelines and deliverables for the implementation of the SMS. Some delays have occurred in some regions due to emergent issues (e.g. Ebola virus emergency planning, immunization, and flu season), but there is an ongoing commitment to fully implement the SMS elements.

Performance Measures

To achieve a culture of safety, by March 31, 2020 there will be no harm to patients or staff.

By March 31, 2017, fully implement a provincial Safety Alert/ Stop the Line System.

This target date has been changed to 2018. Find more information about implementation of the system in the first column of this page.

By March 31, 2015, Stop the Line will be replicated in three acute care facilities in Saskatoon and one other agency or region.

Although this target was not met; Stop the Line has been successfully established in St. Paul's Hospital in Saskatoon. The spread of Stop the Line to Saskatoon City Hospital and Royal University Hospital is planned for 2015-16.

Level of readiness for provincial Safety Alert / Stop the Line in each health region.

Health regions across the province have made process improvements that help to build a culture of safety. Nine of thirteen regions have Safety Alert / Stop the Line (SA/STL) procedures, standard work, and communication tools. A provincial readiness assessment tool was developed in January 2015. Key elements and processes that constitute the SA/STL initiative are being identified and will form the basis for the provincial replication plan to roll SA/STL to all health regions.

Number of incidents reported by staff, and by patients and family members.

In order to understand how to enhance the safety of healthcare settings and to be strategic in focusing improvement efforts where they will be most effective, leaders need to know what types of safety issues are occurring. This information comes primarily from those closest to the work. The best reporting of safety issues occurs when patients and staff feel they can speak up and issues will be addressed.

Saskatoon Health Region's Safety Alert / Stop the Line "model line" is helping to build and validate processes that improve safety culture. These processes encourage easy and complete reporting, set expectations for leaders to respond to incidents when they are reported, and build capacity for trend analysis. The levels are:

Level 1: No injury or non-medically significant (no harm or near miss).

Level 2: Minor injury or near miss, requiring first aid, that may result in increased monitoring; staff may have work restrictions, but no time loss.

Level 3: Adverse outcome or significant potential for adverse outcome, including suicide attempt while under care, Stage II pressure ulcers, and staff incidents that result in time loss.

Level 4: Serious adverse event with irreversible complications/death or the potential for serious adverse event with irreversible complications/death, including unanticipated death, suicide while under care, and reportable patient safety incidents.

Health regions have made process improvements to help to build a culture of safety. Nine of 13 health regions have SA/STL procedures, standard work, and communication tools. A provincial Readiness Assessment Tool was developed in January and is being trialed currently. Work is underway to identify key elements and processes that constitute the SA/STL initiative. These will be used to form the provincial replication plan, due in 2015-16.

In 2014-15 twice as many safety incidents were reported, which is an indicator of a strengthening culture of safety.

Number of incidents investigated for root cause, with implementation of a corrective action plan and time from incident to implementation of corrective action plan, and the time from incident to implementation of corrective action plan.

Measures to report these targets are being developed by Saskatoon Health Region.

50 per cent reduction in Shoulder and Back Injuries so that by March 31, 2016 there will be zero shoulder and back injuries.

The target of a 50 per cent reduction from 2013-14 was not met.

Note: *While the healthcare system may not have met all the targets for 2014, improvements have occurred. These, along with the system focus on safety in healthcare workplaces, have resulted in a $0.06 reduction to the premium rate for healthcare industry, which is a savings to the system of $1.23M. This signals staff are working safer with fewer injuries.*

50 per cent reduction in Accepted Workplace Injury Claims:

The target of a 50 per cent reduction in Accepted Workplace Injury Claims was achieved from the baseline established in 2011-12.

Rural Physician Supply

In 2009, the Ministry of Health launched a physician recruitment strategy to increase the number of physicians practicing in the province. To ensure the strategies are addressing physician resource needs in the province, the Ministry brought together stakeholders to review the current strategies through value stream mapping and rapid process improvement workshops.

Government will continue to focus on retaining and attracting physicians, and much progress has been made in the last few years. Since 2007, the number of doctors practicing in the province has increased by over 400. (Speech from the Throne 2014)

Results

Value Stream Map the recruitment process and develop plan for subsequent process improvements.

The Ministry and The Physician Recruitment Agency of Saskatchewan (saskdocs) facilitated the creation of a value stream map of the recruitment process in the spring of 2014. The Ministry led recruitment workshop in fall 2014 resulted in an action plan to streamline and improve the recruitment and retention of physicians. The Ministry continues to work with stakeholders to advance the actions identified.

Develop clear strategic direction for rural training exposure of medical students and residents.

A key component is more focused recruitment of University of Saskatchewan medical residents; the Ministry and saskdocs created a standard recruitment process for medical residents; ongoing consultation is occurring.

The Ministry continues to work with the University of Saskatchewan College of Medicine to develop a strategic plan for distributed medical education. A task group has been created, led by the College of Medicine with Ministry of Health participating.

An additional family medicine training site, Moose Jaw, was established in 2014-15, with further sites under development.

The province has increased the number of rural family medicine distributed training seats from six in 2007 to 20 in 2014.

Develop a provincial physician resource plan and align future physician recruitment strategies with the plan.

A physician resource planning report was commissioned by the Ministry. External experts (Health Intelligence Inc. and Social Sector Metrics) were contracted to lead consultations with stakeholders and draft a physician resource planning framework for the province. The Ministry has received a draft report.

The report will describe the physician supply and demand in the context of team-based care, innovative delivery models, population demographics, and disease predicted over the next ten years; this approach is consistent with a patient first approach and improved patient access. The provincial physician resource plan report will also make a number of key recommendations to ensure both short and long-term strategies align with physician supply needs over time.

The final report is expected to be received by the Ministry in 2015-16 and will be used by the Ministry and health system stakeholders to guide physician resource planning in Saskatchewan over the next 10 years.

Standardize provincial primary care physician contracts.

The Ministry has begun preliminary discussions with health regions to prepare for primary care contract standardization. Formal negotiations have not yet commenced.

By March 31, 2017, increase rural physician supply by 33 per cent.

There are 249 active practicing rural physicians; the result of a seven per cent increase in the number of active practicing rural physicians in 2014-15. In greater context, the number of rural physicians in the province has increased by 21 per cent since March 31, 2013 (from 205 to 249).

A Saskatchewan-based program to assess foreign-trained physicians has been developed; the Saskatchewan International Physician Practice Assessment (SIPPA) supports

the recruitment of more physicians to our province by assessing foreign-trained family physicians from a broad range of countries. Since its inception in 2011, there are currently 180 more physicians practicing in the province. Approximately 96 per cent of these physicians are practicing in rural or regional communities, with an overall retention rate of 92 per cent to-date.

By March 31, 2015, decrease rural physician turnover to eight per cent from 18.1 per cent.

Rural physician turnover has remained stable, averaging around 16 per cent over the last five years; the target of 8.1 per cent has not been achieved. The current turnover measure reflects a variety of factors including physicians who have left the province, have stayed in the province yet moved to another location, or have changed billing practices. Turnover as currently defined does not provide a true reflection of physician retention in the province; as such the Ministry is currently exploring a more accurate measurement.

Although this target was not achieved within the timeframe indicated, there has been significant progress in the number of practicing rural physicians (see above).

2014-15 Financial Overview

The Ministry spent or allocated $5.0 billion in expenditures in 2014-15, $3.9 million less than provided in its budget. During 2014-15, the Ministry received $14.5M through special warrant funding for capital facility construction pressures. The expense savings can mainly be attributed to negotiated agreement savings.

In 2014-15, the Ministry received $15.5 million of revenue, $3.5 million more than budgeted. The additional revenue is primarily due to physician expense reimbursements and the correction of previous year accruals.

Ministry of Health's 2014-15 FTE utilization is 489.8 FTEs, 7.1 FTEs less than its 496.9 FTE budget.

Ministry of Health Comparison of Actual Expense to Estimates

	2013-14 Actuals $000s	2014-15 Estimates $000s	2014-15 Actuals $000s	2014-15 Variance $000s	Notes
Central Management and Services					
Ministers' Salary (Statutory)	95	96	96	-	
Executive Management	2,762	2,437	2,389	(48)	
Central Services	5,020	6,529	4,866	(1,663)	
Accommodation Services	3,299	3,801	3,378	(423)	
	11,176	**12,863**	**10,729**	**(2,134)**	
Regional Health Services					
Athabasca Health Authority Inc.	6,897	7,032	7,032	-	
Cypress Regional Health Authority	115,219	120,491	120,326	(165)	
Five Hills Regional Health Authority	135,957	141,306	140,365	(941)	
Heartland Regional Health Authority	86,639	90,514	90,449	(65)	
Keewatin Yatthe Regional Health Authority	25,375	26,283	26,016	(267)	
Kelsey Trail Regional Health Authority	107,161	111,056	111,056	-	
Mamawetan Churchill River Regional Health Authority	26,917	28,149	28,149	-	
Prairie North Regional Health Authority	201,064	203,923	203,606	(317)	
Prince Albert Parkland Regional Health Authority	199,228	200,260	199,650	(610)	
Regina Qu'Appelle Regional Health Authority	857,613	868,161	867,440	(722)	
Saskatoon Regional Health Authority	963,774	1,005,262	1,003,841	(1,421)	
Sun Country Regional Health Authority	126,618	129,672	129,672	-	
Sunrise Regional Health Authority	183,210	184,454	184,454	-	
Regional Targeted Programs and Services	142,295	135,786	132,969	(2,817)	
Saskatchewan Cancer Agency	148,308	155,680	152,985	(2,695)	
Facilities - Capital	39,554	35,815	75,568	39,753	(1)
Equipment - Capital	13,896	15,300	16,449	1,149	
Regional Programs Support	19,453	18,442	19,513	1,071	
Subtotal	**3,399,178**	**3,477,586**	**3,509,539**	**31,953**	
Provincial Health Services					
Canadian Blood Services	39,273	39,325	38,849	(476)	
Provincial Targeted Programs and Services	64,769	64,273	63,275	(998)	
Provincial Laboratory	25,394	25,912	26,802	890	
Health Research	5,784	5,630	5,830	200	
Health Quality Council	4,871	4,968	5,468	500	
Immunizations	14,738	13,782	13,846	64	
eHealth Saskatchewan	61,144	63,374	66,730	3,356	
Provincial Programs Support	10,590	9,376	9,155	(221)	
Subtotal	**226,563**	**226,640**	**229,955**	**3,315**	

Ministry of Health Comparison of Actual Expense to Estimates

	2013-14 Actuals $000s	2014-15 Estimates $000s	2014-15 Actuals $000s	2014-15 Variance $000s	Notes
Medical Services & Medical Education Programs					
Medical Services - Fee-for-Service	488,652	493,574	513,084	19,510	
Medical Services - Non-Fee-for-Service	145,533	177,922	143,104	(34,818)	(2)
Medical Education System	59,403	67,060	57,661	(9,399)	(3)
Optometric Services	6,856	7,049	9,101	2,052	
Dental Services	1,677	2,183	1,849	(334)	
Out-of-Province	121,228	128,612	122,120	(6,492)	(4)
Program Support	3,932	4,361	3,730	(631)	
Subtotal	**827,281**	**880,761**	**850,649**	**(30,112)**	
Drug Plan & Extended Benefits					
Saskatchewan Prescription Drug Plan	288,724	295,110	297,718	2,608	
Saskatchewan Aids to Independent Living	38,396	43,011	39,849	(3,162)	
Supplementary Health Program	20,214	24,052	21,789	(2,263)	
Family Health Benefits	4,478	4,712	4,011	(701)	
Multi-Provincial Human Immunodeficiency Virus Assistance	222	263	213	(50)	
Program Support	4,128	4,513	4,629	116	
Subtotal	**356,162**	**371,661**	**368,209**	**(3,452)**	
Early Childhood Development	**10,992**	**10,993**	**10,993**	**-**	
Provincial Infrastructure Projects	**71,790**	**43,317**	**59,328**	**16,011**	(5)
APPROPRIATION	**4,903,142**	**5,023,821**	**5,039,403**	**15,582**	
Special Warrant	–	14,500	–	(14,500)	(5)
REVISED TOTAL APPROPRIATION	**4,903,142**	**5,038,321**	**5,039,403**	**1,082**	
Capital Asset Acquisition	(72,306)	(58,240)	(60,159)	(1,919)	(5)
Non-Appropriated Expense Adjustment	4,096	5,435	2,392	(3,043)	
TOTAL EXPENSE	**4,834,932**	**4,985,516**	**4,981,636**	**(3,880)**	
FTE STAFF COMPLEMENT	**515.6**	**496.9**	**489.8**	**(7.1)**	

Approximately 90 percent of the expenditures were provided to third parties for health care services, health system research, information technology support, and coordination of services such as the blood system. The majority of the remaining funding was primarily paid to individuals through the Saskatchewan Prescription Drug Plan and extended benefit programs.

Explanations for Major Variances:

Explanations are provided for all variances that are both greater than 5 percent of the Ministry's 2014-15 Estimates and greater than 0.1 percent of the Ministry's total expense.

1. Increased investments in capital facilities.
2. Primarily due to one-time savings related to physician services.
3. Primarily due to one-time savings related to physician services.
4. Program utilization below budgeted levels.
5. Increased investments for Provincial Infrastructure Projects.

Ministry of Health Comparison of Actual Revenue to Estimates

	2014-15 Estimates $000s	2014-15 Actuals $000s	Variance $000s	Notes
Other Own-source Revenue				
Interest, premium, discount and exchange	115	87	(28)	
Other licenses and permits	42	54	12	
Sales, services and service fees	2,311	2,390	79	
Other	1,417	6,277	4,860	(1)
Total	3,886	8,808	4,922	
Transfers from the Federal Government	8,122	6,736	(1,386)	(2)
TOTAL REVENUE	**12,008**	**15,544**	**3,536**	

The Ministry collects transfer revenue from the federal government for various health-related initiatives and services. The major federal transfers include amounts for some air ambulance services, implementation of the *Youth Criminal Justice Act*, employment assistance for persons with disabilities, programs to assist with drug treatments for youth and programs to assist the integration of internationally-educated health professionals. The Ministry also collects revenue through fees for services such as personal care home licenses and water testing fees. All revenue is deposited to the credit of the General Revenue Fund.

Explanations for Major Variances:

Variance explanations are provided for all variances greater than $1,000,000.

1. Primarily as a result of physician expense reimbursements and correction of previous year accruals.
2. Primarily a result of a new agreement maximums being lower than previous agreements.

2014-15 Regional Health Authorities

Government of Saskatchewan

Operating Fund Audited Financial Statements[1] ($000s)

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Operating Revenues:						
Ministry of Health - General Revenue	124,557	145,432	92,133	27,098	113,180	28,024
Other Provincial Revenue	359	1,785	247	760	1,132	2,132
Federal Government Revenue	55	235	1	53	1	19
Funding from other Provinces	-	-	-	-	-	-
Patient & Client Fees	7,966	3,693	9,617	1,201	8,526	366
Out of Province Revenue (Reciprocal)	990	794	769	4	544	43
Out of Country Revenue	31	106	39	-	30	10
Donations	66	18	64	-	20	1
Ancillary Operations - income	-	192	210	-	772	124
Investment Income	407	335	214	73	198	45
Recoveries	1,601	1,905	1,102	62	770	541
Research Grants	-	-	-	-	-	-
Other Revenue	696	10	249	236	182	208
Total Operating Revenue	**136,729**	**154,505**	**104,645**	**29,487**	**125,355**	**31,514**
Operating Expenses:						
Inpatient & resident services						
Nursing Administration	3,985	1,560	4,626	325	3,658	-
Acute	19,085	23,818	6,427	5,026	15,111	3,704
Supportive	18,188	35,423	9,551	1,783	19,313	1,007
Integrated	9,513	-	22,304	-	5,790	-
Rehabilitation	-	-	-	-	-	-
Mental health & addictions	1,644	2,339	-	-	-	-
Total inpatient & resident services	**52,414**	**63,140**	**42,907**	**7,134**	**43,873**	**4,712**
Physician compensation	**15,368**	**14,770**	**2,434**	**37**	**11,022**	**857**
Ambulatory care services	**3,015**	**7,132**	**186**	**-**	**3,239**	**-**
Diagnostic & therapeutic services	**11,979**	**12,474**	**9,225**	**1,980**	**11,463**	**2,227**
Community health services						
Primary health care	1,999	2,097	1,233	2,694	2,467	3,276
Home care	6,571	9,388	7,291	1,424	8,018	2,059
Mental health & addictions	2,964	7,080	3,051	2,698	2,718	3,316
Population health	3,044	4,199	3,289	2,800	4,985	5,166
Emergency response services	4,781	3,039	5,465	2,502	3,874	1,482
Other community services	1,209	724	450	-	630	796
Total community health services	**20,568**	**26,527**	**20,779**	**12,118**	**22,692**	**16,095**
Support services						
Program support	7,130	7,517	6,639	3,498	7,104	4,434
Operational support	22,116	17,244	20,086	4,188	23,882	3,277
Other support	320	238	490	84	448	31
Employee future benefits	(57)	(42)	(24)	24	(21)	41
Total support services	**29,509**	**24,957**	**27,191**	**7,794**	**31,413**	**7,783**
Ancillary	**22**	**132**	**209**	**-**	**-**	**17**
Total Operating Expenses	**132,875**	**149,132**	**102,931**	**29,063**	**123,702**	**31,691**
Operating Fund Excess/(Deficiency)	**3,854**	**5,373**	**1,714**	**424**	**1,653**	**(177)**
Interfund Transfers	(1,643)	(5,373)	(1,689)	(422)	(1,425)	(397)
Increase (decrease) in fund balances	**2,211**	**-**	**25**	**2**	**228**	**(574)**
Operating Fund Balance - Beginning of the year	7,581	1,428	(1,361)	(1)	(5,647)	762
Operating Fund Balance - End of Year	**9,792**	**1,428**	**(1,336)**	**1**	**(5,419)**	**188**
STATEMENT OF FINANCIAL POSITION						
Operating Assets:						
Cash and Short-term Investments	24,606	20,252	7,590	3,331	9,039	3,054
Accounts Receivable:						
Saskatchewan Health	364	358	85	-	70	-
Other	1,566	1,426	917	750	1,149	916
Inventory	786	813	1,414	238	544	219
Prepaid Expenses	188	912	525	146	789	160
Due from (Community Trust Fund)	-	-	-	-	-	-
Investments	2,008	83	4,255	10	1,280	-
Other Assets	-	-	-	-	33	-
Total Operating Assets	**29,518**	**23,844**	**14,786**	**4,475**	**12,904**	**4,349**
Liabilities and Operating Fund Balance:						
Accounts Payable	5,104	6,932	1,472	1,315	3,691	472
Bank Indebtedness	-	-	-	-	-	-
Accrued Liabilities:						
Accrued Salaries	2,480	3,626	3,478	564	2,762	989
Vacation Payable	7,846	6,126	6,645	1,378	7,123	1,235
Other	-	-	-	-	-	-
Employee future benefits	3,262	3,022	3,034	781	4,093	785
Deferred Revenue	1,033	2,711	1,493	438	655	680
Ministry of Health	577	1,759	827	305	473	324
Non-Ministry of Health	456	952	666	133	182	357
Total Operating Liabilities	**19,725**	**22,417**	**16,122**	**4,476**	**18,324**	**4,162**
Externally Restricted	-	-	-	-	-	-
Internally Restricted	-	-	-	-	-	-
Unrestricted	9,791	1,428	(1,338)	-	(5,418)	189
Operating Fund Balance	**9,791**	**1,428**	**(1,338)**	**-**	**(5,418)**	**189**
Total Liabilities and Fund Balance	**29,516**	**23,845**	**14,784**	**4,476**	**12,906**	**4,351**

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Operating Revenues:							
Ministry of Health - General Revenue	214,660	212,779	925,914	1,067,160	138,108	198,851	3,287,896
Other Provincial Revenue	4,110	1,394	10,935	13,691	857	2,022	39,424
Federal Government Revenue	90	506	6,840	1,197	-	1	8,998
Funding from other Provinces	38,292	-	-	-	-	-	38,292
Patient & Client Fees	11,719	7,000	26,069	14,626	11,028	13,613	115,424
Out of Province Revenue (Reciprocal)	2,671	928	11,499	9,541	527	3,327	31,637
Out of Country Revenue	91	52	1,247	2,344	22	(8)	3,964
Donations	284	37	1,148	-	159	397	2,194
Ancillary Operations - income	806	1,219	7,022	17,942	-	1,267	29,554
Investment Income	202	170	176	-	144	274	2,238
Recoveries	3,875	4,637	13,876	22,612	2,430	1,894	55,305
Research Grants	-	-	286	-	-	-	286
Other Revenue	894	489	7,505	3,923	94	171	14,657
Total Operating Revenue	**277,695**	**229,212**	**1,012,517**	**1,153,036**	**153,369**	**221,810**	**3,629,874**
Operating Expenses:							
Inpatient & resident services							
Nursing Administration	7,822	4,751	3,989	10,582	515	5,413	47,226
Acute	43,364	42,652	221,009	273,775	6,925	33,579	694,475
Supportive	37,124	37,497	120,803	147,179	27,055	46,342	501,265
Integrated	-	-	21,564	-	33,197	-	92,368
Rehabilitation	-	-	6,746	5,072	-	-	11,818
Mental health & addictions	14,466	6,119	12,652	11,718	1,749	2,547	53,234
Total inpatient & resident services	**102,776**	**91,018**	**386,763**	**448,326**	**69,441**	**87,881**	**1,400,385**
Physician compensation	**21,638**	**21,659**	**88,674**	**109,169**	**6,825**	**11,892**	**304,345**
Ambulatory care services	**12,598**	**11,779**	**91,358**	**87,959**	**2,363**	**6,939**	**226,568**
Diagnostic & therapeutic services	**28,868**	**20,004**	**126,906**	**156,019**	**10,410**	**20,742**	**412,297**
Community health services							
Primary health care	6,159	3,151	17,889	4,119	2,443	3,634	51,161
Home care	10,804	12,347	36,510	40,187	10,181	13,137	157,917
Mental health & addictions	11,430	12,497	27,648	34,093	4,804	4,764	117,063
Population health	8,906	7,515	21,182	28,756	4,117	7,050	101,009
Emergency response services	7,018	4,317	17,389	18,680	5,514	6,350	80,411
Other community services	1,434	347	4,129	7,810	483	1,686	19,698
Total community health services	**45,751**	**40,174**	**124,747**	**133,645**	**27,542**	**36,621**	**527,259**
Support services							
Program support	15,967	10,945	51,605	71,302	9,352	14,585	210,078
Operational support	44,432	33,248	152,753	150,084	23,362	38,235	532,907
Other support	404	377	2,935	3,981	2,403	1,598	13,309
Employee future benefits	98	48	155	(73)	3	(37)	115
Total support services	**60,901**	**44,618**	**207,448**	**225,294**	**35,120**	**54,381**	**756,409**
Ancillary	**1,056**	**493**	**2,767**	**11,985**	**-**	**1,325**	**18,006**
Total Operating Expenses	**273,588**	**229,745**	**1,028,663**	**1,172,397**	**151,701**	**219,781**	**3,645,269**
Operating Fund Excess/(Deficiency)	**4,107**	**(533)**	**(16,146)**	**(19,361)**	**1,668**	**2,029**	**(15,395)**
Interfund Transfers	(4,282)	(1,044)	(447)	(858)	(1,285)	(1,958)	(20,823)
Increase (decrease) in fund balances	**(175)**	**(1,577)**	**(16,593)**	**(20,219)**	**383**	**71**	**(36,218)**
Operating Fund Balance - Beginning of the year	(15,070)	(20,201)	(114,406)	(93,284)	(7,023)	(38,482)	(285,704)
Operating Fund Balance - End of Year	**(15,245)**	**(21,778)**	**(130,999)**	**(113,503)**	**(6,640)**	**(38,411)**	**(321,922)**
STATEMENT OF FINANCIAL POSITION							
Operating Assets:							
Cash and Short-term Investments	11,793	7,551	366	13,244	9,419	2,614	112,859
Accounts Receivable:							
Saskatchewan Health	730	33	2,583	3,082	178	287	7,770
Other	3,290	2,012	14,118	17,410	2,610	1,860	48,024
Inventory	1,880	876	4,165	10,625	679	1,157	23,396
Prepaid Expenses	1,595	1,119	7,540	7,527	1,037	1,918	23,456
Due from (Community Trust Fund)	-	-	(7,568)	-	66	-	(7,502)
Investments	2,148	-	-	-	17	733	10,534
Other Assets	-	-	-	-	-	-	33
Total Operating Assets	**21,436**	**11,591**	**21,204**	**51,888**	**14,006**	**8,569**	**218,570**
Liabilities and Operating Fund Balance:							
Accounts Payable	7,977	6,647	39,742	44,712	3,134	6,614	127,812
Bank Indebtedness	-	-	-	-	-	10,402	10,402
Accrued Liabilities:							
Accrued Salaries	5,084	3,770	16,933	23,062	4,582	5,107	72,437
Vacation Payable	13,934	12,352	51,652	50,700	7,623	13,222	179,836
Other	-	-	-	-	-	1,446	1,446
Employee future benefits	7,099	5,820	25,334	27,073	3,657	6,522	90,480,300
Deferred Revenue	2,584	4,779	18,542	19,844	1,649	3,668	58,075,859
Ministry of Health	1,538	3,101	12,233	13,594	687	2,880	38,298
Non-Ministry of Health	1,046	1,678	6,309	6,250	961	788	19,778
Total Operating Liabilities	**36,678**	**33,368**	**152,203**	**165,391**	**20,644**	**46,981**	**540,491**
Externally Restricted	-	-	-	-	-	-	-
Internally Restricted	368	-	(898)	-	5	49	(476)
Unrestricted	(15,612)	(21,777)	(130,101)	(113,503)	(6,643)	(38,461)	(321,449)
Operating Fund Balance	**(15,244)**	**(21,777)**	**(130,999)**	**(113,503)**	**(6,638)**	**(38,412)**	**(321,925)**
Total Liabilities and Fund Balance	**21,434**	**11,591**	**21,204**	**51,888**	**14,006**	**8,569**	**218,566**

[1] Some items may not balance due to rounding.

Restricted Fund Financial Statements[1,2] ($000s)

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Restricted Revenues:						
Ministry of Health - General Revenue Fund	33,607	3,703	829	166	2,159	85
Other Government of Saskatchewan	-	45	206	-	321	566
Federal Government revenue	-	-	-	-	-	-
Funding from other Provinces	-	-	-	-	-	-
Donations	494	8,981	3,839	-	1,099	56
Ancillary Operations - income	-	21	-	-	-	-
Investment Income	72	424	107	-	87	5
Recoveries	-	-	-	-	-	-
Other Revenue	9,525	15	82	28	5	-
Total Restricted Revenue	**43,698**	**13,189**	**5,063**	**194**	**3,671**	**712**
Restricted Expenses:						
Inpatient & resident services						
Nursing Administration	-	51	-	-	-	656
Acute	1,714	695	154	74	1,674	8
Supportive	931	274	54	33	2,029	62
Integrated	507	-	3,861	-	1,176	-
Rehabilitation	-	-	-	-	-	-
Mental health & addictions	-	17	-	-	-	-
Total inpatient & resident services	**3,152**	**1,037**	**4,069**	**107**	**4,879**	**726**
Physician compensation	**-**	**-**	**-**	**-**	**-**	**-**
Ambulatory care services	**93**	**131**	**-**	**-**	**-**	**-**
Diagnostic & therapeutic services	**425**	**577**	**-**	**60**	**-**	**-**
Community health services						
Primary health care	-	160	3	15	-	-
Home care	-	272	29	-	-	-
Mental health & addictions	-	5	-	1	-	-
Population health	-	2	3	27	-	25
Emergency response services	147	1	340	50	132	-
Other community services	-	8	-	-	45	-
Total community health services	**147**	**448**	**375**	**93**	**177**	**25**
Support services						
Program support	-	314	45	68	-	69
Operational support	-	420	-	851	93	-
Other support	-	4,536	-	-	-	-
Total support services	**-**	**5,270**	**45**	**919**	**93**	**69**
Ancillary	**-**	**-**	**-**	**-**	**-**	**1**
Total Restricted Expenses	**3,817**	**7,463**	**4,489**	**1,179**	**5,149**	**821**
Restricted Fund Excess/(Deficiency)	**39,881**	**5,726**	**574**	**(985)**	**(1,478)**	**(109)**
Interfund Transfers	1,640	5,373	1,689	422	1,425	397
Other Transfers	-	-	-	-	-	-
Increase (decrease) in fund balances	**41,521**	**11,099**	**2,263**	**(563)**	**(53)**	**288**
Restricted Fund Balance - Beginning of the year	78,783	53,755	64,238	23,105	56,156	9,434
Restricted Fund Balance - End of Year	**120,304**	**64,854**	**66,501**	**22,542**	**56,103**	**9,722**
STATEMENT OF FINANCIAL POSITION						
Restricted Assets:						
Cash and Short-term Investments	3,886	29,153	4,831	1,248	6,768	833
Accounts Receivable:						
Saskatchewan Health	-	-	417	-	217	-
Other	1,556	374	1,152	-	460	23
Prepaid Expenses	-	-	-	-	-	52
Due From (Community Trust Fund)	-	-	-	-	-	-
Investments	-	272	1,253	1	-	-
Capital Assets	117,277	36,307	65,202	21,292	57,556	8,872
Other Assets	37,308	-	-	-	-	-
Total Restricted Assets	**160,027**	**66,106**	**72,855**	**22,541**	**65,001**	**9,780**
Liabilities and Restricted Fund Balance:						
Accounts Payable	413	8	1,604	-	170	58
Accrued Liabilities	-	-	-	-	-	-
Deferred Revenue (Non-Ministry of Health)	-	-	-	-	-	-
Debt	39,311	1,241	4,751	-	8,727	-
Total Restricted Liabilities	**39,724**	**1,249**	**6,355**	**-**	**8,897**	**58**
Invested in Capital Assets	115,942	35,066	60,451	21,292	48,829	8,866
Externally Restricted	1,656	540	3,433	203	5,339	810
Internally Restricted	2,705	29,250	2,617	1,047	1,936	47
Unrestricted	-	-	-	-	-	-
Restricted Fund Balance	**120,303**	**64,856**	**66,501**	**22,542**	**56,104**	**9,723**
Total Liabilities and Restricted Fund Balance	**160,027**	**66,105**	**72,856**	**22,542**	**65,001**	**9,781**

STATEMENT OF OPERATIONS AND CHANGE IN FUND BALANCES	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Restricted Revenues:							
Ministry of Health - General Revenue Fund	3,262	6,526	13,799	25,695	5,514	2,999	98,344
Other Government of Saskatchewan	-	-	520	39	110	-	1,807
Federal Government revenue	57	-	-	-	-	-	57
Funding from other Provinces	675	-	-	-	-	-	675
Donations	2,434	724	8,040	5,426	4,483	535	36,111
Ancillary Operations - income	-	-	-	-	-	-	21
Investment Income	81	94	24	4,128	70	38	5,130
Recoveries	-	33	-	-	-	-	33
Other Revenue	45	2,099	2,941	3,261	-	131	18,132
Total Restricted Revenue	**6,554**	**9,476**	**25,324**	**38,549**	**10,177**	**3,703**	**160,310**
Restricted Expenses:							
Inpatient & resident services							
Nursing Administration	-	548	-	-	-	8	1,263
Acute	4,221	2,543	8,832	-	349	615	20,879
Supportive	1,924	840	2,044	-	2,163	613	10,967
Integrated	-	-	412	-	1,665	-	7,621
Rehabilitation	-	-	566	-	-	-	566
Mental health & addictions	96	6	-	-	-	2	121
Total inpatient & resident services	**6,241**	**3,937**	**11,854**	**-**	**4,177**	**1,238**	**41,417**
Physician compensation	**-**	**1**	**-**	**-**	**-**	**-**	**1**
Ambulatory care services	**-**	**192**	**338**	**-**	**-**	**26**	**780**
Diagnostic & therapeutic services	**-**	**461**	**687**	**-**	**5**	**491**	**2,706**
Community health services							-
Primary health care	107	4	111	-	57	22	479
Home care	79	18	13	-	4	16	431
Mental health & addictions	-	332	7	-	1	5	351
Population health	11	59	16	-	403	4	550
Emergency response services	107	143	1,544	-	290	63	2,817
Other community services	-	-	-	-	-	7	60
Total community health services	**304**	**556**	**1,691**	**-**	**755**	**117**	**4,688**
Support services							-
Program support	1,914	51	1,520	40,504	-	17	44,502
Operational support	-	551	15,056	-	-	180	17,151
Other support	-	256	-	-	-	5,603	10,395
Total support services	**1,914**	**858**	**16,576**	**40,504**	**-**	**5,800**	**72,048**
Ancillary	**-**	**55**	**331**	**-**	**-**	**25**	**412**
Total Restricted Expenses	**8,459**	**6,060**	**31,477**	**40,504**	**4,937**	**7,697**	**122,052**
Restricted Fund Excess/(Deficiency)	**(1,905)**	**3,416**	**(6,153)**	**(1,955)**	**5,240**	**(3,994)**	**38,258**
Interfund Transfers	4,282	1,044	447	858	1,285	1,958	20,820
Other Transfers	-	-	-	-	-	-	-
Increase (decrease) in fund balances	**2,377**	**4,460**	**(5,706)**	**(1,097)**	**6,525**	**(2,036)**	**59,078**
Restricted Fund Balance - Beginning of the year	66,590	92,571	329,490	474,795	75,394	65,575	1,389,886
Restricted Fund Balance - End of Year	**68,967**	**97,031**	**323,784**	**473,698**	**81,919**	**63,539**	**1,448,964**
STATEMENT OF FINANCIAL POSITION							
Restricted Assets:							
Cash and Short-term Investments	1,990	14,520	5,384	92,604	7,418	5,081	173,716
Accounts Receivable:							
Saskatchewan Health	1,074	631	30	-	-	-	2,369
Other	1,745	553	3,100	1,648	951	57	11,619
Prepaid Expenses	-	-	-	-	-	-	52
Due From (Community Trust Fund)	-	-	7,568	-	-	-	7,568
Investments	134	-	850	88,084	3	300	90,897
Capital Assets	72,014	89,682	317,114	331,497	77,300	73,152	1,267,265
Other Assets	-	550	43	-	-	-	37,901
Total Restricted Assets	**76,957**	**105,936**	**334,089**	**513,833**	**85,672**	**78,590**	**1,591,387**
Liabilities and Restricted Fund Balance:							
Accounts Payable	299	653	2,488	2,754	655	-	9,102
Accrued Liabilities	-	-	-	-	-	24	24
Deferred Revenue (Non-Ministry of Health)	-	-	-	-	-	-	-
Debt	7,690	8,253	7,817	37,381	3,098	15,026	133,295
Total Restricted Liabilities	**7,989**	**8,906**	**10,305**	**40,135**	**3,753**	**15,050**	**142,421**
Invested in Capital Assets	64,324	81,429	309,297	294,116	73,548	58,126	1,171,286
Externally Restricted	2,824	8,790	13,475	179,498	8,031	1,600	226,199
Internally Restricted	1,820	6,811	1,012	84	340	3,814	51,483
Unrestricted	-	-	-	-	-	-	-
Restricted Fund Balance	**68,968**	**97,030**	**323,784**	**473,698**	**81,919**	**63,540**	**1,448,968**
Total Liabilities and Restricted Fund Balance	**76,957**	**105,936**	**334,089**	**513,833**	**85,672**	**78,590**	**1,591,389**

[1] The restricted fund consists of the Capital Fund and Community Trust Fund. The Capital Fund reflects the equity of the RHA on capital assets and any associated long-term debt. The Capital Fund revenue includes revenue from the General Revenue Fund provided for construction of capital projects and/or the acquisition of capital assets. Expenses consist mainly of amortization expense. The Community Trust Fund reflects community-generated assets transferred to the RHA by amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations from donations or municipal tax levies.

[2] Some items may not balance due to rounding.

Operating Fund Audited Financial Statements[1] ($000s)

SCHEDULE OF EXPENSES BY OBJECT	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Operating Expenses:						
Advertising & Public Relations	35	76	59	8	46	20
Board costs	77	56	63	88	93	99
Compensation - benefits	14,489	13,847	13,165	4,076	15,048	4,495
Compensation - employee future benefits	(57)	(42)	(24)	-	(21)	41
Compensation - salaries	77,359	70,177	68,674	18,322	75,481	17,812
Continuing Education Fees & Materials	506	245	114	298	259	97
Contracted-out Services - Other	2,422	2,308	866	309	239	966
Diagnostic imaging supplies	51	132	36	17	9	4
Dietary Supplies	25	144	131	33	130	2
Drugs	1,362	1,561	608	237	679	324
Environmental remediation	-	-	-	-	-	-
Food	2,038	1,226	1,496	304	1,758	210
Grants to ambulance services	1,912	2,948	135	-	2,877	1,231
Grants to Health Care Organizations & Affiliates	2,117	28,408	2,939	336	783	380
Housekeeping and laundry supplies	859	620	574	14	357	28
Information technology contracts	750	648	533	31	777	104
Insurance	256	232	330	90	243	45
Interest	9	3	29	-	222	5
Laboratory supplies	1,102	1,023	611	156	1,047	144
Medical and surgical supplies	2,878	2,899	1,424	381	2,729	359
Medical remuneration and benefits	14,255	14,353	2,440	-	10,992	880
Meeting Expense	-	6	33	-	99	25
Office supplies and other office costs	1,046	539	647	436	423	361
Other	669	65	567	109	523	354
Professional fees	768	876	1,052	300	891	498
Prosthetics	419	514	-	-	-	-
Purchased salaries	162	192	267	1,086	1,008	596
Rent/lease/purchase costs	1,182	1,433	994	823	1,318	648
Repairs and maintenance	2,752	1,735	2,079	626	1,645	648
Supplies - Other	207	141	224	48	417	185
Therapeutic Supplies	-	93	18	-	-	2
Travel	1,350	1,085	919	541	1,211	864
Utilities	1,875	1,589	1,929	395	2,421	264
Total Operating Expenses	**132,875**	**149,132**	**102,932**	**29,064**	**123,704**	**31,691**
Restricted Expenses:						
Amortization	3,111	7,093	4,279	1,179	4,910	656
Loss/(gain) on disposal of fixed assets	292	-	(5)	-	-	-
Mortgage interest	78	101	163	-	209	-
Other	334	267	53	-	29	165
Total Restricted Expenses	**3,815**	**7,461**	**4,490**	**1,179**	**5,148**	**821**
Total Operating and Restricted Expenses	**136,690**	**156,593**	**107,422**	**30,243**	**128,852**	**32,512**

SCHEDULE OF EXPENSES BY OBJECT	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Operating Expenses:							
Advertising & Public Relations	49	132	225	259	134	164	1,207
Board costs	117	70	106	82	68	75	994
Compensation - benefits	32,110	26,641	111,552	119,932	16,711	28,146	400,212
Compensation - employee future benefits	96	48	155	(73)	3	-	126
Compensation - salaries	158,055	130,579	551,026	585,475	84,120	141,612	1,978,692
Continuing Education Fees & Materials	428	215	670	1,942	300	206	5,280
Contracted-out Services - Other	7,132	3,547	19,338	25,445	986	3,118	66,676
Diagnostic imaging supplies	256	120	648	2,728	10	184	4,195
Dietary Supplies	307	169	80	287	160	269	1,737
Drugs	2,966	2,393	14,349	28,790	409	2,287	55,965
Environmental remediation	-	-	75	-	-	-	75
Food	3,949	2,792	7,967	7,744	1,482	3,055	34,021
Grants to ambulance services	3,472	4,131	3,090	12,977	507	3,626	36,906
Grants to Health Care Organizations & Affiliates	6,809	9,987	65,085	111,434	23,242	1,075	252,595
Housekeeping and laundry supplies	1,374	1,329	3,266	4,630	329	1,645	15,025
Information technology contracts	1,586	635	5,834	4,299	645	1,136	16,978
Insurance	396	351	1,768	1,645	408	459	6,223
Interest	31	26	239	672	17	212	1,465
Laboratory supplies	2,054	1,214	6,194	9,381	604	1,269	24,799
Medical and surgical supplies	8,056	5,161	49,919	52,234	1,741	3,608	131,389
Medical remuneration and benefits	21,822	23,069	87,284	104,431	6,728	10,448	296,702
Meeting Expense	107	53	295	269	67	56	1,010
Office supplies and other office costs	2,178	727	3,947	6,406	1,030	1,654	19,394
Other	3,680	398	7,610	3,350	415	514	18,254
Professional fees	1,487	1,019	13,726	1,780	2,575	1,621	26,593
Prosthetics	450	1,654	22,427	17,931	-	198	43,593
Purchased salaries	1,535	3,325	1,342	8,756	645	75	18,989
Rent/lease/purchase costs	1,637	2,046	14,820	11,960	1,261	3,703	41,825
Repairs and maintenance	4,648	2,147	14,424	25,124	2,861	2,971	61,660
Supplies - Other	1,296	1,094	3,626	2,559	309	401	10,507
Therapeutic Supplies	3	99	992	409	77	104	1,797
Travel	1,928	1,841	4,724	4,972	1,604	2,394	23,433
Utilities	3,572	2,733	11,860	14,567	2,249	3,498	46,952
Total Operating Expenses	**273,586**	**229,745**	**1,028,663**	**1,172,397**	**151,697**	**219,783**	**3,645,269**
Restricted Expenses:							
Amortization	8,155	5,502	29,422	36,554	3,915	7,071	111,847
Loss/(gain) on disposal of fixed assets	-	-	375	-	-	-	662
Mortgage interest	299	239	242	718	148	625	2,822
Other	4	319	1,438	3,232	873	-	6,714
Total Restricted Expenses	**8,458**	**6,060**	**31,477**	**40,504**	**4,936**	**7,696**	**122,045**
Total Operating and Restricted Expenses	**282,044**	**235,805**	**1,060,140**	**1,212,901**	**156,633**	**227,479**	**3,767,314**

[1] Some items may not balance due to rounding.

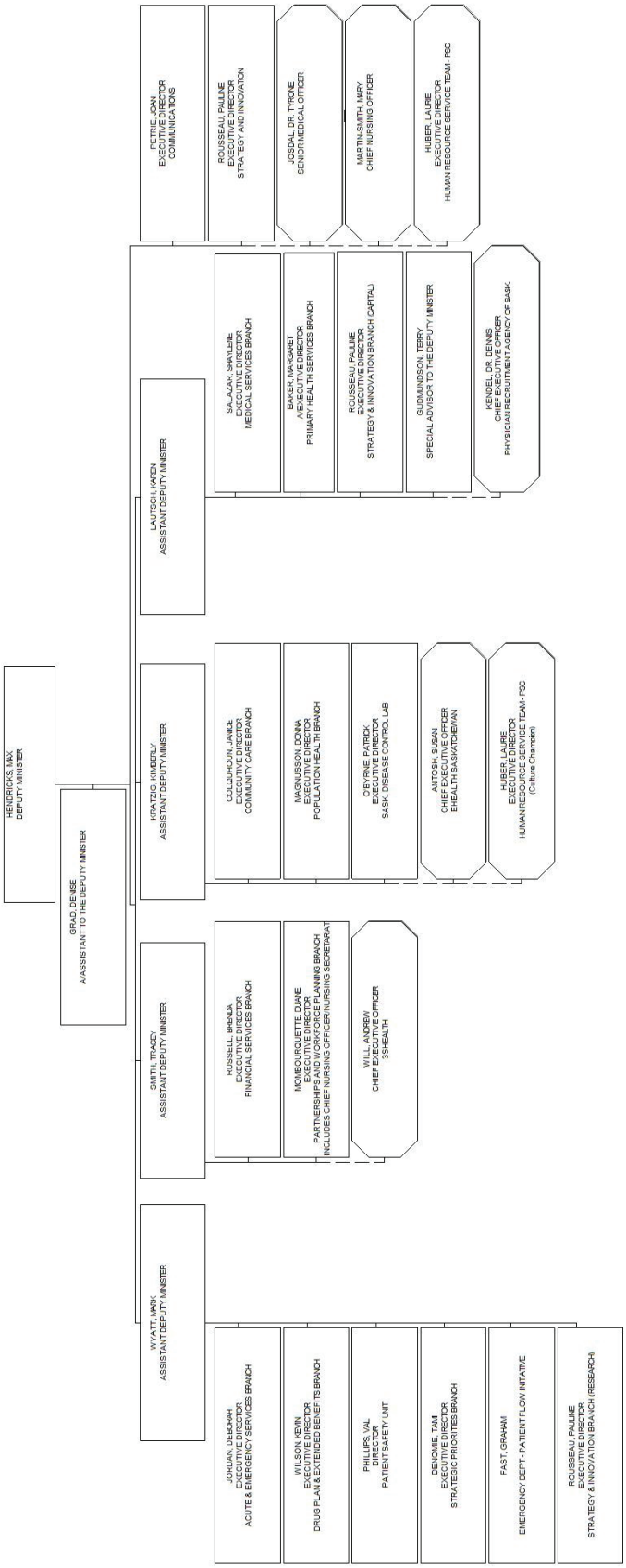
For More Information

This annual report is available online at www.saskatchewan.ca/government/government-structure/ministries/health.

Please visit the Government of Saskatchewan website at www.saskatchewan.ca for more information on the Government of Saskatchewan's programs and services.

Contact information for Ministry of Health programs and services can be found in Appendix III of this report called Saskatchewan Ministry of Health - Directory of Services.

Appendix I: Ministry of Health Executive Organizational Chart



Government of Saskatchewan

Appendix II: Critical Incidents Summary

Saskatchewan was the first jurisdiction in Canada to formalize critical incident reporting through legislation that came into force on September 15, 2004.

A "critical incident" is defined in the Saskatchewan Critical Incident Reporting Guideline, 2004 as "a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a health region or health care organization." With legislative changes enacted in 2007, reporting of critical incidents also became mandatory for the Saskatchewan Cancer Agency (SCA). In addition to the definition of critical incident, the Saskatchewan Critical Incident Reporting Guideline, 2004 contains a specific list of events that are to be reported to the Ministry of Health.

The province has an established network of professionals in place within health regions and the SCA who identify events where a patient is harmed (or where there is a potential for harm), report de-identified information to the Provincial Quality of Care Coordinators (PQCCs) in the Ministry of Health, conduct an investigation and implement necessary changes. Arising out of their review of critical incidents, health regions and the SCA generate recommendations for improvement that they are then responsible for implementing.

The role of the PQCCs is to aggregate, analyze and report on critical incident data, and broadly disseminate applicable system improvement opportunities. The PQCCs also provide advice and support to health regions and the SCA in their investigation and review of critical incidents.

During 2014/15, a total of 194 critical incidents were reported to the Ministry of Health. The number of critical incidents reported in this fiscal year is the same as the total for the previous fiscal year; these two years mark the highest number of incidents reported in a single fiscal year since inception of reporting and are a 22 per cent increase over the number of incidents reported in the 2012/13 fiscal year. A growth in the number of reported critical incidents may be due to increased awareness of, and compliance with, the legislation and regulations. It does not necessarily indicate a growth in the number of critical incidents occurring in the health system.

The Ministry-reported total number of critical incidents for a given fiscal year can change. In exceptional circumstances, an incident may be initially reported to the Ministry of Health, however later determined to not meet the definition of a critical incident. Requests to remove an event from the critical incident are taken seriously, and carefully considered by the Ministry of Health before granting this request.

In these cases, events were deemed to not meet the criteria. The previous year's annual report data showed a total of 195 critical incidents for 2013/14 and 161 critical incidents for 2012/13, which at the time of preparing this report has been amended to 194 and 159 critical incidents, respectively.

Delivery of health care services is a complex process involving many inter-related systems and activities. The formal critical incident reporting process has the potential to increase patient safety by reducing or eliminating the recurrence of similar critical incidents in Saskatchewan through implementation of targeted recommendations which address the underlying, or root causes, of critical incidents. Monitoring of critical incidents can also be used to direct region-wide patient safety and improvement initiatives. When recommendations are felt to be broadly applicable, the learnings are shared with a provincial network of Quality of Care Coordinators, risk managers, health providers, and health education program leaders.

Critical incidents are classified according to the Saskatchewan Critical Incident Reporting Guideline, 2004 in the following categories and sub-categories:

Category	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10	2008/09	2007/08	2006/07	2005/06
I. Surgical Events										
a) Surgery performed on wrong body part	0	0	1	1	1	1	2	3	1	1
b) Surgery performed on the wrong patient	0	0	0	0	0	0	1	0	0	0
c) The wrong surgical procedure performed on a patient	0	2	1	2	0	3	1	0	0	0
d) Retention of a foreign object in a patient after surgery or other procedure	4	3	8	1	3	1	2	3	4	3
e) Death during or immediately after surgery of a normal, healthy patient, or of a patient with mild systemic disease	0	1	1	1	0	0	1	1	1	2
f) Unintentional awareness during surgery with recall by the patient	0	0	1	0	0	0	0	0	0	2
g) Other surgical event	4	6	5	3	11	2	2	5	4	3
Total	**8**	**12**	**17**	**8**	**15**	**7**	**9**	**12**	**10**	**11**
II. Product and Device Events										
a) Contaminated drugs, devices, or biologics provided by the RHA/HCO	1	3	6	1	0	2	2	4	1	0
b) Use or function of a device in patient care in which the device is used or functions other than as intended	5	2	3	1	3	6	9	3	5	6
c) Intravascular air embolism	0	0	0	1	0	0	0	1	0	2
d) Other product or device event	4	6	3	6	5	3	7	2	5	5
Total	**10**	**11**	**12**	**9**	**8**	**11**	**18**	**10**	**11**	**13**
III. Patient Protection Events										
a) An infant discharged to the wrong person	0	0	0	0	0	0	1	0	0	0
b) Patient disappearance	10	8	1	2	5	2	5	5	0	5
c) Patient suicide or attempted suicide	15	17	6	7	17	6	7	9	21	8
d) Other patient protection event	5	2	3	1	3	0	2	1	3	1
Total	**30**	**27**	**10**	**10**	**25**	**8**	**15**	**15**	**24**	**14**

Category	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10	2008/09	2007/08	2006/07	2005/06
IV. Care Management Events										
a) Medication or fluid error	19	22	18	10	18	21	13	11	20	11
b) Hemolytic reaction due to the administration of ABO-incompatible blood or blood products	0	4	1	0	0	0	0	1	2	3
c) Maternal death or serious disability	3	2	2	0	1	1	0	1	3	1
d) Full-term fetal or neonatal death or serious disability	9	10	7	3	2	4	1	4	2	5
e) Hypoglycemia while in the care of the RHA/HCO	0	0	0	0	1	1	0	1	0	6
f) Neonatal death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia	0	0	0	0	0	0	0	0	0	0
g) Stage 3 or 4 pressure ulcers acquired after admission to a facility	7	10	9	6	5	5	1	10	27	16
h) Delay or failure to transfer	5	3	0	1	5	4	6	3	2	1
i) Error in diagnosis	7	19	6	9	6	6	4	5	10	14
j) Other care management issues	49	31	37	36	29	31	44	21	31	30
Total	**99**	**101**	**80**	**65**	**67**	**73**	**69**	**57**	**97**	**87**

V. Environmental Events										
a) Electric shock while in the care of the RHA/HCO	0	0	0	0	0	0	0	0	0	0
b) Oxygen or other gas contains the wrong gas or is contaminated by toxic substances	0	0	0	1	1	0	0	0	0	0
c) Burn from any source	0	1	3	0	0	0	3	1	2	4
d) Patient death from a fall	21	20	17	18	15	8	15	19	12	16
e) Use or lack of restraints or bed rails	0	7	4	1	0	0	0	0	0	3
f) Failure or de-activation of exit alarms or environmental monitoring devices	1	2	0	0	0	1	1	0	1	1
g) Transport arranged or provided by the RHA/HCO	0	1	4	1	4	0	0	0	0	3
h) Delay or failure to reach a patient for emergent or scheduled services	9	2	6	1	2	0	1	2	0	2
i) Other environmental event	3	4	2	4	3	4	4	1	7	3
Total	**34**	**37**	**36**	**26**	**25**	**13**	**24**	**23**	**22**	**32**

Category	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10	2008/09	2007/08	2006/07	2005/06
VI. Criminal Events										
a) Care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider	0	0	0	0	0	0	0	0	0	0
b) Abduction of a patient of any age	0	1	0	0	0	0	0	0	0	0
c) Sexual assault of a patient	5	0	3	3	1	1	2	5	3	0
d) Physical assault of a patient within or on grounds owned or controlled by the RHA/HCO	3	3	0	2	1	0	2	0	1	1
e) Sexual or physical assault of a patient perpetrated by an employee	1	1	1	3	4	1	2	2	2	1
f) Other criminal event	4	1	0	1	0	1	2	3	1	1
Total	**13**	**6**	**4**	**9**	**6**	**3**	**8**	**10**	**7**	**3**
Total CIs Reported	**194**	**194****	**159****	**127**	**146**	**115**	**143**	**127**	**171**	**160**

* Data current as of April 14, 2015

*** Note: Numbers with a double asterisk have changed from the 2013/14 annual report submission as occasionally cases initially reported to the Ministry of Health are later determined to not meet the definition of critical incident and are removed from the total.*

Appendix III: Saskatchewan Ministry of Health Directory of Services

Regional Health Authorities

www.saskatchewan.ca/live/health-and-healthy-living/provincial-health-system

Regional Health Authority offices:

Athabasca Health Authority	(306) 439-2200
Cypress Regional Health Authority	(306) 778-5100
Five Hills Regional Health Authority	(306) 694-0296
Heartland Regional Health Authority	(306) 882-4111
Keewatin Yatthé Regional Health Authority	(306) 235-2220
Kelsey Trail Regional Health Authority	(306) 873-6600
Mamawetan Churchill River Regional Health Authority	(306) 425-2422
Prairie North Regional Health Authority	(306) 446-6606
Prince Albert Parkland Regional Health Authority	(306) 765-6600
Regina Qu'Appelle Regional Health Authority	(306) 766-7777
Hospitals	(306) 766-5100
Saskatoon Regional Health Authority	(306) 655-3300
Sun Country Regional Health Authority	(306) 842-8399
Sunrise Regional Health Authority	(306) 786-0100

Saskatchewan Cancer Agency

Regina	(306) 766-2213
Saskatoon	(306) 655-2662

Saskatchewan Health Card Applications

To apply for a Saskatchewan Health Services Card, report changes to personal or registration information, or for more information about health registration:

Health Registries:
Phone: 306-787-3251
1-800-667-7551 *(toll-free Canada & US)*

Email: change@ehealthsask.ca

Vital Statistics:
Phone: 306-787-3251
1-800-667-7551 *(toll-free Canada & US)*

Email: vitalstatistics@ehealthsask.ca

Apply online for a Saskatchewan Health Services Card at www.saskatchewan.ca/live/health-and-healthy-living/health-cards

Update personal and registration information online at www.saskatchewan.ca/live/health-and-healthy-living/health-cards

Email: change@ehealthsask.ca

More information available at www.saskatchewan.ca/live/health-and-healthy-living/health-benefits-and-prescription-drug-plans

For health information from a registered nurse 24 hours a day,

Call HealthLine: 811
TTY ACCESS: 1-888-425-4444
HealthLine Online: www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/healthline

Problem Gambling Help Line:

1-800-306-6789

Smokers' HelpLine:

1-877-513-5333
www.smokershelpline.ca

Saskatchewan Air Ambulance program

Saskatoon: (306) 933-5255
24-Hour Emergency in Saskatoon: (306) 933-5360
24-Hour Emergency Toll-free: 1-888-782-8247
www.saskatchewan.ca/live/health-and-healthy-living/emergency-medical-services/ambulance-services

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Supplementary Health Program

Regina: (306) 787-3124
Toll-Free within Saskatchewan: 1-800-266-0695
www.saskatchewan.ca/live/health-and-healthy-living/health-benefits-and-prescription-drug-plans/extended-benefits-and-drug-plan/programs

Family Health Benefits

For eligibility and to apply:
Regina: (306) 787-4723
Toll-Free: 1-888-488-6385

For information on what is covered:
Regina: (306) 787-3124
Toll-Free: 1-800-266-0695

www.saskatchewan.ca/live/health-and-healthy-living/health-benefits-and-prescription-drug-plans/extended-benefits-and-drug-plan/programs

Special Support applications for prescription drug costs:

To apply:
www.saskatchewan.ca/live/health-and-healthy-living/health-benefits-and-prescription-drug-plans/extended-benefits-and-drug-plan/programs/special-support-program

Applications also available at all Saskatchewan pharmacies

For inquiries:
Regina: (306) 787-3317
Toll-Free within Saskatchewan: 1-800-667-7581

Saskatchewan Aids to Independent Living (SAIL)

Regina: (306) 787-7121
Toll Free: 1-888-787-8996
www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/support-programs-and-services/sail

Email: dp.sys.support@health.gov.sk.ca

Out-of-province health services:

Regina: (306) 787-3475
Toll-Free within Saskatchewan: 1-800-667-7523
www.saskatchewan.ca/live/health-and-healthy-living/health-benefits-and-prescription-drug-plans

To obtain refunds for out-of-province physician and hospital services, forward bills to:

Medical Services Branch
Ministry of Health
3475 Albert Street
Regina SK S4S 6X6

Prescription Drug Program:

Regina: (306) 787-3317
Toll-Free within Saskatchewan: 1-800-667-7581

To obtain refunds for out-of-province drug costs, forward bills to:

Drug Plan and Extended Benefits Branch
Ministry of Health
3475 Albert Street
Regina SK S4S 6X6

Appendix IV: Summary of Saskatchewan Ministry of Health Legislation

The Ambulance Act

The Act regulates emergency medical service personnel and the licensing and operation of ambulance services.

The Cancer Agency Act

The Act sets out the funding relationship between Saskatchewan Health and the Saskatchewan Cancer Agency and its responsibility to provide cancer-related services.

The Chiropractic Act, 1994

The Act regulates the chiropractic profession in the province.

The Dental Disciplines Act

The Act regulates the six dental professions of dentistry, dental hygiene, dental therapists, dental assistants, denturists and dental technicians.

The Dieticians Act

The Act regulates dieticians in the province.

The Emergency Medical Aid Act

The Act provides protection from liability for physicians, nurses and others when they are providing, in good faith, emergency care outside a hospital or place with adequate facilities or equipment.

The Family and Community Services Act

This Act authorizes the Minister to undertake any action needed to promote the growth and development of family and community services and resources.

The Fetal Alcohol Syndrome Awareness Day Act

The Act establishes that September 9th of each year is designated as Fetal Alcohol Syndrome Awareness Day

The Health Administration Act

The Act provides the legal authority for the Minister of Health to make expenditures, undertake research, create committees, operate laboratories and conduct other activities for the benefit of the health system.

The Health Districts Act

Most of the provisions within this Act have been repealed with the proclamation of most sections of *The Regional Health Services Act*. Provisions have been incorporated with regard to payments by amalgamated corporations to municipalities.

The Health Facilities Licensing Act

The Act governs the establishment and regulation of health facilities such as nonhospital surgical clinics.

The Health Information Protection Act

The Act protects personal health information in the health system in Saskatchewan and establishes a common set of rules that emphasize the protection of privacy, while ensuring that information is available to provide efficient health services.

The Health Quality Council Act

The Act governs the Health Quality Council, which is an independent, knowledgeable voice that provides objective, timely, evidence informed information and advice for achieving the best possible health care using available resources within the province.

The Hearing Aid Sales and Services Act

The Act regulates private businesses involved in the testing of hearing and the selling of hearing aids.

The Human Tissue Gift Act

The Act regulates organ donations in the province.

The Licensed Practical Nurses Act, 2000

The Act regulates licensed practical nurses in the province.

The Medical Laboratory Licensing Act, 1994

The Act governs the operation of medical laboratories in the province.

The Medical Laboratory Technologists Act

The Act regulates the profession of medical laboratory technology.

The Medical Profession Act, 1981

The Act regulates the profession of physicians and surgeons.

The Medical Radiation Technologists Act, 2006

The Act regulates the profession of medical radiation technology. Once proclaimed, this Act will repeal and replace *The Medical Radiation Technologists Act*.

The Mental Health Services Act

The Act regulates the provision of mental health services in the province and the protection of persons with mental disorders.

The Midwifery Act

The Act regulates midwives in the province.

The Naturopathy Act

The Act regulates naturopathic practitioners in Saskatchewan.

The Occupational Therapists Act, 1997

The Act regulates the profession of occupational therapy.

The Opticians Act

The Act regulates opticians (formally known as ophthalmic dispensers) in the province. Once proclaimed, this Act will repeal and replace *The Ophthalmic Dispensers Act*.

The Optometry Act, 1985

The Act regulates the profession of optometry.

The Paramedics Act

The Act regulates paramedics and emergency medical technicians in the province.

The Personal Care Homes Act

The Act regulates the establishment, size, and standards of services of personal care homes.

The Pharmacy Act, 1996

The Act regulates pharmacists and pharmacies in the province.

The Physical Therapists Act, 1998

The Act regulates the profession of physical therapy.

The Podiatry Act

The Act regulates the podiatry profession.

The Prescription Drugs Act

The Act provides authority for the provincial drug plan and the collection of data for all drugs dispensed within the province.

The Prostate Cancer Awareness Month Act

The Act raises awareness of prostate cancer in Saskatchewan.

The Psychologists Act, 1997

The Act regulates psychologists in Saskatchewan.

The Public Health Act

Sections 85-88 of this Act remain in force in order that governing boards of some facilities can continue to operate.

The Public Health Act, 1994

The Act provides authority for the establishment of public health standards, such as public health inspection of food services.

The Regional Health Services Act

This Act addresses the governance and accountability of the regional health authorities, establishes standards for the operation of various health programs and will repeal *The Health Districts Act*, *The Hospital Standards Act*, and *The Housing and Special-care Homes Act*.

The Registered Nurses Act, 1988

The Act regulates registered nurses in Saskatchewan.

The Registered Psychiatric Nurses Act

The Act regulates the profession of registered psychiatric nursing.

The Residential Services Act

The Act governs the establishment and regulation of facilities that provide certain residential services. The Ministries of Justice, Social Services, and Health administer this Act.

The Respiratory Therapists Act

The Act regulates the profession of respiratory therapists.

The Saskatchewan Health Research Foundation Act

The Act governs the Saskatchewan Health Research Foundation, which designs, implements, manages, and evaluates funding programs to support a balanced array of health research in Saskatchewan.

The Saskatchewan Medical Care Insurance Act

The Act provides the authority for the province's medical care insurance program and payments to physicians.

The Speech-Language Pathologists and Audiologists Act

The Act regulates speech-language pathologists and audiologists in the province.

The Tobacco Control Act

This Act controls the sale and use of tobacco and tobacco-related products and allows for making consequential amendments to other Acts.

The Tobacco Damages and Health Care Costs Recovery Act

The Act is intended to enhance the prospect of successfully suing tobacco manufacturers for the recovery of tobacco related health care costs. It was proclaimed in force and became law in May 2012.

The Vital Statistics Act, 2009

This Act provides authority for the keeping of vital statistics and making consequential amendments to other Acts.

The Vital Statistics Administration Transfer Act

This Act originally provided authority for the transfer of the administration of *The Vital Statistics Act, 1995*, *The Change of Name Act, 1995* and other statutory duties of the Director of Vital Statistics to the Information Services Corporation of Saskatchewan, and making consequential amendments to other Acts. This Act was amended to transfer the administration of *The Vital Statistics Act, 1995*, *The Change of Name Act, 1995* and other statutory duties of the Director of Vital Statistics to eHealth Saskatchewan.

The White Cane Act

The Act sets out the province's responsibilities with respect to services for the visually impaired.

The Youth Drug Detoxification and Stabilization Act

The Act provides authority to detain youth who are suffering from severe drug addiction/abuse.

Appendix V: Legislative Amendments in 2014-15

In the 2014-15 year, one Act was introduced for amendment.

The Mental Health Services Amendment Act, 2013

The amendments to The Mental Health Services Act that were introduced included a number of administrative and programming changes. These amendments received Royal Assent, but are not yet proclaimed in force.

- Administrative changes are aimed at reflecting a decentralized, regional delivery of mental health services.
- Programming changes include:

a) Repealing sections of the Act dealing with confidentiality and release of information and substituting *The Health Information Protection Act* to allow for better collaboration between government Ministries;

b) Reducing the criteria for Community Treatment Orders (CTOs), allowing for involuntary treatment in the community, and increasing the time period of CTOs in order to reduce barriers to treatment for very vulnerable clients;

c) Transferring the responsibility for licensing Mental Health Approved Homes from the Ministry to health regions, to align closer with operational practices.

d) Allowing for use of modern technology and Justices of the Peace to issue warrants for involuntary examination under *The Mental Health Services Act*, thus increasing access to persons in need; and

e) Using *The Facility Designation Regulations* instead of *The Mental Health Services Act* to designate facilities.

Appendix VI: Repealed Legislation in 2014-15

In the 2014-15 year, a number of Acts were repealed through *The Miscellaneous Statutes Repeal Act, 2013* (No.2). This Act repealed four Public Acts and 13 Private Acts.

The Public Acts that were repealed were:

1. ***The Dental Care Act***

   This Act from 1979 used to govern the Ministry's former dental program. Currently, the Ministry provides funding for dental health to the regions and northern areas to deliver this programming. As service delivery devolved to the regions, this Act was no longer needed.

2. ***The Medical and Hospitalization Tax Repeal Act***

   This Act from 1979 repealed taxes and premiums from 3 separate Acts:

   - The premium levied under *The Saskatchewan Medical Care Insurance Act* (section was repealed in 2002).
   - The tax levied under *The Saskatchewan Hospitalization Act* (Act repealed in 2002).
   - The personal tax levied upon the residents of Health Region No. 1 (Swift Current) under *The Health Services Act* (Act repealed in 1997).

   This repeal Act stated that the aforementioned joint and personal taxes shall not be levied in 1974 and succeeding years. The Act was no longer needed as the aforementioned had long since been repealed.

3. ***The Mutual Medical and Hospital Benefit Associations Act***

   This Act from 1941 was used to govern Mutual Medical and Hospital Benefit Associations (i.e. the affairs of community clinics). All community clinics are now continued under *The Co-operatives Act, 1996*. Given this shift, this Act was no longer required as its purpose was fulfilled.

4. ***The Senior Citizens' Heritage Program Act***

   This Act from 1986 provided Heritage Grants to certain senior citizens (i.e. low-income senior citizens). In 1992, the Act was amended to end the availability of this particular grant program to seniors, making no person eligible for a grant with respect to any year commencing after December 31, 1992. Being that the program is long discontinued, the purpose of this Act was fulfilled and was no longer required.

The Private Acts that were repealed were:

1. ***An Act to validate a Certain Agreement with regard to the Lady Minto Union Hospital at Edam***

   This Act from 1917 related to a one-time capital agreement between the area municipalities for the construction of the hospital. The facility was later decommissioned and demolished. It was replaced in 1991 with a new facility (the Lady Minto Health Care Centre). Given this, the purpose of this Act was fulfilled and it was no longer required.

2. ***An Act to incorporate Les Soeurs de la Charité de Notre Dame d'Evron***

   The Sisters *(Les Sœurs de la Charité de Notre Dame d'Evron)* supported the repeal of their incorporating Act. As they are currently based in Alberta with no Sisters in this province, this Act was no longer required.

3. ***An Act to provide for Tax Exemption of Certain Property of Sisters of Charity, Providence Hospital, Moose Jaw***

   This Act from 1939 related to the hospital providing acute care services in Moose Jaw; services were later consolidated with the Moose Jaw Union Hospital in the early 1990s. The facility has since been decommissioned and demolished, thus the purpose of this Act was fulfilled and it was no longer required.

4. ***An Act to Incorporate Regina Grey Nuns' Hospital***

   This corporation was used in relation to the formerly known Regina Grey Nuns Hospital (currently the Pasqua Hospital). Since Grey Nuns had not utilized this corporation for many years, the Act was no longer needed.

5. ***An Act to incorporate St. Joseph's Hospital (Grey Nuns) of Gravelbourg***

   This Act from 1959 related to hospital ownership, which was later transferred to the Saskatchewan Catholic Health Corporation. Through an Order in Council, the corporation is continued as a non-profit under *The Non-profit Corporations Act, 1995*. As such the Act was no longer required.

6. ***An Act to confirm a Certain Agreement between the City of Yorkton and Yorkton Union Hospital Board***

   This Act from 1960 was respecting certain agreement between the City of Yorkton and Yorkton Union Hospital Board. In 1994, the Yorkton Union Hospital Board was dissolved and the facility was transferred to the former East Central District Health Board. Given this, the purpose of the Act was fulfilled and was no longer needed.

7. ***An Act to incorporate St. Elizabeth's Hospital of Humboldt***

   This Act came into force in 1961. Hospital ownership was transferred to the Catholic Health Corporation of Saskatchewan and through an Order in Council, the corporation is continued as a non-profit. The hospital corporation was amalgamated with the Saskatoon Health Region in 2009 and the hospital was subsequently demolished. Given this, the purpose of the Act was fulfilled and was no longer needed.

8. ***An Act to incorporate St. Joseph's Hospital of Macklin***

   This Act came into force in 1961. Hospital ownership and operation was transferred to the Catholic Health Corporation of Saskatchewan in 2013. Through an Order in Council, the corporation has been continued as a non-profit under *The Non-profit Corporations Act, 1995*. Given this, the purpose of the Act was fulfilled and was no longer needed.

9. ***An Act to incorporate St. Michael's Hospital of Cudworth***

   This Act came into force in 1961. The hospital was closed in 1976 and decommissioned in 1998. Given this, the purpose of the Act was fulfilled and was no longer needed.

10. ***An Act to incorporate Holy Family Hospital, Prince Albert***

    This Act came into force in 1966. The hospital provided acute care services in Prince Albert and in the early 1990s, services were consolidated at the Victoria Hospital. The facility was amalgamated with the former Prince Albert Health District and was eventually demolished. Given this, the purpose of the Act was fulfilled and was no longer needed.

11. ***An Act to incorporate Swift Current Nursing Home***

    This Act came into force in 1967. The facility was sold to the Swift Current Health District (which took over the Care Centre on April 1, 1997). As such, the purpose of the Act was fulfilled and was no longer needed.

12. ***An Act to incorporate St. Therese Hospital, Tisdale***

    This Act came into force in 1969. The hospital became a municipally owned facility (Tisdale Union Hospital) in the 1970s, and was then amalgamated with the former Pasqua District Health Board in 1993. Given this, the purpose of the Act was fulfilled and was no longer needed.

13. ***The Sisters of Charity (Grey Nuns) of Saskatchewan Amendment Act, 1996***

    This Act was repealed as it had not been utilized by the Grey Nuns for many years.

Appendix VII: New Regulations in 2014-15

In 2014-15 one new set of regulations was created.

The Newborn Screening Regulations

These regulations were developed to:

- Provide a regulatory framework for the program which aids in the detection, prevention and management of screenable diseases in all newborns;
- Clarify responsibility for program delivery including sample collection, recording of results, locating newborns, disclosure and request for information to CEOs of health regions;
- Provide a clear process for parents who decline to participate in the program; and
- Establish guidelines to inform the health care system and public.

Appendix VIII: Regulatory Amendments in 2014-15

In the 2014-15 year, five sets of regulations were amended.

The Disease Control Amendment Regulations, 2014

These regulations were amended to improve disease control in Saskatchewan. Specifically, they:

- Require medical health officers to investigate clusters of non-communicable diseases to determine if there are public health implications;
- Strive to standardize HIV reporting and management. This aligns with the goals of the HIV Strategy for Saskatchewan and supports approaches aimed at decreasing HIV;
- Expand information sharing from medical laboratories with Canadian Blood Services to ensure the blood supply remains safe for the public;
- Allow sharing of information with the Saskatchewan Transplant Program;
- Allow for improved surveillance of communicable diseases in Saskatchewan;
- Allow for a central laboratory surveillance program for designated communicable diseases in Saskatchewan;
- Allow medical health officers to conduct more comprehensive and relevant investigations by enabling them to obtain previous test results on individuals with a category I or category II communicable disease. This helps to establish the risk period and narrow the time frame for identifying contacts that require notification and follow-up; and,
- Enable for the reporting of diseases with the most public health significance.

The Drug Schedules Amendment Regulations, 2014

These amendments enable pharmacists to dispense medications that have been prescribed to Saskatchewan patients by Nurse Practitioners from other jurisdictions.

The Health Information Protection Amendment Regulations, 2015

These amendments were made to reflect the changes in trusteeship of registration information, as a subset of personal health information, which is used to register individuals for health services.

The Hospital Standards Amendment Regulations, 2014

These amendments involved the following areas:

- Repealing references to newborn screening (due to the introduction of The Newborn Screening Regulations);
- Repealing references to disease control (due to amendments known as The Disease Control Amendment Regulations, 2014);
- Enabling Nurse Practitioners to provide peri-operative care and assessment to patients who have been referred for surgery;
- Updating language to align with other amendments being made in the system (i.e. amendments to The Mental Health Services Act); and,
- Repealing references to the specific administration of anaesthetics and associated equipment during surgery. As these are highly documented and regulated processes pertaining to clinical practice, it is more timely and optimal to rely on clinical practise guidelines rather than regulations, as the guidelines are established and updated by professional bodies that set and monitor these clinical practises).

The Saskatchewan Medical Care Insurance Payment Amendment Regulations, 2014

These amendments were required to update the Physician Payment Schedule for negotiated and approved rates effective April 1, 2013, and newly negotiated and approved insured services effective October 1, 2013 and April 1, 2014.

Appendix IX: Acronyms and Definitions

3P	Production, Preparation, and Process (Lean term)
A3	An project plan detailing targets and measures (Lean term)
DVM	Daily Visual Management helps teams keep their work on track, make improvements, monitor improvements and monitor progress towards priorities and goals. A visibility wall (a Lean term) is an essential element of daily visual management. Provides a permanent location to easily view unit data and charts posted under the following categories: quality, cost, delivery, safety and morale. (Lean term)
EHR	Electronic Health Record
EMR	Electronic Medical Record
FTE	Full Time Equivalent (used in Human Resources)
HCO	Health Care Organization
Hoshin Kanri	A strategic planning method used to determine and deploy breakthrough priorities that will transform health care, and obtain feedback from people closest to the service to prioritize and implement the breakthroughs. (Lean term)
Hoshins	Individual breakthrough activities designed to achieve significant performance improvements or to make significant changes in the way an organization, department, or process operates. (Lean term)
HQC	Health Quality Council
Lean	Patient-first approach that puts the needs and values of patients and families at the forefront, and uses proven methods to continuously improve the health system.
Kaizen	A Japanese term for "continuous improvement" or "change for the better." Typically, a short team-based improvement effort.
KPO	Kaizen Promotion Office (Lean term)
KOT	Kaizen Operations Team (Lean term)
MedRec	Medication Reconciliation. A formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.
P3	Public-Private Partnership
PDSA	Plan Do Study Act. A four-step improvement cycle for managing small tests of change.
PHC	Primary Health Care
QI	Quality Improvement (Lean term)
RHA	Regional Health Authority, also called a health region
RPIW	Rapid Improvement Workshop. Brings a team of employees, physicians, and a patient together for a week to examine a problem, propose solutions, and implement sustainable changes. See an example at https://youtu.be/ewGe25wMfec
Plan for Growth	A document detailing ____called the Saskatchewan Plan for Growth Vision 2020 and Beyond
SCA	Saskatchewan Cancer Agency
SDCL	Saskatchewan Disease Control Laboratory (formerly known as the Provincial Laboratory)
SIMS	Saskatchewan Immunization Management System
SHN!	Safer Healthcare Now! is a program of the Canadian Patient Safety Institute improving the safety of patient care throughout Canada by providing resources and expertise for frontline health care providers and others who want to improve patient safety.
SIS	Surgical Information System
SSO	Shared Services Organization
Standard Work	Standard work describes how a process should consistently be executed. It provides a baseline from which a better approach or process can be developed. (Lean term)

Tertiary Care	Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities (merriam-webster.com)
Value stream	Value stream refers to the steps in a process required to produce a product or service. (Lean term)
Visibility Wall	Provides a permanent location to easily view the Lean and quality improvement work of an organization. (Lean term)
Waste	Waste refers to any activity that does not add value to the final output. (Lean helps to eliminate seven types of waste: overproduction, excess inventory, excess waiting, excess transportation, excess motion, unnecessary steps in a process, and defects. (Lean term)