The Saskatchewan Surgical Initiative was the first major initiative arising from Saskatchewan’s 2009 independent Patient First Review. This review identified surgical wait times as a key concern for patients and families, and provided recommendations about improving surgical care and reducing wait times. The Saskatchewan Surgical Initiative is striving to offer “sooner, safer, and smarter” surgical care that improves the patient’s experience.

Established in March 2010, the four-year initiative aims to improve surgical care and experience for patients at all stages of the patient journey, from primary care through the acute care system and post-surgical recovery. An ambitious goal was established to provide all patients with the option to have surgery within three months (or sooner for urgent cases). Unlike past programs to address surgical improvement, which primarily emphasized wait time reduction, this initiative also gives priority to quality, safety, patient experience, and sustainability.

The Surgical Initiative strategic plan is innovative in that it was developed through extensive collaboration with former surgical patients, surgeons, family physicians, nurses, therapists, health care administrators, and health sector organizations. Patients, providers, and other health system partners play a key role in guiding the implementation of the plan.

Saskatchewan’s Surgical Initiative is accomplished through the following means:

**SOONER**

- Surgical capacity has been expanded to reduce the backlog of patients on the waiting list. This includes Regina and Saskatoon, where most surgeries are performed, but also smaller surgical centres where there is an opportunity to make better use of health providers and facilities.
- Saskatchewan is using third-party providers to increase surgical and diagnostic capacity in the publicly funded and administered system. Health regions have entered into contracts with third-party providers to provide day surgeries, including orthopedics, ophthalmology, dental, and ear/nose/throat procedures.
- Pooled referrals and other strategies have been introduced to address the uneven distribution of patients among surgeons and maximize the use of all surgeons. This will give patients faster access to the first available surgeon with the required expertise. Patients may still choose any surgeon they prefer, but know they may wait longer. There are currently 15 specialty groups pooling referrals in the province.
- The online Specialist Directory at [www.health.gov.sk.ca/specialist-directory](http://www.health.gov.sk.ca/specialist-directory) helps patients work with their family doctors to understand options and determine which specialists have the shortest wait times.

**SAFER**

- Surgical safety checklists standardize procedures in all Saskatchewan hospital operating rooms. The checklists promote improved communication among the surgical team and consistent use of practices that are proven effective in increasing patient safety before, during, and after surgery.
- Safer Healthcare Now!, a Canadian Patient Safety Institute initiative, has developed processes to prevent surgical site infections. Implementation of these prevention protocols is underway.
- Saskatchewan health regions are implementing medication reconciliation at admission to acute care. MedRec prevents errors by ensuring that a patient’s medication history is verified, and that medication and doses are appropriate.
- A falls prevention initiative now helps identify risk factors that can contribute to seniors falling, and promotes ways to prevent these injuries.

healthcouncilcanada.ca/innovation
SMARTER

- New patient pathways are being introduced to streamline the care process and ensure patients receive appropriate, timely care, whether they require surgery or not.
  - Hip & Knee Pathway: Family physicians can now refer potential hip or knee surgical patients to multidisciplinary clinics in Regina, Saskatoon, Prince Albert, and Moose Jaw.
  - Spine Pathway: Saskatchewan is introducing a new way to assess and treat patients with lower back pain. Primary health care providers (family physicians, chiropractors, and physiotherapists) can now take an online continuing education course on handling lower back pain.
  - New pathways are being introduced for prostate cancer and uro-gynecology. Planning for additional pathway development and implementation is underway.
- Shared decision-making tools are being introduced through all of the pathways to ensure patients are educated, informed participants in their care.
- Groups of clinicians are studying clinical variation and developing standard approaches to help ensure patients receive the most appropriate care.
- The Lean Management System is being introduced across all health regions and is leading to improvements in patient care, more efficient processes, and engagement of health care providers.
- Targeted funding has supported the training of over 100 additional operating room nurses through the perioperative-nurse training program at the Saskatchewan Institute of Applied Science and Technology (SIAST).

IMPACT:

The Surgical Initiative releases monthly progress reports on patient wait times, by region and by regional health authority, at www.sasksurgery.ca. Other performance measures are reported at www.qualityinsight.ca.

Ninety per cent of all patients who had their surgery between July 1 and December 31, 2012, received their procedure within six months, and 78% received their surgery within three months.

From November 2007 to December 2012,

- The number of patients waiting more than 18 months for surgery has dropped by 93%.
- The number of patients waiting more than 12 months for surgery has dropped by 82%.
- The number of patients waiting more than six months for surgery has dropped by 58%.
- The number of patients waiting more than three months for surgery has dropped by 46%.

As of December 31, 2012, all three components of the surgical safety checklist were performed in 96% of audited surgeries throughout the province.

*An outcomes update for the Saskatchewan Surgical Initiative was released on March 18th, 2013 and includes wait times data up and until January 30th, 2013. For more information, please visit the following website:

http://www.gov.sk.ca/adx/asp/adxGetMedia.aspx?mediald=0ec0f584-27b5-4f45-803b-6b6941324a26&PN=Shared

APPLICABILITY/TRANSFERABILITY:

A transition plan is being developed to ensure the improvements and momentum achieved during the formal four-year period of the Surgical Initiative are continued into the future and advanced through daily continuous improvement.

An embedded researcher has been located in the Surgical Initiative branch at the ministry of Health and will be publishing a dissertation on the facilitators and barriers to transformational change based on her experience observing the change process. The embedded researcher project is a collaboration between the ministry of Health, CFHI, and the Johnson-Shoyama Graduate School of Public Policy.

Content has been adapted from the following sources and relevant websites:


Government of Saskatchewan news release (April 23, 2012), Funding for surgical care flows to health regions [http://www.gov.sk.ca/news?newsId=1c06badb-12d7-4905-9c8f-ac905f1bd132]

Saskatchewan Surgical Initiative website: [http://www.sasksurgery.ca]


CONTACT INFORMATION:

Name: Mark Wyatt
Title: Executive Director, SKSI
Organization: Saskatchewan Ministry of Health
Email address: mark.wyatt@health.gov.sk.ca
Telephone number: (306) 787-3153

Information last updated on: January 24, 2012

Annual Quality Improvement Plans (QIPs) as part of Ontario’s Excellent Care for All Act (ECFAA)

JURISDICTION: Ontario
HEALTH THEME: System Level Quality Improvement

FRAMEWORK CATEGORY: Emerging
PUBLICATION DATE: March 2013

ORIGINAL SOURCE: Which way to quality? Key perspectives on quality improvement in Canadian health care systems

PRACTICE DESCRIPTION:

The Excellent Care for All Act (ECFAA) came into law in June of 2010. The Act puts Ontario patients first by strengthening the health care sector’s organizational focus and accountability to deliver high-quality patient care. Quality improvement plans (QIPs), one of the components of ECFAA, are often referred to as the cornerstone of the legislation.

The ECFAA calls for the following:

- quality committees that are responsible for monitoring and reporting on quality issues;
- annual quality improvement plans (QIPs), which each health care organization must develop and make public;
- executive compensation to be linked to achieving performance improvement targets set out in the annual quality improvement plan;
- patient/client/caregiver surveys to assess satisfaction with services;
- staff (employee and service provider) surveys to assess satisfaction with employment experience and views about the quality of care provided by the health care organization;
- a patient declaration of values developed after public consultation by health care organizations that are currently without one; and
- a patient relations process to address patient experience issues and reflect the organization’s declaration of values.

Annual quality improvement plans are developed by the health care organization and include quality indicators, measurable performance improvement targets, and planned improvement activities that align with the organization’s quality improvement goals and priorities. The ministry provides guidance, common templates, and other supports to health care organizations to assist in the development of a QIP that aligns with system priorities. QIPs are developed annually, posted publicly, and submitted to Health Quality Ontario. Posting publicly is meant to promote the principles of the ECFAA, including accountability and transparency. Further accountability is found in the legislative provision that ties each hospital CEO’s compensation with the achievement of a hospital’s quality improvement goals.

The QIP is a tool that enables hospitals to identify, report, and achieve QI objectives in a structured way. Every hospital has a Quality Committee with oversight for the development of the QIP, which must be certified by the chair of the hospital board and the chief executive officer.

Excellent QIPs and well-executed implementation will strengthen the hospital sector’s ability to deliver high-quality patient care. Quality improvement plans are used in a variety of health care practices across the world to ensure an evidence base for public accountability. As Ross Baker outlined in his seminal report Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations, quality improvement plans are used at Virginia Mason Medical Center by the board and senior managers as part of a broader strategic agenda. Further, at the Vancouver Island Health Authority the board works with VIHA staff to set quality and patient safety priorities in a quality plan, taking into account the ministry of Health’s direction.

QIPs submitted to Health Quality Ontario are reviewed and used to inform feedback to the field. For the 2012/13 hospital QIPs, this resulted in development of the QIP: An Analysis for Improvement report. The report describes overall progress from one year to the next and identifies hospitals that have exemplary plans and practices. As well, the report includes the provincial average and comparative performance information for a series of indicators. These indicators include Clostridium difficile infection, ventilator-associated pneumonia, hand hygiene, central line–associated bloodstream infection, pressure ulcers, falls, surgical safety checklist, physical restraints, hospital standardized mortality ratio, total margins, emergency department length of stay for admitted patients, patient satisfaction, 30-day readmission rate, and percentage of alternate level of care (ALC) days.
QIPs were also introduced for interprofessional team-based primary care models (including Family Health Teams, Community Health Centres, Nurse Practitioner–Led Clinics, and Aboriginal Health Access Centres) in 2013 as an essential focus of Ontario’s health care transformation agenda.

**IMPACT:**

According to Health Quality Ontario’s 2012/2013 QIP: An Analysis for Improvement, there has been progress made since the initial QIPs were submitted under the ECFAA in 2011/2012. HQO highlights three key areas of progress, including:

- perfect QIP submission compliance (i.e. all hospitals submitted plans);
- QIPs captured clear aims that were aligned with hospitals’ strategic priorities, and included appropriate measures and targets; and
- QIPs gave rise to innovative and thought-provoking change ideas.

The inclusion of specific indicators and targets in QIPs facilitates analysis of their impact on health outcomes and health care performance. The 2012/2013 Analysis for Improvement does illustrate improved performance related to central line bloodstream infection, ventilator-associated pneumonia, hand hygiene, and patient satisfaction. However, analysis indicates that there is still improvement to be made, since many hospitals did not reach their targets for ALC days and emergency department wait times.

A 2012 study was undertaken to understand how the ECFAA, including its quality improvement plan requirements, had influenced some Ontario organizations’ governance practices for quality and patient safety. Results indicated that, in the near term, the requirements may hinder the effectiveness of high-performing organizations with an existing focus in these areas. As well, there were some concerns about the measures, e.g., in some cases their focus on provincial priorities caused distraction from efforts to address local priorities. However, this same study notes that the ECFAA has helped “raise the bar” on quality of care and patient safety, and supports alignment between governance and the delivery of quality care.

**APPLICABILITY/TRANSFERABILITY:**

Senior leaders in Ontario have indicated that QIPs drive transparency by holding organizations accountable. As of March 2013, QIPs are required in hospitals and interprofessional primary care organizations. There are plans to support health care organizations across the care continuum with adopting the principles of the ECFAA; development and implementation of quality improvement plans is part of this vision.

Content has been adapted from the following website:


**CONTACT INFORMATION:**

Name: Jillian Paul  
Title: Manager  
Organization: Ministry of Health and Long-Term Care  
Email address: jillian.paul@ontario.ca  
Telephone number: (416) 325-5600  

Information last updated on: March 11, 2013  

British Columbia’s Clinical Care Management (CCM)

<table>
<thead>
<tr>
<th>JURISDICTION:</th>
<th>British Columbia</th>
<th>HEALTH THEME:</th>
<th>System Level Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRAMEWORK CATEGORY:</td>
<td>Emerging</td>
<td>PUBLICATION DATE:</td>
<td>February 2013</td>
</tr>
<tr>
<td>ORIGINAL SOURCE:</td>
<td>Quelle voie mène à la qualité? Principales perspectives sur l’amélioration de la qualité des systèmes de soins de santé au Canada</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PRACTICE DESCRIPTION:**

British Columbia’s Clinical Care Management (CCM) initiative began in 2010 as a key part of British Columbia’s Innovation and Change Agenda which supports innovation and transformation across the entire health system, including all areas of care (health promotion and prevention, community care, acute care and end of life care).

As a “Key Result Area” of the Innovation and Change Agenda, CCM pursues the goal of “implementing a guideline-driven, evidence informed, clinical care management system to improve the quality, safety and consistency of key clinical services and improve patient experiences of care.” To achieve this goal, CCM takes a system-wide approach, with participation from BC’s Ministry of Health, regional health authorities and the BC Patient Safety and Quality Council (BCPSQC). It is a shared strategy that involves everyone working together for the common goal of better quality care.

CCM is designed to harness the collective energy and commitment of healthcare providers across the province to promote guideline-driven care and clinical best practice. It provides a provincial forum to identify, establish and promote clinical best practice guidelines by connecting physicians with provincial decision makers. Across the province, Clinical Expert Groups have been formed to review clinical evidence, develop practice standards and recommend province-wide adoption of guidelines, protocols and quality improvement metrics. Guidelines and practice standards are essentially developed from the ground-up with clinician input from the inception of the process, right through to implementation. The connection between the Clinical Expert Groups and the CCM Steering Committee – comprised of senior Ministry leadership (Assistant Deputy Minister), health authority vice presidents of quality / medicine, and the Chair of the BCPSQC – ensures that clinicians have the ability to raise quality of care barriers, opportunities and successes to senior leadership. This connection between senior decision makers and frontline clinicians helps ensure improving quality of care for patients remains the central mandate of the CCM initiative.

To date, CCM has identified eleven Clinical Care Areas (CCA): Hospital care for seniors (48/6), antimicrobial stewardship, stroke, sepsis, surgical site infection, surgical checklist, hand hygiene, heart failure, venous thromboembolisms, medication reconciliation, and critical care related to glycemic control. To support the Clinical Expert Groups for each CCA a provincial quality lead is appointed by the BCPSQC. Quality Leads are experts in change management, engagement and coordination, and they support guideline development and implementation from a provincial perspective, ensuring appropriate communication and coordination among regional health authorities. In addition, they speak on behalf of the clinical expert group that champions guideline driven care in the focused topic area. The role of the BCPSQC as part of the CCM structure is to engage with physicians and nurture these eleven clinical expert groups. As the BCPSQC is an independent organization it is able to have honest and open discussions with clinical experts about priority areas of health care and then take that information to the Ministry of Health for province wide implementation. The BCPSQC helps connect physicians and the Ministry of Health by providing change management, communications and engagement activities across the province.

**IMPACT:**

Clinical Care Management’s structure of integrated decision making between physicians and policy officials for quality improvement has not been formally evaluated at this time.

**APPLICABILITY/TRANSFERABILITY:**

Many high performing health care systems have adopted a system-wide approach to establishing, promoting, and implementing evidence based clinical best practices. British Columbia’s Clinical Care Management’s approach has reviewed models implemented in other health systems, notably Intermountain Health Care in Utah.

**CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:**

Contact List for the CCM: [http://www.bcpsqc.ca/quality/documents/ClinicalCareManagementContactDirectory.pdf#page=9](http://www.bcpsqc.ca/quality/documents/ClinicalCareManagementContactDirectory.pdf#page=9)