Ministry of Health




Annual Report for 2015-16

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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 28, 2016

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

May it Please Your Honour:

This annual report outlines how our the health system's actions support government's overall direction and Budget for 2015-16 and reflects government's commitment to increased accountability, honouring its commitments, and responsibly managing expenditures.

Our health system is committed to thinking and acting as one, and this document reflects our team approach across health regions, agencies and the Ministry of Health to provide the best patient and family centred care and bend the cost curve. You will see evidence of incremental changes in the health system that benefit patients through continuous improvement activity in health regions.

These times will be remembered for the province's visionary patient-centred focus that continues to be observed and adopted across the country and internationally. We are proud of the work that health providers are doing in our priority areas of seniors' care, emergency department waits, and patient flow as well as all other areas. We are excited about the participation levels of patients and their families who are contributing directly to improvements in care for all of the residents of the province.

We respectfully submit the Annual Report of the Ministry of Health for the fiscal year ending March 31st, 2016.

Dustin Duncan

Minister of Health

Greg Ottenbreit

Minister Responsible for Rural and Remote Health

Max Hendricks
Deputy Minister of Health

July 28, 2016

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 respectfully submit the Annual Report of the Ministry of Health for the fiscal year ending March 31, 2016.

As Deputy Minister of Health, I take responsibility for our Ministry's public accountability and ensure all key actions and associated economic or fiscal implications contained in this report are, to the best of my knowledge, accurate and reliable.

The health system has overcome many challenges this year including serving an increasing population, managing lower revenues, welcoming Syrian refugees, and managing the tremendous health response to the forest fires which threatened northern Saskatchewan. Our health system went above and beyond in every case to help make sure residents' health needs were met.

This annual report captures how through diligence, concern, and compassion, the Ministry of Health and health system partners are doing our best to help Saskatchewan 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.

Max Hendricks

Deputy Minister of Health

Introduction

This annual report for the Ministry of Health presents the Ministry's results for the fiscal year ending March 31, 2016. It provides results of publicly committed strategies, key actions, and performance measures identified in the *Ministry of Health Plan for 2015-16*. It also reflects progress toward commitments from the *Government Direction for 2015-16*, the *Saskatchewan Plan for Growth – Vision 2020 and Beyond*, throne speeches and the Ministry.

The annual report demonstrates the Ministry's commitment to effective public performance reporting, transparency and accountability to the public.

Alignment with Government's Direction

The Ministry's activities in 2015-16 align with Government's vision and four goals:

Saskatchewan'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."

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

Together, all ministries and agencies support the achievement of Government's four goals and work towards a secure and prosperous Saskatchewan.

Ministry Overview

The Ministry of Health:

- Provides leadership on strategic policy;
- Sets goals and objectives for the provision of health services;
- Allocates funding and leads financial planning for the health system;
- Provides provincial oversight for programs and services, including acute and emergency care, community services, and long term care;
- Monitors and enforces standards in privately delivered programs such as personal care homes;
- Administers public health insurance programs such as the Saskatchewan Medical Care Insurance Plan;
- Provides eligible residents with prescription drug plan benefits and extended health benefits, including: Supplementary Health, Family Health Benefits, and Saskatchewan Aids to Independent Living (SAIL);
- Provides 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;
- Provides leadership on health human resource issues; and,
- Has leadership on and responsibility for approximately 50 different pieces of legislation.
(See Appendix IV on page 62).

Through leadership and partnership, the Ministry of 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 quality improvement 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 2015-16 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:

Figure 1: Health System Strategic Direction

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.

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 can focus 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.

The health care system in Saskatchewan is multi-faceted and complex and is composed of 12 health regions (see figure 2), 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. 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 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 continuous improvent, and other methods and tools. This includes program review, 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 continuous improvement initiatives.

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.

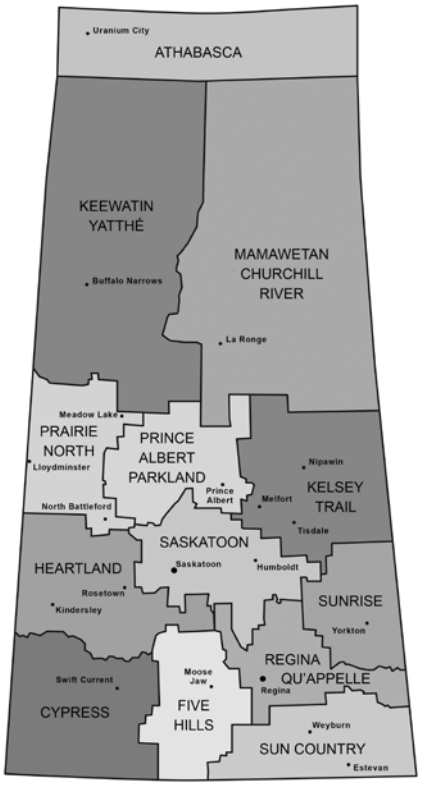


Figure 2: Regional Health Authorities

The Ministry of Health employs 499.4 full-time employees or equivalents (FTEs), 2.5 FTEs greater than its 496.9 FTE budget. The variance of 2.5 FTEs is a result of the additional hire of students.

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.

The Ministry did not receive any disclosures in 2015-16.

Progress in 2015-16

Better Health

Government Goals

Sustaining growth and opportunities for Saskatchewan people

Meeting the challenges of growth

Securing a better quality of life for all Saskatchewan people

Delivering responsive and responsible government

These actions support of the *Saskatchewan Plan for Growth* with *Better Health*.

Ministry Goal

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

Supports for Seniors

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. If needs progress to requiring long term care, it is a priority to ensure seniors have the highest quality of care possible.

Key Actions and Results

Support seniors to remain at home as long as possible while reducing the need for acute care admissions through the Home First/Quick Response Home Care Program. In 2015-16, the Home First/Quick Response Home Care pilot projects in the Regina Qu'Appelle, Saskatoon, and Prince Albert Parkland Health Regions will be enhanced. In addition, the pilot project in the Prairie North Health Region will be expanded to an additional site.

The Home First/Quick Response projects in the Regina Qu'Appelle Saskatoon, Prince Albert Parkland Health Region and Prairie North Health Regions have enhanced and improved services in order to sustain seniors in their homes, facilitate appropriate discharge from acute care to the community, prevent unnecessary presentations to emergency rooms, and delayed admissions to long term care facilities. They have done this by creating a more coordinated approach by care teams, providing more intensive short-term home care services, and/or by reorganizing service delivery processes.

$8.0 million was provided for the HomeFirst/Quick Response Home Care program in 2015-16, an increase of $3.5 million over 2014-15. The Saskatoon, Prince Albert Parkland, Regina Qu'Appelle, and Prairie North Health Regions have all implemented Home First/Quick Response Home Care and have seen success in keeping individuals at home longer.

The Home First/Quick Response Home Care pilots reported successes that include:

- ⇨ improved access to home care facilitated by Home First/ Quick Response Home Care nurses in the emergency department;
- ⇨ increased assessment resulting in an increase of seniors being referred for home care services and post hospital follow up;
- ⇨ use of expanded Primary Health Care Networks leading to increased access to supports for clients in the home and reducing the need for a number of emergency department visits;
- ⇨ provision of "health checks" and education to seniors reducing admissions to emergency department;
- ⇨ use of Transition Home Teams and Admission, Assessment and Review Team to provide timely discharges and transition of clients from hospital to community, reducing admission to an acute care bed for further assessment;
- ⇨ utilization of Treatment Centers to provide treatments such as wound care, suture and clip removal, injections, IV teaching/therapy and catheter care in the community;
- ⇨ supported transition out of acute care to Alternate Level of Care in the community where appropriate;
- ⇨ high client satisfaction rate regarding services received through Home First/Quick Response program;
- ⇨ collaborated with other Ministry initiatives such as Seniors House Calls initiative/ emergency department waits; and,

- ⇨ addressing the mental health needs of clients through the use of Mental Health Nursing to complete home visits for seniors.

The number of clients with a MAPLe score of 3-5 living in the community was 3,031, which is just above the year-end target of 3,022. Since the beginning of the 2015-16 year, there has been a 2.3 per cent increase in the number of clients living in the community with a MAPLe score of 3-5. This means that since last year, an additional 68 individuals with heavy care needs are being managed in the community, delaying admission to long-term care.

Better meet the needs of long-term care residents and improve quality outcomes and resident safety by implementing Purposeful Rounding in all health regions across the province. Purposeful Rounding is the practice of regularly checking on residents' needs using the 4Ps – positioning, personal needs, pain and proximity of personal items such as the call light – with the promise to return in a prescribed amount of time.

In 2015-16, health regions were to have implemented Purposeful Rounding in one-third of all long-term care facilities (or 51 facilities). $1.0 million was provided to all health regions to implement Purposeful Rounding and success has been seen in reducing call lights and resident falls while increasing resident and staff satisfaction. By March 31, 2016, Purposeful Rounding was implemented in 89 long-term care facilities (67 per cent of facilities). The Ministry of Health received feedback regarding the positive outcomes of Purposeful Rounding, especially in the area of decreasing falls and reducing the use of call bells.

Progress towards implementation of pilot projects. And performance measure - By March 31, 2016, the successful full-year implementation of Seniors' House Calls pilot programming will have occurred in the Saskatoon and Regina Qu'Appelle Health Regions.

The Regina Qu'Appelle Health Region launched the Seniors' House Call Project in the fall of 2015. Regina's program focuses on helping seniors who have complex health conditions and need medical care and support provided in their home. Regina's program is designed to receive referrals from acute care (both the emergency department and acute care units in the hospital) as well as community care (such as home care and family physicians). These home visits are based on a need for urgent access to care or post-acute follow-up care, often due to the client being unable to access their family doctor. This access challenge may be due to mobility challenges, acute illness challenges, as well as lack of urgent to semi-urgent access to family doctors. The Seniors' House Calls program funded two nurse practitioners (NP's) and a half-time IV therapy nurse that have been combined with the Home First/Quick Response program nurses and community paramedics and home care IV therapy coordinators to create a multidisciplinary Seniors' House Calls team. This team supports clients with seven-day-a-week access to seniors focused urgent mobile primary health care services. The goal of the team is to provide responsive home-based holistic and enhanced primary health care services to meet the needs of seniors as well as connect them with longer term care services such as home care. This allows clients to access the care they need and remain at home, thus avoiding emergency department visits or needing readmission after an admission in acute care.

Saskatoon Health Region did not implement the Seniors' House Calls pilot programming in 2015-16. The Saskatoon Health Region is currently in the design phase of aligning its senior-focused community services to offer quick and simple access to support and sustain seniors to remain safely in their home.

Provide more services and eliminate current waitlists for the Individualized Funding Program through home care in Five Hills, Prairie North, Regina Qu'Appelle and Saskatoon Health Regions. Individualized Funding provides increased choice and flexibility for home care clients to choose their care provider.

$2.0 million was provided to the Five Hills, Prairie North, Regina Qu'Appelle and Saskatoon Health Regions to eliminate their wait lists for the Individualized Funding Program. The investment increased the number of clients accessing Individualized Funding provincially, allowing them to arrange and manage their own supportive services, increasing their independence. In July 2015, the four health regions that received additional funding indicated their current wait lists were eliminated. This means that more individuals were able to access this service option and, in turn, individualized funding services were provided to additional individuals.

Develop specialized dementia/behaviour units in Regina and Saskatoon to better meet the needs of a small group of individuals who have complex and difficult to manage behaviours.

$2.8 million was provided to the Regina Qu'Appelle and Saskatoon Health Regions to plan for the development of specialized dementia/behaviour units. Regina Qu'Appelle's unit opened in April 2016 and Saskatoon will secure a location in 2016-17 and start the process of renovating.

Develop a geriatric program in the Regina Qu'Appelle Health Region, including the recruitment of a geriatrician to provide a range of services to seniors, including support for quality in long-term care.

$700 thousand was provided to the Regina Qu'Appelle Health Region to strengthen geriatric services. A family physician with an interest in geriatrics is providing leadership for the Geriatric Services Program until a geriatrician is recruited and hired. The Geriatric Services Program will serve the five southern health regions and will work closely with the dementia/behaviour unit in Regina.

Monitor seven quality indicators in long-term care to ensure appropriate quality of care is provided and where required, work with regions to identify root causes and improvement plans.

The Ministry of Health is monitoring quality indicators in long-term care and has implemented a process which identifies facilities that are not reaching the established targets, in terms of the 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.

Figure 3: Quality indicators monitored in long-term care in 2015-16

Quality indicators monitored in long-term care.	2015-16 Target	2015-16 Actual	Target Met?
Residents in daily physical restraints.	Reduce to 10.73 per cent	10.56 per cent	✓
Taking antipsychotics without a diagnosis of psychosis.	Reduce to 29.0 per cent	26.33 per cent	✓
Falls among long-term care residents.	Reduce to 10.0 per cent	10.32 per cent	not met
Worsening pain.	Reduce to 9.0 per cent	8.82 per cent	✓
Worsening bladder continence	Reduce to 17.0 per cent	16.72 per cent	✓
Worsening stage 2 to 4 pressure ulcers	Reduce to 2.0 per cent	1.81 per cent	✓
Newly occurring stage 2 to 4 pressure ulcers	Reduce to 2.0 per cent	1.65 per cent	✓

Expand Seniors' House Calls pilot projects in the Saskatoon and Regina Qu'Appelle Health Regions. The Seniors' House Calls program will support seniors with complex issues with a mobile team that includes physicians, nurse practitioners, and other healthcare providers, who will offer home visits and other services that better meet the needs of seniors.

The Seniors' House Calls program is developing services in the Regina and Saskatoon Health Regions to support seniors who have complex health issues and who are unable to see their family doctor. While some HomeFirst projects include Registered Nurses and/or Nurse Practitioners, for the most part, home care programs do not employ health care providers that can prescribe or adjust medications, or order diagnostic tests when needed. As a result, many of these seniors rely on the emergency department or need to be hospitalized to help them regain their health. The Seniors' House Calls program brings primary health services to the senior allowing them to remain safely in their home as long as possible. Helping seniors stay healthy in the community reduces their use of the emergency department for support thereby creating capacity in our hospitals to care for those patients who require emergency services.

Performance Measures

Use of daily physical restraints. By March 31, 2016, the use of daily physical restraints will be reduced from current levels in long-term care.

The 2015-16 target for residents in daily physical restraints was to achieve 10.73 per cent of the Saskatchewan residents in long-term care and at the end of 2015-16 Saskatchewan was at 10.56 per cent.

Use of antipsychotics without a diagnosis of psychosis. By March 31, 2016 the use of antipsychotics without a diagnosis of psychosis will be reduced from current levels in long-term care.

The 2015-16 target for taking antipsychotics without a diagnosis of psychosis was 29.00 per cent and at the end of 2015-16 Saskatchewan was at 26.33 per cent. Figure 4.

Number of clients with MAPLe (Method of Assigning Priority Levels) scores 3 to 5 living in the community supported by home care. By March 2017, increase the number of clients with MAPLe scores 3 to 5 living in the community supported by home care (indicator of maintaining heavier levels of care in the community).

The 2015-16 target for the number of clients with a MAPLe score of 3 to 5 living in the community supported by home care was to increase by at least 2 per cent, or 3,022 clients or greater. At the end of 2015-16 Saskatchewan met the target with 3,031 home care clients having a MAPLe score of 3 to 5 or an increase of 2.3 per cent. Figure 4.

Figure 4: Target and actual results for decreasing the use of daily physical restraints and use of antipsychotics without a diagnosis of psychosis; as well as increasing the number of clients with MAPLe scores 3 to 5 living in the community supported by home care.

Measure	2015-16 Target	2015-16 Actual	Met
Use of daily physical restraints	<10.73%	10.56%	✓
Use of antipsychotics without a diagnosis of psychosis	<29.00%	26.33%	✓
Number of clients with MAPLe (Method of Assigning Priority Levels) scores 3 to 5 living in the community supported by home care	>=2% increase	10.32 per cent	✓

Number of emergency department visits in client cohort (defined group of patients). Decreased number of emergency department visits in client cohort by 50 per cent over baseline (compared to the prior year usage).

The goal to decrease the number of emergency department (ED) visits by 50 per cent within the group was not met. Regina experienced difficulty staffing their program and the program did not start until September 2015. Of the 202 clients served between January and March, 2016, 28 per cent avoided an ED visit because of the services provided by the Seniors House Calls Program. Figure 5.

Saskatoon was not able to start their Seniors House Calls program in 2015-16 and therefore did not decrease the number of ED visits by 50 per cent with the defined client group.

Figure 5: Percentage of emergency department visits avoided in Regina in 2016 because of the services provided by the Seniors House Calls Program.

Regina 2016	Total
Number of clients seen	202
Number of emergency department visits avoided*	56
Percentage of emergency department visits avoided	28 per cent

** To determine if a visit results in an ED Visit avoided one of the following criteria must be met: acute episodic event, client unable to access provider, urgent/semi-urgent condition where ED is the next option of care, client refuses to see primary provider care, client requires diagnostics, pre-admission medical assessment whereby ED is avoided.*

Rate of hospital admissions in client cohort (defined group of patients). Decreased rate of hospital admissions in client cohort by 50 per cent over baseline.

Measuring the number of admissions avoided for these clients is difficult. Seniors have a high probability of admission to hospital after every ED visit. Most of the clients served by this team are over 70 years old, and are frail. A medium to high proportion of the ED visits avoided for this particular population likely have also resulted in an avoided acute admission. Unfortunately at this time more specific admission avoidance data is not available. New measures will be developed in 2016-17 to improve program data collection and evaluation. See figure 6.

Figure 6: Rate of hospital readmissions in client cohort in Regina January-March, 2016.

Regina 2016	January	February	March	Total
Number of clients seen.	55	61	86	202
Number of readmissions avoided. **	1	2	4	7
Percentage of readmissions avoided.	2	3	5	3

*** Readmissions avoided are based on client referrals from direct in-patient units for post-acute care follow-ups.*

Health Promotion, Disease Prevention

Work in Addition to Health Plan Goals: Health Promotion and Protection, Disease Prevention, and Collaboration Efforts to Close the Health Disparity Gap

Key Actions and Results

Reduce HIV rates and risk factors, and improve the quality of life for those living with HIV.

The Saskatchewan HIV Strategy (2010-2014) focused efforts and resources on reducing HIV rates and risk factors, and improving the quality of life for those living with HIV. It also laid the foundation for continued system improvements. The rate of new HIV cases has declined 44 per cent from 199 in 2009 to 112 in 2014. As of 2015-16, annualized funding now totals $3.956 million, and the rate per 100,000 has declined from the 19.2 in 2009 to 9.8 in 2014 as seen in Figure 7 below.

The Saskatchewan HIV Strategy evaluation (June 2015) indicated that system improvements and increased resources positively impacted patient care and outcomes. The following were key successes of the strategy:

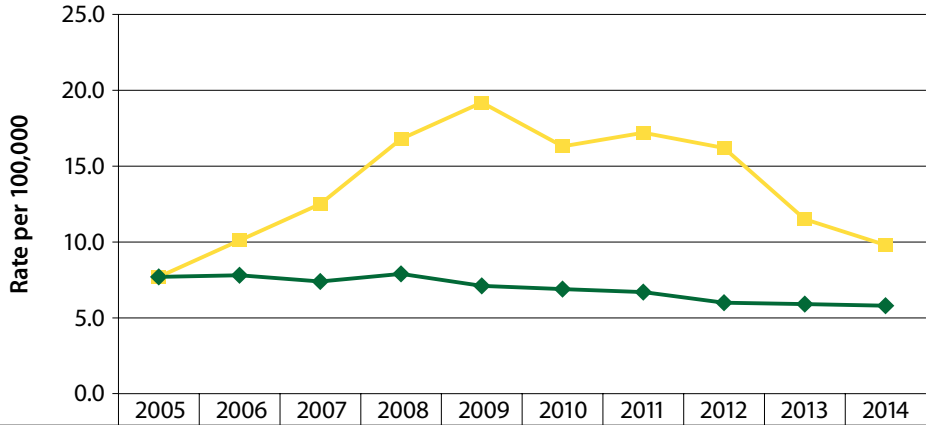
- An increase in HIV testing and access to testing;
  - 72,069 tests were completed in 2015, representing a 48 per cent increase from the 48,843 tests done in 2009.
  - Since 2012 the number of HIV Point of Care testing sites has more than doubled, from 20 to 48 sites (as of April 2016);
- Increased educational and engagement opportunities;
- Improved focs on patient engagement and patient-centered initiatives;
- Improved access to multidisciplinary care in rural areas; and
- Decreased health care utilization.

While the new cases of HIV have decreased, the rates remain the highest in Canada, at just under twice the national average. The Saskatchewan HIV Collaborative and various working groups continue to implement programs and develop policies to address risk factors associated with the acquisition of HIV, while supporting timely diagnosis, and ongoing links to care for those living with HIV.

As access to testing, treatment, and care is expanded, there may be an increase in the incidence of HIV.

In 2015-16:

- It is important to educate and inform the public about HIV prevention and management. A social marketing campaign including a 30 second video, radio ad and posters conveyed the message that testing and treatment for HIV have advanced, making it a manageable disease.
- With appropriate interventions, rates of perinatal HIV transmission during labour and delivery can be significantly reduced. Standardized provincial protocols to prevent HIV transmission from mother to unborn child were finalized and distributed.
- Free formula continued to be available for infants born to mothers who are HIV positive preventing the transmission of HIV through breast feeding.
- Early identification of HIV helps people live longer, healthier lives. Access to HIV testing was expanded through HIV Point of Care testing and the Routine HIV Testing Policy was disseminated. The policy provides guidance to health care providers to routinely offer HIV testing to their patients which allows for earlier access to services, care and treatment. Early identification of HIV helps people live longer, healthier lives.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
SK	7.7	10.1	12.5	16.8	19.2	16.3	17.2	16.2	11.5	9.8
Canada	7.7	7.8	7.4	7.9	7.1	6.9	6.7	6.0	5.9	5.8
Comparison SK vs Canada	0	1.3	1.7	2.1	2.7	2.4	2.6	2.7	1.9	1.7

Figure 7: Rates per 100,000 of HIV cases, 2009 to 2014 for Saskatchewan and Canada

- Infectious Disease Specialists are located in Saskatoon and Regina. Specialist support in rural and remote communities was expanded through:
  - HIV/Hepatitis C Virus (HCV)/Sexually Transmitted Infections (STIs) outreach clinics in Regina Qu'Appelle, Sunrise and Prince Albert Parkland Health Regions (including some First Nations communities); and
  - Use of remote presence technology such as "Doc in the Box", reducing travel for patients and increasing access to specialist expertise.
- Additional support for Primary Care teams was implemented through:
  - The Saskatchewan Infectious Disease Capacity Augmentation Project (SIDCAP), a weekly HIV/HCV/ tuberculosis (TB) case study/clinical care webinar series;
  - Development of a clinical reference tool to support physicians to provide ongoing care for HIV patients. Dissemination is expected in 2016; and
  - Mentorship programs/opportunities to increase multi-disciplinary capacity.
- Provincial training opportunities to build the capacity of health care and allied professionals including: provincial HIV Rounds offered via Telehealth, an annual e-learning event, HIV/HCV online and face-to-face training and further dissemination of the HIV and Sexual Health modules throughout the province.
- To better support clinical record keeping and measure outcomes for patients, an electronic medical record, developed in Regina specifically to support Infectious Disease Clinics, was expanded to Prince Albert to better support clinical record keeping and measure outcomes for patients.

Reduce Rates of Tuberculosis

Saskatchewan's Tuberculosis (TB) rate is one of the highest in Canada. In 2015, the rate was 5.8 per 100,000, compared to the 2014 Canadian rate of 4.4 per 100,000. See figure 8. The numbers in Saskatchewan reflect both our higher proportion of aboriginal population and the increase in foreign born residents:

- 45 per cent (30) of the new TB cases occurred in the three per cent of the population residing in the north, down from 50 per cent (49 cases) last year; and
- New cases in foreign born residents increased from 14 cases in 2011 to 24 cases in 2015.

A comprehensive Saskatchewan TB strategy was released in June 2013. In December 2014, a *TB Visioning Session* was led by the Ministry of Health, TB Prevention and Control Saskatchewan and the Ministry Continuous Improvement Office. One outcome from the visioning session was the re-establishment of the TB Partnership Working Group to provide oversight and strengthen coordination among the key partners; namely TB Prevention and Control – Saskatoon Health Region, Health Canada's First Nations and Inuit Health Branch, Northern Inter-Tribal Health Authority, Regional Health Authorities, and Saskatchewan Disease Control Laboratory.

The initial focus of the strategy is on targeted northern communities which have consistently cycled through higher rates of tuberculosis, outbreaks and interventions from year to year. Work continues in the targeted high incidence communities to improve early identification, enhance follow-up for individuals who have previously been treated for the latent form of TB and reduce the stigma of TB within communities through community engagement.

TB Prevention and Control Saskatchewan continues to develop updates to its Clinical Guidelines. Updated policies and procedures were released in 2015-16 for TB medication administration, delivery and management in Saskatchewan First Nations communities and tuberculin skin testing.

Figure 8: Tuberculosis in Saskatchewan and Canada 2011 to 2015**

	2015		2014		2013		2012		2011	
	Can.	Sask.	Can.	Sask.	Can.	Sask.	Can	Sask.	Can.	Sask.
Rate per 100,000	N/A	5.8	4.4	6.7	4.7	6.9	4.9	7.7	4.7	6.9
New Cases (number)	N/A	66	1568	77	1651	78	1700	84	1621	75
Foreign Born (%)	N/A	36%	69%	25%	70%	30%	65%	20%	67%	19%
Canadian Born Aboriginal* (%)	N/A	59%	21%	70%	19%	67%	23%	73%	19%	73%
Canadian Born Non-Aboriginal (%)	N/A	5%	10%	5%	9%	4%	10%	7%	12%	8%
Aboriginal* Pop (%)	N/A	14%	4%	14%	4%	14%	5.6%	14%	5.6%	14%

** First Nations (North American Indian), Métis, Inuit*
*** TB Prevention and Control Saskatchewan*
N/A – not available

Improve STI Services in Saskatchewan

Sexually Transmitted Infection (STI) rates continue to be high in Saskatchewan. Gonorrhea rates are three times the Canadian rate and chlamydia one and a half times the Canadian rate.

The Ministry mapped services in public health offices and STI clinics operated by public health and used information collected to develop a survey to gather more information from primary care providers which will be used to inform further work to improve STI services in Saskatchewan.

The flow of information from front-line providers to public health was found to be a key challenge. As a result, revisions to the STI Notification Form were made and included:

- ⇨ Adding information identified as key to providers.
- ⇨ Making the form more accessible to providers - eHealth has incorporated the form into the electronic medical record to accommodate providers striving to go paperless.

Customer-focused meetings were held with public health stakeholders to determine priorities for action including developing an STI action plan for 2016-17.

Immunization

Saskatchewan has a comprehensive program of vaccines that are free to the public. The Ministry of Health provides publicly funded vaccines for childhood diseases such as diphtheria, tetanus, pertussis, polio, Haemophilus influenza type b, influenza, measles, mumps, rubella (German measles), meningitis, pneumonia, rotavirus, varicella (chickenpox), human papilloma virus (girls only) and hepatitis B. The annual budget is close to $14.0 million. The Ministry also funds vaccines for targeted high-risk individuals, such as pneumococcal vaccine for individuals with medical conditions that put them at high-risk of complications.

Regional public health nurses deliver childhood immunization programs. Improving immunization coverage rates requires a multi-faceted approach and is time and resource intensive. As part of the regional accountability process, health regions report immunization coverage rates for children at two and seven years of age. Immunization coverage rates measure those who have received the appropriate doses by a specific date and are a reliable indicator of the preventive measures to control the spread of disease. For example, by age two, 74 per cent of children received the recommended vaccines against whooping cough, measles and meningitis; the rate increases to 77 per cent for children seven years of age.

In October, the Ministry launched the second "Arm Yourself" media campaign encouraging people to get the influenza vaccine and protect or "arm" themselves against the flu. The campaign included television closed-captioning, online ads, and posters. It targeted parents and others who are responsible for the most vulnerable people, including young children and older adults.

Innovative immunization outreach strategies took place across the province. Heightened outreach efforts saw public health nurses traveling to residents to provide immunizations. Across the province, public gatherings, such as sporting events, schools, trade schools, and other community events were targeted as on site clinics to simplify and add convenience to the process for individuals and families to be immunized against influenza.

Saskatchewan pharmacists were actively involved for the first time in the public health system's promotion and delivery of influenza vaccine to those nine years of age and older in 2015-16. Their involvement helped increase access to the vaccine by providingd additional access points for the public to receive the influenza immunization. Legislation for enabling pharmacists to provide immunizations was passed just before the start of the influenza vaccine season on October 19, 2015 and lead time to plan for any changes to the scheduling of public health immunization clinics was limited as a result. Additionally, it was unknown as to what the demand and capacity would be for pharmacists to provide vaccine.

A variety of other options to improve public access to influenza vaccines included:

- ⇨ Provision of vaccine at time of discharge of patients from hospitals;
- ⇨ Vaccine delivery by obstetricians and paediatricians, family physicians and primary care centres; and
- ⇨ Immunizations within hospitals and regional health facility lobbies.

In addition to the routine publicly funded immunization program, during 2015-16 the following vaccines were made available to special populations/groups:

- ⇨ Meningococcal B vaccine for medically high risk children including those with HIV, asplenia, and other immunodeficiency syndromes;
- ⇨ Human papillomavirus (HPV) vaccine for HIV positive boys aged 9-17 years old; and,
- ⇨ Second dose of varicella (chickenpox) vaccine for grade six students.

As of April 30, 2016, 377,200 doses of vaccine were shipped from the Ministry of Health to immunization providers. 270,448 doses of vaccine have been administered: 214,718 by public health nurses and others and 55,730 by pharmacies. 830 pharmacists in 263 pharmacies from 72 communities across Saskatchewan provided 21 per cent of the total influenza vaccines. Flu immunizations continued past the end of the fiscal year. The final report for the 2015-16 Influenza season is currently pending final submissions of data by the health regions. Overall, based on submissions to date, the number of individuals immunized in the 2015-16 program year appears to be lower than in 2014-15. The final report will be available in 2016-17.

Assist Public Health Professionals to Effectively Manage Vaccine Inventories, Immunizations, Communicable Disease Investigations and Outbreaks, and Family Health

Panorama is a comprehensive, integrated electronic public health information system that when fully implemented will assist public health professionals to effectively manage vaccine inventories, immunizations, communicable disease investigations and outbreaks, and family health. Co-led by the Ministry of Health and eHealth Saskatchewan, Panorama is partially funded by Canada Health Infoway. The Panorama system consists of five modules and has replaced the Saskatchewan Immunization Management System and in the future, will replace the integrated Public Health Information System.

The vaccine inventory module in Panorama was implemented in early 2014. The immunization module followed in February of 2015. In 2015-16 the immunization module provided the ability to record all immunizations administered in the province, forecast or provide a recommended immunization schedule, and enhance the ability to invite or remind families and individuals that they are due for an immunization. The ability to track immunization coverage both by region and province has improved, and regions are better able to plan and target programs. Dates for implementation of communicable disease investigations and family health modules are to be determined.

Panorama is also the repository for immunization information within the Electronic Health Record Viewer (part of the provincial electronic health record), providing physicians and nurse practitioners access to information to improve patient care. It is also a source for immunization records for clients who wish to access their own health information through the Client Health Information Portal (CHIP), which is currently being piloted.

Promote a Consistent and Standardized Approach to Child Health Clinic Services Across the Province

In September of 2015, all regional public health nursing services implemented the *Provincial Child Health Clinic Guidelines for Standard Practice*. These guidelines promote a consistent and standardized approach to child health clinic services across the province. Children are assessed for nutrition, growth, immunization needs and parental concerns. Referrals to other health care services are made as needed. The new guidelines were developed in collaboration with public health nurses.

The *Nutrition and Growth Assessment Manual for Infants and Children*, developed by public health nutritionists in collaboration with the Ministry, was also implemented in 2015. This reference tool supports the new *Guidelines for Standard Practice* by providing the evidence base for the standards and outlining preventative guidance. Additional supports for both parents and health professionals are under development using a staggered process. Most recently, a background paper for professionals on *Vitamin D for Healthy Term Infants* was released.

Public health nurses in all health regions incorporated the Edinburgh Postnatal Depression Scale screening tool for new moms at the two and six month clinics. This tool assists in identifying those at risk for post-partum depression and/or anxiety. If concerns are present, the public health nurse will offer information and/or referral to the mother's primary care provider, mental health services and/or the Maternal Wellness Program.

The Maternal Wellness Program is an interim service for at risk mothers who are referred by Public Health Nurses to HealthLine (the provincial 24/7 health information service). HealthLine staff phone the referred moms and offer assessment and support while the mothers are waiting for primary care/mental health services. This program is currently available in six of the 13 health regions and will be available province-wide by the end of the 2016-2017 fiscal year. Evaluation of this project has been positive, indicating that mothers are receiving much needed support.

Support the Health Needs of Syrian Refugees

The Ministry of Health, and Prince Albert Parkland, Saskatoon, Regina Qu'Appelle, and Five Hills Health Regions worked collaboratively with community stakeholders to develop recommendations and deliver immunization and health screening services to about 1,000 Syrian refugees new to Saskatchewan. Many of the refugees are non-English speaking families with young children who may not have historical immunization records. The process was facilitated through use of translated resources like vaccine fact sheets and health screening documents. Immunization services were offered at public health clinics and community clinics as well as locations where refugees are residing. Many services were offered outside of regular business hours. A reference table of specific immunization recommendations for Syrians was developed for consistent immunization service delivery across the province. Influenza vaccine was also offered.

Provide Up-To-Date Information about Facilities through the Restaurant Inspection Report Website

Public health inspections are conducted on more than 5,000 public eating establishments in Saskatchewan, including dining rooms, fast food outlets, caterers, mobile food vendors, ice cream stands, concession booths and public cafeterias.

Saskatchewan residents can now access online restaurant inspection information on a new and improved website. This new resource makes it easier for residents to find up-to-date information about facilities they visit regularly or that are new to them, and be confident that they are clean and safe.

Data for the website, known as *Inspection InSite*, is delivered from a data management system that allows inspectors to perform inspections on electronic handheld devices (tablets) while providing greatly expanded capabilities in terms of data collection, analysis and reporting. As a result, the website is populated with more detailed and user friendly information very quickly after an inspection is done.

Provide Online Water Quality Information to Assist Users of Beaches in Making Informed Decisions

Over the 2015 summer season, the Ministry of Health and health regions monitored health risks at 68 public beaches. Extra sampling of lakes in the Qu'Appelle Valley was done following a torrential rainstorm in late July to ensure the public's safety at beaches throughout the Qu'Appelle chain. When water sample results exceeded guidelines, "Do Not Swim" notices were posted.

To encourage local participation in the program, partnerships were made with two Watershed Groups as well as community volunteers who assisted in sampling at 11 beaches.

In 2017 the Ministry plans to implement a program which will provide online water quality information to assist users of beaches in making informed decisions when selecting swimming areas.

West Nile Virus

The Ministry of Health maintains a surveillance system for West Nile Virus (WNV) which includes mosquito trapping and testing, horse surveillance, and monitoring the temperature, precipitation, and habitat conditions that would increase the risk from this disease. During the summer season, weekly risk assessments and reports are provided to health regions and the public through the government website. This includes information on mosquito numbers, infection rates, environmental temperatures, and public messaging on level of risk to humans by ecological area, prevention activities and public education.

WNV has become endemic in Saskatchewan since it was first identified in 2002 and is no longer considered an emergent disease. There have been 155 cases of serious neuroinvasive disease and 17 deaths from WNV since 2003. Figure 9.

Figure 9: Human WNV Neuroinvasive Cases in Saskatchewan 2003-2015

Year	Neuroinvasive Cases	Deaths
2003	63	7
2004	0	0
2005	6	3
2006	3	0
2007	76	6
2008	1	0
2009	0	0
2010	0	0
2011	0	0
2012	0	0
2013	7	1
2014	1	0
2015	0	0
Total	**157**	**17**

** Some deaths did not have neuroinvasive symptoms (encephalitis or meningitis).*

Lyme Disease

Lyme disease is an emerging disease in Saskatchewan. The risk of acquiring it increases in areas where the black-legged or "deer tick," is established. These ticks are capable of transmitting the bacteria that causes Lyme Disease to humans when they bite them. The range of this tick has expanded significantly in parts of southern Canada, including areas of Manitoba. As a result, the potential for exposure of Canadians to acquire Lyme disease has increased.

Figure 10: Total Ticks and Blacklegged Ticks Positive for Lyme Disease in Saskatchewan between 2008 and 2015.

A Year	B Number of Ticks Collected (all species)	C Black-legged ticks	D Black-legged ticks positive for **both** *Borrelia burgdorferi* and *Anaplasma phagocytophilum*	E Black-legged ticks positive *Borrelia burgdorferi* **only**	F Black-legged ticks positive for *Anaplasma phagocytophilum* **only**	G Total ticks positive for *Borrelia burgdorferi* **and/or** *Anaplasma phagocytophilum*
2008	N/A	5	0	0	1	1
2009	1,395	5	1	0	0	1
2010	1,184	3	0	0	0	0
2011	687	3	0	1	0	1
2012	2,885	1	0	0	0	0
2013	1,771	10	1	0	1	2
2014	3,121	5	0	0	0	0
2015	4,671	9	1	0	0	1
Total	**15,714**	**41**	**3**	**1**	**2**	**6**

In Saskatchewan, the Ministry of Health collaborates with the University of Saskatchewan and the Saskatchewan Disease Control Laboratory to monitor ticks in the province. This includes identification of ticks submitted by the public and direct surveys of tick habitat. There are no known established populations of black-legged ticks in Saskatchewan, but small numbers of infected ticks are transported into the province by migrating birds and these have been detected through the surveillance program. Some have tested positive for Lyme disease. Therefore the risk of acquiring Lyme disease in Saskatchewan is low, but not zero.

In the past ten years (2006-2015), there have been two confirmed cases of Lyme disease in Saskatchewan. One was possibly acquired locally and one was linked to travel in an area outside of Canada where the disease is more prevalent. Figure 10.

Tanning Regulations

On November 1, 2015 new regulations came into force that prohibit use of indoor tanning beds by youth under the age of 18. They are part of *The Health Hazard Regulations* and apply to tanning facilities and businesses that offer indoor tanning services, such as gyms and spas.

These regulations:

- require operators of tanning facilities to register with the regional health authorities;
- prohibit operators of tanning facilities from permitting youth under 18 years of age from using UV tanning equipment in a tanning facility;
- enable operators of tanning facilities to request proof of age documentation;
- require operators of tanning facilities to post signage regarding age restrictions and health risks;
- prohibit the advertising of UV tanning services to persons under the age of 18; and allow, with some restrictions, youth under 18 years of age to access UV tanning equipment if the individual has obtained a prescription from a physician for treatment of a medical condition.

Mental Health and Addictions

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

Key Actions and Results

Monitor wait times at all levels of urgency for outpatient mental health and additions services to ensure individuals are seen in the appropriate timeframe.

Data on the percentage of individuals meeting the thresholds across four triage categories: very severe (less than 24 hours); severe (five working days); moderate (20 working days); and mild (30 working days) is being collected. Collectively, the health regions are meeting the thresholds in adult and child and youth outpatient mental health and addiction services but there are exceptions in some health regions which require corrective action plans. See the performance measure below.

Support implementation of the Mental Health and Addictions Action Plan led by the Ministry of Health, and (performance target) develop a defined staged implementation plan for the Mental Health and Addictions Action Plan is developed by March 31, 2016.

- On December 1, 2014, the Minister of Health endorsed Dr. Fern Stockdale Winder's report, *Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan* as a guide for government to improve its response to individuals with mental health and addictions issues, and their families.
- The Ministry of Health has been leading the development of a multi-ministry implementation plan, in partnership with the Ministries of Justice, Social Services and Education which has included sequencing the recommendations and determining areas for focused work until the *Action Plan* is fully implemented
- Within the recommendations for which the Ministry of Health is the lead, there is good progress on some key recommendations that will improve our response to individuals with mental health and addictions issues. These include:

Initiative	Description	Alignment with the Mental Health and Addictions Action Plan Recommendations
Outpatient Mental Health and Addictions Wait Time Reduction: Work to reduce wait times for contract and salaried psychiatry and outpatient mental health and addictions services by meeting benchmarks to improve access.	In 2015-16, the Ministry of Health worked with health regions to make systematic improvements to improve service delivery and reduce wait times. Improvement targets were set at 85 per cent of triage benchmarks being met in outpatient mental health and addiction services, and 50 per cent in contract and salaried psychiatry. In 2015-16, 100 per cent of adults with very severe mental health problems were seen within 24 hours; 97 per cent of those with severe problems within five working days; 93 per cent of those with moderate problems within 20 working days; and 96 per cent with mild problems within 30 working days. One hundred per cent of children and youth with very severe mental health problems were seen within 24 hours; 97 per cent of those with severe problems within five working days; 82 per cent of those with moderate problems within 20 working days; and 90 per cent with mild problems within 30 working days. In 2015-2016, 100 per cent of adults who presented for outpatient addiction services with very severe problems were seen within five working days; 99 per cent with severe problems within 30 working days; 98 per cent of those with moderate problems within 20 working days; and 99 per cent with mild problems within 30 working days. One hundred per cent of youth who presented for outpatient services with addiction problems were seen within the triage thresholds wait times for each level of severity.	Recommendation 2 – *Decrease wait times for mental health and addictions treatments, services, and supports to meet or exceed public expectations, with early focus on counseling and psychiatry supports for children and youth.*
Mental Health First Aid: This course aims to provide a better understanding of mental health and addictions issues, to reduce stigma and to increase awareness. It focuses on the signs and symptoms of addictions and several types of the more common mental health conditions	Saskatchewan's Drug Treatment Funding Program funded a five day instructor's course in January 2015. Twelve experienced health region staff were certified by the Mental Health Commission of Canada as instructors of the Mental Health First Aid Course. Since January 2015, 2-day courses have been offered by the newly trained instructors to over 30 groups around the province involving over 700 participants including police, educators, approved home operators and staff from mental health, group homes, community living staff, settlement agencies, the Lighthouse (Saskatoon), corrections, primary health care, private home care, KidsFirst staff, Aboriginal family violence agencies, and Emergency Medical Technicians.	Recommendation 11.1 – *Provide front-line providers across sectors with targeted and relevant education about mental health and addictions issues, including how other service providers work and how to connect clients to services through referral networks.* Recommendation 14.2 – *Develop a public education and awareness program that helps people readily identify mental health and addictions issues and makes it socially acceptable to seek help.*
Suicide Prevention Protocols: The Ministry of Health continues to work closely with health regions to measure the implementation of the suicide prevention protocols within mental health and addiction services.	In 2015-16, the Ministry of Health in collaboration with health regions developed a measure of implementation for the suicide prevention protocols within mental health and addiction services and piloted suicide risk management client file audits.	Recommendation 8.6 – *Enhance the efforts for assessing suicide risk with emphasis on populations most at risk, such as seniors and youth.*

Initiative	Description	Alignment with the Mental Health and Addictions Action Plan Recommendations
Mental Health Services Act: The revised *Mental Health Services Act* was proclaimed on October 30, 2015 and allows for more effective delivery of mental health services.	On October 30, 2015, the revised *Mental Health Services Act* was proclaimed. The amended legislation and regulations are in line with current practice, and assists in the provision of more expedited and effective services.	Recommendation 3 – *Help primary health care providers fulfill their vial role as first contact and ongoing support for individuals with mental health and addictions issues.* Recommendation 11 – *Improve coordination of services within and across service sectors so that any door is the right door for people with mental health and addictions issues.* Recommendation 11.1 – *Improve transitions within and across services.* Recommendation 11.4 – *Enable information sharing within and between all of the service sectors dealing with mental health and addictions and align relevant policies.*
Take Home Naloxone Kits: The Take Home Naloxone Program was launched in response to increased concerns over opioid overdoses and deaths, including fentanyl-related incidents in Saskatchewan.	In November 2015, a pilot program was launched in Saskatoon, in partnership with the Mayfair Clinic and Mayfair Drugs pharmacy.	Recommendation 8.1 – *Promote and enable community health initiatives with focus on higher needs populations.*
Saskatchewan Hospital North Battleford: Rebuilding of the psychiatric rehabilitation hospital, and increasing the number of beds from 156 to 188.	The new 284 bed provincial psychiatric facility, will replace the existing 156 bed facility, and will include 188 psychiatric rehabilitation beds, and a secure 96 bed unit for male and female offenders living with mental health issues. Ground breaking occurred on September 21, 2015, with construction now underway. It is anticipated that this project will be complete by spring 2018.	Recommendation 11.3 – *Use a cross-sector approach to better identify and address the needs of individuals and families who have significant mental health and/or addictions issues that may require more than a single type of service to provide early intervention, improve stability, and decrease the risk of adverse events.*
Seniors Mental Health: Health regions are continuing to improve the quality of care for residents living in long-term care facilities and who are experiencing mental health issues.	Six health regions are currently training staff in the *Gentle Persuasion Approach*, which helps them provide better care for residents with difficult behaviours and/or dementia. Two dedicated Dementia/Behaviour Assessment Units have been planned; a 5 bed unit opened in Regina in April 2016 and a 5 bed unit in Saskatoon is under development.	Recommendation 6.1 – *Promote care cultures that improve mental health in long-term care facilities.* Recommendation 6.2 – *Provide formal training for staff in long-term care and home care in mental health and addictions issues most experienced by seniors and enhance resourcing to better respond to identified needs.*

Initiative	Description	Alignment with the Mental Health and Addictions Action Plan Recommendations
Regulation Changes to Better Facilitate Information Sharing: Introduction of amendments to better facilitate information sharing across Ministries and organizations participating in common or integrated services.	Changes to regulations were made in 2015-16 and will be proclaimed June 1, 2016.	Recommendation 11.4 – *Enable information sharing within and between all of the service sectors dealing with mental health and addictions and align relevant policies.*
Leveraging Immediate Non-Urgent Knowledge (LINK): Piloting of a provincial telephone consultation service to give primary care providers and their patients rapid access to specialist for non-urgent health concerns.	Adult Psychiatry is the first specialty group to offer the provincial LINK service in this pilot. See page 29 of this report for more information.	Recommendation 2.3 – Facilitate improved access in northern, rural and remote communities through the use of technology, mobile services or other innovations. Recommendation 3.1 – Support the work of primary health care providers through team approaches that include ready access to mental health and addictions counselors and consultant psychiatry.
Police and Crisis Team (PACT): Police officer and mental health worker team attend calls related to individuals experiencing mental health crises.	In November 2015, PACT teams were launched in Regina; there are currently two PACT teams operating in Saskatoon and one in Regina.	Recommendation 4.1 – *Enhancing after-hours supports for crises.* Recommendation 4.2 – *Reduce wait times and improve responses in emergency departments for mental health and addictions issues.* Recommendation 7.3 – *Support police efforts to improve responses to situations involving individuals with mental health and addictions issues, including police partnering with mental health workers in crisis teams.* Recommendation 11.1 – *Provide front-line providers across sectors with targeted and relevant education about mental health and addictions*

- The Maternal Wellness Program, referenced on pages 15 and 24 supports recommendation 8.2 of the Action Plan: *Strengthen access to maternal mental health supports*.
- Additionally, work underway to better integrate primary health and mental health services aligns with recommendation 3: *Help primary care providers fulfill their vital role as first contact and ongoing support for individuals with mental health and addictions issues*.
- Work is underway to identify improvement work for the 2016-17 year, under the themed areas of:
  - Appropriate and Coordinated Care;
  - Improved Transitions;
  - Emergency and Crisis Response; and
  - Supportive and Independent Living.
- Inter-ministerial teams have helped to scope areas of greatest need, and efforts within the health system and across government will ensure that:
  - Work continues to address wait times for outpatient mental health and addictions services including:
    - The spread of service matching tools into health regions across the province that will help to ensure that the intensity of services offered to clients supports their level of service need; and
    - Improved utilization of the provincial internet cognitive behavioural therapy service;
- There is increased capacity among front line service providers, to more appropriately respond to individuals with mental health and addictions issues;
- There is improved, and more seamless responses to individuals and their families who are moving across services; and
- There is increased awareness of how to access services.

Performance Measures

Wait times for outpatient mental health and addiction services measured at all levels of urgency.

By March 31, 2019, there will be increased access to quality mental health and addiction services, and decreased wait times for outpatient and psychiatry service

This measure aligns with recommendation two from the Mental Health and Addictions Action Plan: *Decrease wait times for mental health and addictions treatments, services and supports to meet or exceed public expectations, with early focus on counseling and psychiatry supports for children and youth*.

The Ministry of Health has worked collaboratively with the health regions since 2011 to develop strategic measures to assist in wait time reduction including the introduction of a number of standardized processes and efficiency measures, including establishing criteria for reducing inactive files, adopting a clinical face-time benchmark, using time limited and goal-focused approaches, reducing "no shows" and better matching servies to level of need. Improvements in provincial wait time data are already being realized as a result of implementation of these practices, as well as through regional improvements in the area of clinical supervision.

By March 31, 2016, meet triage benchmarks for outpatient mental health and addiction services 85 per cent of the time.

Triage benchmarks were met and surpassed. See figure 11 mental health services wait times and figure 12 addictions services wait time.

Wait times for contract and salaried psychiatry services. By March 31, 2016, meet triage benchmarks for waits to see contract and salaried psychiatrists 50 per cent of the time.

Collectively, health regions met the thresholds for adult psychiatry in the very severe and severe categories with some exceptions requiring corrective action plans. Targets were not

Figure 11: Wait times for outpatient mental health services measured at all levels of urgency with targets.

Measure	Adult 2015-16 Target	Adult 2015-16 Actual	Met	Child & Youth 2015-16 Target	Child & Youth 2015-16 Actual	Met
Very severe mental health issues seen within 24 hours	85%	100%	✓	85%	100%	✓
Severe mental health issues seen within 5 working days	85%	97%	✓	85%	97%	✓
Moderate mental health issues seen within 20 working days	85%	93%	✓	85%	82%	not met
Mild mental health issues seen within 30 working days	85%	96%	✓	85%	90%	✓

met in the moderate and mild categories and corrective action plans were employed. 99 per cent of adults requiring psychiatry services with very severe mental health issues were seen within 24 hours; 92 per cent with severe mental health issues were seen within five working days and 59 per cent with mild issues were seen within 30 working days, figure 13.

The two health regions that collect data on child and youth psychiatry (Regina Qu'Appelle and Prince Albert Parkland) generally met the thresholds in the very severe and severe categories. Issues remain in the moderate and mild categories and were addressed with corrective action plans.

The Ministry is working with other health regions where there are contract and salaried psychiatrists to collect, monitor and reduce the wait times for appointments with these doctors. This is only a subset of the total number of psychiatrists in the province. Additional work is going on with private practice psychiatrists through the Wait1 Access to specialist initiatives.

Improvement work supporting the adult psychiatry wait time reduction initiatives was done through the establishment of triage benchmarks for contract and salaried psychiatrists, the adoption of shared care practices such as GP consultations, tele-psychiatry, specialized psychiatry provided to rural and northern locations, utilization of pooled referrals for fee for service, contract and salaried psychiatrists, as well as other regional specific initiatives.

In 2015-16, 100 per cent of children and youth with severe mental health issues requiring psychiatry services were seen within 24 hours; 82 per cent with severe mental health issues were seen within five working days; 26 per cent with moderate mental health issues were seen within 20 working days and 24 per cent with mild mental health issues were seen within 30 working days, figure 13.

The number of licensed psychiatrists has increased by 23 per cent in the province since 2007.

Figure 12: Wait times for addiction services measured at all levels of urgency with targets.

Measure	Adult 2015-16 Target	Adult 2015-16 Actual	Met	Youth 2015-16 Target	Youth 2015-16 Actual	Met
Very severe addiction issues seen within 24 hours	85%	100%	✓	85%	100%	✓
Severe addiction issues seen within 5 working days	85%	99%	✓	85%	100%	✓
Moderate addiction issues seen within 20 working days	85%	98%	✓	85%	99%	✓
Mild addiction issues seen within 30 working days	85%	99%	✓	85%	100%	✓

Figure 13: Contract and/or Salaried Psychiatry in Health Regions.

Measure	Adult 2015-16 Target	Adult 2015-16 Actual	Met	Child & Youth 2015-16 Target	Child & Youth 2015-16 Actual	Met
Very severe psychiatric issues seen within 24 hours	50%	99%	✓	50%	100%	✓
Severe psychiatric issues seen within 5 working days	50%	92%	✓	50%	82%	✓
Moderate psychiatric issues seen within 20 working days	50%	59%	✓	50%	26%	not met
Mild psychiatric issues seen within 30 working days	50%	30%	not met	50%	24%	not met

Primary Health Care

Primary Health Care (PHC) is the "everyday care" that individuals, families, and communities require to protect, maintain or restore health. It also involves a proactive approach to preventing health problems and ensuring better management and follow-up once a health problem has occurred. 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 areas where recruitment and retention of family physicians is a challenge.

The vision for Primary Health Care in Saskatchewan is that PHC is sustainable, offers a superior patient experience, and results in an exceptionally healthy Saskatchewan population. 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.

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. For more information on primary health care in Saskatchewan, visit www.saskatchewan.ca.

Guidance on primary health care delivery draws on the vision of the 2012 Framework and the experiences of teams providing care. Health system efforts to improve care are also supported by available data on patients' needs. A particular focus rests with Saskatchewan residents who are living with one or more chronic conditions. According to the Public Health Agency of Canada (PHAC- 2010), three out of five Canadians older than 20 years of age have at least one chronic condition; four out of five are at risk. Chronic disease rates are increasing faster among Canadians aged 35-64 years than among those 65 years and older. More children are being affected by chronic diseases previously only seen in adults. Aboriginal peoples experience higher rates of diseases such as heart disease, diabetes, cancer and asthma; the Aboriginal population is expected to grow at more than twice the rate of the general population.

In terms of impact, chronic diseases are the most significant cause of death (63 per cent) worldwide (World Health Organization). Treatment of chronic disease consumes 67 per cent of all direct health care costs. Costs associated with lost productivity associated with chronic conditions are substantial. Six chronic conditions that figure prominently in Saskatchewan include: chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), heart failure (HF), asthma, diabetes, and mood and anxiety disorders (including depression). Trends over the past five years indicate that while the number of Saskatchewan residents living with these conditions is increasing (prevalence), the number of new cases (incidence) is decreasing – see figure 14 below. (Source: Saskatchewan Health Quality Council)

These trends reveal that supported by prevention and care management efforts, the rate of new patients diagnosed is dropping for the whole population, and the prevalence of chronic disease is increasing in the province. Increased efforts to support conditions for healthy aging and to improve team-supported and patient self-management of chronic conditions are required.

Work to date has focused on supporting customized and targeted care improvements. This work is necessary given the broad population affected by chronic disease and the fact that primary health care providers are generally the first and most frequent provider supporting the everyday needs of patients. Knowing that social determinants of health affect individuals' health status, primary health also focuses on population health initiatives that support healthy lifestyles and community environments. Further work on the social determinants of health is supported by the collaborative efforts of many Ministries across government that aim to address other factors that affect health, such as: income, early childhood development, education, housing, employment, for example *The Poverty Reduction Strategy*.

Figure 14: Incidence and prevalence rate of six chronic conditions in Saskatchewan, 2008-09 compared to 2015-16.

Condition	Fiscal Year	Incidence Rate Per 100,000	Prevalence Rate Per 100,000	Fiscal Year	Incidence Rate Per 100,000	Prevalence Rate Per 100,000
Chronic Obstructive Pulmonary Disease (COPD)	2008-09	1,009	6,338	2015-16	440 ↓	8,288 ↑
Coronary Artery Disease (CAD)	2008-09	826	6,520	2015-16	196 ↓	6,985 ↑
Heart Failure (HF)	2008-09	479	2,880	2015-16	159 ↓	2,962 ↑
Asthma	2008-09	584	6,960	2015-16	99 ↓	8,690 ↑
Diabetes	2008-09	648	5,919	2015-16	155 ↓	7,262 ↑
Mood and Anxiety Disorders	2008-09	13,301	Not available	2015-16	7,348 ↓	Not available

Efforts in 2015-16 to support residents living with chronic conditions include:

- Continued support of the registered nurse (RN) case manager roles and primary health care counselor. RN Case Managers coordinate care and provide support for individuals with chronic medical conditions, while PHC Counselors support early identification and brief treatment for mental health and addictions needs including anxiety and depression This work is focused on increasing access to mental health and addictions services within a PHC setting and aligns with the recommendations of the *Mental Health and Addictions Action Plan*.
- Expansion of the Chronic Disease Management Quality Improvement Program (CDM-QIP) to include two new chronic conditions (COPD and HF). This program provides electronic tools, for example an electronic flowsheet and reporting tools, for health care providers to support optimal care consistent with best practices.
- Continued support is being provided for the Enhanced Preventative Dental Services Program in all health regions to address high rates of early childhood tooth decay. These enhanced services are intended to supplement existing health region efforts to help improve children's oral health by increasing access to dental care, preventive services, and early education.
- Implementation of Connecting to Care (Hotspotting) pilot projects in Regina and Saskatoon that provide patient centred care to individuals with complex health needs who frequently use emergency or in-hospital services (see page 26 of this report); and
- Expansion of HealthLine 811's Outbound Call Initiatives. These initiatives provide assistance through follow-up calls to patients who have been identified as needing additional resources and supports.
  - In 2013, HealthLine 811 launched its first outbound call initiative to offer support to women at risk of postpartum depression and/or anxiety in Saskatchewan The Maternal Wellness Program was expanded to six of the 13 health regions in 2015-16 and will be available province-wide by the end of the 2016-2017 fiscal year. This work will support the *Mental Health and Addictions Action Plan* recommendations by increasing access to appropriate mental health services as well as improving transitions and coordination in the system. Find more information about the Maternal Wellness Program on page 15 of this report.
  - In February 2016, HealthLine 811 in partnership with the Regina Qu'Appelle Health Region, Saskatchewan Cancer Agency and patient advisors launched the Breast Cancer Lymphedema Pilot Program, a supportive resource for men and women who have undergone a mastectomy or lumpectomy. Outbound calls will increase awareness of Lymphedema in an effort to prevent, or at least minimize, the complications associated with the condition. Planning also began on an outbound call program to support patients living with COPD in Kelsey Trail Health Region. Implementation is planned for 2016-17.

In addition, the Ministry is supporting specific work on diabetes. This work relates to enabling best practice care, as well as better planning, monitoring and supports to diabetes programming across the province:

- A provincial scan was conducted to create a comprehensive catalogue of diabetes programs and services available in health regions. An analysis of the findings will be completed in 2016-17.
- Provincial patient diabetes education resource materials for clinicians are being updated. The work will be completed in 2016-17.
- A measurement framework for diabetes services was produced to support development of indicators and progress reporting on quality improvement. Data collected through that framework will be included in the 2016-17 Ministry annual report.
- The Ministry supported enhancements to the Saskatchewan Pediatric Endocrinology and Diabetes Program based in the Saskatoon Health Region. Funding for additional program staff has had a positive impact on wait times for these services.

In 2015-16, efforts to strengthen PHC also included the following:

- Establishing a primary healthcare evaluation and measurement framework. This framework established the timelines, assumptions and metrics that will be used to assess new primary health care roles (i.e. Registered Nurse Case Manager and Primary Healthcare Counsellor), models (i.e. Collaborative Emergency Centres and Hotspotting) and primary healthcare teams.
- Continued implementation and monitoring of Collaborative Emergency Centres. $2.05 million was provided in 2015-16 to strengthen PHC in the province, including implementation of new Collaborative Emergency Centres and primary health care teams. This funding also enhanced staffing and operations for 95 primary health care teams in Saskatchewan.

Key Actions and Results

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. FIgure 15.

Currently we are not on track to meet our overall goal of a 30 per cent reduction by March 31, 2017. Based on review of data and progress made this measure has been revised in 2016-17 to reflect a goal of a 10 per cent decrease in hospitalizations by March 2017. To better support progress towards the target, the Ministry and health care partners are: enhancing engagement efforts and supports for health provider utilization of best practice tools for chronic disease management; supporting the emergency department waits reduction initiative; and assessing new primary health care roles and models of care with the aim of spreading successful models.

Note: This data is derived from two administrative databases. Due to delays in submission of data to both databases more recent accurate data is not available.

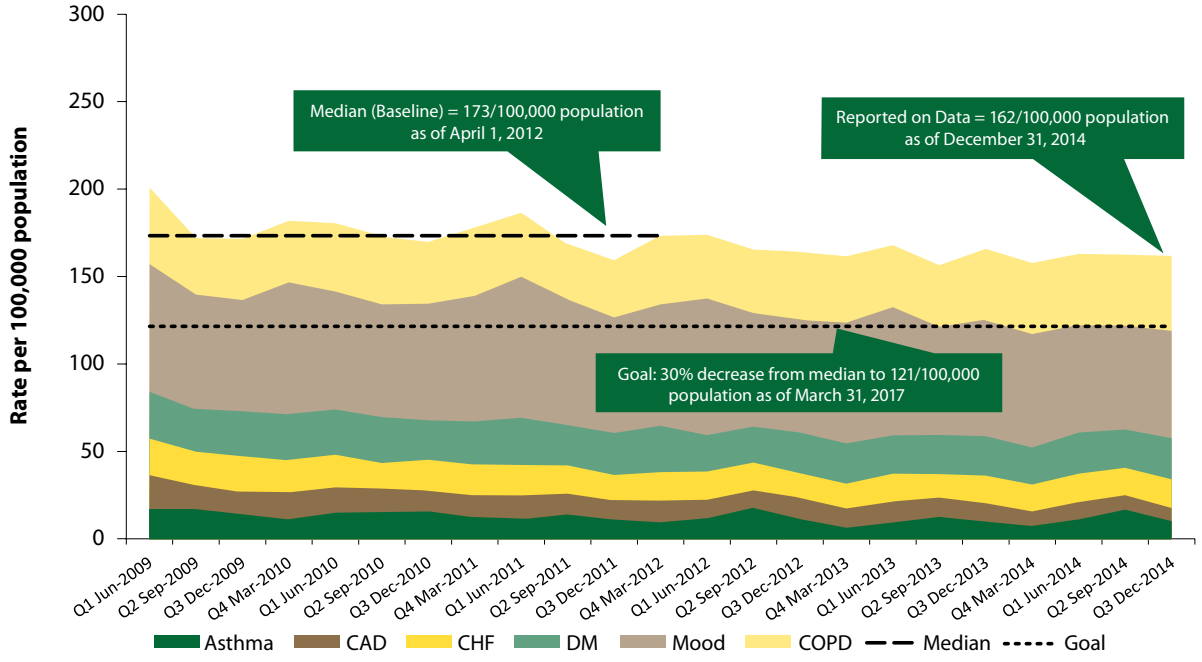
By March 31, 2017, there will be a 50 per cent improvement in the number of people who say, "I can access my Primary Health Care Team for care on my day of choice either in-person, on the phone or via other technology."

At the end of December 2015 (the last month where complete data is available) 89.4 per cent of people surveyed reported they received an appointment on their day of choice. This is a 28.38 per cent improvement over 2013-14. While this shows significant progress, this measure is not 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.

By March 31, 2020, 80 per cent of patients with six common chronic conditions (diabetes, coronary artery disease (CAD), chronic obstructive pulmonary diseas (COPD), 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 and the EMR viewer.

To date, under the Chronic Disease Management-Quality Improvement Program (CDM-QIP), best practice guidelines and indicators have been identified for four chronic conditions: COPD, CAD, HF, and diabetes. Paper and electronic medical records (EMR) versions of standardized, evidence-based flow sheets have been implemented for diabetes, CAD, COPD and HF.

Figure 15: Age and sex-adjusted hospitalization rates for six common chronic conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, depression, heart failure, and asthma)



These flow sheets assist health care providers in using current best practice guidelines to provide optimal care.

Two interim measures and targets have been developed by the CDM-QIP Steering Committee to track in-year (i.e. 2015-16) progress in adoption of CDM-QIP tools:

- ⇨ Number of providers using flowsheets: 650 general practitioners and Nurse Practioners enrolled in the CDM-QIP who have two or more visits submitted and saved in the CDM repository. This target was met. As of March 31, 2016, 658 providers (570 general practitioners and 88 Nurse Practitioners) had submitted at least two visits to the CDM-QIP repository.
- ⇨ Number of patients for whom data is being submitted through the CDM-QIP program. Target: 40,000 discrete patients with CDM-QIP flow sheet data within the CDM repository. 92.8 per cent of the target was met with, as of March 31, 2016, 37,128 discrete Saskatchewan residents living with chronic conditions served: 27,025 patients with diabetes, 5,402 patients with CAD and 4,701 patients with both diabetes and CAD.

Work continued in 2015-16 to deploy and support adoption of previously launched flow sheets for diabetes and CAD. Work in 2016-17 will focus on four chronic conditions (COPD, CAD, HF, and diabetes). The measure will change in the next fiscal year to incorporate COPD and HF.

Key Actions and Results

Increase patient access to integrated primary health and mental health services through mental health and addictions screening and enhanced referral to specialized services.

Improvement efforts focused on increasing the number of teams offering early detection and brief treatment to patients for mental health and addictions issues within a primary health care clinic setting. See the "number of teams" measure in the Performance Measures below for results. This work will continue in 2016-17.

Work was also started in 2015-16 to identify best practices that support positive mental health and the prevention of alcohol and drug use. This work will continue in 2016-17 and is expected to result in implementation of initiatives to build resiliency and positive mental health in children and youth.

Evaluate Connecting to Care hotspotting pilot projects which provide customized care to complex needs patients.

Saskatchewan's *Connecting to Care* 'hotspotting' pilot projects (one in Regina and one in Saskatoon) are an innovative approach using data analysis to identify high-cost, high-use patients who are not well served by the current system. The goal is to provide customized, intensive case management and outreach services for each patient who chooses to participate.

The health system struggles to meet the needs of patients with complex and varied issues – sometimes related to mental health. Often, mental health and addictions issues are co-morbidities for patients with one or more chronic medical condition. Patients with the most complex needs are frequently hospitalized and repeatedly seek services in the emergency department. The result is one per cent of hospital patients account for about 20 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 health resources.

Two Connecting to Care 'hotspotting' pilots were fully implemented in 2015-16 with care teams delivering targeted, high-impact supports to better meet patients' needs. The multidisciplinary teams consists of primary health care nurses, social workers, counselors, wellness advocates, client navigators and a First Nations Elder (Saskatoon). Emerging patient stories revealed gaps are being addressed, including connection to community-based services, navigation to appropriate services, and more holistic care. Early results show avoidance of emergency department visits and prevention of hospitalizations.

The Regina pilot initiated services to 13 patients in the last quarter of fiscal 2014-15. The Regina and Saskatoon pilots added 86 patients to their caseloads over the next fiscal year, for a total of 99 patients receiving services by the end of 2015-16. Evaluation of the two pilots began in 2015-16 and is scheduled to be finalized in 2016-17.

Performance Measures

Fifty per cent increase in the number of teams providing patients with integrated primary health and mental health programming.

At the beginning of 2015-16, eight Primary Health Care teams were offering enhanced mental health and addictions services (one clinic each in the communities of Moose Jaw, Lloydminster, Leader, North Battleford, Meadow Lake and Regina, as well as two clinics in Prince Albert). By the end of the fiscal year, health regions had created new roles providing mental health and addictions supports in primary health care clinics at Yorkton, Weyburn, Hudson Bay and two in Regina – for a total of five. The addition of five sites represents more than a 50 per cent increase.

Fifty per cent increase in the number of patients who have completed a Healthy Living Questionnaire (mental health and addiction screening) and a 50 per cent increase in the number of patients who access mental health services provided by Primary Health Care teams.

The Ministry encountered inconsistencies in data reporting from sites enhancing mental health and addictions services; as a result there was no baseline data available for the targets. Regions were engaged through 2015-16 on a new data collection tool for consistent reporting that was implemented by the end of 2015-16. With that capacity in place, baseline data will be collected in 2016-17.

Combined measures: 10 per cent reduction in the average health system cost of services for patients enrolled in the Regina Qu'Appelle Health Region and the Saskatoon Health Region hotspotting pilots;

A 50 per cent increase in patient self-reported satisfaction with services received; and 50 per cent reduction in emergency department visits of hotspotting pilot patients, pre- and post-pilot period.

Two Connecting to Care pilots were fully implemented in 2015-16 but there won't be sufficient data from the pilots to evaluate results until Fall 2016. An evaluation report will be complete in late 2016-17.

Preliminary results and outcomes indicate significant decreases in health system costs and emergency department visits by patients in the programs, as well as increases in patient satisfaction with their health care experience.

Update from 2014-15 Health Plan

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

The province now has three fully operational Collaborative Emergency Centres (CECs) (Maidstone, Shaunovan and Canora) implemented in fiscal 2013-14 and 2014-15. Two more CECs (Spiritwood and Wakaw) are in development using a phased-in approach.

- ⇨ As of May 2014, Wakaw began offering extended hours access to PHC services. In September 2014, urgent and emergent care until midnight daily was implemented, led by a two paramedic team supported by on-call physicians. A program review conducted by the health region in 2015-16 found that patients, community stakeholders and health providers are pleased with the service.
- ⇨ In Spiritwood, a plan was finalized in 2014-15 to support CEC implementation in 2015-16. As of September 2015, in addition to extended hours access to PHC services, urgent and emergent care services were re-established seven days a week from 8 a.m. to 8 p.m. The Region and Ministry continue working on development and implementation of urgent and emergent services after 8 p.m. daily.

Results regarding access to urgent care from the first three CECs and Wakaw have been positive. Over 2,700 people were provided with urgent, after hours care by the end of March 2016; the majority of these individuals (77 per cent) were treated in the community rather than being transferred to a hospital, with physicians on-call for emergency services 24/7. Emergency service disruptions were common in these sites prior to implementation of CECs; there was one service disruption in one of the CEC communities in 2015-16.

A provincial evaluation of the program will be done in 2016-17.

Work in Addition to Health Plan Goals

Multiple Sclerosis Advisory Panel of Saskatchewan

Multiple Sclerosis (MS) is a degenerative neurological disease that impairs or destroys the function of nerve cells in the brain and spinal cord. About 3,700 Saskatchewan people are affected.

The recommendations of the 11-person Multiple Sclerosis Advisory Panel of Saskatchewan's report released in 2015-16 suggests options for improving treatment and support for people with MS and their caregivers, while expanding Saskatchewan's capacity for MS research and education was received. Their recommendations will guide our efforts in the coming years to improve the care and support for people affected by MS, and to advance MS research in Saskatchewan. Find more information at saskatchewan.ca.

The report outlines nine recommendations, including:

- ⇨ the establishment of an advisory council on degenerative neurological diseases;
- ⇨ the creation of a registry of Saskatchewan people diagnosed with MS;
- ⇨ a series of improvements – such as the recruitment of clinicians – to strengthen Saskatchewan's ability to focus on MS care, training and research; and,
- ⇨ ongoing funding for a multidisciplinary care team, a research leader and research support services.

More Doctors are Practicing in Saskatchewan

The health system has worked hard to make Saskatchewan a great place for physicians to call home and efforts are paying off. Saskatchewan residents are benefitting from greatly improved access to physicians with the addition of 633 new doctors since March 2007. That represents a 36.3 per cent increase. As of March 2016 there were 2,375 licensed physicians in Saskatchewan.

Saskatchewan's physician recruitment and retention initiatives include:

- ⇨ A competitive compensation package for physicians – one of the best in Canada.
- ⇨ The number of post-graduate physician training seats at the College of Medicine has doubled to 120 and the number of undergraduate medical education seats has expanded from 60 to 100.
- ⇨ The Rural Family Physician Incentive Program provides recent graduates with up to $120,000 over five years if they set up practice in a community with fewer than 10,000 people.
- ⇨ Training more family medicine residents in sites outside Regina and Saskatoon (Prince Albert, Swift Current, La Ronge, North Battleford and Moose Jaw).

Figure 16: Increase in Licenced General Practitioners and Specialists since 2007

Licensed	March 2007	March 2008	March 2009	March 2010	March 2011	March 2012	March 2013	March 2014	March 2015	March 2016	Variance between March 2007 to March 2016	
											Change	(%)
General Practitioners	961	975	1,003	1,013	1,034	1,024	1,067	1,160	1,181	1,251	↑290	↑30.2
Specialists	781	807	833	869	912	961	977	1,005	1,043	1,124	↑343	↑43.9
Total	**1,742**	**1,782**	**1,836**	**1,882**	**1,946**	**1,985**	**2,044**	**2,165**	**2,224**	**2,375**	**↑633**	**↑36.3**

Source: Physicians with their own MSP billing number who are licensed by the College of Physicians and Surgeons of Saskatchewan and practising in Saskatchewan under MSP coverage at the end of the year; includes temporary licensed locum physicians but excludes educational locums and medical residents.

- ⇨ Creating the Saskatchewan International Physician Practice Assessment program to include physicians trained from a wider range of countries.
- ⇨ A rural physician locum pool, to provide additional physician coverage and assistance to rural family physicians.
- ⇨ The province created the Saskatchewan International Physician Practice Assessment (SIPPA) to ensure that internationally trained physicians possess clinical skills and knowledge to provide quality patient care. Almost 180 doctors have passed and are providing service in the province. The vast majority of them (87 per cent) are in a rural or regional community.

Improving Access to Midwifery Services

Midwives have participated in the delivery of approximately 2,500 babies in Saskatchewan, and work continues to improve access to midwifery services in the province.

In 2015-16 $2.2 million was invested in midwifery to help increase capacity, a 45 per cent increase from 2007-08 when the province began funding these services. This increase in funding has allowed us to expand the number of midwife positions from eight to fifteen. This funding also allows health providers, other than midwives, to be the second attendants at home births. This helps increase client access to home births, and it also improves work-life balance for midwives who don't need to be on call as often for home births.

New Health Facilities in 2015-16

Dr. F.H. Wigmore Regional Hospital for Moose Jaw and Surrounding Area

The remarkable new hospital follows through on government's commitment to build a brand new regional hospital to serve Moose Jaw and southern Saskatchewan. The state-of-the-art facility is a showcase for how to meet the health care needs of Saskatchewan people by putting patients first.

The hospital is equipped with a new helipad, a hyperbaric chamber, and features the first permanent MRI scanner outside of Regina and Saskatoon. The $99.5 million facility's innovative design also allows health care teams to bring most services directly to patients in a treatment room or a patient's private room. The provincial government contributed nearly $80 million to the total cost of the project.

Canora Health and Wellness Centre

The Canora Health and Wellness Centre in the newly renovated space at Canora Hospital serves patients better because of the co-location of the primary health care clinic and collaborative emergency centre (CEC). The first two phases of the CEC model have been in operation since July 2014. The emergency department nighttime model has been in place at the Canora Hospital and extended hours of primary health care available at the Canora Medical Clinic, which was downtown.

The new centre provides a 'one stop shop' for patients, where they can receive stable, timely access to health services in the community. This care enhances the patient experience while improving work-life balance for our excellent health care providers. Three conmponents make up Canora project: the CEC model to stabilize emergency department coverage, extended hours of primary health care appointments, and construction of the Canora Health and Wellness Centre to bring the team together under one roof. Staff at the center are able to offer patients more options for appointment times including the evening through the CEC.

The provincial government contributed $775,000 toward the renovation at Canora Hospital and is providing $375,000 in annual funding to support the operation of the CEC in Canora. The town of Canora, several surrounding municipalities and the local health foundation have pledged additional funding of approximately $200,000 to cover primary health clinic equipment, furniture and other expenses.

Better Care

Government Goals

Sustaining growth and opportunities for Saskatchewan people

Meeting the challenges of growth

Securing a better quality of life for all Saskatchewan people

Delivering responsive and responsible government

These actions support the *Saskatchewan Plan for Growth with Better Teams*.

Ministry Goal

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

Referral to Specialists and Diagnostics

By March 31, 2019, there will be a 50 per cent decrease in wait time for appropriate referral from primary care provider to all specialists or diagnostics.

While the Saskatchewan Surgical Initiative significantly reduced patient wait times for surgery after they see a specialist, for patients the waiting starts the day their primary care provider refers them to a specialist. The health system is now working to ensure patients have timely access to an appropriate specialist and diagnostic services.

By reducing the wait time for a consult with a specialist or diagnostic services (such as MRI and CT scans), patients will be able to access treatment sooner. Improvements include strengthening communications between providers, and between patients and providers; and coordinating appointments and diagnostics to save time and travel for patients throughout the referral journey.

Key Actions and Results

Establish a provincial model to reduce the wait time to see a specialist. Combined with performance measure by March 31, 2016, a provincial framework for an appropriate referral to a specialist or diagnostics is developed and tested.

A provincial referral model has been developed that streamlines the patient journey to see a specialist. Key elements of the model include:

- The use of standardized referral forms to support primary care providers in providing complete and appropriate information when sending a referral.
- Central intake and pooled referrals, which efficiently direct referrals to an appropriate specialist while providing patients with the choice of seeing the next available specialist.
- The use of multidisciplinary teams, including specialists, nurses, physical and occupational therapists, working together to provide coordinated assessment, triage and treatment.
- Standardized and timely specialist consult letters from the specialist to the referring primary care provider so they know the care plan and can help manage care for their patient.
- LINK (Leveraging Immediate Non-urgent Knowledge), a telephone consultation service providing primary care providers and their patients with timely access to specialists for non-urgent patient health concerns. Having a specialist available to take calls for non-urgent concerns helps primary care providers work to their full scope of practice and avoid some types of referrals. Similar services are being used in British Columbia and Ontario to help direct referrals more appropriately and reduced the number of emergency department visits.

Test the model to demonstrate a 50 per cent reduction in wait times.

Many of the key elements of the provincial referral model were implemented in the Regina Hip and Knee Treatment and Research Centre. The six-month evaluation reported improved access to specialist care with high patient satisfaction. Wait times to see an orthopedic surgeon in Regina for a hip or knee consult decreased from up to nine months in 2014-15 to an average of one month in June 2015, an 89 per cent improvement. The new clinic also received a satisfaction score of 92 per cent by patients that went through the new clinic during this same period. Many patients commented that they liked how well the new clinic coordinated their care.

"When I went into the hospital I knew exactly what to expect and things progressed similar to what I was expecting which was very helpful."

- Patient

"I spent almost a day at the Regina Hip and Knee Clinic and they went through everything with me. I saw the anaesthesiologist that day; I saw my internal medicine doctor, and several other people. I was interviewed, filled out a lot of forms, and then I had a full morning with therapists who talked about what the operation was going to be like and what I would experience and what I would need and all those things. It was all excellent. They were very informative."

- Patient

"I think it's really good to be handed from the doctor to the therapists. This is a really, really good process. I hope it extends beyond just knees and hips."

- Patient

Begin replication of the model with two other specialty groups.

Group number one: Work towards implementation of the provincial referral model with rheumatologists in Regina and Saskatoon is underway. This is the first group of specialists to attempt to implement this new referral model provincially.

To-date the rheumatologist group has designed a standardized referral form, adopted nationally developed decision support tools to help guide referring providers, and have begun design of a central intake and triage process that will utilize multidisciplinary teams to route patients quickly and efficiently to the most appropriate provider. Roll-out of the new referral model in rheumatology is expected in the later part of 2016.

Group number two: In 2016-17, the Regina Mental Health Clinic will begin utilizing its redesigned central intake, assessment and triage model for all adult psychiatry referrals. This includes using a single, simplified referral form that will help patients access all mental health services available at the clinic. Additionally, adult psychiatrists in Regina will begin offering patients the option of seeing the next available specialist. Primary care providers and their patients will benefit from this streamlined process by providing access to the mental health services offered by the clinic's multidisciplinary team. Another benefit to the referring provider is the improved communication back to the primary care provider regarding their patient's progress. While Regina adult psychiatrists are not directly participating in LINK at this time, other adult psychiatrists in the province are available to family physicians for telephone consultations.

Emergency Department Waits and Patient Flow

Overcrowding within hospital wards and long delays for many patients who seek help in the emergency departments (EDs) prompted the Government of Saskatchewan to call for improvements to ED waits times in the 2012 Growth Plan. The Emergency Department Waits and Patient Flow Initiative and the ED Waits Team (the Team) was created in response and aims to aggressively address emergency department wait times, in efforts to provide sooner, safer and smarter care for patients.

In the first two years of the initiative, teams across the health care system worked together to identify the root causes of hospital overcrowding and develop and implement plans to improve access to care in pre-hospital primary care settings, services in hospital and services in the community after a patient leaves hospital.

It takes time to develop and implement system-wide change. As part of the concerted and coordinated effort across the health care system, and supported by data and research, the provincial government affirmed its commitment to significantly reduce wait times in hospital emergency departments, establishing a new target of a 60 per cent reduction in wait times by 2019. Wait time measures targeted for a 60 per cent reduction include: ED length of stay for admitted non-admitted patients time waiting for an inpatient bed; and the wait for a physician's initial assessment. See figure 17.

Reducing wait times by 60 per cent by March 2019 will put Saskatchewan among the leaders in the country in meeting the Canadian Association of Emergency Physicians guidelines for safe, appropriate and timely ED care.

Figure 17 shows improvement from Jan 2015 to Jan 2016 for admitted patients being seen in the ED compared to the baseline. The length of stay in the ED from the time a patient registers to the time a decision is made for them to be admitted has gone down from 28 hours in 2013-14 to 27 hours in 2015-16, a decrease of approximately 3.6 per cent. 90 per cent of non-admitted patients that visited an ED in 2015-16 waited a similar amount of time or a little longer than they did in 2013-14.

Similarly, the time waited in the ED for an inpatient bed has decreased over the past year. Figure 17 shows that the time patients wait following the decision to be admitted until they were in a bed on the unit from Jan 2015 to Jan 2016 has decreased from 23 hours to 19 hours, a 17 per cent improvement.

Process improvements within provincial EDs have been monitored using measures defined by the Canadian Association of Emergency Physicians. The Canadian Triage and Acuity Scale (CTAS) enables EDs to prioritize patient care requirements and examine patient care processes, workload, and resource requirements relative to case mix and community needs. See figure 18.

Figure 17: Comparison of length of stay for admitted patients in the emergency department, length of stay for non-admitted patients in the emergency department, and time waiting for an inpatient bed in the emergency department.in Regina, Saskatoon and Prince Albert combined.

Indicator (Regina, Saskatoon and Prince Albert combined.)	2013-14 Baseline	2014/2015 Actual	2015/2016 Actual	2015-16 Goal	Year over year change in hours
Length of stay for admitted patients in ED	28.1	28.4	28.6	22	Increase 0.2 hours
Length of stay for non-admitted patients in ED CTAS 1-3	8.4	8.5	8.6	8.0	Increase 0.1 hours
Length of stay for non-admitted patients in ED CTAS 4, 5	5.9	6.1	6.4	5.0	Increase 0.3 hours
Time waiting for an inpatient bed in ED	22.8	22.2	21.9	18.2	Decrease 0.3 hours

Research has shown that long waits in the ED are a symptom of patient flow issues across the entire continuum of care. There is compelling evidence that gaps in community-based care, lack of coordination between many different health services and hospital overcrowding have a direct impact on delays in EDs. As such, solutions are equally complex and will require a system wide approach, with improvements made in each phase of the patient's journey. The two largest drivers of long wait times are hospital occupancy rates and the number of people who come to the ED. Both of these can be attributed to inadequacies in the primary health care services available in the community.

Figure 18: Canadian Triage Acuity Scale (CTAS)

Level	Acuity level
I	Resuscitation
II	Emergent
III	Urgent
IV	Less Urgent
V	Non-Urgent

Accordingly, the 2016-17 health system strategic priority is "To improve access for patients and reduce ED Waits by 60 per cent, by making necessary improvements in key areas including primary health care, specialist consults, diagnostics, mental health and addictions, long term care, home care, and acute care by 2019." This more inclusive health system priority will assist in aligning all system improvement efforts to achieve the 60 per cent target.

Work continues to develop and implement provincial level processes to improve patient flow and reduce ED wait times. These efforts are augmented by work being led by individual health regions across the province in their local effort to improve patient wait times in emergency departments.

In 2015-16 several new provincial processes were designed as part of a provincial *Patient Flow Toolkit*. This toolkit consists of modules which focus improvement efforts on key parts of the patient's hospital journey. Toolkit modules developed to date include:

- ⇨ Alternative Level of Care (ALC) designation and data collection;
- ⇨ Interdisciplinary Team Rounds at the bedside; and
- ⇨ Inter and intra-regional transfers of care.

Emergency Department Waits and Patient Flow

Existing efforts to reduce emergency department waits across the health system will continue in 2015-16. Reducing emergency department waits and improving patient flow remains a key priority.

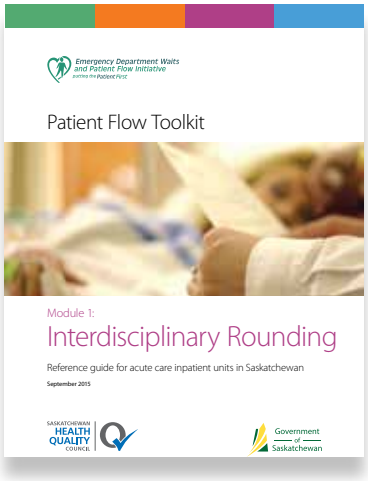
Key Actions and Results

Ensure that patients and families receive the right care at the right time and are actively involved in the creation of an integrated care plan and patient goal setting. This will be done through the implementation of Interdisciplinary Team Rounds and Back to Basics care across medical and surgical acute care units.

Physician attended Interdisciplinary Rounding at the bedside is recognized as best practice in patient and family centred care helping to enusre patients and their families are included in the creation of the patient care plan and goal setting.

The use of IDR has been shown to reduce the patient's length of stay, which in turn ensures space for new patients needing to be admitted. Prior to the development of the Interdisciplinary Team Rounds (IDR) training module in the *Patient Flow Toolkit* there was no standard process for how interdisciplinary team rounds occurred in the province. Part of the standardized approach to rounding outlined in the training module includes a Back To

Basics Checklist which ensures patients' pain management, nutritional intake, bladder and bowel function, mobility and daily activities are met prior to discharge.



In 2015-16 health regions were asked to implement daily IDR in 50 per cent of their medical, surgical and critical care units in tertiary and regional hospitals. Regions have made significant progress moving the rounding processes to the bedside and improving care coordination among team members. This target was not completely achieved due to the significant workplace culture changes required. This work will continue into 2016-17 with the goal of having daily IDR implemented in 100 per cent of medical, surgical and critical care units in tertiary and regional hospitals by the end of 2016-17.

To support the implementation of IDR, an outreach team was created to provide coaching support to regions and ensuring the provincial standard processes were being implemented. Regional team leads meet regularly to problem solve and share successes. This work will continue in 2016-17.

Ensure patients receive the right care, at the right time, in the right setting, by the right providers by implementing the Transfer of Care Strategy across all tertiary sites.

At times patient care requires that patients be moved to another health care facility to receive the level of care they require. This may involve moving patients to another facility within their own region or to a facility in another region to ensure that the right care is provided by the right provider at the right time. Coordinating safe and timely transfers enables patients to seamlessly move throughout Saskatchewan facilities and return to their home communities. Several process improvement events occurred in 2015-16 related to patient transfers and have generated important learnings and promising results. A memorandum of understanding was signed by chief executive officers of all health regions which outlines the principles for all transfers, which can be viewed at hqc.sk.ca.

When transferring a patient there is clinical data that must move in advance of the patient to support care planning on the receiving end of the transfer. Accordingly, the *Patient Flow Toolkit* includes information to support a provincial approach so the patient and clinical information move in a well-coordinated manner and the transfer of care between facilities is seamless. This module will be implemented in 2016-17 and will guide the roll out of a provincial approach to patient transfers.

Performance Measures

Reduce total length of Acute Care Length of Stay by 10 per cent in units that have fully implemented Interdisciplinary Team Rounds.

This target was not met because the measurement tool was still in development in 2015-16. Additional factors associated with the delay were the significant process and culture changes required to implement the length of stay reductions.

It is anticipated that length of stay reductions will be achieved as teams progress in their deployment of the rounding process.

In addition to a measurement tool, a scoring tool was developed to measure maturity and progress of the rounding process. Since the scoring tool was developed, significant progress has been made by all of the identified hospital units to improve the implementation of Interdisciplinary Team Rounds. Data collection will begin in April 2016.

20 per cent reduction in total Acute Care Length of Stay for patients awaiting transfer to their home region from tertiary care.

This target was not met. A provincial process and work standards was developed and incorporated into a module for the *Patient Flow Toolkit* which was shared with all regions in the winter of 2015. Implementation of the process was delayed until 2016-17.

Work in Addition to Health Plan Goals

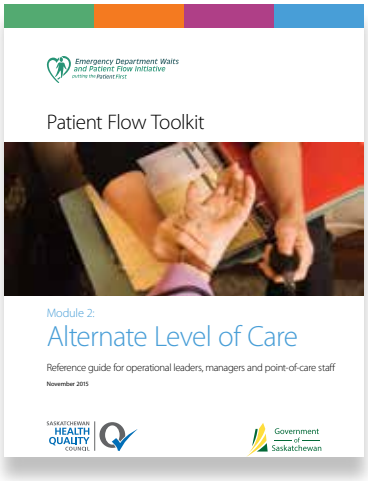
Alternate Level of Care Strategy

An Alternate Level of Care (ALC) patient is a patient who does not require the intensity of services provided in the facility they are being treated in. The prolonged presence of this population within acute care is reflective of the system's inability to meet their care needs within the community. Some may be waiting for a more appropriate level of care, such as a long-term care facility or for home care. Others lack access to community supports to complete their convalescence closer to home.

Patients in this situation are designated ALC and the systems inability to provide alternate care for these patients is a significant factor contributing to high hospital occupancy rates and the waits within Saskatchewan emergency departments.

A process was developed to collect accurate and reliable provincial ALC data to inform the health system about what additional services need to be created or bolstered to support the clinical needs of these ALC patients. This data will continue to provide valuable information to help the system provide better care in the most appropriate setting. It will inform the decisions regarding the allocation of resources to improve the flow of patients through the health care system and reduce wait times in the emergency department. More importantly, it will ensure patients receive the care that best meets their needs in the right place and at the right time.

The data that emerges through the ALC strategy will also be used for health system modelling to develop virtual pilots prior to developing new services. This modelling will help inform future health system strategic investments.



Physician Initial Assessment Data Capture Strategy

In partnership with eHealth Saskatchewan, a Rapid Process Improvement Workshop that focused on reducing how Physician Initial Assessment data is captured was held in 2015-16. The workshop resulted in the creation of standard definitions and work standards.

Regina Qu'Appelle Health Region

The Regina Qu'Appelle Health Region has worked across the care continuum and piloted various initiatives that support care in the emergency department, within specific hospital units and throughout the community including:

1. **Patient Treatment and Assessment** in the ED has been improved through the creation of an intake model of emergency care which streams mid- acuity patients to other services to ensure timely physician assessment of emergency patients. Physician Initial Assessment wait times has begun to show improvement in all CTAS categories with the biggest gains seen in the CTAS 1 category. Read more on page 31.
2. **The Accountable Care Unit pilot** is a new model of inpatient care that significantly improves the coordination of patient care. The model utilizes co-located interdisciplinary teams to conduct daily bedside rounding. North American hospitals that have implemented the Accountable Care model have experienced decreased lengths of stay, decreased mortality rates and increased patient and staff satisfaction. While early results of this pilot are promising, full evaluation of this pilot will occur in 2016-17.
3. **Assessor Coordinator Coverage** has been increased at the Pasqua and Regina General Hospitals to ensure patients' care plans are carried out seven days per week.
4. **The Police and Crisis Team (PACT)** partnership was created between Regina Police Service and Regina Qu'Appelle. Modeled after Saskatoon's PACT program, this team ensures patients who are experiencing a mental health crisis receive the immediate care they require and are linked to a variety of community services specific to the patient's need.
5. **A Nurse Practitioner in Pioneer Village Long Term Care (LTC) Facility** was added to provide assessment and preventative care to help avoid unnecessary transfers to the ED. Prior to introducing a nurse practitioner to Pioneer Village approximately 26 residents a month were being transferred to Regina hospitals to have their care needs addressed. Since this pilot began in April 2015 the number of transfers has been reduced to approximately 17 residents per month, a 35 per cent reduction in resident transfers.
6. **Mutchmore Lodge** partnered with Regina Qu'Appelle Health Region to provide ALC patients with accessible and affordable living options. This program supports patients designated as ALC in acute care and who do not have suitable living arrangements in the community.
7. **Connecting to Care** (see page 26).
8. **Seniors House Calls** (see page 9).

Saskatoon Health Region

The Saskatoon Health Region implemented initiatives within the hospital and throughout the community including:

1. **Enhanced interprofessional staffing on the medicine Clinical Teaching Unit (CTU) at Royal University Hospital.** This work improves interprofessional practices including referral process, development of patient and family goals and transition milestones, development of an interprofessional care plan, use of standard communication tools, and expanded coverage for some professions like social work and therapies. This has resulted in decreased wait times for referrals; improved communication; reduced number of hand offs between providers; and team attendance at daily interprofessional bullet rounds.
2. **Police and Crisis Team (PACT)** was implemented in response to the high number of calls the Saskatoon City Police services received from people experiencing mental health and addictions issues. This program pairs a police officer with a mental health professional who respond together to mental health crises calls received in the community. This initiative has reduced the number of police transports to the ED, and ensures individuals in crisis receive appropriate care. This program is jointly funded by the Ministry of Justice and the Ministry of Health.
3. **Community Transition Beds** provide an alternative for patients who no longer require acute care but still require some additional support before returning home. These transitional beds at Preston Park Retirement Residence in Saskatoon allow patients to stay and receive appropriate care services for up to 60 days.
4. **Client Patient Access Services** has been enhanced through additional assessor/coordinator coverage in acute care to prevent delays in providing service to patients, assessing for community services, and assisting with care transitions.

5. **Sanctum HIV Hospice** is Saskatchewan's first HIV transitional care home and hospice. Their mission is to provide care to people living with HIV/AIDS that is dignified, non-judgmental and unconditional. The hospice operates from a renovated home donated by St. Paul's Hospital Foundation and is funded by the Saskatoon Health Region and a grant from a federal program, the Saskatchewan Housing Initiatives Partnership Strategy (SHIPS). A volunteer board provides oversight for this new service.

   The healthcare team at Sanctum provides holistic care in a community setting, reducing visits to the emergency department and inpatient bed utilization.

   The ten-bed facility opened November 3, 2015 and is intended specifically for people living with HIV or dying of AIDS who require supportive care. Issues may include homelessness, poverty, addictions and/or mental health needs. The hospice offers three types of care: supportive, end of life and respite. Seven beds have been allocated to clients who require supportive, sub-acute, or rehabilitative care; two beds are prioritized for clients who require end-of-life care. The last bed is dedicated to respite care clients who need a place to stay for up to 14 days.

6. **Paramedicine Pilot** Project was undertaken in March 2015 by Saskatoon Health Region to determine if faster assessment and appropriate intervention could help people avoid the emergency department. The pilot delivered enhanced non-emergency and emergency medical services to residents at Luther Special Care Home and Porteous Lodge. In the three months before the pilot, 200 residents from Saskatoon's 30 long-term care homes were taken by ambulance to the region's hospital emergency departments. While some of these visits were the result of medical emergencies (e.g., heart attack, stroke), many others resulted in routine transfers for non-emergency procedures that could have been treated by paramedics at the residents' bedside. Although each long-term care facility in Saskatoon employs highly skilled healthcare professionals such as registered nurses, they are not always able to provide onsite treatment to residents. With the launch of the pilot project in March 2015, one paramedic from MD Ambulance was available to perform geriatric assessments at the pilot sites to determine if residents can be treated onsite (e.g. intravenous treatment for low blood sugar) or need to be transported by ambulance to the hospital.

   The Saskatoon Community Paramedicine Pilot appears to be having a significant effect on the reduction in hospital or primary care visits. During the first quarter of 2016-17 (April 1, 2016 to June 31, 2016) the Saskatoon Community Paramedic Pilot received 232 calls. Of those calls only 32 patients required a transfer to acute care facility while the remaining 200 patients were able to be treated on site. The program which is still in its pilot phase, continues to grow by providing community paramedic services to 20 of its long-term care home locations within the city of Saskatoon.

7. **The Lighthouse Pilot Project** is a partnership between Lighthouse Supported Living, Saskatoon Health Region and MD Ambulance. The expansion of services is designed to decrease emergency department visits and consults, ambulance and police calls, and inpatient admissions to acute care by ensuring the right care by the right provider at the right time in the right place. The pilot included:

   - ⇨ Dedicating another eight beds to clients with mental health complex needs and expand support to clients 24 hours a day. The increase in beds from 9 to 17 supported the transition to independent living.
   - ⇨ Expanding the Stabilization Unit to 24 hours from 4 p.m. to 8 a.m. for clients under the influence of drugs or alcohol. The increase in hours reduces substance misuse and mental health-related admissions to emergency departments, and improves access to addiction support.
   - ⇨ Expanding the Lighthouse Mobile Outreach service from six to 16 hours a day, improving access to services, reducing the use of ambulances, and ensuring case managers can spend less time transporting clients and more time assisting them one-on-one. The Mobile Outreach service allows a team of two to provide transportation to homeless or struggling individuals to the Lighthouse or other support services.
   - ⇨ Having a paramedic on site 12 hours a day, seven days a week. An embedded paramedic on the Lighthouse's primary health team provides emergency assessment and triage, as well as general paramedicine, reducing the need for ambulance and acute care access.
   - ⇨ Adding a care aide, addictions counsellor and increased primary health nurse practitioner hours to the team to improve continuity of care, enhance referral and access to appropriate services, and advance coordination of multiple health team members on site.

Saskatoon Health Region is evaluating the pilot project and plan to release the report in 2016-17.

Prince Albert Parkland Health Region

The Prince Albert Parkland Health Region was able to reduce their Physician Initial Assessment times by increasing physician and nursing coverage during peak times in the ED by identifying patterns in patient demand in the Victoria Hospital ED. Based on these patterns, additional physician and nurse coverage has been provided during peak times and staffing has been adjusted when demand was predictably low. Overall wait times were reduced from 185 minutes to 161 minutes for 90 percent of patients, a 13 per cent improvement.

Other Health Region Improvements in 2015-16

In addition to the provincially funded activities in Regina Qu'Appelle, Saskatoon, and Prince Albert Parkland Health Regions, other health regions have made significant improvements to improve their ED wait times. In the Five Hills Health Region a large number of patients were being seen in the

ED with conditions that could be managed in a family practice setting. To address this, the region opened the Crescent View Clinic which offers extended walk in hours. Increased access for those patients who can only see a doctor after daytime working hours allows patients to seek basic primary care in a community setting instead of the hospital.

The Kelsey Trail Health Region also experienced a high number of patients going to their ED for basic care needs due to not having a primary care physician. The region set a goal of attaching 70 per cent of those patients to a primary care provider in 2015-16. The region was successful in meeting that goal and is now working to ensure all patients in their region have a primary care provider by March 31, 2017.

Similarly, Sunrise Health Region has begun to redirect patients who are presenting in the Yorkton ED with non-urgent care needs to a physician and nurse practitioner in the community.

Appropriateness of Care

The Saskatchewan health system is committed to improving Appropriateness of Care.

Appropriate care is defined as *"the right care, provided by the right provider, to the right patient, in the right place, at the right time, resulting in optimal care." (Canadian Medical Association, 2013)*

At times patients don't always receive the best treatment options for a variety of reasons, including availability of services, access to care, variation in clinician practices and lack of solid evidence available for clinicians to support best treatment options, leading to uncertainty and variation in decision-making. All these factors contribute to inappropriate care, including overuse, underuse, misuse, and variation in health care. Unnecessary tests, treatments and procedures do not add value and take away from care by potentially exposing patients to harm, and at times lead to more testing to investigate false positives, adding stress for patients. This wastes precious resources within an already stretched health care system and contributes to increased wait times for patients who really do require medical tests and procedures.

In early 2015 the *Appropriateness of Care Program* was established to develop a framework for improving appropriateness of care in Saskatchewan; to create a provincial support structure to implement the framework; and to lead and support appropriateness of care projects. The provincial *Appropriateness of Care Framework* was finalized in December 2015 and has been shared broadly with various health system stakeholders, including health regions, the Saskatchewan Cancer Agency, the College of Medicine, the Saskatchewan Registered Nurses Association, the Saskatchewan College of Physicians and Surgeons, the Saskatchewan Medical Association and other health care professional associations.

The *Appropriateness of Care Framework* includes five components that will help guide the implementation of appropriateness of care projects:

- A standard quality improvement methodology which involves using evidence and data to guide the improvement and measure the performance;
- A physician involvement strategy that focuses on increasing awareness of appropriateness of care among physicians, providing education and training to physicians who will be leading appropriateness of care projects, and providing incentives for their involvement;
- An engagement strategy for involving other healthcare providers, patients, families and the public in improving appropriateness of care;
- A data strategy that focuses on how to develop measurements, collect data, and analyze and report the results; and
- Tools to support implementation of this framework (e.g. criteria for selecting appropriateness of care projects, a tool for involving patients in treatment decisions, data and measurement tools).

Improving appropriateness of care is a long term strategy which involves changing the culture of health care clinicians. Successful implementation of the *Appropriateness of Care Framework* depends on engagement of a large contingent of stakeholders across the health care system, including physicians and other healthcare professionals, health system leaders, patients, families and the public. To raise awareness of the *Appropriateness of Care Framework*, presentations have been provided to key stakeholders, including the Provincial Leadership Team, provincial Senior Medical Officers , the Saskatchewan College of Physicians and Surgeons, the Saskatchewan Medical Association , physician advisory committees and department heads in Regina Qu'Appelle and Saskatoon Health Regions, and the Patient and Family-Centred Care Guiding Coalition.

In November 2015, a provincial Appropriateness of Care network was established to facilitate a collaborative approach to implementing the framework within the Saskatchewan health system. The Network is comprised of the provincial Appropriateness of Care program team, representatives (mainly physicians and administrative leads) from all health regions, the Saskatchewan Cancer Agency, and the Saskatchewan Medical Association (SMA). The Network will play a critical role in implementing and replicating provincial Appropriateness of care projects as well as in sharing information and tools.

Provincial appropriateness of care work strongly aligns with the Choosing Wisely Canada campaign launched in April 2014 by the Canadian Medical Association to reduce unnecessary testing and treatments. More than 175 recommendations/guidelines for physicians and patient educational materials in various clinical areas have been developed by physician specialty groups in Canada. The appropriateness of care program team has been working collaboratively with the SMA to align provincial work with Choosing Wisely Canada.

Physicians play a key role in the health system, and are integral to quality of care and patient safety. To start educating and training physicians in the quality improvement methodology that the *Appropriateness of Care Framework* is based on, a lecture has been developed and was embedded into the undergraduate curriculum at the College of Medicine in January 2016; a number of physicians have attended the Advanced Training Program at Intermountain Health in Utah to learn how to apply the quality improvement methodology to improve Appropriateness of Care; and a mini advanced training program will be developed by the Saskatchewan Health Quality Council to locally train Saskatchewan physicians in the *Appropriateness of Care* methodology.

Strategy

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

Key Actions and Results

Introduce a prototype under the 2014-15 Appropriateness Framework in Magnetic Resonance Imaging (MRI) of the lumbar spine. The prototype will test the effectiveness of the framework's planning and deployment strategy, engagement strategy, and data analysis capability. By March 31, 2016, at least one clinical area within a service line will have deployed care standards and will be actively using measurement and feedback to inform improvement.

The components of the *Appropriateness of Care Framework* were tested in the clinical area of lumbar spine MRI. This project was led by a provincial clinical development team comprised of orthopedic surgeons, neurosurgeons, radiologists, a family physician, chiropractor and patients. The goal of this project was to improve appropriate ordering of MRI lumbar spine. They developed a provincial MRI Checklist for lumbar spine based on best practice guidelines which was piloted in Saskatoon and Regina Qu'Appelle health regions in the fall of 2015.

Using principles developed in the *Appropriateness of Care Framework*, the pilot project was able to successfully engage physicians in implementing the provincial MRI checklist, and by the end of the pilot, the physician compliance rate for use of the MRI Checklist was above 90 per cent. This indicates that the checklist has become part of daily work for many physicians, particularly orthopedic surgeons and neurosurgeons who frequently order lumbar spine MRIs.

Increasing patient demand for MRI is one of the important factors that contribute to inappropriate ordering of lumbar spine MRI. Patient educational material developed by Choosing Wisely Canada to help physicians engage patients in conversations about unnecessary MRI for lower back pain was provided to physicians to use along with the checklist.

Any lessons learned from this project, including effectiveness of the strategies used to involve and communicate with physicians, patients, health system leaders and providers as well as the tools used to collect, analyze and share data, will be used to evaluate the framework and inform implementation of the next provincial Appropriateness of Care projects in 2016-17.

One of the key lessons learned during the MRI Lumbar Spine Checklist pilot which created significant challenges is the variation in privacy processes within health regions. Individual regions have developed local privacy processes to comply with *The Health Information and Protection Act* (HIPA). This variation has made provincial quality improvement work challenging. Work is underway to develop a provincial standard process for assessing and mitigating privacy risks associated with data collection, analysis, and sharing.

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

The Appropriateness of Care target included in the *2015-16 Ministry of Health and Health System Plan* has been revised. The original goal "*50 per cent reduction in inappropriate services*" is a broad generic statement. Improving clinical Appropriateness of Care requires focused work in specific clinical areas with targeted measureable outcomes. The revised outcome target for Appropriateness of Care approved by the Provincial Leadership Team is: ***by March 31, 2018, 80 per cent of clinicians in three selected clinical areas within two or more service lines will be utilizing agreed upon best practices.***

Progress toward meeting the Appropriateness of Care target statement was tracked by collecting data obtained during the three month pilot in Regina and Saskatoon during implementation of the Lumbar Spine MRI Checklist. Evidence based best practice guidelines were embedded in the checklist and compliance regarding use of the checklist by physicians who ordered an MRI was measured for three months during the pilot project. Evaluating the impact of the MRI Checklist in reducing the number of inappropriate lumbar spine MRIs has not been measured due to the short timeframe of the pilot, the complexity of measuring requests for MRI and waitlisted patients in that time.

90 per cent of physicians who ordered Lumbar Spine MRIs during the trial were using the checklist, which were considered appropriate. The checklist will be revised based on feedback from physicians, and will be implemented provincially later this spring. Ongoing spot audits will be conducted in 2016-17.

Better Value

Government Goals

Sustaining growth and opportunities for Saskatchewan people

Meeting the challenges of growth

Securing a better quality of life for all Saskatchewan people

Delivering responsive and responsible government

These actions support the *Saskatchewan Plan for Growth with Better Teams*.

Ministry Goal

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

Patients, families and health care providers are seeing real benefits from Saskatchewan's healthcare system transformation. Continuous improvement and a focus on patient safety are the foundations for the exceptional health system we all want to build for patients and families.

However, when you:

- ⇨ improve quality and safety;
- ⇨ eliminate mistakes in the system;
- ⇨ remove the barriers that cause re-work; and,
- ⇨ involve patients and health providers at the point of care in the design of new processes…

When you include the above points the health system saves money. Sometimes the savings are dollars you can count immediately that go directly to the bottom line. In other situations, when time and space is saved or when capacity and productivity increase, the improvements themselves add more value.

Bending the Cost Curve

Health costs continue to increase. A focused effort is required to ensure the health system is sustainable into the future. Ongoing, as part of a multi-year budget strategy, the health system will bend the cost curve by achieving a balanced or surplus budget.

Key Actions and Results

Combined measure: Organizations will continue to pursue shared services initiatives that improve quality and reduce cost and organizations will continue to pursue continuous improvement efficiencies.

Health Regions and participating organizations continue to pursue quality and safety improvements, and identify opportunities for greater operational efficiency. From the start of the health system's continuous improvement journey in 2008 through March 2016, health regions and other participating organizations have identified a projected financial benefit of approximately $140 million. While that is a significant saving, particularly in times of restraint, the dollar amount alone doesn't reflect the work health system providers and patient representatives are doing to improve the quality and safety of health care delivery overall.

Performance Measures

As part of a multi-year budget strategy, the health system (including health regions, Athabasca Health Authority, and the Saskatchewan Cancer Agency) will bend the cost curve by achieving a balanced or surplus budget, as measured by surplus or deficit.

Not all health system organizations are projected to be in a balanced or surplus position at year-end. This is mainly as a result of increased use of previous year revenue and increased operating expenses due to volume pressures. The average Ministry of Health appropriation budget increase since 2008 is five per cent compared to the previous eight years of eight per cent. See figure 19.

Figure 19: Average increase in Ministry of Health appropriation budget from 1999 to 2016.

	1999-00 to 2007-08	2008-09 to 2016-17
Average percentage of increase in Ministry appropriation budget	8.0%	5.0%

Strategic Investment in Infrastructure

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

Key Actions and Results

Evaluate the effectiveness of alternative funding or delivery option strategies and build them into overall program management.

No results achieved in 2015-16. As a result evaluation of the effectiveness of alternative funding or delivery approaches is ongoing and will progress into 2016-17.

Explore options to improve asset management across the system.

- ⇨ A capital asset plan including recommendations for improvement is on schedule for completion by the end of June, 2016. Various options to improve asset management are being explored as part of that process.
- ⇨ eHealth Saskatchewan has developed an integrated multi-year provincial roadmap for information technology/information management (IT/IM) which is focused on alignment with healthcare priorities
- ⇨ 3sHealth completed work with Regions to review current asset management systems for equipment needs.

Re-design and streamline the capital development process.

No action/progress taken on this action this year. The focus was on the development of the capital asset plan which may inform the re-design of the capital development process.

Streamline and consolidate the provincial equipment prioritization and funding processes.

Work is underway with health regions to review equipment asset management systems and to establish an inventory of health equipment in the province. 3sHealth is leading work on the identification of group purchasing opportunities that may be available for future equipment purchases.

Draft a provincial IT strategic planning process, including an approved structure and decision-making process.

- ⇨ An integrated multi-year provincial roadmap for IT/IM, focused on alignment with 2015-16 healthcare priorities was completed.
- ⇨ 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.
- ⇨ A draft governance structure for the IT information management strategy has been completed. Review and approval is planned for April 2016.
- ⇨ Conducted an inventory of current standards (e.g. enterprise architecture, single identity management solution for providers) and developed processes for standards.

By March 31, 2016, address three high-impact capital areas in information technology, facilities, and equipment that are at heightened risk for critical failure, using an alternative funding approach.

Information technology (IT), facilities, and equipment were addressed over 2015-16 including the following:

- ⇨ The Data Centre project, which is intended to improve the reliability and maintenance of health information systems will result in improved processing times. Other benefits include standardization of technology and process efficiencies as well as creating a solid foundation for future scalability and disaster recovery plans.
- ⇨ Multidisciplinary teams completed planning and testing activities and the highly complex move of hardware, systems and services began in 2015-16. A plan is in place for the new data center to be in completed in mid 2016.
- ⇨ Equipment – Hospira Smart Pumps for Medication Delivery. Approximately 3,000 new IV pumps were put into service over 2015-16. The new pumps differ from older IV pumps in that they are pre-programmed with the provincial drug library that includes minimum and maximum dosing limits. The pumps increase patient safety by reducing dosing errors. The new pumps will also result in lower operational costs through a 3sHealth negotiated seven-year contract with Hospira, who supplies the pumps and consumables.
- ⇨ Facilities – Saskatoon Health Region was granted approval to borrow $15.5 million for repairs of the 1984 portion of the Royal University Hospital parkade through the Municipal Financing Corporation. The loan is being paid for through parking revenue.

Better Teams

Government Goals

Sustaining growth and opportunities for Saskatchewan people

Meeting the challenges of growth

Securing a better quality of life for all Saskatchewan people

Delivering responsive and responsible government

These actions support the *Saskatchewan Plan for Growth with Better Teams*.

Ministry Goal

Build safe, supportive and quality workplaces that support 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.

Culture of Safety

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

Key Actions and Results

Stop the Line is a process that not only allows, but expects, anyone (for example, staff members, patients, or family members) who encounters a safety issue or concern to report it immediately. The organization has an obligation to respond according to a pre-established process that will stop the reported activity. STL has been implemented at St. Paul's Hospital in Saskatoon. In 2015-16, STL will be replicated at Saskatoon City Hospital and Royal University Hospital.

As of September 2015, Stop the Line (STL) has been implemented at all tertiary care hospitals in Saskatoon Health Region (St. Paul's, City, and Royal University Hospitals). Patients, families, staff and physicians can report all safety incidents through a 24/7 phone line. Satisfaction with the phone line is high and the number of safety incidents being reported has increased more than 100 per cent from pre-STL implementation levels (2013-14 baseline). An increased rate of voluntary safety incident reporting reflects a strengthening culture of safety.

Support all health regions to prepare for STL implementation by conducting a readiness assessment and addressing any gaps.

The provincial implementation assessment measures whether health regions have implemented the 17 foundational elements of STL which include policies, process improvements and reporting criteria.

As of December 2015, all regions had completed the provincial implementation assessment in preparation for implementation of STL and prepared implementation plans for 2016-17.

The 17 key elements addressed within the provincial implementation assessment are:

1. Leadership support of those who report safety incidents.
2. Standard process for responding to critical/serious STL incidents.
3. Leaders know and can lead root cause analyses for safety events.
4. Leaders communicate about safety.
5. Locally meaningful staff and patient safety data are posted on unit/program visibility walls.
6. Staff and patient safety incident/occurrence data are posted and reported on regional visibility walls.
7. Leaders review progress towards reducing risk through routine review of trends;
8. The organization is aware of current safety state.
9. The organization identifies trends and risks through analysis of incident report data;
10. The organization analyzes and takes action to reduce harm.
11. Actions for organization-wide trends and risks are tracked, reported and completed;
12. Staff safety reporting is linked to OHS Committees.
13. Regional policy outlines core SA/STL 'SAFER' expectations.
14. Regional policy outlines core expectations for respectful behavior.
15. Regional policy outlines expectations for disclosure of safety events.
16. New staff are trained in the SA/STL policy and expectations.
17. All staff are trained to recognize potentially harmful situations, how to respond, and how to report patient and staff incidents.

The average score was 58 per cent, indicating that over half of the 17 key elements of STL are in place in most regions. As of March 31, 2016, three health regions (Saskatoon, Sunrise, and Sun Country) have STL processes available to patients and families, staff and physicians.

Full implementation of the Safety Management System (SMS), a focused process that supports safe work practices in which healthcare providers work together with patients, families and care providers.

The healthcare system is committed to achieve full implementation of the SMS. All health regions have identified a facility of focus and have identified timelines and deliverables. Delays have occurred in some health regions due to emergent issues (e.g. fires in the north, flu season), but there is an ongoing commitment to fully implement the SMS elements.

Performance Measures

By March 31, 2016, the number of reported events by month, severity level (1 through 4), and facility unit are reported by staff, patients and physicians from all units at City and Royal University Hospitals. This measure has been revised. New measure: Number of safety incidents in Saskatoon Health Region voluntarily reported through the STL reporting system, comparing status of incident (e.g. 'good catch', resolved, or not resolved) at report. Target: By March 31, 2016, safety incidents are being reported by staff, patients and physicians from all units at St. Paul's, City, and Royal University Hospitals.

Access to the 24/7 phone line for voluntary reporting of safety incidents started with St. Paul's Hospital in April 2014 and spread to City and Royal University Hospitals in Saskatoon Health Region in September 2015, with a corresponding increase in the number of voluntarily reported incidents. Figure 20. The green triangle (below) represents the number of safety incidents that were 'good catches': risks identified and resolved prior to impacting patients or staff. The blue portion of the bar represents the number of safety incidents that were resolved prior to reporting: defects that reached patients or staff but were resolved prior to reporting. The yellow bar depicts the number of safety incidents that reached patients or staff and were not resolved prior to reporting. The STL initiative expects staff and physicians to stop and resolve safety risks in the moment. As STL improvements spread, the proportion of 'good catches' is expected to increase.

By March 31, 2016, all health regions have conducted a readiness assessment for implementation of Stop the Line and prepared an action plan.

See key action on page 39.

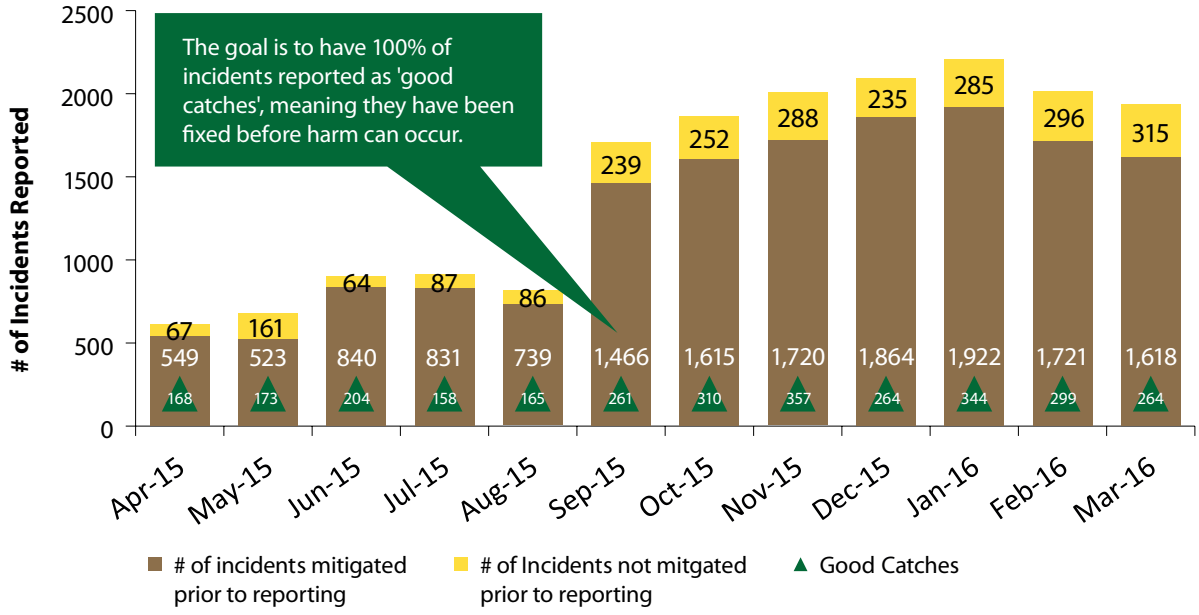
By March 31, 2016, there will be zero Workers' Compensation Board claims for shoulder and back injuries. This measure has been revised. New measure: By March 31, 2016, there will be a 50 per cent reduction in accepted WCB shoulder and back injury claims from the 2014-15 baseline.

The targeted 50 per cent reduction was not achieved; however, there was a 15 per cent reduction from the previous year. A new measure was introduced to help lead the work to the reduction in accepted WCB shoulder and back injury claims. Figure 21.

Incidents of injury involving shoulder and back remain the highest incident of injury type in health care; they are the highest costs and the type of injury that is most challenging to recover from/ regain full range of motion/function for the individual.

The health system has achieved some exceptional gains, and as we get closer to the ultimate goal of Zero we often revisit the system's ability to achieve the targets. Through consultation with the health region occupational health and safety practitioners the aggressive target of achieving zero within this timeframe (March31, 2016) was considered to be overly optimistic and

Figure 20: 2015-16 Saskatoon Health Region Model Line - Number of Voluntarily Reported Incidents Mitigated and Not Mitigated Prior to Reporting, and Number of Good Catches



not viewed as being realistic or achievable. The decision to reduce the target from 100 per cent to 50 per cent by March 31, 2016 was viewed to be more in line with reaching a reduction, keeping the focus on shoulder and backs and have the target still be aggressive in nature. Evidence of the aggressive nature of the target being at 50 per cent reduction is shown in the results of a 15 per cent reduction (albeit still progress) however not achieving the proposed 50 per cent reduction.

The revision of the target from 'zero' to 50 per cent reduction in no-way detracts from the overall system goals to achieve a culture of safety in healthcare. The focus as a collective to address our highest incident of injury remains top of mind and the revised target helps engage staff in such a way to have more confidence in an achievable target.

Figure 21: Number of Accepted Shoulder and Back Injury Claims

2014-15 Baseline	2015-16 Accepted Claims
935	468

New Measure: By March 31, 2016, 100 per cent of reported time loss injuries involving shoulder and/or back injuries will be investigated to root cause.

Investigation to root cause will identify recommendations to enhance preventative action and reduce the likelihood of reoccurrence of such injuries. Given the number of shoulder and back injuries, the increasing targets of 75 per cent and 100 per cent for completed root cause investigations proved to be challenging. There is commitment to continue the appropriate follow-up on all incidents to root cause.

The progress on achieving these targets, along with efficient management of claims processing and effective return to work programs, has had a positive impact on the premium rate for the healthcare industry. In 2014, the premium rate for healthcare was at $1.98 million and was reduced to $1.75 million in 2015 (the lowest that it has been in 11 years). This represents a savings/cost avoidance to the system of $5 million.

Financial Overview

The Ministry spent or allocated $5.1 billion in expenditures in 2015-16, $6.7 million less than its 2015-16 budget. The savings can mainly be attributed to under-expenditures in physician services and capital expenditures.

In 2015-16, the Ministry received $13.5 million of revenue, $3.2 million more than its 2015-16 budget. The additional revenue is primarily due to higher than anticipated bursary repayments.

Ministry of Health's 2015-16 FTE utilization is 499.4 FTEs, 2.5 FTEs greater than its 496.9 FTE budget.

Ministry of Health Comparison of Actual Expense to Estimates

	2014-15 Actuals $000s	2015-16 Estimates $000s	2015-16 Actuals $000s	2015-16 Variance $000s	Notes
Central Management and Services					
Ministers' Salary (Statutory)	96	96	96	-	
Executive Management	2,389	2,364	2,238	(126)	
Central Services	4,866	6,164	4,724	(1,440)	
Accommodation Services	3,378	2,353	2,742	389	
	10,729	**10,977**	**9,800**	**(1,177)**	
Regional Health Services					
Athabasca Health Authority Inc.	7,032	7,034	7,034	-	
Cypress Regional Health Authority	120,326	122,060	121,261	(799)	
Five Hills Regional Health Authority	140,365	144,397	143,897	(500)	
Heartland Regional Health Authority	90,449	91,938	91,590	(348)	
Keewatin Yatthe Regional Health Authority	26,016	26,911	26,911	-	
Kelsey Trail Regional Health Authority	111,056	112,696	112,180	(516)	
Mamawetan Churchill River Regional Health Authority	28,149	28,854	28,684	(170)	
Prairie North Regional Health Authority	203,606	212,157	211,373	(784)	
Prince Albert Parkland Regional Health Authority	199,650	210,357	210,073	(284)	
Regina Qu'Appelle Regional Health Authority	867,440	904,402	904,043	(359)	
Saskatoon Regional Health Authority	1,003,841	1,032,147	1,030,113	(2,034)	
Sun Country Regional Health Authority	129,672	137,616	137,193	(423)	
Sunrise Regional Health Authority	184,454	193,894	193,894	-	
Regional Targeted Programs and Services	132,969	83,621	89,477	5,856	(1)
Saskatchewan Cancer Agency	152,985	157,257	154,695	(2,562)	
Facilities - Capital	75,568	99,419	95,563	(3,856)	
Equipment - Capital	16,449	15,300	8,040	(7,260)	(2)
Regional Programs Support	19,513	26,648	29,614	2,966	
Subtotal	**3,509,539**	**3,606,708**	**3,595,635**	**(11,073)**	
Provincial Health Services					
Canadian Blood Services	38,849	39,100	43,329	4,229	
Provincial Targeted Programs and Services	63,275	61,298	53,189	(8,109)	(3)
Provincial Laboratory	26,802	26,170	27,311	1,141	
Health Research	5,830	-	-	-	
Health Quality Council	5,468	4,968	4,763	(205)	
Immunizations	13,846	13,782	13,928	146	
eHealth Saskatchewan	66,730	64,337	61,937	(2,400)	
Provincial Programs Support	9,155	-	-	-	
Subtotal	**229,955**	**209,655**	**204,457**	**(5,198)**	

	2014-15 Actuals $000s	2015-16 Estimates $000s	2015-16 Actuals $000s	2015-16 Variance $000s	Notes
Medical Services & Medical Education Programs					
Medical Services - Fee-for-Service	513,084	505,751	543,877	38,126	(4)
Medical Services - Non-Fee-for-Service	143,104	188,478	151,019	(37,459)	(4)
Medical Education System	57,661	68,800	59,888	(8,912)	(5)
Optometric Services	9,101	8,879	11,699	2,820	
Dental Services	1,849	2,183	2,112	(71)	
Out-of-Province	122,120	127,412	136,358	8,946	(6)
Program Support	3,730	4,397	3,854	(543)	
Subtotal	**850,649**	**905,900**	**908,807**	**2,907**	
Drug Plan & Extended Benefits					
Saskatchewan Prescription Drug Plan	297,718	294,828	301,929	7,101	(6)
Saskatchewan Aids to Independent Living	39,849	43,084	42,436	(648)	
Supplementary Health Program	21,789	24,304	23,132	(1,172)	
Family Health Benefits	4,011	4,803	4,093	(710)	
Multi-Provincial Human Immunodeficiency Virus Assistance	213	263	225	(38)	
Program Support	4,629	4,567	4,530	(37)	
Subtotal	**368,209**	**371,849**	**376,345**	**4,496**	
Early Childhood Development	**10,993**	**11,102**	**11,032**	**(70)**	
Provincial Infrastructure Projects	**59,328**	**12,262**	**15,685**	**3,423**	
APPROPRIATION	**5,039,403**	**5,128,453**	**5,121,761**	**(6,692)**	
Capital Asset Acquisitions	(60,159)	(12,685)	(15,778)	(3,093)	
Non-Appropriated Expense Adjustment	2,392	4,856	3,562	(1,294)	
TOTAL EXPENSE	**4,981,636**	**5,120,624**	**5,109,545**	**(11,079)**	
FTE STAFF COMPLEMENT	**489.8**	**496.9**	**499.4**	**2.5**	

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 2015-16 program budget and greater than 0.1 percent of the Ministry's total expense.

1. Increased Regional Health Authority operating pressures.
2. Delayed investments in capital equipment.
3. Net program under-expenditures and utilization below budgeted levels.
4. Primarily related to the physician agreement costs budgeted in Non-Fee-for-Service but paid in Fee-for-Service and other programs as well as increased utilization in Fee-for-Service.
5. Primarily due to one-time savings in clincial services.
6. Program utilization above budgeted levels.

Ministry of Health Comparison of Actual Revenue to Budgeted Revenue

	2015-16 Estimates $000s	2015-16 Actuals $000s	Variance $000s	Note
Other Own-source Revenue				
Investment Income	115	250	135	
Other fees and charges	2,259	2,385	126	
Miscellaneous	1,417	5,019	3,602	(1)
Total	3,791	7,654	3,863	
Transfers from the Federal Government	6,456	5,828	(628)	
TOTAL REVENUE	**10,247**	**13,482**	**3,235**	

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 higher than anticipated bursary repayments.

Regional Health Authorities

Operating Fund Financial Statements[1] (In 000s Dollars)

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	125,665	149,288	94,313	27,475	114,801	29,709
Other Provincial Revenue	250	2,058	263	570	1,251	874
Federal Government Revenue	46	214	-	85	2	35
Funding from other Provinces	-	-	-	-	-	-
Patient & Client Fees	8,020	3,850	9,854	1,276	8,590	380
Out of Province Revenue (Reciprocal)	1,197	1,034	735	1	511	43
Out of Country Revenue	91	142	27	-	17	12
Donations	44	128	143	-	16	3
Ancillary Operations - income	-	343	205	-	792	140
Investment Income	285	227	196	55	117	42
Recoveries	2,299	1,832	1,642	53	1,215	525
Research Grants	-	-	-	-	-	-
Other Revenue	487	21	243	88	1,022	262
Total Operating Revenue	**138,384**	**159,136**	**107,621**	**29,603**	**128,332**	**32,026**
Operating Expenses:						
Inpatient & resident services						
Nursing Administration	3,605	1,679	4,382	242	3,847	-
Acute	16,433	23,880	6,623	5,167	15,363	3,908
Supportive	17,972	37,437	9,570	2,481	19,472	1,185
Integrated	14,464	-	23,527	-	6,017	-
Rehabilitation	-	-	-	-	-	-
Mental health & addictions	1,706	2,252	-	-	-	-
Total inpatient & resident services	**54,180**	**65,247**	**44,102**	**7,889**	**44,699**	**5,093**
Physician compensation	**15,630**	**16,000**	**3,163**	**37**	**10,582**	**529**
Ambulatory care services	**3,110**	**7,431**	**150**	**-**	**3,341**	**-**
Diagnostic & therapeutic services	**12,127**	**13,803**	**10,002**	**2,179**	**11,888**	**2,495**
Community health services						
Primary health care	2,327	2,094	1,237	2,713	2,637	3,391
Home care	6,825	10,209	7,368	1,393	8,446	2,115
Mental health & addictions	3,064	7,127	3,356	2,540	2,882	3,287
Population health	2,882	4,337	3,394	2,807	5,088	4,732
Emergency response services	5,001	3,344	6,225	2,688	4,395	1,721
Other community services	1,505	830	431	-	654	430
Total community health services	**21,604**	**27,941**	**22,011**	**12,141**	**24,102**	**15,676**
Support services						
Program support	6,538	7,660	6,065	2,917	7,008	3,478
Operational support	22,994	18,389	20,205	3,878	24,434	3,580
Other support	784	296	536	84	788	(7)
Employee future benefits	(28)	(1)	10	32	7	48
Total support services	**30,288**	**26,344**	**26,816**	**6,911**	**32,237**	**7,099**
Ancillary	**20**	**128**	**210**	**-**	**-**	**17**
Total Operating Expenses	**136,959**	**156,894**	**106,454**	**29,157**	**126,849**	**30,909**
Operating Fund Excess/(Deficiency)	**1,425**	**2,242**	**1,167**	**446**	**1,483**	**1,117**
Interfund Transfers	(2,984)	(2,239)	(1,166)	(445)	(1,450)	(820)
Increase (decrease) in fund balances	**(1,559)**	**3**	**1**	**1**	**33**	**297**
Operating Fund Balance - Beginning of the year	9,791	1,428	(1,338)	-	(5,418)	189
Operating Fund Balance - End of Year	**8,232**	**1,431**	**(1,337)**	**1**	**(5,385)**	**486**
STATEMENT OF FINANCIAL POSITION						
Operating Assets:						
Cash and Short-term Investments	25,133	21,740	9,691	4,006	10,426	4,136
Accounts Receivable:						
Saskatchewan Health	815	1,000	450	66	538	-
Other	933	1,553	1,085	449	1,214	781
Inventory	660	812	1,465	265	513	161
Prepaid Expenses	180	816	588	126	737	170
Due from (to) Restricted Fund	-	-	-	-	-	-
Investments	2,008	101	3,236	10	1,274	-
Other Assets	-	-	-	-	34	-
Total Operating Assets	**29,729**	**26,022**	**16,515**	**4,922**	**14,736**	**5,248**
Liabilities and Operating Fund Balance:						
Accounts Payable	5,814	7,344	975	1,562	4,438	736
Bank Indebtedness	-	-	-	-	-	-
Accrued Liabilities:						
Accrued Salaries	3,203	4,956	4,111	735	3,617	777
Vacation Payable	8,812	6,517	7,301	1,490	7,603	1,555
Other	-	-	-	-	-	-
Employee Future Benefits	3,234	3,022	3,044	813	4,100	833
Deferred Revenue	436	2,756	2,422	322	363	863
Ministry of Health	39	1,991	302	137	185	318
Non-Ministry of Health	397	765	2,119	185	178	545
Due to (from) other funds						
Total Operating Liabilities	**21,499**	**24,595**	**17,852**	**4,922**	**20,121**	**4,764**
Externally Restricted	-	-	-	-	-	-
Internally Restricted	-	-	-	-	-	-
Unrestricted	8,229	1,428	(1,338)	-	(5,386)	484
Operating Fund Balance	**8,229**	**1,428**	**(1,338)**	**-**	**(5,386)**	**484**
Total Liabilities and Fund Balance	**29,728**	**26,023**	**16,514**	**4,922**	**14,735**	**5,248**

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	220,708	219,979	946,312	1,112,787	140,804	201,471	3,383,312
Other Provincial Revenue	4,157	2,710	15,950	17,332	833	2,004	48,252
Federal Government Revenue	112	715	8,064	1,019	-	1	10,293
Funding from other Provinces	41,004	-	-	-	-	-	41,004
Patient & Client Fees	2,737	7,177	26,259	14,714	11,303	13,433	107,593
Out of Province Revenue (Reciprocal)	223	1,309	10,166	9,871	492	2,458	28,040
Out of Country Revenue	415	167	2,509	1,908	17	87	5,392
Donations	175	93	1,705	-	503	254	3,064
Ancillary Operations - income	961	1,182	8,147	17,749	-	1,278	30,797
Investment Income	4,201	129	43	-	178	292	5,765
Recoveries	-	4,456	13,435	25,825	3,248	4,172	58,702
Research Grants	-	-	161	-	-	-	161
Other Revenue	1,880	637	6,739	4,256	550	1,067	17,252
Total Operating Revenue	**288,451**	**238,554**	**1,039,490**	**1,205,461**	**157,927**	**226,516**	**3,751,501**
Operating Expenses:							
Inpatient & resident services							
Nursing Administration	7,870	4,758	3,655	10,663	452	5,433	46,586
Acute	44,035	44,254	216,095	281,897	5,883	34,645	698,183
Supportive	39,974	39,173	124,072	152,735	25,490	47,385	516,946
Integrated	-	-	21,665	-	37,701	-	103,374
Rehabilitation	-	16	6,899	5,278	-	-	12,193
Mental health & addictions	15,012	6,052	13,013	13,280	1,863	2,617	55,795
Total inpatient & resident services	**106,890**	**94,253**	**385,399**	**463,853**	**71,390**	**90,081**	**1,433,076**
Physician compensation	**22,501**	**22,984**	**91,830**	**118,459**	**7,074**	**12,997**	**321,786**
Ambulatory care services	**13,445**	**12,443**	**91,212**	**93,650**	**2,404**	**6,773**	**233,959**
Diagnostic & therapeutic services	**30,939**	**21,252**	**130,474**	**162,576**	**11,272**	**21,485**	**430,492**
Community health services							
Primary health care	6,467	3,984	37,859	4,682	2,396	3,903	73,690
Home care	11,919	13,372	24,652	53,225	10,591	13,278	163,393
Mental health & addictions	12,048	12,792	28,218	39,441	4,986	4,903	124,644
Population health	9,101	7,677	17,919	29,619	4,249	7,259	99,064
Emergency response services	7,842	4,780	18,893	22,335	5,986	6,757	89,967
Other community services	1,424	394	4,490	8,424	482	1,397	20,461
Total community health services	**48,801**	**42,999**	**132,031**	**157,726**	**28,690**	**37,497**	**571,219**
Support services							
Program support	18,294	10,675	54,722	72,022	9,100	14,014	212,493
Operational support	45,154	33,404	155,594	155,075	23,989	38,264	544,960
Other support	429	448	9,033	3,967	2,065	1,273	19,696
Employee future benefits	232	113	433	238	-	42	1,126
Total support services	**64,109**	**44,640**	**219,782**	**231,302**	**35,154**	**53,593**	**778,275**
Ancillary	**1,084**	**397**	**3,963**	**13,558**	**-**	**1,997**	**21,374**
Total Operating Expenses	**287,769**	**238,968**	**1,054,691**	**1,241,124**	**155,984**	**224,423**	**3,790,181**
Operating Fund Excess/(Deficiency)	**682**	**(414)**	**(15,201)**	**(35,663)**	**1,943**	**2,093**	**(38,680)**
Interfund Transfers	(1,438)	(949)	(369)	(803)	(1,124)	(2,186)	(15,973)
Increase (decrease) in fund balances	**(756)**	**(1,363)**	**(15,570)**	**(36,466)**	**819**	**(93)**	**(54,653)**
Operating Fund Balance - Beginning of the year	(15,617)	(21,777)	(130,999)	(116,121)	(6,637)	(38,412)	(324,911)
Operating Fund Balance - End of Year	**(16,373)**	**(23,140)**	**(146,569)**	**(152,587)**	**(5,818)**	**(38,505)**	**(379,564)**
STATEMENT OF FINANCIAL POSITION							
Operating Assets:							
Cash and Short-term Investments	14,554	8,825	-	650	12,369	1,900	113,430
Accounts Receivable:							
Saskatchewan Health	1,782	897	6,904	8,343	785	1,136	22,716
Other	4,192	2,305	14,720	18,302	2,640	1,298	49,472
Inventory	1,844	1,105	4,140	10,823	693	1,175	23,656
Prepaid Expenses	1,537	327	5,955	5,274	322	2,072	18,104
Due from (to) Restricted Fund	-	-	(11,207)	-	-	-	(11,207)
Investments	2,338	-	-	-	18	519	9,504
Other Assets	-	-	-	-	-	-	34
Total Operating Assets	**26,247**	**13,459**	**20,512**	**43,392**	**16,827**	**8,100**	**225,709**
Liabilities and Operating Fund Balance:							
Accounts Payable	9,989	8,058	40,584	51,090	2,659	4,906	138,155
Bank Indebtedness	-	-	7,500	-	-	10,749	18,249
Accrued Liabilities:							
Accrued Salaries	7,759	5,622	25,182	34,833	7,383	7,443	105,621
Vacation Payable	15,574	13,725	56,085	55,940	7,724	14,485	196,811
Other	3	-	-	-	-	971	974
Employee Future Benefits	7,327	5,932	25,767	27,311	3,699	6,564	91,646
Deferred Revenue	1,968	3,263	11,963	11,320	1,180	1,486	38,342
Ministry of Health	489	1,944	5,604	4,597	303	686	16,595
Non-Ministry of Health	1,479	1,319	6,359	6,723	877	800	21,746
Due to (from) other funds				15,485			15,485
Total Operating Liabilities	**42,620**	**36,600**	**167,081**	**195,979**	**22,645**	**46,604**	**605,282**
Externally Restricted	-	-	-	-	-	-	-
Internally Restricted	387	-	(753)	-	3	49	(314)
Unrestricted	(16,761)	(23,142)	(145,816)	(152,587)	(5,822)	(38,553)	(379,268)
Operating Fund Balance	**(16,374)**	**(23,142)**	**(146,569)**	**(152,587)**	**(5,819)**	**(38,504)**	**(379,582)**
Total Liabilities and Fund Balance	**26,246**	**13,458**	**20,512**	**43,392**	**16,826**	**8,100**	**225,700**

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

Restricted Fund Financial Statements[1,2] (in Dollars)

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	74,454	8,269	997	503	7,900	51
Other Government of Saskatchewan	-	45	137	-	242	-
Federal Government revenue	-	-	-	-	-	-
Funding from other Provinces	-	-	-	-	-	-
Donations	1,792	4,555	1,606	-	3,642	4
Ancillary Operations - income	-	21	-	-	-	-
Investment Income	43	247	92	-	69	8
Recoveries	-	-	-	-	-	-
Other Revenue	11,736	17	35	8	18	6
Total Restricted Revenue	**88,025**	**13,154**	**2,867**	**511**	**11,871**	**69**
Restricted Expenses:						
Inpatient & resident services						
Nursing Administration	-	45	-	-	-	665
Acute	1,662	1,338	147	76	1,578	-
Supportive	1,419	271	46	32	2,073	191
Integrated	1,081	-	4,870	-	1,019	-
Rehabilitation	-	-	-	-	-	-
Mental health & addictions	-	15	-	-	-	-
Total inpatient & resident services	**4,162**	**1,669**	**5,063**	**108**	**4,670**	**856**
Physician compensation	**-**	**-**	**-**	**-**	**-**	**-**
Ambulatory care services	**210**	**192**	**-**	**-**	**-**	**-**
Diagnostic & therapeutic services	**883**	**1,674**	**-**	**66**	**-**	**-**
Community health services						
Primary health care	-	14	3	11	-	4
Home care	-	379	23	-	-	-
Mental health & addictions	-	5	-	1	-	-
Population health	-	2	4	29	-	-
Emergency response services	322	-	315	53	95	-
Other community services	-	9	-	-	63	-
Total community health services	**322**	**409**	**345**	**94**	**158**	**4**
Support services						
Program support	-	644	135	76	-	1
Operational support	-	577	-	847	88	-
Other support	-	5,066	-	-	-	-
Total support services	**-**	**6,287**	**135**	**923**	**88**	**1**
Ancillary	**-**	**-**	**-**	**-**	**-**	**1**
Total Restricted Expenses	**5,577**	**10,231**	**5,543**	**1,191**	**4,916**	**862**
Restricted Fund Excess/(Deficiency)	**82,448**	**2,923**	**(2,676)**	**(680)**	**6,955**	**(793)**
Interfund Transfers	2,984	2,239	1,166	445	1,450	820
Other Transfers	-	-	-	-	-	-
Increase (decrease) in fund balances	**85,432**	**5,162**	**(1,510)**	**(235)**	**8,405**	**27**
Restricted Fund Balance - Beginning of the year	152,617	131,621	100,115	22,542	58,546	9,723
Restricted Fund Balance - End of Year	**238,049**	**136,783**	**98,605**	**22,307**	**66,951**	**9,750**
STATEMENT OF FINANCIAL POSITION						
Restricted Assets:						
Cash and Short-term Investments	1,269	19,824	4,908	2,023	5,781	1,138
Accounts Receivable:						
Saskatchewan Health	147	-	278	-	2,714	-
Other	1,990	13	159	-	1,969	216
Prepaid Expenses	-	-	-	-	-	-
Due From (Community Trust Fund)	-	-	-	-	-	-
Investments	-	281	1,323	1	-	-
Capital Assets	235,466	117,825	96,139	20,284	65,812	8,602
Other Assets	119,238	-	-	-	179	-
Total Restricted Assets	**358,110**	**137,943**	**102,807**	**22,308**	**76,455**	**9,956**
Liabilities and Restricted Fund Balance:						
Accounts Payable	-	7	25	-	1,537	23
Accrued Liabilities	-	-	-	-	-	-
Deferred Revenue (Non-Ministry of Health)	-	68	-	-	-	9
Due to (from) other funds						
Debt	120,063	1,084	4,176	-	7,966	175
Total Restricted Liabilities	**120,063**	**1,159**	**4,201**	**-**	**9,503**	**207**
Invested in Capital Assets	234,641	116,741	91,962	20,284	57,847	8,427
Externally Restricted	753	255	4,293	672	6,544	533
Internally Restricted	2,653	19,787	2,350	1,352	2,562	789
Unrestricted	-	-	-	-	-	-
Restricted Fund Balance	**238,047**	**136,783**	**98,605**	**22,308**	**66,953**	**9,749**
Total Liabilities and Restricted Fund Balance	**358,110**	**137,942**	**102,806**	**22,308**	**76,456**	**9,956**

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	1,322	17,707	11,732	14,629	611	600	138,775
Other Government of Saskatchewan	-	-	339	3,444	107	-	4,314
Federal Government revenue	52	-	-	-	-	-	52
Funding from other Provinces	793	-	-	-	-	-	793
Donations	2,381	801	5,305	7,492	545	1,116	29,239
Ancillary Operations - income	-	-	-	-	-	-	21
Investment Income	64	113	24	2,539	105	61	3,365
Recoveries	-	-	-	-	603	-	603
Other Revenue	602	1,343	285	3,221	2	165	17,438
Total Restricted Revenue	**5,214**	**19,964**	**17,685**	**31,325**	**1,973**	**1,942**	**194,600**
Restricted Expenses:							
Inpatient & resident services							
Nursing Administration	-	522	-	-	-	9	1,241
Acute	4,291	2,495	10,041	-	340	570	22,538
Supportive	1,741	1,702	1,707	-	1,589	600	11,371
Integrated	-	-	407	-	3,770	-	11,147
Rehabilitation	-	-	577	-	-	-	577
Mental health & addictions	91	5	-	-	-	4	115
Total inpatient & resident services	**6,123**	**4,724**	**12,732**	**-**	**5,699**	**1,183**	**46,989**
Physician compensation	**-**	**1**	**-**	**-**	**-**	**-**	**1**
Ambulatory care services	**-**	**279**	**1,293**	**-**	**-**	**28**	**2,002**
Diagnostic & therapeutic services	**-**	**457**	**439**	**-**	**5**	**447**	**3,971**
Community health services							-
Primary health care	117	3	112	-	57	31	352
Home care	82	19	12	-	12	17	544
Mental health & addictions	-	537	6	-	1	5	555
Population health	5	55	21	-	76	9	201
Emergency response services	237	144	1,599	-	276	57	3,098
Other community services	-	-	-	-	-	1	73
Total community health services	**441**	**758**	**1,750**	**-**	**422**	**120**	**4,823**
Support services							-
Program support	2,171	51	1,602	44,519	-	16	49,215
Operational support	-	739	15,215	-	-	184	17,650
Other support	-	231	-	-	-	5,503	10,800
Total support services	**2,171**	**1,021**	**16,817**	**44,519**	**-**	**5,703**	**77,665**
Ancillary	**-**	**55**	**335**	**-**	**-**	**19**	**410**
Total Restricted Expenses	**8,735**	**7,295**	**33,366**	**44,519**	**6,126**	**7,500**	**135,861**
Restricted Fund Excess/(Deficiency)	**(3,521)**	**12,669**	**(15,681)**	**(13,194)**	**(4,153)**	**(5,558)**	**58,739**
Interfund Transfers	1,438	949	369	803	1,124	2,186	15,973
Other Transfers	-	-	-	-	-	-	-
Increase (decrease) in fund balances	**(2,083)**	**13,618**	**(15,312)**	**(12,391)**	**(3,029)**	**(3,372)**	**74,712**
Restricted Fund Balance - Beginning of the year	70,877	97,031	323,784	473,698	99,384	63,540	1,603,478
Restricted Fund Balance - End of Year	**68,794**	**110,649**	**308,472**	**461,307**	**96,355**	**60,168**	**1,678,190**
STATEMENT OF FINANCIAL POSITION							
Restricted Assets:							
Cash and Short-term Investments	2,191	10,938	633	116,850	7,596	5,163	178,314
Accounts Receivable:							
Saskatchewan Health	1,084	631	-	-	-	-	4,854
Other	903	132	1,893	1,343	79	45	8,742
Prepaid Expenses	-	-	-	-	-	290	290
Due From (Community Trust Fund)	-	-	11,207	-	(422)	-	10,785
Investments	85	-	629	21,521	3	-	23,843
Capital Assets	72,683	106,723	301,778	363,905	92,290	68,285	1,549,792
Other Assets	-	554	43	-	-	-	120,014
Total Restricted Assets	**76,946**	**118,978**	**316,183**	**503,619**	**99,546**	**73,783**	**1,896,634**
Liabilities and Restricted Fund Balance:							
Accounts Payable	336	846	456	11,311	356	95	14,992
Accrued Liabilities	-	-	-	-	-	21	21
Deferred Revenue (Non-Ministry of Health)	-	-	-	-	-	-	77
Due to (from) other funds				(15,485)			
Debt	7,814	7,484	7,255	46,486	2,833	13,501	218,837
Total Restricted Liabilities	**8,150**	**8,330**	**7,711**	**42,312**	**3,189**	**13,617**	**218,442**
Invested in Capital Assets	64,869	99,239	294,523	317,419	89,101	54,784	1,449,837
Externally Restricted	2,137	5,114	12,904	143,804	5,915	1,779	184,703
Internally Restricted	1,790	6,296	1,045	84	1,340	3,604	43,652
Unrestricted	-	-	-	-	-	-	-
Restricted Fund Balance	**68,796**	**110,649**	**308,472**	**461,307**	**96,356**	**60,167**	**1,678,192**
Total Liabilities and Restricted Fund Balance	**76,946**	**118,979**	**316,183**	**503,619**	**99,545**	**73,784**	**1,896,634**

[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 Financial Statements[1] (In 000s Dollars)

SCHEDULE OF EXPENSES BY OBJECT	Cypress	Five Hills	Heartland	Keewatin Yatthé	Kelsey Trail	Mamawetan Churchill River
Operating Expenses:						
Advertising & Public Relations	35	98	49	11	49	17
Board costs	60	55	54	110	69	93
Compensation - benefits	14,582	13,930	13,210	3,551	14,690	4,332
Compensation - employee future benefits	(28)	(1)	10	-	7	48
Compensation - salaries	80,935	73,968	71,198	19,103	78,859	17,829
Continuing Education Fees & Materials	197	211	93	209	183	136
Contracted-out Services - Other	2,470	2,273	896	285	261	1,350
Diagnostic imaging supplies	61	178	30	2	6	2
Dietary Supplies	34	159	143	33	156	3
Drugs	1,420	1,532	730	213	755	268
Environmental remediation	-	-	-	-	-	-
Food	2,189	1,382	1,599	270	1,893	214
Grants to ambulance services	2,054	3,280	136	-	3,346	1,297
Grants to Health Care Organizations & Affiliates	2,170	29,297	3,090	263	721	276
Housekeeping and laundry supplies	919	654	627	22	316	26
Information technology contracts	626	652	512	31	728	144
Insurance	270	216	360	89	242	46
Interest	12	2	31	-	211	5
Laboratory supplies	1,104	1,007	747	177	1,020	162
Medical and surgical supplies	2,934	2,775	1,403	404	2,922	363
Medical remuneration and benefits	14,500	15,525	3,123	-	10,525	659
Meeting Expense	-	4	19	-	81	32
Office supplies and other office costs	1,011	668	611	459	446	353
Other	565	100	616	105	510	392
Professional fees	706	822	949	402	1,037	234
Prosthetics	324	483	-	-	-	-
Purchased salaries	154	924	283	1,118	1,066	428
Rent/lease/purchase costs	1,384	1,979	948	880	1,482	649
Repairs and maintenance	3,043	1,704	2,056	468	1,363	313
Supplies - Other	197	167	231	46	452	195
Therapeutic Supplies	-	115	18	-	-	-
Travel	1,122	1,165	860	595	1,359	793
Utilities	1,911	1,571	1,824	314	2,095	249
Total Operating Expenses	**136,961**	**156,895**	**106,456**	**29,160**	**126,850**	**30,908**
Restricted Expenses:						
Amortization	4,779	9,639	5,294	1,191	4,750	665
Loss/(gain) on disposal of fixed assets	664	-	58	-	30	-
Mortgage interest	47	92	98	-	115	-
Other	87	501	94	-	21	197
Total Restricted Expenses	**5,577**	**10,232**	**5,544**	**1,191**	**4,916**	**862**
Total Operating and Restricted Expenses	**142,538**	**167,127**	**112,000**	**30,351**	**131,766**	**31,770**

SCHEDULE OF EXPENSES BY OBJECT	Prairie North	Prince Albert Parkland	Regina Qu'Appelle	Saskatoon	Sun Country	Sunrise	Grand Total
Operating Expenses:							
Advertising & Public Relations	24	105	193	241	143	147	1,112
Board costs	105	90	76	74	53	90	929
Compensation - benefits	32,174	26,591	113,161	124,424	17,690	28,303	406,638
Compensation - employee future benefits	228	113	433	-	3	-	813
Compensation - salaries	168,572	137,387	573,144	626,568	87,440	145,115	2,080,118
Continuing Education Fees & Materials	419	186	769	1,318	227	189	4,137
Contracted-out Services - Other	6,987	3,267	22,349	28,831	1,436	2,874	73,279
Diagnostic imaging supplies	297	111	562	2,898	13	170	4,330
Dietary Supplies	284	149	88	212	143	306	1,710
Drugs	3,259	2,393	14,598	30,993	433	2,074	58,668
Environmental remediation	-	-	-	-	-	-	-
Food	4,210	2,753	8,155	8,386	1,534	3,273	35,858
Grants to ambulance services	3,808	4,566	3,366	17,058	507	3,892	43,310
Grants to Health Care Organizations & Affiliates	6,879	10,127	66,794	114,778	23,233	1,676	259,304
Housekeeping and laundry supplies	1,478	1,165	3,415	4,400	317	1,380	14,719
Information technology contracts	1,986	631	6,124	4,539	493	1,282	17,748
Insurance	421	397	1,819	1,706	528	442	6,536
Interest	29	34	392	1,024	15	315	2,070
Laboratory supplies	2,031	1,363	6,335	9,620	566	1,329	25,461
Medical and surgical supplies	8,051	5,605	46,113	55,107	1,841	3,896	131,414
Medical remuneration and benefits	23,220	24,784	90,690	113,826	6,985	11,704	315,541
Meeting Expense	93	28	267	183	75	68	850
Office supplies and other office costs	2,162	704	3,750	5,687	875	1,738	18,464
Other	4,437	395	6,718	3,412	288	454	17,992
Professional fees	1,537	1,018	13,555	2,312	2,184	1,319	26,075
Prosthetics	491	1,493	20,259	19,070	-	189	42,309
Purchased salaries	1,395	3,458	1,134	8,146	732	83	18,921
Rent/lease/purchase costs	1,833	2,186	14,678	11,548	1,228	3,614	42,409
Repairs and maintenance	4,653	2,434	15,100	23,484	2,895	2,412	59,925
Supplies - Other	1,355	924	3,796	2,630	322	517	10,832
Therapeutic Supplies	4	120	928	435	91	110	1,821
Travel	1,789	1,781	4,520	5,000	1,448	2,373	22,805
Utilities	3,557	2,614	11,410	13,214	2,250	3,090	44,099
Total Operating Expenses	**287,768**	**238,972**	**1,054,691**	**1,241,124**	**155,988**	**224,424**	**3,790,197**
Restricted Expenses:							
Amortization	8,127	6,780	30,781	36,799	4,287	6,971	120,063
Loss/(gain) on disposal of fixed assets	48	-	140	-	(2)	-	938
Mortgage interest	293	170	170	3,619	130	530	5,264
Other	265	346	2,275	4,101	1,709	-	9,596
Total Restricted Expenses	**8,733**	**7,296**	**33,366**	**44,519**	**6,124**	**7,501**	**135,861**
Total Operating and Restricted Expenses	**296,501**	**246,268**	**1,088,057**	**1,285,643**	**162,112**	**231,925**	**3,926,058**

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

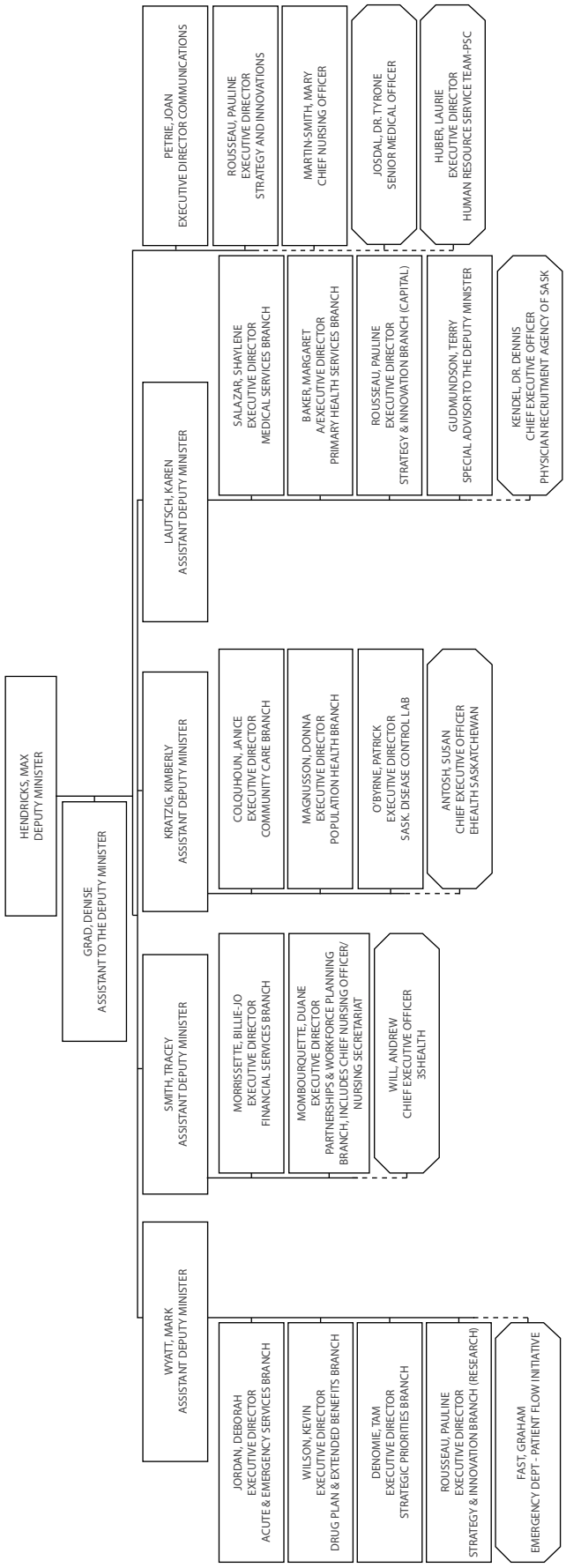
For More Information

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



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.

Reporting of critical incidents by anyone in the health system is encouraged, because it presents the opportunity for a thorough system based review to help understand what went wrong, how a similar circumstance may be prevented, and it supports a culture of safety.

The province has an established network of professionals in place within health regions and the SCA who receive information about, or identify events where a patient is harmed (or where there is a potential for harm). The health regions and the SCA 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 PQCCs is to aggregate, analyze, and report on critical incident data, and broadly disseminate applicable system improvement opportunities. PQCCs also provide advice and support to health regions and the SCA in their investigation and review of critical incidents.

During 2015-16, a total of 249 critical incidents were reported to the Ministry of Health, a 28.4 per cent increase compared to the previous fiscal year. This is the highest number of critical incidents reported in a single fiscal year since inception of reporting. 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.

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. Data is current as of May 4, 2016.

Category	2015-16	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	1	0	0	1	1	1	1	2	3	1	1
b) Surgery performed on the wrong patient	1	0	0	0	0	0	0	1	0	0	0
c) The wrong surgical procedure performed on a patient	0	0	2	1	2	0	3	1	0	0	0
d) Retention of a foreign object in a patient after surgery or other procedure	6	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	0	1	1	1	0	0	1	1	1	2
f) Unintentional awareness during surgery with recall by the patient	0	0	0	1	0	0	0	0	0	0	2
g) Other surgical event	11	4	6	5	3	11	2	2	5	4	3
Total	**19**	**8**	**12**	**17**	**8**	**15**	**7**	**9**	**12**	**10**	**11**

Category	2015-16	2014-15	2013-14	2012-13	2011-12	2010-11	2009-10	2008-09	2007-08	2006-07	2005-06
II. Product and Device Events											
a) Contaminated drugs, devices, or biologics provided by the RHA/HCO	0	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	3	5	2	3	1	3	6	9	3	5	6
c) Intravascular air embolism	0	0	0	0	1	0	0	0	1	0	2
d) Other product or device event	5	4	6	3	6	5	3	7	2	5	5
Total	**8**	**10**	**11**	**12**	**9**	**8**	**11**	**18**	**10**	**11**	**13**

Category	2015-16	2014-15	2013-14	2012-13	2011-12	2010-11	2009-10	2008-09	2007-08	2006-07	2005-06
III. Patient Protection Events											
a An infant discharged to the wrong person	0	0	0	0	0	0	0	1	0	0	0
b) Patient disappearance	10	10	8	1	2	5	2	5	5	0	5
c) Patient suicide or attempted suicide	24	15	17	6	7	17	6	7	9	21	8
d) Other patient protection event	14	5	2	3	1	3	0	2	1	3	1
Total	**48**	**30**	**27**	**10**	**10**	**25**	**8**	**15**	**15**	**24**	**14**

Category	2015-16	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	20	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	0	4	1	0	0	0	0	1	2	3
c) Maternal death or serious disability	3	3	2	2	0	1	1	0	1	3	1
d) Full-term fetal or neonatal death or serious disability	4	9	10	7	3	2	4	1	4	2	5
e) Hypoglycemia while in the care of the RHA/HCO	0	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	0
g) Stage 3 or 4 pressure ulcers acquired after admission to a facility	17	7	10	9	6	5	5	1	10	27	16
h) Delay or failure to transfer	1	5	3	0	1	5	4	6	3	2	1
i) Error in diagnosis	25	7	19	6	9	6	6	4	5	10	14
j) Other care management issues	56	49	31	37	36	29	31	44	21	31	30
Total	**126**	**99**	**101**	**80**	**65**	**67**	**73**	**69**	**57**	**97**	**87**

Category	2015-16	2014-15	2013-14	2012-13	2011-12	2010-11	2009-10	2008-09	2007-08	2006-07	2005-06
V. Environmental Events											
a) Electric shock while in the care of the RHA/HCO	0	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	0	1	1	0	0	0	0	0
c) Burn from any source	0	0	1	3	0	0	0	3	1	2	4
d) Patient death from a fall	36	21	20	17	18	15	8	15	19	12	16
e) Use or lack of restraints or bed rails	0	0	7	4	1	0	0	0	0	0	3
f) Failure or de-activation of exit alarms or environmental monitoring devices	0	1	2	0	0	0	1	1	0	1	1
g) Transport arranged or provided by the RHA/HCO	0	0	1	4	1	4	0	0	0	0	3
h) Delay or failure to reach a patient for emergent or scheduled services	5	9	2	6	1	2	0	1	2	0	2
i) Other environmental event	3	3	4	2	4	3	4	4	1	7	3
Total	**44**	**34**	**37**	**36**	**26**	**25**	**13**	**24**	**23**	**22**	**32**

Category	2015-16	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	0
b) Abduction of a patient of any age	0	0	1	0	0	0	0	0	0	0	0
c) Sexual assault of a patient	2	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	1	3	3	0	2	1	0	2	0	1	1
e) Sexual or physical assault of a patient perpetrated by an employee	0	1	1	1	3	4	1	2	2	2	1
f) Other criminal event	1	4	1	0	1	0	1	2	3	1	1
Total	**4**	**13**	**6**	**4**	**9**	**6**	**3**	**8**	**10**	**7**	**3**
Total CIs Reported	**249**	**194**	**194***	**159***	**127**	**146**	**115**	**143**	**127**	**171**	**160**

** Note: These numbers changed between the 2013-14 Annual Report and the 2014-15 Annual Report publications because cases initially reported to the Ministry of Health were later determined to not meet the definition of critical incidents.*

Appendix III: Contact information for Ministry of Health Programs and 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
Regina Qu'Appelle Regional Health Authority 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:

(639) 625-2010

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 address: 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

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 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 MRI Facilities Licensing Act

The Act regulates the licensing and operation of certain facilities providing Magnetic Resonance Imaging services 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: New Legislation in 2015-16

One new Act was introduced in 2015-16.

The MRI Facilities Licensing Act

The new legislation received Royal Assent and is proclaimed in force. Specifically, the legislation:

- ⇨ Offers patients the option to directly pay for Magnetic Resonance Imaging (MRI) scans obtained in private facilities in Saskatchewan;
- ⇨ Requires private vendors to provide a free second MRI scan to an individual on the public MRI waitlist; and
- ⇨ Established *The MRI Facilities Licensing Regulations* to support and/or prescribe how the service will be administered and operated.

Appendix VI: Legislative Amendments in 2015-16

Six Acts were introduced for amendment in 2015-16.

The Vital Statistics Amendment Act, 2014

Amendments to *The Vital Statistics Act, 2009* received Royal Assent and are proclaimed in force. Specifically, the amendments:

- ⇨ Allow prescribed practitioners including Nurse Practitioners to complete medical certificates of death, interim medical certificates of death, medical certificates of stillbirth, and interim medical certificates of stillbirth;
- ⇨ Provide the Minister of Health with the discretion to disclose vital statistics information in unique situations;
- ⇨ Further enable the electronic submission of vital event statements; and
- ⇨ Include various housekeeping amendments, including those necessitated by the transfer of the Person Health Registration System (PHRS) to eHealth Saskatchewan.

The Health Administration Amendment Act, 2014

The Ministry of Health transferred the Health Registration Program to eHealth Saskatchewan and the amendments were required to align legislation with current practice. The amendments received Royal Assent and are in force. Specifically, the amendments:

- ⇨ Enable eHealth Saskatchewan to administer and provide services related to the Person Health Registration System (PHRS) and other health registration related services.

The Pharmacy and Pharmacy Disciplines Act

Amendments to *The Pharmacy Act, 1996* received Royal Assent and are proclaimed in force. Amendments include:

- ⇨ Changing the name of the Act to *The Pharmacy and Pharmacy Disciplines Act* to reflect that once *The Pharmacy Act, 1996* is amended that the Saskatchewan College of Pharmacists (SCP) will be responsible for regulating two separate pharmacy professions as well as proprietary pharmacies;
- ⇨ Providing pharmacists with an enhanced scope of practice;
- ⇨ Regulating pharmacy technicians; and,
- ⇨ Clarifying terminology related to "proprietorship" and "ownership" of proprietary pharmacies.

The Human Tissue Gift Act, 2014

The legislation was introduced to provide flexibility for Saskatchewan health providers by adopting emerging and improved opportunities for organ donation and transplantation. The legislation received Royal Assent, but has not yet been proclaimed in force. The legislation was developed to:

- ⇨ Repeal and replace *The Human Tissue Gift Act*, modernize language and include substantive provisions in line with current drafting standards;
- ⇨ Include an exclusion clause for the prohibition of buying or selling tissue;
- ⇨ Include an allowance for the Lieutenant Governor in Council to make regulations that establish standards, practices and procedures to improve access to transplantation; and,
- ⇨ Change the offence provision by increasing the limit of a fine from $1,000 to $100,000.

The Health Information Protection Amendment Act, 2014

These amendments reinforce existing provisions and introduce new provisions. The amendments received Royal Assent, but are not yet proclaimed in force. Changes include:

- ⇨ The addition of a provision authorizing the Minister of Health to appoint a person or body to take control of abandoned records of an active trustee until custody or control of the records can be re-established;
- ⇨ The introduction of a new "snooping" offence provision for inappropriate access to and use of personal health information;
- ⇨ A new provision for an individual offence of willful disclosure of personal health information that not only applies to trustees and information management service providers but also their employees; and,
- ⇨ The addition of a strict liability offence that will forego the need to establish evidence of the specific intent to abandon patient records.

The Naturopathic Medicine Act

Amendments to *The Naturopathy Act* received Royal Assent, but are not yet proclaimed in force. The amendments include:

- ⇨ Renaming the Act to *The Naturopathic Medicine Act* to reflect current language used by the profession;
- ⇨ Inclusion of provisions that effectively ensure public protection;
- ⇨ Introduction of provisions that support the scope of practice of naturopathic doctors (NDs) as NDs in Saskatchewan are currently restricted from practicing to their level of training and expertise; and,
- ⇨ Alignment of *The Naturopathy Act* with other health profession legislation and interprovincial agreements.

Appendix VII: New Regulations in 2015-16

Two new regulations were created in 2015-16.

The Critical Incident Regulations, 2016

These regulations were developed to:

- ⇨ Enable the sharing of personal health information between a health care organization and a regional health authority for the purposes of notification, investigation and reporting critical incidents to a regional health authority;
- ⇨ Require a health care organization and regional health authority to collaborate on critical incident investigations;
- ⇨ Provide a process for the Saskatchewan Cancer Agency to use when reporting a critical incident; and,
- ⇨ Repeal and replace *The Critical Incident Regulations*.

The MRI Facilities Licensing Regulations

- ⇨ These regulations were required to prescribe and support the administration of *The MRI Facilities Licensing Act*. The regulatory framework was introduced to: Prescribe specific license categories that would enable a private facility to accept private payment from patients for Magnetic Resonance Imaging (MRI) services;
- ⇨ Authorize the Minister of Health to outline the terms and conditions of a license under which a MRI facility must operate;
- ⇨ Ensure a benefit to the public system by requiring private vendors provide a second scan free of charge to an individual waiting on the public MRI list each time an individual chooses to privately pay for MRI services;
- ⇨ Ensure all aspects of MRI services in a MRI facility are provided in accordance with generally accepted standards;
- ⇨ Outline the criteria which the MRI services are to be performed under the continuous supervision of a Medical Director who is a duly qualified medical practitioner recognized by the College of Physicians and Surgeons of Saskatchewan;
- ⇨ Reinforce the MRI Facilities Accreditation Program, established by the College of Physicians and Surgeons of Saskatchewan, as the accreditation program operator for the MRI facilities; and,
- ⇨ Ensure the addition of private services is not detrimental to the public system as both public and private services rely on the same human resource pool.

Appendix VIII: Regulatory Amendments in 2015-16

Twelve regulations were amended in 2015-16.

The Facility Designation (Mental Health Services) Amendment Regulations, 2016

Amendments to the regulations involved the:

- ⇨ Creation of the facility category "mental health center" to align with the October 2015 amendments to *The Mental Health Services Act* and the current system of health facility designations in Saskatchewan;
- ⇨ Clarification that mental health services are provided by residential treatment centers; and,
- ⇨ Outlining of required services provided by facility type to serve as an essential public communication tool for services provided by each facility.

The Health Hazard Amendment Regulations, 2015

These amendments address activities related to youth tanning as follows:

- ⇨ Require tanning facility operators to register with a Regional Health Authority;
- ⇨ Prohibit tanning facility operators from allowing youth under the age of 18 years to use UV tanning equipment in a tanning facility;
- ⇨ Allow youth under 18 years of age access to UV tanning equipment, with some restrictions, if the youth has obtained a prescription to undergo UV tanning from a physician;
- ⇨ Enable tanning facility operators the ability to request proof of age documentation;
- ⇨ Require tanning facility operators to post age restrictions and health risks signage; and,
- ⇨ Prohibit UV tanning service advertisements to persons under the age of 18.

The Health Information Protection (Information Sharing Agreements) Amendment Regulations, 2016

The amendments facilitate disclosure of essential personal health information between government institutions and third party agencies delivering common or integrated services with or for the provincial government.

The Hearing Aid Sales and Services (Labour Mobility) Amendment Regulations, 2015

Amendments were made to allow the regulations to be compliant with the Agreement on Internal Trade and the New West Partnership Trade Agreement as it relates to non-audiologist Hearing Instrument Practitioners. The definition of Hearing Instrument Practitioners (HIPs) was amended to ensure that HIPs who want to relocate to Saskatchewan would not face barriers to employment in their field of practice.

The Medical Care Insurance Beneficiary and Administration (MRI Services) Amendment Regulations, 2016

The amendments were required to clarify that MRI services are not insured services under the regulations.

The Medical Care Insurance Beneficiary and Administration (Residents) Amendment Regulations, 2015

The regulations were amended to reduce the period of time Saskatchewan residents must be physically present in the province, from six to five months of the year, to retain their health coverage eligibility under the provincial health insurance plan.

The Medical Care Insurance Beneficiary and Administration Amendment Regulations, 2015

These amendments were required to establish the authority of the new agreement items (recently negotiated with the Saskatchewan Association of Optometrists -effective April 1, 2013) as well as items negotiated in previous agreements, but not yet added to the regulations.

The Mental Health Services Amendment Regulations, 2015

The amendments to the regulations were required to align with October 2015 revisions to *The Mental Health Services Act* for the effective delivery of mental health services:

- ⇨ Allow the Ministry to address issues that recognize a person's need for timely access to service, the integration of mental health and addiction services and information sharing, and the resolution of governance and administration issues affecting the Ministry and regional health authorities;

- ⇨ Support the *Mental Health and Addictions Action Plan* by increasing opportunities for client-centred care and inter-ministerial cooperation;
- ⇨ Give authority to peace officers to apply for warrants by submitting an oath by telephone or other means of telecommunications to a judge designated by the Chief Judge of the Provincial Court;
- ⇨ Define a prescribed health professional who, under the new Act, can use section 18 to compel a person be taken for a psychiatric examination;
- ⇨ Revise Form A, "Certificate of Physician or Prescribed Health Professional that Psychiatric Examination is Required";
- ⇨ Add to the rules governing the operation of Mental Health Approved Homes by adding items formally in policy and making them more consistent with those rules governing Personal Care Homes;
- ⇨ Expand the number of electroconvulsive therapy treatments from 8 to 12 for involuntary patients before the appeal process can be repeated; and,
- ⇨ Expand the role of the Officer in Charge for persons detained in a mental health center to include making a reasonable effort to determine the nearest relative, proxy or personal guardian of any person subject to an order or notice.

The Saskatchewan Medical Care Insurance Payment (Physician Schedule) Amendment Regulations, 2016

The amendments were necessary to update the Physician Payment Schedule for negotiated and approved rates effective April 1, 2013, and three new insured services within the existing agreement with the Saskatchewan Medical Association effective October 1, 2015.

The Saskatchewan Medical Care Insurance Payment Amendment Regulations, 2015

The amendments to the regulations were made to provide authority to pay for:

- ⇨ New insured services negotiated in the recent agreement with the Saskatchewan Association of Optometrists effective April 1, 2013; and,
- ⇨ New insured services within the existing agreement with the Saskatchewan Medical Association, included in an updated Physician Payment Schedule released April 1, 2015.

The Vital Statistics (Statements of Events) Amendment Regulations, 2015

The amendments enable the following changes:

- ⇨ Allow nurse practitioners and other prescribed practitioners to complete medical certificates of death, interim medical certificates of death, medical certificates of stillbirth, and interim medical certificates of stillbirth to reduce delays families experience in burying deceased loved ones;
- ⇨ Further enable the electronic submission of vital event statements allowing the Vital Statistics Registry to continue to modernize and embrace technology;
- ⇨ Provide clarity to Vital Statistics customers on words used in *The Vital Statistics Act, 2009* and *The Vital Statistics Regulations, 2010*, in relation to eligibility for receiving Vital Statistics information; and,
- ⇨ Enable the Registrar to determine eligibility rules for access to Vital Statistics information when written authorization is provided, and ensure properly authorized individuals have access to the information.

The Youth Drug Detoxification and Stabilization (Information Sharing Agreements) Amendment Regulations, 2016

The following amendments made to the regulations:

- ⇨ Facilitate delivery of common or integrated services in accordance with an information sharing agreement entered in to by a trustee and at least one government institution under the proposed new provisions;
- ⇨ Permit an individual with information subject to the confidentiality provisions of *The Youth Drug Detoxification and Stabilization Act*, to disclose personal health information of an individual for the purpose of determining eligibility of the individual for common or integrated services or assessing or delivering that service; and,
- ⇨ These amendments were made to align the language regarding information sharing within *The Health Information Protection Act* and Regulations that were amended at the same time.

Appendix IX: List of Publications in 2015-16

Patient Flow Toolkit

The modules in this toolkit are a resource for operational leaders, managers, and point of care staff in Saskatchewan. The modules are intended to be a guide to make lasting improvements to patient flow, so that patients receive the right care, in the right place, by the right teams across the continuum of care, ultimately shortening wait times in the emergency room.

For information on this toolkit, or to provide feedback, please contact the Emergency Department Waits and Patient Flow Initiative at (306) 668-8810.

Also available online at http://hqc.sk.ca/Portals/0/Patient%20Flow%20Toolkit%20April%202016.pdf?ver=2016-05-05-093543-867

Appendix IX: Acronyms and Definitions

ALC	Alternate Level of Care patient. This patient not require the intensity of services provided in the facility they are being treated in.
CAD	
CDM-QIP	Chronic Disease Management-Quality Improvement Program
COPD	
CTAS	Canadian Triage Acuity Scale. The Canadian Triage & Acuity Scale (CTAS) is a tool that enables emergency departments to prioritize patient care requirements and examine patient care processes, workload, and resource requirements relative to case mix and community needs These measures are defined by the Canadian Association of Emergency Physicians.
EHR	Electronic Health Record. Find out more at www.ehealthsask.ca.
EMR	Electronic Medical Record. Find out more at www.sma.sk.ca.
FTE	Full Time Equivalent (used in Human Resources)
HF	
HQC	The Health Quality Council works closely with Saskatchewan's health regions and Cancer Agency, the Ministry of Health, and health providers to make care better and safer for patients in this province. Find more information at hqc.sk.ca.
MAPLe Score	A tool used by health care professionals to prioritize clients' needs and to appropriately allocate home care resources and placement in long-term care facilities.
PHC	Primary Health Care. Find out more on page 23 of this report and at saskatchewan.ca.
PQCC	Provincial Quality of Care Coordinators. The role of PQCCs is to aggregate, analyze, and report on critical incident data, and broadly disseminate applicable system improvement opportunities. PQCCs also provide advice and support to health regions and the SCA in their investigation and review of critical incidents.
SAIL	Saskatchewan Aids to Independent Living provides people with physical disabilities and certain chronic health conditions a basic level of coverage for disability related equipment, devices, products, and supplies in a cost effective and timely manner. Find more information at Saskatchewan.ca.
SCA	The Saskatchewan Cancer Agency operates prevention and early detection programs, conducts innovative research and provides safe, patient and family-centred care. Two locations: Saskatoon and Regina.
SDCL	Saskatchewan Disease Control Laboratory (formerly known as the Provincial Laboratory) works to identify, respond to, and prevent illness and disease in the province. The lab provides reference testing, specialized screening and diagnostic testing. Find more information at Saskatchewan.ca.
Tertiary Care	Level of care that consists of complex procedures given in a health care center that has highly trained specialists and often advanced technology.