Health Innovation Portal:
Archive of Innovative Practices

Theme: **Access and Wait Times (Vol. 1)**

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Selected Search Output Table (December 16, 2013)

SEARCH TERMS:	**N/A**	**LOCATION:**	**All**
HEALTH THEME:	**Access and Wait Times**	**FRAMEWORK CATEGORY:**	**All**
HEALTH SECTOR:	**All**	**SEARCH RESULTS:**	**29 results out of 80**

1. Pharmacists Practising in Family Health Teams

Implementation Year: Tuesday, December 9, 2003 - 16:00	**Location: Ontario**	**Practice Website: http://www.health.gov.on.ca/en/pro/programs/fht/fht_progress.aspx**

SNAPSHOT:

Family Health Teams (FHTs) were introduced in Ontario in 2003 and were designed to address issues related to accessibility and quality of primary care. The goal of involving pharmacists in FHTs was to improve appropriate medication therapy management, particularly given the prevalence of chronic illnesses. There are now approximately 150 pharmacists in Ontario practising with FHTs.

CONTACT INFORMATION:

Name: Lisa Dolovich Title: Research Director and Professor, Department of Family Medicine Organization: McMaster University Email address: ldolovic@mcmaster.ca Telephone number: (905) 525-9140 ext 28509 Information last updated on: October 15, 2013

2. Quality Improvement Training and Support

Implementation Year: Sunday, December 9, 2007 - 15:45	**Location: Ontario**	**Practice Website: http://www.hqontario.ca/quality-improvement/primary-care**

SNAPSHOT:

This innovative practice provides quality improvement (QI) training and support to primary care practices. The practice was launched Ontario and has involved 750 interprofessional practice-based teams supported by QI coaches.

CONTACT INFORMATION:

Susan Taylor Program Manager Health Quality Ontario Telephone: 416-323-6868 ext. 245 Email: Susan.Taylor@hqontario.ca

3. Patient Enrolment with a Primary Care Provider

Implementation Year: Tuesday, December 9, 2003 - 15:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice involving patient enrolment in a primary health care practice formalizes an ongoing relationship between primary care providers and patients; provides the basis for population-based funding, capitation-based provider payment, and primary care performance measurement; and facilitates pro-active preventive care and chronic disease management. The practice has been implemented in Ontario in most primary care settings and involves more than three quarters of Ontario residents and primary care physicians.

CONTACT INFORMATION:

Phil Graham Manager, Family Health Teams and Related Programs Primary Care Branch Negotiations and Accountability Management Division Ontario Ministry of Health and Long-Term Care Telephone: 416-212-0832 Email: Phil.Graham@ontario.ca

4. Midwifery in Ontario

Implementation Year: Friday, December 9, 1994 - 15:15	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice expands the accessibility and choice of maternal and newborn care through the use of midwives. The practice was launched across Ontario and involves provincial government funding of midwifery education and payment for the provision of midwifery services.

CONTACT INFORMATION:

Richard Yampolsky Program Manager, Specialized Models Programs Primary Health Care Branch Negotiations and Accountability Management Division Ontario Ministry of Health and Long-Term Care 1075 Bay Street, 9th Floor Toronto ON M5S 2B1 Telephone: 416-325-1957 Email: Richard.Yampolsky@ontario.ca

5. Integration of Primary Health Care Nurse Practitioners (PHC NPs)

Implementation Year: Wednesday, December 9, 1998 - 15:00	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice improves accessibility and quality of primary care through the use of nurse practitioners The practice has been implemented in Ontario in more than 300 primary care settings and involves provincial government funding of nurse practitioner (NP) education and clinical positions in family health teams, community health centres, nurse practitioner–led clinics, and other primary care practices and organizations.

CONTACT INFORMATION:

Ministry of Health and Long-Term Care Email: nursingsecretariat.moh@ontario.ca)

6. Alberta Access Improvement Measures (AIM)

Implementation Year: Friday, December 9, 2005 - 14:30	Location: Alberta	Practice Website: http://www.albertaaim.ca

SNAPSHOT:

This innovative practice helps family physicians, speciality care physicians, and Alberta Health Services programs and their teams reduce or eliminate wait times, improve office efficiency, and improve patient care by using quality improvement methods. The initiative has involved 19 learning collaborative supporting improvement teams across Alberta, including 614 family physicians from 133 primary care clinics.

CONTACT INFORMATION:

Steven Clelland Director, Alberta AIM Email: steven.clelland@albertahealthservices.ca Telephone: 780-342-8823

7. Sault Ste. Marie Group Health Centre

Implementation Year: Tuesday, December 9, 1997 - 14:30	Location: Ontario	Practice Website: http://www.ghc.on.ca/index.php

SNAPSHOT:

This innovative practice facilitates improved accessibility and comprehensiveness of primary care service delivery. The Group Health Centre was originally founded in Sault Ste. Marie in 1962. As a progressive, multi-specialty, ambulatory health organization, the health centre integrated an electronic health record system in 1997 and now serves 71,000 residents of Sault Ste. Marie and Algoma District (population 75,000), with 81 doctors and 350 employees.

CONTACT INFORMATION:

Name: Garry Walsh Title: Vice President of Communications Organization: Group Health Centre Email address: walsh_gary@ghc.on.ca Telephone

number: 705-759-5562 Information last updated on: November 13, 2013

8. Oncology Patient-Navigator Nurse (infirmière pivot en oncologie)

Implementation Year: Sunday, November 27, 2005 - 10:00	**Location: Quebec**	**Practice Website: http://www.msss.gouv.qc.ca/sujets/prob_sante/cancer/index.php?accueil**

SNAPSHOT:

This innovative practice helps patients with cancer navigate the health system by improving the accessibility of resources, the coordination of services, continuity of care, and communications with providers. The first oncology patient-navigator position was introduced at Laval University's Hospital Centre in Quebec City in 2005. The position was designed to provide a direct link for patients with cancers of the neck and throat to the health care system. There are currently over 250 oncology patient-navigator nurses integrated in hospital-based health care teams across the province of Quebec.

CONTACT INFORMATION:

Name: Lise Fillion Title: Registered Nurse Organization: Faculty of Nurses, Laval University Email address: lise.fillion@fsi.ulaval.ca Telephone number: (418) 525-4444 ext. 15754 Information last updated on: August 20, 2013

9. Remote Order Telepharmacy Review

Implementation Year: Monday, November 26, 2007 - 14:30	**Location: International**	**Practice Website: http://www.mercydubuque.com/**

SNAPSHOT:

This innovative practice improves accessibility, efficiency, and safety of pharmaceutical services through the use of electronic medical records, standardized formularies, and tailored communication protocols among pharmacists, physicians, and nurses. The telepharmacy services were implemented in seven rural critical access hospitals in Iowa in 2007 and have continued to expand to a total of 10 locations, all of which were identified as having inconsistent pharmacist coverage.

CONTACT INFORMATION:

Name: Douglas Wakefield Title: Director Organization: Centre for Health Care Quality; Missouri, United States Email address: wakefielddo@health.missouri.edu Information last updated on: August 22, 2009

10. Registered Nurse–Surgical First Assist

Implementation Year: Sunday, November 26, 2006 - 14:00	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice reduces wait times for surgical services by improving the supply of appropriate health human resources available. The registered nurse–surgical first assist (RN-SFA) role was initiated by the Ontario Ministry of Health and Long-Term Care (the Ministry) as part of the HealthForceOntario strategy in May 2006. It involved 34.2 full-time equivalent (FTEs) in 20 organizations and has since expanded to 78.5 FTEs in 35 organizations across Ontario.

CONTACT INFORMATION:

Name: Colleen Lipskie Title: Team Lead/ Senior Policy Analyst Organization: Ministry of Health and Long-Term Care Email address: colleen.lipskie@ontario.ca Telephone number: 416-212-3846 Information last updated on: August 21, 3013

11. Primary Care Clinical Associate Initiative

Implementation Year: Friday, November 26, 2004 - 14:00	**Location: Alberta**	**Practice Website: www.westviewpcn.ca**

SNAPSHOT:

This innovative practice improves the accessibility, coordination, continuity, and comprehensiveness of primary care services in the Westview Primary Care Network Catchment area in Alberta. The Clinical Associate Initiative was introduced in 2005 for a four-year term, and since 2009 has continued to expand in its scope and capacity among the eight participating family practice clinics.

CONTACT INFORMATION:

Name: Grace Moe Title: Executive Director, Strategic Planning Organization: WestView Primary Care Network Email address: grace.moe@westviewpcn.ca Telephone number: 780-948-2435 Information last updated on: August 7, 2013

12. Mental Health Liaison

Implementation Year: Friday, November 26, 2004 - 14:00	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1017161**

SNAPSHOT:

This innovative practice improves the level of coordination and accessibility of mental health care services in a rural setting in Alberta by providing a direct link among physicians, nurses, and patients. In 2004, the mental health liaison was added as a new position to the Access and Early Intervention Program of Mental Health Services in the community of Rocky Mountain House, Alberta. There are now 27 mental health liaison positions throughout the central region of the province.

CONTACT INFORMATION:

Name: Gloria Bruggencate Title: Instructor Organization: Mental Health Services Email address: gbruggencate@dthr.ab.ca Telephone number: 403-783-7907

13. Community Liaison Discharge Planning, First Nations Health Programs, Whitehorse General Hospital

Implementation Year: Tuesday, November 26, 2002 - 11:00	**Location: Yukon**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the complex needs of First Nations, Inuit, and Métis patients who are discharged from hospital to rural and remote communities in the Yukon. The practice was established as a component of the First Nations Health Programs at Whitehorse General Hospital in 2002, and involves a community liaison discharge planner.

CONTACT INFORMATION:

Name: Laura Salmon Title: Director, First Nations Health Programs Organization: Yukon Hospital Corporation Email address: laura.salmon@wgh.yk.ca Telephone number: 1 (867) 393 8756 Information last updated on: September 16, 2013

14. Supporting Métis seniors and families—Métis Nation of Ontario (MNO) community centres

Implementation Year: Friday, November 26, 1993 - 10:15	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the need to support Métis senior citizens who are at risk of falling through the cracks of a complex health system. The first community centres were established in the mid-1990s, with the remaining centres developing since that time. Programming involves partnerships with different ministries, Aboriginal groups and the volunteer sector. Care delivery involves interdisciplinary health staff, community centre workers and volunteers.

CONTACT INFORMATION:

Name: Wenda Watteyne, Title: Director of Healing and Wellness Organization: Métis Nation Ontario Email address:wendaw@metisnation.org Telephone number: 613.798.1488 Information last updated on: October 23, 2013

15. Manitoba's Specialized Services for Children and Youth (SSCY)

Implementation Year: Tuesday, October 7, 2003 - 15:00	**Location: Manitoba**	**Practice Website: http://www.sscy.ca/**

SNAPSHOT:

This innovative practice addresses the need to increase coordination of care for disabled children with complex needs. The practice was launched in Manitoba and consisted of a large planning team with representatives from various departments of the Manitoba government, regional health authority involvement, and several community service providers.

CONTACT INFORMATION:

Name: Collette Wilson Title: Coordinator Organization: SSCY Family Resource Centre Email address: collettew@rccinc.ca Telephone number: 204-453-9820

16. Emergency Department Decongestion Incentive Model: Rewarding target transit times that improve access and reduce wait times in the emergency department

Implementation Year: Thursday, November 1, 2007 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of improving access and patient flow through emergency departments (EDs) by rewarding hospitals with financial incentives when pre-determined performance targets for ED length-of-stay are met. This pay-for-performance (P4P) model was piloted in 2007 in four acute care hospitals within the Vancouver Coastal Regional Health Authority in British Columbia and expanded across the province in 2010.

CONTACT INFORMATION:

Name: Dr. Les Vertesi Title: Executive Director Organization: Health Services Purchasing Organization (HSPO) Email address: les.vertesi@gov.bc.ca Telephone number: N/a Information last updated on: August 29, 2013

17. Integrated Community Clerkship Program for MD Undergraduate Clinical Education at the University of British Columbia

Implementation Year: Tuesday, February 3, 2004 - 00:15	Location: British Columbia	Practice Website: http://mdprogram.med.ubc.ca/program-information/integrated-community-clerkships/

SNAPSHOT:

This innovative practice addresses the shortage of physicians in rural and remote communities. The practice was launched in September 2004 at the Chilliwack General Hospital, British Columbia, and involved six family practitioners as primary preceptors and a group of faculty leaders to execute program planning.

CONTACT INFORMATION:

Name: Dr. Mark MacKenzie Title: ICC Program Director Organization: UBC Faculty of Medicine Email address: Icc.admin@ubc.ca Telephone number: 604-875-4111 (ext. 62380) Information last updated on: June, 2013

18. Geriatric Day Hospital: Improving Health Outcomes of Seniors Living in the Community

Implementation Year: Saturday, February 3, 1990 - 00:30	Location: Ontario	Practice Website: http://www.nygh.on.ca/Default.aspx?cid=1199&lang=1

SNAPSHOT:

This innovative practice addresses the issue of improving the health outcomes of senior patients living in the community through an interprofessional, patient-centred approach within a specialized geriatric day hospital setting. This program was launched about 25 years ago in Ontario within the Seniors' Health program at a large hospital.

CONTACT INFORMATION:

Name: Timmy Olanubi Title: Registered Nurse Organization: Senior's Health Centre – North York General Hospital Email address: timmy.olanubi@nygh.on.ca Telephone number: (416) 756 6050 ext. 8053 Information last updated on: July 7 2013

19. Total Joint Assessment Clinic

Implementation Year: Saturday, February 10, 2007 - 00:15	**Location: Ontario**	**Practice Website: http://www.gtarehabnetwork.ca/uploads/File/bpd/2008/bpd2008-pres-6d.pdf**

SNAPSHOT:

This innovative practice aims to decrease the wait times for assessment and treatment of patients with hip and knee arthritis.

CONTACT INFORMATION:

Name: Maureen Sly-Havey Title: Advanced Practice Nurse, Project Manager for Regional Hip and Knee Replacement Program Organization: Queensway Carleton Hospital and Champlain LHIN Email address: mslyhavey@qch.on.ca Telephone number: 613-721-2000 x 3550 Information last updated on: March 24, 2013

20. Saskatchewan's Clinical Practice Redesign (CPR)

Implementation Year: Saturday, February 3, 2007 - 01:00	**Location: Saskatchewan**	**Practice Website: https://www.sma.sk.ca/Default.aspx?cid=838&lang=1&pre=view**

SNAPSHOT:

This innovative practice is a set of tools and methodologies that improve access to care, communications, office processes, and effectiveness between office settings and other health care providers. Launched in Saskatchewan in 2007, this program aims to help health care professionals enhance communication, streamline office processes and make the best use of everyone's time.

CONTACT INFORMATION:

Name: Lisa Clatney Title: Program Director Organization: Health Quality Council Email address: lclatney@hqc.sk.ca Telephone number: 306-668-8810 ext. 106

21. Advanced Access for Family Physician Appointments in Manitoba

Implementation Year: Saturday, February 3, 2007 - 00:00	**Location: Manitoba**	**Practice Website: http://www.gov.mb.ca/health/primarycare/access/advancedaccess.html**

SNAPSHOT:

This innovative practice aims to reduce concerns about the length of time patients waited for appointments with family physicians and about overuse of emergency departments. Launched in 2007 in Manitoba, the goal is to eliminate patient wait times to get an appointment and minimize the amount of time each patient spends at an appointment.

CONTACT INFORMATION:

Name: Roberta Vyse Title: Project Lead Organization: Manitoba Health Email address: Roberta.vyse@gov.mb.ca Telephone number: 204-788-6340

22. OsteoArthritis Service Integration System (OASIS)

Implementation Year: Thursday, February 9, 2006 - 00:30	**Location: British Columbia**	**Practice Website: http://oasis.vch.ca/**

SNAPSHOT:

This innovative practice addresses the fragmentation of osteoarthritis services for non-operative patients. It was launched in 2006 in the Vancouver Coastal Health Authority and since has been implemented in Richmond and North Shore as well.

CONTACT INFORMATION:

Name: Cindy Roberts Title: Director Musculoskeletal Programs & Special Projects Primary Care, Director of the OASIS Program Organization: Vancouver Coastal Health Email address: cindy.roberts@vch.ca Telephone number: 604-875-5228

23. Alternative Relationship Plan–Rheumatology Project

Implementation Year: Saturday, February 4, 2006 - 00:45	**Location: Alberta**	**Practice Website: http://www.departmentofmedicine.com/documents/dom/reports/innovation_report_07.pdf**

SNAPSHOT:

This innovative practice addresses the issue of access to appropriate and timely rheumatology care through effective coordination between health care through central referral and intake. This program was launched in 2006 across the Calgary Health Region.

CONTACT INFORMATION:

Name: Terri Lupton Title: Registered Nurse Organization: Alberta Health Services Email address: theresa.lupton@albertahealthservices.ca Telephone number: 403-944-4426

24. Primary Outreach Services in British Columbia

Implementation Year: Saturday, February 3, 2007 - 01:00	**Location: British Columbia**	**Practice Website: http://www.vch.ca/home/**

SNAPSHOT:

This innovative practice addresses supported housing and emergency shelter residents' overall health by delivering clinical services on-site, improve residents' access to health services, create a strong partnership model in delivering health services, and reduce non-urgent hospital emergency department visits. Implemented in the Vancouver Coastal Health Authority since 2007, the program targets individuals who are chronically homeless, live chaotic lifestyles, and have multiple chronic health conditions, including mental health conditions and addiction.

CONTACT INFORMATION:

Name: Anne McNabb Organization: Vancouver Coastal Health Authority Email address: anne.mcnabb@vch.ca Telephone number: 604-730-7605 x 7605

25. Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative

Implementation Year: Saturday, February 3, 2007 - 00:30	**Location: British Columbia**	**Practice Website: http://www.bcchildrens.ca/Services/SpecializedPediatrics/RICHERInitiative/default.htm**

SNAPSHOT:

This innovative practice addresses child health inequities through a publicly funded, community-based primary health care and specialist pediatrics service designed to meet the needs of children, youth, and families living in Vancouver's inner-city neighbourhoods. BC Children's Hospital developed the Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative in 2007 as a means to promote access to health care for all.

CONTACT INFORMATION:

Name: Dr. Judith Lynam Title: Professor and RICHER Research Lead Organization: University of British Columbia School of Nursing Email address: judith.lynam@nursing.ubc.ca Telephone number: 604-822-7476

26. An Interprofessional Model of Care That Integrates Musculoskeletal Ambulatory Services

Implementation Year: Friday, February 3, 2006 - 01:00	**Location: Ontario**	**Practice Website: http://www.sunnybrook.ca**

SNAPSHOT:

This innovative practice was developed In response to the Ontario Wait Time Strategy to implement an interprofessional approach to improve access and care for

patients requiring hip and knee replacement. The Advanced Practice Physiotherapist (APP) was introduced in 2006, leveraging existing health human resources to provide independent, comprehensive physical assessments for triage and post-operative follow up.

CONTACT INFORMATION:

Name: Susan Robarts Title: Clinical Supervisor, Advanced Practice Physiotherapist Organization: Sunnybrook Health Sciences Centre Email address: susan.robarts@sunnybrook.ca Telephone number: 416.967.8634

27. Specialized Rehabilitation Outpatient Program

Implementation Year: Thursday, February 1, 2001 - 01:00	Location: Alberta	Practice Website:

SNAPSHOT:

This innovative practice focuses on outpatient redesign efforts targeted to increase access, improve service coordination across the care continuum, alignment of patients' needs to interventions, and use of the right mix of service providers. In January 2011, Glenrose Rehabilitation Hospital (GRH) in Edmonton, Alberta, redesigned its adult and geriatric outpatient services to support a province-wide initiative to improve inpatient flow.

CONTACT INFORMATION:

Name: Val Guiltner Title: Director, Pediatric Rehabilitation Division Organization: Glenrose Rehabilitation Hospital Email address: val.guiltner@albertahealthservices.ca Telephone number: 780-735-8229

28. Hamilton Family Health Team—Mental Health Program

Implementation Year: Friday, February 3, 2006 - 02:45	Location: Ontario	Practice Website: http://www.hamiltonfht.ca/i-am-a-patient/mental-health

SNAPSHOT:

This innovative practice was initially established in recognition that primary care physicians play a central role in delivering mental health care, often with minimal support from mental health services. Since 1994, the Hamilton Family Health Team (formerly Hamilton Health Service Organization) Mental Health Program (HFHT-MHP) has successfully integrated mental health counsellors and psychiatrists into the offices of 150 family physicians in 81 practices across the City of Hamilton.

CONTACT INFORMATION:

Name: Dr. Nick Kates Title: Acting Chair, Dept. of Psychiatry and Behavioural Neurosciences Organization: McMaster University Email address: nkates@mcmaster.ca Telephone number: 905-536-0966

29. Home First

Implementation Year: Saturday, February 3, 2007 - 00:30	Location: Ontario	Practice Website: http://www.lhincollaborative.ca/Page.aspx?id=1902

SNAPSHOT:

This innovative practice addresses the issue of of Alternate Level of Care (ALC) patients waiting for beds in long-term care facilities. In the last few years, Ontario has developed a Home First program that sends patients back to their communities and homes with intensive case management.

CONTACT INFORMATION:

Name: Liane Fernandes Title: Interim Senior Director Organization: LHINCollaborative Email address: liane.fernandes@lhins.on.ca Telephone number: 416-969-3891 Last updated: 30 November 2012 (checked November 30)

Pharmacists Practising in Family Health Teams

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: Family Health Teams (FHTs) were introduced in Ontario in 2003 and were designed to address issues related to accessibility and quality of primary care. The goal of involving pharmacists in FHTs was to improve appropriate medication therapy management, particularly given the prevalence of chronic illnesses. There are now approximately 150pharmacists in Ontario practising with FHTs.

PRACTICE DESCRIPTION:

Family Health Teams (FHTs) are comprised of physicians and other health care professionals, including pharmacists. Each FHT offers seven-days-a-week access to care, providing a range of services determined by community needs. Interprofessional involvement is made possible through blended payment models, including a combination of capitation, fee for service, bonuses for achieving prevention targets, and special payments to expand care services such as palliative, home, or pre-natal care. Pharmacists' role in the FHTs has been growing as they work to ensure better prescribing practices and care for the whole patient through comprehensive assessments and follow-ups.

FHTs are organized through the local health integration network and funded by the Ministry of Health and Long-Term Care. Identified stakeholders include the Ontario Pharmacists Association and the Association of Family Health Teams of Ontario, Primary Care Pharmacists Specialty Network.

IMPACT:

The greater involvement of pharmacists in FHTs has been supported by evidence generated by the Seniors Medication Assessment Research Trial (SMART) study, which was conducted in 2000 (see http://spep.phm.utoronto.ca/spep/SMARTPROJECTSUMMARYSPEP.htm). This study involved 1,554 patients referred to a pharmacist for comprehensive assessment in the first 24 months alone. SMART was randomized and designed to determine effectiveness of pharmacy consulting on physician prescribing behaviours. Qualitative reporting indicated fewer drug-related problems and greater physician compliance to pharmacist recommendations (72.3%, 790/1093). SMART provided a strong base for subsequent programming. Funding was provided by the Health Transition Fund, part of Health Canada, and the Ontario Ministry of Health and Long-Term Care.

The regular monitoring and evaluation of FHTs has demonstrated largely positive results with respect to patient satisfaction and job satisfaction. The Ontario government is investing $300 million annually in FHTs; however, evidence of the cost-effectiveness of this model is not yet publically available.

APPLICABILITY/TRANSFERABILITY:

The findings from SMART informed the development of Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics (IMPACT) (see http://www.impactteam.info/impactHome.php), which also contributed to an evidence base for increased pharmacist involvement. This program was designed to provide a demonstration of how pharmacists could be integrated into the primary care office setting to ultimately improve patient outcomes through optimal drug therapy. During the implementation period of 2004–2006, pharmacists were working two to three days a week for 31 months in seven family practice sites across Ontario. Altogether, there were seven pharmacists and 70 physicians to cover approximately 150,000 patients. Primary responsibilities for pharmacists in this program included conducting individualized patient medication assessments, providing drug information and education, developing office system enhancements to optimize drug therapy, and facilitating integration activities. While this model also produced positive reporting, efforts were transitioned into the provincial FHT model.

Given the current reach of FHTs and changes related to pharmacist involvement, this primary care model is highly transferable. The establishment of the electronic health record system was noted as a key facilitator to enable communication among different providers. Next steps will include demonstrating cost-effectiveness or return on investment on a provincial level.

CONTACT INFORMATION:

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Information last updated on: October 15, 2013

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

Publications:

Dolovich, L. (2012). Ontario pharmacists practicing in family health teams and the patient-centered medical home. *Annals of Pharmacotherapy*, *46*(Suppl 1), S33–S39. Retrieved from

http://www.impactteam.info/documents/LDolovich2012.pdf

Farrell, B., Dolovich, L., Emberley, P., Gagné, M.A., Jennings, B., Jorgenson, D., … Woloschuk, D. (2012). Designing a novel continuing education program for pharmacists: Lessons learned. *Canadian Pharmacists Journal, 145*(4), e7–e16. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3567806/

Farrell, B., Pottie, K., Haydt, S., Kennie, N., Sellors, C., & Dolovich, L. (2008). Integrating into family practice: The experiences of pharmacists in Ontario, Canada. *International Journal of Pharmacy Practice, 16*(5), 309–315. Abstract retrieved from http://onlinelibrary.wiley.com/doi/10.1211/ijpp.16.5.0006/abstract

Ontario Ministy of Health and Long-Term Care. (2013). Family health teams: Guide to interdisciplinary provider compensation. Retrieved from http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_inter_provider.pdf

Personal Communications:

Dolovich, L. (October 15, 2013).

Alternative Profiles:

CareFirst. (n.d.). *Patient centered medical home (PCMH)*. Retrieved from https://member.carefirst.com/individuals/patient-centered-medical-home/patient-centered-medical-home-pcmh.page

External Source: http://www.health.gov.on.ca/en/pro/programs/fht/fht_progress.aspx

Quality Improvement Training and Support

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

Snapshot: This innovative practice provides quality improvement (QI) training and support to primary care practices. The practice was launched Ontario and has involved 750 interprofessional practice-based teams supported by QI coaches.

Practice Description:

In 2007, the Ministry of Health and Long-Term Care established the Quality Management Collaborative, with an initial mandate to assist family health teams (FHTs) to navigate the transition to a new team-based model of primary health care. In 2009, the organization became an independent not-for-profit entity and was renamed the Quality Improvement and Innovation Partnership (QIIP). Its expanded mandate is to support quality improvement across the primary care sector. During 2008 and 2009, QIIP ran a series of three learning collaboratives for interprofessional, practice-based QI teams from FHTs and community health centres (CHCs), modelled on the Institute for Healthcare Improvement's Breakthrough series. Participants received coaching support and focused their quality improvement efforts on chronic disease management (diabetes), prevention (colorectal cancer screening), and office practice redesign (access and efficiency).

In 2010, QIIP launched the Learning Community, which combines virtual and face-to-face learning on the application of QI methods and tools, and support from QI coaches In Wave 1, interprofessional teams from FHTs and CHCs participated in one or more of six action groups focused on improving chronic disease management (asthma, chronic obstructive pulmonary disease, diabetes, hypertension), preventive care (integrated cancer screening) and access and efficiency (office practice redesign). Waves 2 through 5 focused on advanced access and efficiency; they were open to practice-based teams from any primary care model. Wave 6 addressed chronic disease management in addition to advanced access and efficiency.

In April 2011, QIIP merged with three other quality-related organizations funded by the ministry to form Health Quality Ontario (HQO). The Learning Community has continued under the new organization.

HQO is about to pilot a CME/e-Learning model that adopts a hybrid approach for delivering QI training and support for advanced access in primary care organizations. Compared to the traditional learning collaborative model, the hybrid model combines fewer learning sessions and less HQO coaching with a series of four online learning modules and peer-champion support. The revised program will allow interprofessional primary care teams to access the program continuously rather than in discrete waves. In partnership with McMasterUniversity, HQO is mounting a demonstration of the hybrid approach with approximately 20 primary care practices.

Impact:

A research team from the Centre for Studies in Family Medicine at Western University and the Centre for Studies in Primary Care at Queen's University conducted a multi-component, mixed method, external evaluation of the three QIIP learning collaboratives that were mounted during the period from 2008 to 2010 (Harris et al., 2013). The evaluation examined the impact of the program on type 2 diabetes management, colorectal cancer screening, access to care, and team functioning. The performance of the practices before and after participation was compared with the performance of randomly selected non-participating practices from the same geographic location and model of care (FHT or CHC) during the same time periods.

Key findings included the following:

- Participants' knowledge of QI methods (the Model for Improvement) and the Chronic Disease Prevention and Management framework increased.
- Participants improved interprofessional capacity in their practice through better understanding of each other's roles and working together to improve patient care.
- The learning collaboratives facilitated improved team interactions, sharing of information and resources, and collaboration among team members.

- QI coaches were instrumental in helping teams implement QI activities.
- The performance of both participating and control practices improved over time.
- Among patients with diabetes, participating practices showed greater improvement in lipid profile monitoring (chart audit), eye examinations (chart audit and administrative data), peripheral neuropathy examinations (chart audit), and documentation of body mass index (chart audit).
- Participating practices showed greater improvement in HbA1c testing of patients with diabetes (administrative data).
- Among patients with HbA1c above the study target (? 7.3%) at baseline, patients in participating practices were more likely than patients in control practices to be at the Canadian practice guidelines target of ? 7.0% post-collaborative (chart audit).
- Participating practices had greater improvement than control practices in the proportion of patients with diabetes whose LDL cholesterol was at target (? 2.0 mmol/L) (chart audit).
- Among patients with diabetes, participating practices had small but statistically significantly greater increases than control practices in prescribing statin and angiotensin converting enzyme inhibitor (ACE) or angiotensin receptor blocker (ARB) (administrative data).
- Participating practices had greater improvement than control practices in the proportion of eligible patients screened for colorectal cancer (administrative data).
- Participating practices were more likely than control practices to adopt an advanced access model (48% versus 29%). However, the study was not adequately powered for this outcome to detect a difference of this magnitude, and therefore the difference was not statistically significant.
- The median time to third-next available appointment post–learning collaborative was 2.0 days among participating practices and 4.0 days in the control practices. However, the study was not adequately powered for this outcome to detect a difference of this magnitude, and therefore the difference was not statistically significant.

Zorzi et al. (2013) conducted a multi-component formative and summative evaluation of the HQO Advanced Access and Efficiency initiative (Learning Community Waves 3 and 4) in 2011/12. The evaluators urged caution in the interpretation of the summative findings because of the absence of a comparison group and because the patient perspective was not captured. Among their findings:

- Most (91%) of the participating practices reported the time to third-next available appointment measure on a regular basis.
- Almost all of the practices surveyed (80%) were satisfied with their experience in the initiative. Practices in the structured learning stream (six hours/month of face-to-face or virtual coaching support, access to the virtual workspace, monthly calls with participating practices, and two face-to-face learning sessions) tended to be more satisfied (82% satisfied) than those in the self-directed stream (one hour/month of virtual coaching support, access to the virtual workspace, and monthly calls with participating practices) (71% satisfied).
- Two third of practices indicated that the initiative met their expectations completely. Some practices indicated that the program did not meet their expectations, either because it was more time consuming than they expected, or because they didn't perceive the resources and measures to be relevant to the way their practice was set up.
- Key Learning Community strengths identified by participating practices were coaching, QI method/approach, and resources (roadmap and workbook). Key concerns were the time commitment required, the virtual workspace, and measures and specific tools not being applicable to some types of practices.
- QI coaches were considered to be essential by 75% of the practices.
- As of October 2012, 18% of Wave 3 practices and 17% of Wave 4 practices had withdrawn after the first learning session. All withdrawn practices interviewed indicated they left the initiative because there was a lack of interest and buy-in among the team members. In addition, many had difficulty juggling competing priorities with limited time, and some hadn't understood the time commitment that was needed.
- Over half of the participating practices said they were applying the QI principles (plan-do-study-act cycles) from the Learning Community to other aspects of their work. A number of practices mentioned that they have spread their advanced access knowledge and data collection practices across and beyond their organization.
- Eighteen of the 24 practices interviewed found the data reporting aspects of the initiative to be very useful. The data reporting piece was only valuable if the practices were using the measures to identify areas of concern, inform changes, and monitor progress.

- Decreases in time to third-next available appointment (TNA) and cycle time (total length of office visit) were statistically significant, averaging one day per month and one minute per month, respectively.
- Red zone time (percent of the visit spent with a care team member) increased significantly by an average of 1% per month.
- Average improvement in TNA between month one and month six was 2.7 days in the self-directed stream and 5.5 days in the structured stream.
- 52% of teams in the self-directed stream and 66% of teams in the structured stream had moderate (20–49%) or high (> 50%) improvement in TNA.

An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

The success of the program is dependent on:

• building relationships with key partners (e.g., medical associations, nursing associations);

• willingness of primary care providers to participate in the initiative;

• targeting participation by all providers on the team rather than individual providers;

• providing information to teams on how the initiative can assist their practice;

• engaging champions to demonstrate the benefits of QI work;

• establishing requirements for QI (e.g., QI plans, alignment of quality indicators with strategic priorities);

• dedicating resources to the coaching of teams;

• the ability of teams to retrieve data from information systems; and

• continuous assessment of the QI training and support program in order to revise practices, methods, and processes based on lessons learned.

Training and support for primary care QI have been implemented in many other jurisdictions internationally and in Canada, including in British Columbia, Alberta, and Saskatchewan.

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External Source: http://www.hqontario.ca/quality-improvement/primary-care

Patient Enrolment with a Primary Care Provider

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

Snapshot: This innovative practice involving patient enrolment in a primary health care practice formalizes an ongoing relationship between primary care providers and patients; provides the basis for population-based funding, capitation-based provider payment, and primary care performance measurement; and facilitates pro-active preventive care and chronic disease management. The practice has been implemented in Ontario in most primary care settings and involves more than three quarters of Ontario residents and primary care physicians.

Practice Description:

Patient enrolment is a process in which patients are formally registered with a primary care organization, team, or provider. Patient enrolment facilitates accountability by defining the population for which the primary care organization or provider is responsible, and it facilitates a longitudinal relationship between the patient and provider. Formal patient enrolment with a primary care provider lays the foundation for a pro-active, population-based approach to preventive care, chronic disease management, and systematic practice-level performance measurement and quality improvement. It clearly establishes primary health care providers as health stewards for a defined population rather than providers of services to those who present themselves for care.

Formal patient enrolment is a feature of several primary care physician remuneration and organizational models, including capitation-based blended payment (family health organizations (FHOs) and family health networks(FHNs)), fee-for-service-based blended payment (family health groups, comprehensive care management), and salary-based blended payment (rural and northern physician group agreements, blended salary). In nurse practitioner–led clinics and community health centres, patients register with the organization.

Patient enrolment is voluntary for both patients and physicians. Patients are not required to enrol, even if their regular primary care physician participates in a patient enrolment model. Physicians cannot refuse to enrol a patient because of the patient's health status or level of care based on guidelines of the College of Physician and Surgeons of Ontario. When a patient enrols with a primary care physician, the patient agrees to seek care first from the enrolling physician' practice, unless the patient is travelling or experiencing a health emergency. Enrollment with a primary care physician has grown from less than 600,000 in 2002 to 10.1 million (74% of the Ontario population) in June 2013.

Impact:

This innovative practice has been implemented widely in Ontario since 2002 and does not have a completed evaluation at this time. An evaluation is underway of patient enrolment in FHGs and FHOs; it is expected to be completed in 2014. Because patient enrolment is linked to specific provider payment and organizational models, the impact of patient enrolment per seis impossible to assess in the Ontario context. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

Patient enrolment has been adapted from other international jurisdictions and was implemented in Quebec in 2002.

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Personal Communications:

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Midwifery in Ontario

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

Snapshot: This innovative practice expands the accessibility and choice of maternal and newborn care through the use of midwives. The practice was launched across Ontario and involves provincial government funding of midwifery education and payment for the provision of midwifery services.

Practice Description:

Legislation establishing midwifery as a regulated profession and providing for the registration of midwives in Ontario was proclaimed in December 1993. The Ontario Midwifery Education Program was established in 1993 as a collaborative four-year baccalaureate program at three universities. The program is currently undergoing expansion from 60 to 90 places per year. The Midwifery Act was amended in 2011 to expand midwives' scope of practice, including intubation of newborns and an expanded drug list.

The core tenets of midwifery care are continuity of care, informed choice, and choice of birthplace. Ontario midwives have hospital admission and discharge privileges and access to physician referrals for consultation or transfer of care. They provide primary care to women during pregnancy, labour, and delivery, and care to mothers and babies during the first six weeks after birth. Two midwives attend the birth, whether in a home or a hospital. The College of Midwives specifies eligibility criteria for home birth and prescribes the conditions that require consultation with or transfer of care to a physician.

The number of midwives practising in the province increased from 71 to 693 between 1994/95 and 2013/14. More than half of Canadian midwives work in Ontario. Midwife-attended births increased from 1,800 to over 24,000 (12% of births in the province) during the same period. Midwifery program expenditures have grown from $23.7 million in 2002/03 to $125.48 million in 2013/14.

Impact:

A midwifery program evaluation comparing the outcomes of midwifery care and family physician obstetrical care was conducted by the Ministry of Health and Long-Term Care in 2003. However, the report of that evaluation is not publicly available. Personal testimonials, observations, tracking data, and research and evaluation from other jurisdictions suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

No rigorous assessment of the costs and savings of this practice has been completed at this time.

Applicability/Transferability

Midwifery has been adapted from numerous jurisdictions internationally and is a legal and regulated profession in seven other provinces and one territory: British Columbia (1998), Alberta (1998), Quebec (1999), Manitoba (2000), Northwest Territories (2005), Saskatchewan (2008), Nova Scotia (2009), and New Brunswick (2010).

The success of this specific program is dependent on:

• provincial investment in midwifery positions;

• support from stakeholders and providers;

• building human resource capacity through education and training; and

• the willingness of hospitals to integrate midwives (e.g., hospital privileges, policies on the number of midwives and deliveries; cost for midwives; cost of uninsured patients).

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Integration of Primary Health Care Nurse Practitioners (PHC NPs)

LOCATION:	**Ontario**	**HEALTH THEME:**	**Access and Wait Times**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	**Promising**

Snapshot: This innovative practice improves accessibility and quality of primary care through the use of nurse practitioners The practice has been implemented in Ontario in more than 300 primary care settings and involves provincial government funding of nurse practitioner (NP) education and clinical positions in family health teams, community health centres, nurse practitioner–led clinics, and other primary care practices and organizations.

Practice Description:

NPs are "registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice"(CNA, 2009).

Education

The Ontario Primary Health Care Nurse Practitioner Education Program, established in 1995, is a standardized educational program delivered cooperatively by a nine-university consortium. The program uses multiple delivery modalities, including distance education, and is offered in both English and French. Baccalaureate-trained RNs studying full time can complete the seven core graduate-level courses that comprise the NP certificate program in one year. A combined Masters of Nursing/NP Certificate program has been available since 2008, and in most of the participating universities the combined program is now the only option available. The annual number of spaces in the PHC NP education program for full- and part-time students is currently 200.

Regulation

Ontario legislation providing for the registration of PHC NPs was proclaimed in 1998. Initially, NPs were allowed to order only a specified set of medications and diagnostic tests. Restrictions on NPs prescribing (except for controlled substances) and ordering laboratory tests were eliminated in 2011.

NP Practice

The nature and scope of NP practice varies across primary care settings. Some NPs provide care to a general primary care population while others focus on a specific population or health condition. Their work may involve varying combinations of acute illness care, chronic disease management, illness prevention, and health promotion. Some NPs have their own patient panel, but most share responsibility for a patient population with one or more family physicians.

Impact:

Ontario was home to the first randomized controlled trial (RCT) of NPs, which was carried out in a Burlington family practice setting by Spitzer et al. (1974). Since then, many RCTs have been conducted internationally, mainly in the US, the UK, and the Netherlands. Systematic reviews of these RCTs have consistently concluded that NPs deliver safe, effective care (Horrocks, Anderson, and Salisbury, 2002; Newhouse et al., 2011).

A study by Russell et al. (2009) of chronic disease management in Ontario primary care practices concluded that "Across the whole sample and independent of model, high-quality chronic disease management was associated with the presence of a nurse-practitioner." Ducharme, Alder, Pelletier, Murray, and Tepper (2009) evaluated the addition of PHC NPs and physician assistants to community hospital emergency departments in Ontario. In emergency departments that had NPs and/or physician assistants, the wait times, lengths of stay, and proportion of patients who left without being seen were significantly reduced.

While the integration of PHC NPs has not been fully evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

All provinces and territories have legislation in place for the NP role, although implementation has been most widespread in Ontario. The practice informant did not indicate whether the provinces and territories have worked collaboratively in defining the role of the NP.

The success of this specific program is dependent on:

• educating patients, providers, and insurance companies about the role and responsibilities of nurse practitioners and NPLCs;

• establishing effective governance structures, administration, and organizational development (e.g., interprofessional team functioning, information technology);

• engaging nursing stakeholders;

• providing appropriate NP compensation;

• optimizing roles within the team; and

• aligning financial incentives to ensure specialists are not disadvantaged by referrals from NPs.

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Alberta Access Improvement Measures (AIM)

LOCATION:	Alberta	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

Snapshot: This innovative practice helps family physicians, specialty care physicians, and Alberta Health Services programs and their teams reduce or eliminate wait times, improve office efficiency, and improve patient care by using quality improvement methods. The initiative has involved 19 learning collaborative supporting improvement teams across Alberta, including 614 family physicians from 133 primary care clinics.

Practice Description:

Alberta AIM's mission is "to support health care teams to create a culture of improvement through the use of evidence informed principles, resulting in access to care that is both timely and effective." The program, funded by Alberta Health and Alberta Health Services, is governed by a multi-stakeholder partnership that includes Alberta Health, the Alberta Medical Association, Toward Optimized Practice, the Primary Care Network Project Management Office, and family physicians. Each practice-based improvement team, which includes physicians, other health professionals, and office staff, completes a program that extends over 10 to 12 months. During that period, the teams attend five two-day face-to-face learning sessions, and are supported by AIM faculty, a facilitator, measurement resources, and tools for data collection and use. Teams are expected to hold weekly meetings and submit monthly reports to monitor progress and share successes.

Evolution of the program includes implementation of increased use of virtual program delivery and efforts to ensure that physicians, providers, and programs can maintain the gains made while in the formal training portions of the program.

Impact:

According to outcomes data collected by Alberta Health Services, the impact of the program includes:

- Many primary care teams have been able to reduce delays for next-available appointments (TNAs) to less than five days, with some reaching same-day access.
- Many specialty are teams were able to reduce delays for TNAs to less than 30 days, with some reaching near same-day access.
- Improvement team members have shown an increase in satisfaction with clinic access across all collaboratives.
- Primary care teams were able to reduce their cycle time (time from a patient's arrival to departure) by as much as 30% for short appointments and 36% for long appointments.
- Primary care teams were able to reduce no-shows by as much as 33%.
- Specialty care teams were able to reduce no-shows by as much as 31%.

The results of improved TNAs are supported by staff perceptions of improved access.

Improvement team members were asked to rate their satisfaction with clinic access before and after one year of the AIM program. Primary care teams and specialty care teams in multiple collaboratives demonstrated significant improvements in staff satisfaction regarding clinic access.

Initial population-level assessment of the impact of the program has been attempted. Indications are that AIM participation in primary care clinics affects other areas of the system, including reduced emergency department visits (Alberta AIM, 2013). Narrative accounts provided by participating clinics and physicians are available at www.albertaaim.ca.

Although an assessment of the costs and savings of this practice has not been completed at this time, micro-level evaluations with individual physicians and practitioners are suggestive of cost-neutrality and perhaps cost reductions associated with access and clinical improvements.

Applicability/Transferability:

Alberta AIM has been adapted from the work of Mark Murray & Associates and the Institute for Healthcare Improvement's *Breakthrough Series*. Similar quality improvement initiatives targeting primary care have been mounted in many jurisdictions throughout Canada, including British Columbia, Saskatchewan, Manitoba, Ontario, and Nova Scotia.

The success of this specific program is dependent on:

• leadership engagement (physician, clinic, program, funders, partners, and stakeholders);

• development of local and provincial capacity (including but not limited to Alberta-based faculty, local practice facilitators, measurement support, and access to other knowledge-based resources); and

• dedicated focus on alumni support to sustain improvement gains and continuing progress while managing incoming new improvement teams.

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External Source: http://www.albertaaim.ca

Sault Ste. Marie Group Health Centre

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice facilitates improved accessibility and comprehensiveness of primary care service delivery. The Group Health Centre was originally founded in Sault Ste. Marie in 1962. As a progressive, multi-specialty, ambulatory health organization, the health centre integrated an electronic health record system in 1997 and now serves 71,000 residents of Sault Ste. Marie and Algoma District (population 75,000), with 81 doctors and 350 employees.

PRACTICE DESCRIPTION:

The Group Health Centre provides ambulatory care, diagnostic services, integrated care with primary, secondary, and other health care services such as for congestive heart failure, nutrition, physical therapy, and surgery. A range of health care professionals are located on-site, including doctors, nurses, nurse educators, physiotherapists, optometrists, kinesiologists, dietitians, and lab technicians. The centre focuses on providing same day care as well as offering on-site services including laboratory facilities and longer term chronic care support.

Prior to 1997, there was recognition that patients, particularly those with chronic conditions, were slipping through cracks in the health care system and better record-keeping systems were required. Sault Ste. Marie now has the largest primary care electronic medical records system in Canada. With this system ('Epic' http://www.epic.com/software-ambulatory.php), each patient has their own, single electronic medical record. This mode of information storage enables different types of health care providers to access patient data as needed, and facilitates real-time referrals to specialists, thereby increasing interprofessional collaboration and continuity of care. This system allows for greater patient engagement, as patients can access their own health information via an online patient portal and the system generates treatment plans based on best practice templates and algorithms. Another capability of the electronic system is the possibility to aggregate data to track trends and outcomes. With regular monitoring and evaluation, this system can link to the development of new programming based on patient-population needs and integrate accordingly, based on clinical practice guidelines. New programming initiatives are processed through the Committee of Health Promotion Initiatives.

The Group Health Centre functions under an alternative funding structure with support from the Ontario Ministry of Health and Long-Term Care.

IMPACT:

A third-party evaluation of the impact of the electronic medical record system was conducted by Health Informatics Institute (http://www.hiiau.ca/) at Algoma University in 2011. Data were collected through observation, one-on-one interviews, focus groups, and surveys, however, this information is not publically available. Anecdotal evidence from participating health care providers suggests that improved health outcomes can be attributed to the integrative functioning of the electronic medical record and greater satisfaction attributed to being able to devote more time to clinical practice rather than administration.

Group Health Centre has won National Best Practice Awards for four consecutive years and was featured in Maclean's Magazine as one of Canada's top ten models of health care.

APPLICABILITY/TRANSFERABILITY:

'Epic' electronic medical records system functions out of Wisconsin, USA and manages over 170,000,000 American patients. Group Health is one of four health care organizations (Children's Hospital of Eastern Ontario, Women's Health Centre in Toronto, and Hamilton Health Sciences) in Canada to use 'Epic', but is unique in its care for outpatients. The continued and increasing coverage of the Sault Ste. Marie Group Health Centre is exemplary of the possibility for this type of health care model to successfully function within a Canadian community and is therefore theoretically transferrable elsewhere.

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

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Oncology Patient-Navigator Nurse (infermière pivot en oncologie)

LOCATION:	Quebec	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT:

This innovative practice helps patients with cancer navigate the health system by improving the accessibility of resources, the coordination of services, continuity of care, and communications with providers. The first oncology patient-navigator position was introduced at Laval University's Hospital Centre in Quebec City in 2005. The position was designed to provide a direct link for patients with cancers of the neck and throat to the health care system. There are currently over 250 oncology patient-navigator nurses integrated in hospital-based health care teams across the province of Quebec.

PRACTICE DESCRIPTION:

With an increasing burden of cancer on Canadian populations and health care systems, new strategies are required to improve the experiences of and effectiveness of care provided to patients with ongoing, complex needs. Theoretically, the patient navigator provides a catch-all service, to ensure that patients—particularly those receiving care from a multitude of providers in a variety of settings—have a direct point of access to the health care system, feel supported, and are informed about comprehensive care options.

To initiate the role development and introduction of the oncology patient-navigator position into the Laval University Hospital Centre, a committee of representatives from clinical, administrative, and research sectors at the university hospital submitted a proposal to the Quebec Cancer Care Program. Funding was eventually secured through the Regional Health and Social Services Board and the Quebec Coordination Centre for Cancer Control. The oncology patient-navigator position is filled by nurses who have university-level training, are experienced in oncology, and may have a certificate in oncology. The actual role the oncology patient-navigator performs is determined by the local setting's interactions and needs, always maintaining a patient-centred approach. For example, specific tasks may include helping patients book appointments and communicate with physicians; developing coping strategies for patients to deal with their illness, particularly in the cases of changes in appearance and/or loss of speech; helping patients maintain a relatively regular lifestyle; providing social support to reduce general anxiety about patient circumstances; and serving as a resource for other health care providers.

IMPACT:

Interviews were conducted with patients, families, caregivers, and other health care providers collaborating with the University Hospital Centre before, during, and approximately one year after the initial implementation phase. Questions were structured around perceptions of activities and functions of the oncology patient-navigator, as well as changes relative to patients' attitudes, behaviours, and adaptation processes.

Satisfaction with the introduction of the oncology patient-navigator position was extremely high among patients and their families. The provision of social support was identified as the most important role played by the oncology patient-navigator, and there was a general sense that the oncology patient-navigator improved overall the interprofessional services provided and the continuity of care, from which all stakeholders benefited.

Ongoing research is taking place at Laval University to continuously inform the evolution of the oncology patient-navigation nurse role. There is now greater interest in improving competencies relating to psychosocial care and developing measures to increase the standardization of the new role.

APPLICABILITY/TRANSFERABILITY:

Patient navigators are becoming more common in health systems across Canada. The development of the oncology patient-navigator position at the University Hospital Centre is distinctive in that it targets a particular population within the

broader health care structure. Given that there are no cancer care centres in Quebec, special planning is required to integrate the oncology patient-navigator position into interprofessional settings. Each participating hospital (28 in seven regions throughout the province) has budgeted to include at least one oncology patient navigator into each oncology health care team.

From the initial implementation of one oncology patient navigator in the University Hospital Centre in 2005, there are now over 252 nurses taking on this role, and it has been adopted as part of the provincial initiative for cancer care and support on behalf of the Ministry of Health and Social Services. Recommendations for establishing similar models outside of Quebec include the need for strong stakeholder engagement, the creation of a common vision, and maintaining patients at the centre of care.

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Remote Order Telepharmacy Review

LOCATION:	**International**	**HEALTH THEME:**	**Access and Wait Times**
HEALTH SECTOR:	**Acute Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice improves accessibility, efficiency, and safety of pharmaceutical services through the use of electronic medical records, standardized formularies, and tailored communication protocols among pharmacists, physicians, and nurses. The telepharmacy services were implemented in seven rural critical access hospitals in Iowa in 2007 and have continued to expand to a total of 10 locations, all of which were identified as having inconsistent pharmacist coverage.

PRACTICE DESCRIPTION:

In 2005, electronic health record and computerized prescriber-order-entry systems were introduced in affiliation with the Trinity Health Network in Iowa to support expedited, 24/7 medication order review by pharmacists. In 2006, planning began for similar implementation at a regional level, and by 2008 all seven of the participating critical access hospitals had these health information technology systems in place. This gave pharmacists remote access to patients' electronic health records, allowing them to review the record before selecting the appropriate medication. Through this system orders are scanned and sent via email; they can be processed within 60 minutes of being entered into the system. Medications are dispensed through an automated, standardized hospital formulary based on a unique coding system, and security is managed based on the role of the provider requesting patient information.

IMPACT:

This innovative practice has been implemented since 2007 but no formal longitudinal impact assessment is available at this time. As a supplementary evidence base, data were collected over a two-week pilot period in 2012, indicating that the remote order verification was 39% more efficient in processing orders than in the local pharmacy. The cost was $4 per medication review without any reported adverse events. This brief data collection period, along with the overall reporting on increased accessibility, coincided with change in state law in January 2013, which enabled the computerized prescriber-order-entry systems to function outside of regular hours and provide 24/7 coverage.

APPLICABILITY/TRANSFERABILITY:

Similar telepharmacy services exist in other states where enabling laws are present. The broader applicability of these services is largely dependent on legislation and available resources. In Iowa, this model was particularly successful in rural settings where insufficient baseline pharmacist coverage had been an identified. The level of transferability for this innovative practice in the Canadian context is complicated by different financing systems; however, similar models have been employed in British Columbia and Ontario where pharmacist shortages exist in rural areas (see http://www.cadth.ca/products/environmental-scanning/health-technology-update/issue2/telepharmacy).

Barriers to implementing a similar practice in other jurisdictions depend on regulations allowing remote order verification services to function outside of regular pharmacy hours. This was not the case in Iowa at the time this initiative was implemented. In fact, it was not until January 12, 2013, that there was sufficient evidence to allow the electronic health record, computerized prescriber-order-entry systems to function outside of regular pharmacy hours.

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Publications:

Wakefield, D.S., Ward, M.M., Loes, J.L., O'Brien, J., & Sperry, L. (2010). Implementation of a telepharmacy service to provide round-the-clock medication order review by pharmacists. *American Journal of Health System Pharmacy*, *67*(23), 2052–2057. Abstract retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21098378

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Personal Communications:

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External Source: http://www.mercydubuque.com/

Registered Nurse–Surgical First Assist

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice reduces wait times for surgical services by improving the supply of appropriate health human resources available. The registered nurse–surgical first assist (RN-SFA) role was initiated by the Ontario Ministry of Health and Long-Term Care (the Ministry) as part of the HealthForceOntario strategy in May 2006. It involved 34.2 full-time equivalent (FTEs) in 20 organizations and has since expanded to 78.5 FTEs in 35 organizations across Ontario.

PRACTICE DESCRIPTION:

The RN-SFA role was introduced in May 2006 as a partially funded, year-long pilot project. During the pilot phase, a shared funding model was used, whereby the Ministry provided 50% of the salary and benefits for the RN-SFA(s) and the organizations were responsible for the remaining 50%. In May of 2010, Ontario's Minister of Health and Long-Term Care announced 100% funding for the RN-SFA FTEs for the pilot project.

Registered nurses (RNs) implementing the RN-SFA role must have the qualifications and educational preparation required to practice in the role, including,

- valid registration as an RN with the College of Nurses of Ontario;
  - graduation from a recognized Registered Nurse First Assist educational program;
  - current peri-operative nursing certification—CPN (C); and
  - valid Advanced Cardiac Life Support certification.

IMPACT:

In March 2009, focus group discussions were conducted across the 20 host clinical sites, 16 of which also completed surveys. Among the survey respondents involved in the program (n=260), 42% were nurses (RN=SFAs and operating room nurses), 38% were physicians (surgeons, anesthesiologists, and medical surgical first assists), 16% were administrators, and 4% were other members of the operating room team. Outcome measures pertained to satisfaction with the role and its impact, such as filling health human resource shortages, reducing surgical wait times, increasing patient access, enhancing team-based care models, providing patient-centred care, and so on. Responses were extremely positive, with surgeons being the most satisfied stakeholder group. The formal evaluation of the RN-SFA role also reported that it enhances team-based care models and provides support for nursing recruitment/retention strategies by providing career development and skills advancement.

Since the initial two-year data collection period conducted alongside the pilot project, the program has undertaken ongoing monitoring and evaluation for internal informational purposes and planning.

APPLICABILITY/TRANSFERABILITY:

RN-FSA positions have existed in Canada since the 1990s. In 1992, the Operating Nurses Association of Canada was the first organization to formally investigate the expanded role opportunities for peri-operative nurses. In 1994, Quebec became the first province to formally recognize the FN-FSA position, and by 2000 all provinces in Canada had acknowledged the RN-FSA role as existing within the scope of practice of nursing. The surgical first assist position has grown out of this role development for RNs specific to peri-operative, intra-operative, and post-operative competencies. The acceptability of this program is demonstrated through its transition from pilot-project status to a mainstream provincial strategy.

Nova Scotia appears to be the only other province in Canada where this position exists. For broader transferability, suggestions include focusing on fostering greater role clarity among operating room staff and stronger relationships between educating bodies and organizations employing surgical first assists.

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Personal Communications:

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Primary Care Clinical Associate Initiative

LOCATION:	Alberta	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice improves the accessibility, coordination, continuity, and comprehensiveness of primary care services in the Westview Primary Care Network Catchment area in Alberta. The Clinical Associate Initiative was introduced in 2005 for a four-year term, and since 2009 has continued to expand in its scope and capacity among the eight participating family practice clinics.

PRACTICE DESCRIPTION:

The WestView Primary Care Network is one of 35 primary care networks in Alberta. In this network, there are eight family practice clinics, involving 49 family physicians that participate in a team-based care model. This model is supported by the Family Practice Interprofessional Collaborative Practice Initiative, with funding provided through the Alberta Primary Care Initiative, Alberta Health and Wellness, and the Alberta Medical Association.

The clinical associate (CA) is a member of the interprofessional health care team and works closely with the family physician and other health care providers to help optimize respective scopes of practice. The CA position is filled by health professionals from a variety disciplines, including but not limited to registered nurses, licensed practical nurses, pharmacists, psychologists, physiotherapists, and mental health therapists. The actual role of the CA is determined by the needs of the given patient population, the working relationships with and skills mix of the other health care providers, and the CA's professional interests and competencies. To introduce a new CA to a clinic, a role description is submitted to the Clinical Associate Program Physician Lead to ensure that they fit in the overarching vision and guidelines of the WestView Primary Care Network. Each individual clinic is then responsible for all human resources processes, including recruitment and role fulfillment.

IMPACT:

Since this initiative was implementation, there has been ongoing data collection on patient visits and through provider and patient surveys. Preliminary results from patient visits analyzed in 2005/2006 and 2008/2009 showed a clear increase in the number of visits and hours spent with the CA, representing greater capacity and accessibility of services. Later surveys implemented by the WestView Primary Care Network include the Family Practice Clinic Patient Survey (2009, 2011, 2013), the Physician Survey (2007, 2011, 2013), the Other Health Care Provider Survey (2007, 2011, 2013), and the Telephone Survey of the Westview Primary Care Network Catchment Population (2007, 2011, 2013). In one year, from April 2012 to March 2013, the CAs together attended approximately 59,000 patient visits, doubling records in 2008, with each CA doing on average 15 to 20 patient visits per day. Comparing results from 2007 to those from 2013, there were increasing reports of the importance of the CA's role in patient experiences in the primary care setting, as well as the proportion of patients receiving care from nursing professionals independent from the attending physician. Among nonphysician health care providers who responded to the 2013 survey, 85% (n = 16) reported that they were "Very Satisfied/Satisfied" with their role in the primary care setting, the relationship with their patients, and the relationship with the family physicians. Overall, reports show that through these interprofessional health care team models and the involvement of the CA, providers were able to see more patients without compromising quality of care.

APPLICABILITY/TRANSFERABILITY:

In 2011, the Clinical Associate Initiative expanded to the development of two other positions: the proactive office encounter technician and the transition of care clinical associate. Respectively, these positions were created to improve the quality of preventative care particularly for chronic illnesses, and of the transition of ambulatory care from the emergency department to the clinic. There is now a proactive office encounter technician in each of the eight participating family clinics, and two registered nurses have been recruited as transition of care clinical associates. Also, as a result of the innovative practices developed through the WestView Primary Care Network, a family health clinic led by an NP and supported by physicians was introduced into a First Nations community in the catchment area in 2012. Analyses of these additional roles and nurse-led clinic have not yet been reported.

The clinical associate, **p**roactive office encounter technician, and transition of care clinical associate positions have all been designed specific to the needs and capacities of the WestView Primary Care Network. To date, these positions have not been implemented outside of this primary care network. Key elements for transferability include the level of autonomy of the clinic-designed model whereby each clinic is able to tailor CA recruitment and contracting based on population needs. CAs can either be hired as employees or as contractors to increase flexibility related to liability and competencies. Challenges to work through include appropriate system funding, availability of facilities for complex patients, and increased bureaucracy.

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Publications:

Moe, J.S., Bailey, A.L., Kroeker, S., & Moe, G. (2010). An interprofessional collaborative practice model: Primary-care clinical associates at the family practice setting. *Healthcare Management Forum, 23*(4), 159–163. Abstract retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21739816

Personal Communications:

Moe, G. Email, August 8, 2013).

External Source: www.westviewpcn.ca

Mental Health Liaison

LOCATION:	**Alberta**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice improves the level of coordination and accessibility of mental health care services in a rural setting in Alberta by providing a direct link among physicians, nurses, and patients. In 2004, the mental health liaison was added as a new position to the Access and Early Intervention Program of Mental Health Services in the community of Rocky Mountain House, Alberta. There are now 27 mental health liaison positions throughout the central region of the province.

PRACTICE DESCRIPTION:

Key gaps in health care services identified in Rocky Mountain House and neighbouring Aboriginal communities in Alberta included poor coordination and continuity of mental health services; inadequate quality, accessibility, and awareness of available resources; and low numbers of well-trained mental health professionals. Consequently, the development of a mental health liaison stemmed from the need to improve these service gaps to better meet the needs of the population. This was supported by political will at regional levels and in alignment with the Provincial Mental Health Plan. The position was designed for a nonpsychiatric, rural health care setting and involved a broader scope of practice to include any of the following tasks: direct and indirect client intervention, mental health assessment and consultation, risk assessment, crisis intervention, supportive counselling, brief therapy follow-up, advocacy, staff mentoring, education, psychological first aid, research, mental health prevention and promotion, and more. Actual scope of practice for a given mental health liaison practising in a given community is determined by population needs, mental health managers, and site leaders. Ongoing funding for the continuation of this position has been secured through various arrangements of annualizing innovation grants from the province, reorganizing institutionally managed budgets, and adjusting scopes of practice for vacated positions.

IMPACT:

The introduction of this new position in Rocky Mountain House was first evaluated in 2005 by a questionnaire survey of 116 physicians, hospital staff, and community mental health workers. With a 50% response rate, there was unanimous support that the mental health liaison was serving community needs that were previously unmet. Improvements were noted with respect to the appropriateness of mental health care delivered; support for clients, staff, and physicians; continuity of care through follow-up services; and consistency in the coordination of care. While narrative results were consistently positive, reflecting the general acceptance of this position in this community, it is important to note that the results from the Rocky Mountain House setting are highly personality dependent, and thus the data have limited generalizability.

APPLICABILITY/TRANSFERABILITY:

The initial introduction of the mental health liaison position in Alberta was strongly influenced by similar role development undertaken in rural settings in Australia. Although not formally documented, the mental health liaison role in Rocky Mountain House was expanded to seven additional positions in the first year of introduction, and is now practiced by a total of 27 health providers (predominantly nurses) in the Central Region of Alberta. Communities hosting mental health liaison positions are:

• 1 full-time position: Consort, Castor, Coronation; Drayton Valley; Hanna; Hardisty; Innisfail; Killiam; Lamont; Olds; Ponoka; Rocky Mountain House; Stettler; Sundre; Tofield; Vegreville; Vermilion; and Wainwright, Provost

• 1 part-time position: Sylvan Lake

• 2 full-time positions: Camrose, Lacombe, Westaskiwin

• 2 part-time positions: Red Deer, Three Hills

The initial mental health liaison position in Rocky Mountain House is also linked to the integration of mental health liaisons for the Canadian National Committee for Police (http://www.pmhl.ca/Index.html), and is responsible for a similar role (mental health consultant) that is still in place in the community of Drumheller. Other similar mental health liaison positions have been

developed independently across Canada, indicating the level of relevance and transferability of this innovative practice.

Based on the 2005 evaluation, important areas to address for the further expansion of the mental health liaison position include:

• support to prevent burnout, given that the responsibilities overlap with those of physicians, nurses, and staff, and that the incumbents try to provide increasingly accessible services, often outside of regular hours;

• divergence between patient expectations and the professional cultures of physicians, nurses, and staff; and

• determining appropriate remuneration.

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Publications:

Brinkman, K., Hunks, D., Bruggencate, G., & Clelland, S. (2009). Evaluation of a new mental health liaison role in a rural health center in Rocky Mountain House, Alberta: A Canadian story. *International Journal of Mental Health Nursing, 18*(1), 42–52. Abstract retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1447-0349.2008.00582.x/abstract

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Community Liaison Discharge Planning, First Nations Health Programs, Whitehorse General Hospital

LOCATION:	Yukon	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice addresses the complex needs of First Nations, Inuit, and Métis patients who are discharged from hospital to rural and remote communities in the Yukon. The practice was established as a component of the First Nations Health Programs at Whitehorse General Hospital in 2002, and involves a community liaison discharge planner.

PRACTICE DESCRIPTION:

The community liaison discharge planner attends to the complex needs of patients who are in hospital and getting ready for discharge to their home communities. The position focuses on aligning programs and services in patients' home communities to ensure that patients receive the follow-up care they need, and that care transitions are as seamless as possible between hospital and community settings. The practice targets high-risk patients with mental health issues or complex discharge planning needs; seniors constitute a significant proportion of that population.

The community liaison discharge planner is part of the Whitehorse General Hospital's First Nations Health Programs. The discharge planner conducts assessments and complex discharge planning and coordination for First Nations, Inuit, and Métis patients in the hospital, including case management for high-risk patients and their families. The discharge planner is based in the hospital, but must maintain a thorough working knowledge of resources available in communities. The discharge planner works with service providers throughout the Yukon.

The community liaison discharge planner's role differs from usual practice or care. As part of the First Nations Health Programs, the discharge planner brings a holistic approach to their work. Discharge planning starts at admission: the planner tries to anticipate patients' discharge needs and date so that appropriate resources will be in place when patients leave the hospital, and makes sure that patients understand their own care needs and responsibilities before they go. The planner participates in daily discharge planning "huddles," that is, meetings in which the health care team reviews the needs of all patients who will be discharged in the next 24-hour period.

Funding for the community liaison discharge planner position is allocated in the budget for the First Nations Health Programs. The First Nations Health Programs are supported by a transfer from the federal government.

IMPACT:

This innovative practice has been in place since 2002 and does not have a completed evaluation at this time. Personal observations suggest that the practice has the potential for positive outcomes on health.

In a 2009 review of the First Nations Health Programs, patients identified discharge planning practices as a valuable component of the programs, particularly because the practices support safe and coordinated care for patients in the community. The community liaison discharge planner's role is also mentioned in Accreditation Canada's recognition of the Whitehorse General Hospital's First Nations Health Programs as a leading practice.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that WGH Community Liaison Discharge had adapted from and were unaware if the practice was used as a model elsewhere. However, there has been considerable interest in the First Nations

Health Programs as a whole from health care organizations across Canada, and some have adapted aspects of the programs for use in their own program. A challenge that might affect the applicability or transferability of the community liaison discharge planning model to other settings is that it can be difficult to find employees who have the skills and knowledge needed to manage the position's range of responsibilities, for example, from working respectfully and effectively with high-risk patients and their families to maintaining current information on available resources and services throughout the territory.

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Personal Communications:

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Supporting Métis seniors and families—Métis Nation of Ontario (MNO) community centres

LOCATION:	**Ontario**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT:

This innovative practice addresses the need to support Métis senior citizens who are at risk of falling through the cracks of a complex health system. The first community centres were established in the mid-1990s, with the remaining centres developing since that time. Programming involves partnerships with different ministries, Aboriginal groups and the volunteer sector. Care delivery involves interdisciplinary health staff, community centre workers and volunteers.

PRACTICE DESCRIPTION:

One-third of all Aboriginal people in Canada are Métis. The Métis population is also one of the fastest growing populations in Canada, having doubled in the past 10 years or so. It is also an older population compared to other Aboriginal groups. Many Métis seniors are also experiencing significantly higher rates of chronic disease and other complex conditions compared to non-Métis Ontarians. Because Métis people also fall under a different legislative and regulatory structure than do other Aboriginal groups, they do not have the same access to provincial and federal programming supports available to other Aboriginal Canadians such as the Non-Insured Health Benefits program. Many older Métis also have limited incomes and live in more remote and rural areas, compounding problems of access.

It is for all these reasons that the Métis Nation of Ontario (MNO) developed an innovative, family-centred model of community-based care, founded upon the Métis way of life, and built around the unique needs of the Métis clientele. Situated in 18 historical Métis communities across the province of Ontario, MNO community centres were established to serve as important cultural and service hubs that connect Métis citizens to one another, as well as to essential health services and supports within their local areas. They provide much-needed and very tangible support to Métis senior citizens who are at heightened of falling through the cracks in our complex health care system.

The MNO community centres are especially important in providing Métis seniors with much-needed cultural and social supports, as well as assistance in accessing essential health and medical services. Some of the MNO centres also offer specialist services such as foot care clinics for seniors and other Métis people suffering from diabetes. MNO community centre workers are also very actively involved in outreach with Métis seniors and other MNO citizens in need of assistance, visiting their homes on a regular basis to help with meal preparation, house maintenance, and other tasks of daily living, and to provide important social and cultural support. Through the MNO Medical Transportation Program that has been put in place, Métis seniors can also receive assistance in traveling to and from their medical and other appointments. The MNO`s model of community care is founded on a holistic, family-centred, and uniquely Métis approach to health and well-being that has deep roots in the very community-minded Métis culture and way of life.

The MNO service model is unique in the province in both its scope and conceptualization, and has been hailed as a best practice by their governmental partners. MNO works very closely with its provincial government partners and other Aboriginal groups in the development of its programming. MNO receives support through different ministries including the Ministry of Health and Long Term Care's Community Support Services Program, the Ministry of Aboriginal Affairs, and the Ministry of Children and Youth Services, among others. Programs and services are also supported by the MNO's large volunteer base, which includes the MNO Provincial Councils, the MNO Youth Council, and MNO Senators. **IMPACT:**

This innovative practice was first implemented in 1993, with the ongoing development of new community centres since that time. MNO's internal Health Activity Tracking System (H.A.T.S), established for reporting, accountability and evaluation purposes, together with regularly commissioned independent evaluations, indicate that the community centres are having positive impacts on Métis citizen's health and well-being. They are providing critical assistance and support for seniors, particularly those in

more rural and remote areas. They also provide an essential cultural base where Métis seniors can meet with other community members, receive appropriate support and care and link to essential services and programs in the broader community. The centres and their activity within the broader community has also led to an increased awareness of and respect for Métis peoples' culture, unique history, needs and aspirations across the province of Ontario. Most importantly, the MNO centres provide a haven for culturally safe community care for the Métis elders of Ontario.

APPLICABILITY/TRANSFERABILITY

The practice informant did not identify other practices that MNO had adapted from and were unaware if the practice was used as a model elsewhere. However, MNO is regularly approached by provincial ministries to assist in the development and implementation of both Métis and non-Métis Aboriginal policies, programming and services.Two key characteristics of the MNO approach which have contributed to its success are the holistic, needs-driven and culturally-based nature of its community programming and services , and the MNO commitment to collaboration and working closely with government and other Aboriginal partners to address known gaps and to build more effective and integrated care models for Aboriginal populations. Together with committed Métis leadership, the ability to build effective, culturally-based teams with appropriate training for all front line staff and and the direct involvement of Métis community members, including seniors and support from a large volunteer base, are among the key factors contributing to success.

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Personal Communications:

Storm J. Russell and Wenda Watteyne, Métis Nation Ontario (personal and other communications, October, 2013).

Manitoba's Specialized Services for Children and Youth (SSCY)

LOCATION:	Manitoba	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the need to increase coordination of care for disabled children with complex needs. The practice was launched in Manitoba and consisted of a large planning team with representatives from various departments of the Manitoba government, regional health authority involvement, and several community service providers.

PRACTICE DESCRIPTION:

Manitoba has grown over the past decade as a province of immigrants with rising population demands and services to address those demands. Numerous agencies have been established over this period of time, dedicated specifically to children and youth with special needs. However, 10 years of reports from families said the system is hard to navigate, fragmentation of services leads to duplication of efforts, and their children are often treated as individuals who are sick as opposed to children with disabilities.

The Specialized Services of Children and Youth (SSCY) is an organization that arose out of this need to help families navigate the service delivery system for children with disabilities and/or special needs. Upon identifying the barriers to access, SSCY created partnerships with three departments of the Manitoba government (Family Services & Housing; Education, Citizenship & Youth; and Health), the Winnipeg Regional Health Authority, and several community service providers.

SSCY services are delivered in a coordinated, integrated, and family-centred manner. They reflect key features such as a central intake system, a lead case coordinator, integrated services, co-location of key services, and a family-centred resource centre. Two specific initiatives spearheaded by SSCY include the Children's Therapy Initiative (CTI) and the Manitoba Child and Youth Rehabilitation Research Collaborative. The CTI was originally launched in 2002 to coordinate audiology, occupational therapy, physiotherapy, and speech language pathology services.

IMPACT:

Throughout the initiative's development, SSCY has successfully fostered stakeholder engagement and communication. It conducted interactive sessions with families in 2005 and 2012, and designated a family representative to the initiative's working group. They created an SSCY Site Management team in September 2010 and developed staff forms in January 2011 and September 2012. Through stakeholder engagement, SSCY gathered a set of guidelines for desired projects, including details for a resource centre plan and ideas for an SSCY building that would host a variety of services in one setting.

After consultations and development, a family resource centre was officially opened in 2004. SSCY participants sought and obtained $65,000 in funding from the Winnipeg Foundation, Ronald McDonald Children's Charity, and Healthy Child Manitoba for the set-up of the resource centre and purchase of resources in 2003.

At SSCY's inception, CTI was struggling with poor integration of services. They had variable standards for eligibility, access, and services delivery, and children were put on multiple waiting lists with difficult transitions and loss of service continuity. However, throughout the past decade, CTI developed a centralized intake system that achieved a 94% satisfaction rate among families and community members. CTI also underwent a system reconfiguration for PT/OT services that reduced barriers to access. For example, for PT services, the system reconfiguration resulted in a reduction of wait times from 18 months to 2 weeks.

The direct services team also spearheaded the Integrated Children's Services Project, which aimed to address the needs of children with complex needs. As a result of this project, all families with children with complex medical needs that require services from family services and homecare have been given a single service coordinator.

The most current project, the Together Is Better Capital Campaign, is focused on bringing together a multitude of services into

one centralized location that is easily accessible to community members. This campaign was launched in February 2012 and has undergone numerous phases of development. The following stages are complete: design development (October 2012), construction documents (January 2013), cost estimate (February 2013), and the tender award (March 2013). The campaign plans to continue with construction (February 2014), furnishing (April 2014), and the grand opening (fall 2014).

APPLICABILITY/TRANSFERABILITY:

SSCY has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. Implementation of this practice or a similar service integration practice would require the implementation of several change management principles, including:

- establishing a sense of urgency;
- forming a powerful guiding coalition;
- creating a vision;
- communicating the vision;
- empowering others to act on the vision;
- planning for and creating short-term wins;
- consolidating improvements and producing still more change; and
- institutionalizing new approaches

PRACTICE WEBSITE http://www.sscy.ca/

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External Source: http://www.sscy.ca/

Emergency Department Decongestion Incentive Model: Rewarding target transit times that improve access and reduce wait times in the emergency department

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Access and Wait Times**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

VIDEO: This Innovative Practice was featured in the Health Council of Canada's video series "Innovations in Reducing Wait Times": www.healthcouncilcanada.ca/waittimes

SNAPSHOT: This innovative practice addresses the issue of improving access and patient flow through emergency departments (EDs) by rewarding hospitals with financial incentives when pre-determined performance targets for ED length-of-stay are met. This pay-for-performance (P4P) model was piloted in 2007 in four acute care hospitals within the Vancouver Coastal Regional Health Authority in British Columbia and expanded across the province in 2010.

PRACTICE DESCRIPTION:

Timely access to emergency care is a challenge facing many jurisdictions across Canada and around the world. To address ED congestion, increase access to emergency care, and improve patient transitions from the emergency department into either a hospital bed or back to the community, Vancouver Coastal Regional Health Authority (VCH) developed and pilot tested a pay-for-performance (P4P) initiative that rewarded hospitals with financial incentives for meeting predetermined target transit times and patient outcomes.

The pilot was implemented in four VCH emergency departments beginning in September 2007, including Vancouver General, St. Paul's, Richmond, and Lion's Gate Hospitals. Baseline numbers for ED transit times were calculated separately for each of the four hospitals based on the previous year's experience. The program was designed such that hospitals were awarded an incentive of an additional $100-$600 per patient that was treated or admitted above the historical baselines and within targeted transit times. The targets and resulting payments for ED performance were:

1) Lower acuity patients discharged from the emergency department in two hours or less result in a payment to the department of $100;

2) Higher acuity patients discharged from the emergency department in four hours or less result in a payment of $100; and

3) An emergency department patient who requires hospital admission, receiving a bed within 10 hours from time of arrival results in a payment of $600.

Following the success of the pilot in reducing the transit times of patients, the model was expanded to four emergency departments in Fraser Health Regional Health Authority for a second pilot beginning in January 2009.

The previous funding system limited the ability of the health system to reward improved performance and use financial incentives to drive change. The targeted transit time incentive model is innovative in that it moves away from a reliance on block funding to a reimbursement model in which full or partial payments are provided for meeting specific efficiency targets or patient outcomes.

IMPACT:

This P4P pilot program was formally evaluated, with results published in presentations and news releases.

Over the course of the first pilot, each of the EDs reported cumulative improvements in the number of patients (of all types) being seen within the targeted transit times, despite overall increases in volumes and acuity. The VCH evaluation was completed during the 15 months between September 2007 and November 2008. In the first half of 2008, compared to the first half of 2007, VCH saw:

- 22 per cent more patients with lower medical concerns being treated and discharged from emergency within the two-hour target.
- 13 per cent more patients with higher medical concerns getting care within the four-hour target.
- 62 per cent more patients who needed to be admitted getting a hospital bed within the 10-hour target.

Overall, 30 000 more patients were seen within the targeted time for discharge or admission. Importantly, no adverse unintended consequences were reported as a result of this initiative. The VCH pilot resulted in earnings to the regional health authority of $14 million in its first year, which have been reinvested in hospital projects that improve the transit time objectives.

A second evaluation assessed the impact of P4P following its expansion to four EDs in Fraser Health. From April 2009 to January 2010 (compared to April 2008 to January 2009), as a result of P4P, the four busiest Fraser Health emergency departments saw:

- 107 per cent more patients with lower medical concerns being treated and discharged from emergency within the two-hour target.
- 55 per cent more patients with higher medical concerns being treated and discharged from emergency within the four-hour target.
    - 62 per cent more patients who needed to be admitted getting a hospital bed within the 10-hour target.

The P4P pilot was initiated through the 2007/08 Health Innovation Fund. In 2008, further funding was secured through the Lower Mainland Innovation and Integration Fund (LMIIF), with $20-million worth of resources available to support VCH and the expansion to Fraser Health.

APPLICABILITY/TRANSFERABILITY:

The P4P program was part of a larger initiative in British Columbia that allocated $75-million to pilot patient-focused funding (PFF) with the aim to improve patient access, increase efficiency, and encourage better use of resources. Following the success of this P4P pilot and other projects funded through PFF, the British Columbia Ministry of Health Services announced that it would invest an additional $250 million to implement province-wide patient-focused funding (PFF) – $80 million in 2010-11 and $170 million in 2011-12—with plans to roll out PFF across 23 hospitals provincially.

Over 16 other countries in the world have implemented PFF, including the United Kingdom, Australia, and Norway. For example, a payment-by-results system was implemented in the UK in 2003-04, leading to reduced wait times in areas such as day surgery.

This targeted transit time incentive model has not been adapted elsewhere in Canada, but is theoretically applicable and transferable to other settings. Important considerations for successful implementation include:

- Support from leadership is essential
- Success comes from the grassroots level, by increasing ED staff awareness, engagement, and involvement
- Ongoing progress must be monitored and documented—complex systems require careful, systematic analysis and measurement
- Communication is a major focus of the initiative, both among ED staff and elsewhere in the hospital. VCH found it useful to promote the program through its internal bulletins and intranet, as well as posters tracking progress within hospitals
- Focus on engaging non-ED staff and reinvest in hospital capital (especially for admitted patients)

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Integrated Community Clerkship Program for MD Undergraduate Clinical Education at the University of British Columbia

LOCATION:	British Columbia	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice addresses the shortage of physicians in rural and remote communities. The practice was launched in September 2004 at the Chilliwack General Hospital, British Columbia, and involved six family practitioners as primary preceptors and a group of faculty leaders to execute program planning.

PRACTICE DESCRIPTION: In 2004, the University of British Columbia (UBC) piloted the first Integrated Community Clerkship (ICC) program in Canada in an effort to address the chronic shortage of family doctors in rural and remote areas of British Columbia. Six students participated in the pilot and went on to choose family medicine as a career path. Today there are five additional sites in BC offering ICCs, and there are 20 placements available each year, with plans to expand to 24 by 2015.

Integrated community clerkships are a non-traditional approach to clinical training in which students spend a year in one community, with one set of faculty members and ongoing contact with one group of patients. This differs from a conventional clinical training experience, which typically consists of a sequence of six- to eight-week rotations through multiple specialties, often at several different urban tertiary teaching hospitals.

The continuity of the ICC program allows students to follow patient cases from beginning to end, long enough to see the outcomes of their treatment decisions and to develop skills in follow-up and treatment management. Primary preceptors in family medicine oversee medical students' development of competence in all disciplines, while concurrent clinical training with a small group of specialist faculty complements students' overall learning experiences. Students leave the program with an understanding of how health care systems function in smaller communities.

IMPACT:

A comparison of the UBC ICC program and traditional clerkship students' In-Training Evaluation Reports (ITERs) and Objective Structured Clinical Examinations (OSCEs) found that ICC students had higher and more reliable ITER ratings. OSCE results, however, produced weaker correlations between objective and subjective evaluations of clinical skills. In addition, the results of the UBC 2012 Year 4 In-House Exit OSCE completed by both ICC graduates and traditionally trained graduates were statistically equivalent.

Student evaluations of their experience in the ICC program have been positive and have helped inform modifications to the 2004 pilot program. In addition, ICC graduates appear to be making career choices consistent with the goals of the program. Of 54 graduates of the ICC program from 2004–2012, 50% were matched with residencies in family medicine and rural family medicine. The ICC program has not been evaluated against patient outcomes, although this is a research interest expressed by the UBC ICC group.

A cost comparison between ICCs and traditional rotational clerkships is difficult for a number of reasons. ICC programs have been implemented in jurisdictions where education has not previously taken place, necessitating investment by UBC in educational infrastructure, such as videoconferencing technology. Furthermore, economies of scale do not apply to ICCs, making smaller sites more expensive to run. In contrast, traditional rotational programs benefit from shared institutional, teaching, and administration costs.

APPLICABILITY/TRANSFERABILITY:

Integrated clerkships have been successfully established and have shown positive results in some 15 schools in the US, Australia, and South Africa. The model used by UBC was developed in collaboration with Dr. Paul Worley, dean of medicine at

the Flinders University of South Australia in Adelaide, and it borrows heavily from similar programs adopted and validated in rural Australia. The success of the Chilliwack pilot was followed by the creation of similar offerings in Terrace in 2008, Fort St. John in 2009, Duncan in 2010, and Trail and Vernon in 2011. The efficacy of non-traditional clinical medical education has been evaluated by cohort studies in the United States and Australia and reported in peer-reviewed journals, including *Academic Medicine* and the *British Medical Journal*. Results indicate that graduates perform as well as or better than their traditionally trained counterparts on measures of content knowledge, and reported feeling more prepared in patient-centred aspects of care, including handling ethical dilemmas, involving patients in decision-making, and relating well to a diverse population.

The University of Alberta implemented a rural ICC option in 2007, followed by the University of Calgary in 2008. Canada's newest medical school, the Northern Ontario School of Medicine, implemented its own program in 2007, and is the world's first medical school to require enrolment in longitudinal clinical training. Dalhousie, McGill, and Queens Universities have since followed suit. Since 2004 more than 100 schools worldwide have joined an international consortium to discuss and explore the option.

While the ICC at UBC is aimed at rural and remote communities, there is ongoing research into the challenges of starting a longitudinal integrated clerkship in a busy suburban community and how such a program would differ from a rural program. Preliminary findings indicate that the principles of longitudinal integrated clerkships can be applied anywhere but need to be informed by a pragmatic appreciation for local context and resources.

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Personal Communications:

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External Source: http://mdprogram.med.ubc.ca/program-information/integrated-community-clerkships/

Geriatric Day Hospital: Improving Health Outcomes of Seniors Living in the Community

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the issue of improving the health outcomes of senior patients living in the community through an interprofessional, patient-centred approach within a specialized geriatric day hospital setting. This program was launched about 25 years ago in Ontario within the Seniors' Health program at a large hospital.

PRACTICE DESCRIPTION:

The Central Local Health Integration Network (LHIN) in Ontario has a challenge to meet the needs of a rapidly aging population in Central Ontario, including the city of North York. North York has the highest ratio of older adults in the province. North York General Hospital (NYGH) offers a continuum of specialized geriatric services (from in-patients to outpatients) using a unique centralized referral system.

The Geriatric Day Hospital (GDH) program is one of the specialized services that address the complex needs of frail elderly patients. Using an integrated and interprofessional (IP) approach, the GDH is an outpatient medical rehabilitation program that strives to improve the function of frail elderly patients living in the community through the provision and coordination of medical, physical, and social interventions. The program provides care for seniors with medical or mental health problems that threaten their independence or their ability to continue to live safely at home. The interprofessional team consists of geriatricians, nurses, social workers, pharmacists, physiotherapists, occupational therapists, dietitians, recreational therapists, rehab therapists, health care aides, and administrative support.

The GDH program is now offered four mornings a week for typically up to 10 weeks. Originally, the day hospital was a full-time program that was implemented using an interprofessional approach—staff rotated their days of work and had individual cases to manage. The program now runs on a part-time schedule and is delivered in a collaborative IP approach, with consistent daily staff. The program accepts patients that are: 65 or older; have multiple medical, functional, or psychosocial problems; show potential to benefit from a team approach, are not a resident of a long-term care home, and are willing to participate in the group hospital program.

Patients are linked to community programs at discharge in order to promote the continuum of care and encourage a greater quality of life. The program is funded through the Regional Geriatric Program (RGP) of Toronto and the NYGH elder care program.

IMPACT:

The IP team approach and patient-centred goal setting have been shown to be effective in patient care and chronic disease management. The GDH model promotes better efficacy of treatment and is believed by those involved to lead to better outcomes for patients.

The program has been evaluated in terms of both patient outcomes and satisfaction. The day hospital uses a multitude of evaluation tools administered to patient at the beginning and at the end of the program in order to evaluate both subjective and objective outcomes. Evidence-based measurement tools, such as the Goal Attainment Scale (GAS), life satisfaction scale, pain scale, frailty index, Berg balance, Geriatric Depression scale, Montreal Cognitive Assessment, Timed Up and Go (TUG) test, and 2 Min walk test, are used. The significant increase in GAS scores upon completion of the program (when patients meet their treatment goals) reflects achievement of the program goals, as identified by the team in collaboration with patients and families.

Patient satisfaction surveys revealed patients, families, and caregivers were highly satisfied with the GDH program and cited the "team approach" as an integral element in their success. Through GDH, frail elderly patients are empowered to live independently in the community and are more likely to avoid emergency department visits and unnecessary admissions.

APPLICABILITY/TRANSFERABILITY:

With the focus on maintaining older adults in the community, there is a growing need for this model of integrated and comprehensive care in North York and in the Greater Toronto Area. The program also offers a model of interprofessional, patient-centred seniors' care that may be readily applicable to other hospitals and communities throughout Ontario and Canada that are looking to improve care for seniors living in the community.

The day hospital's model of care was designed and implemented using a strong supporting medical and psychiatry framework that calls for the provision of continuing care of frail elderly patients recently discharged from hospital.

The GDH has been working with the RGP and the other day hospitals to stabilize certain processes and outcomes and to improve flow and discharge planning. The NYGH GDH has been a leader in the use of goal attainment scaling, involving families in the patient's program, and having an attending geriatrician on the team and available to the patients.

Challenges:

- operating a full-time program in part-time hours;
- continuous intake of patients to the program throughout the year; and
- balancing adequate patient care and non-patient responsibilities.

Lessons learned:

- over-booking patients in order to maintain the required number;
- administering pre- and post-measures to show the effectiveness of the program;
- following a tight schedule and using a point person to manage scheduling; and
- organizing frequent mass orientation sessions to help screen appropriate patients before starting the program

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Total Joint Assessment Clinic

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice aims to decrease the wait times for assessment and treatment of patients with hip and knee arthritis.

PRACTICE DESCRIPTION:

The Champlain Local Health Integration Network (LHIN) launched its Regional Hip and Knee Replacement Program in 2007 as part of efforts to decrease the wait times for assessment and treatment of patients with hip and knee arthritis. After a proposal for funding was sent to the Ontario Ministry of Health and Long-Term Care, a best-practice model was devised based on a literature review and observations made while visiting clinics with successful joint referral processes. Once a general model was formulated, stakeholders such as surgeons, physicians, LHIN staff, assessors, rheumatologists, and representatives of Arthritis Canada were invited to participate in discussions on how best to refine the proposed model and implement it in daily practice. These discussions led to the creation of a process flowchart followed by subsequent training of assessors by surgeons and radiologists.

The resulting Total Joint Assessment Clinic (TJAC) concept is based on the North York General Hospital and Sunnybrook Hospital's Holland Musculoskeletal Program's effective use of human resources in decreasing patient wait times for initial assessment. The joint replacement referral model is innovative in that it uses assessors as opposed to surgeons to determine a patient's need for surgical intervention. The model consists of the following steps:

1. Physicians submit their referral to a regional central intake centre.
2. Within two weeks, the patient is seen by an assessor who is typically a physiotherapist or advanced practice nurse trained by surgeons and radiologists. The assessor performs a physical assessment, reviews the patient's history, and takes X-rays to determine the patient's eligibility for surgery.
3. The assessor discusses the surgical and non-surgical options with the patient. If a non-surgical option is chosen, the assessor explains community resources to the patient. The assessor then returns the patient file to the referring physician, along with recommended management resources.
4. If a surgical intervention is opted for, risks and benefits are further discussed, followed by a referral to either a selected or next-available surgeon for a 15-minute consult.

The intent of this process is to minimize the amount of inappropriate time spent in consultation with the surgeon and to guide non-surgical candidates through a variety of community resources/services as part of the conservative management program. The conservative management program consists of a group education session taught by a physiotherapist, occupational therapist, dietitian, and pharmacist. In this 75- to 90-minute session, topics such as mobility aids, exercise, diet, weight loss, and pharmacological pain interventions are discussed. Resources such as local recreational guides and schedules are also offered at this educational session.

IMPACT:

The impact of the Hip and Knee Replacement Program, and its use of the TJAC approach, has so far been captured by two patient satisfaction surveys and one health care professional satisfaction survey. Both patient surveys indicated a 95% satisfaction rate or higher, and physicians also highly rated the "one-stop shop" approach to making referrals. Interviews with patients revealed their satisfaction with the next-available-surgeon option—it accelerated their access to surgical interventions, thereby reducing wait time. A rudimentary data outcomes analysis indicated that 90% of patients chose the next-available-surgeon option. As a result, the average wait time for a joint replacement surgery has dropped from 18 months to a maximum of six months.

The wait time for the initial surgical consult has also decreased, which can be attributed to the introduction of the assessor in the baseline assessment. The assessors effectively streamline surgical candidates (15% of population) from those who did not need to spend time consulting with a surgeon. Assessors, on average, they perform six assessments per day. As a result, surgical consults take place at most four weeks after the assessment. Surgeons have reported been able to see up to four patients per hour.

APPLICABILITY/TRANSFERABILITY:

The success of the Hip and Knee Replacement Program has inspired health officials in Eastern Ontario to consider expanding the Queensway Carleton's model for the TJAC region-wide and adapting the system to elective procedures such as diagnostic scans and cataract surgery. Similarly, referral-streamlining efforts have been made in cardiac surgery and cancer screening. In the case of cardiac surgery, a province-wide registry lists all patients' names in order of urgency so that hospitals in 11 cities can collaborate to provide timely access to care for those who need it the most. One similar initiative exists in Saskatchewan in isolation from this practice, indicating that this type of innovative practice is transferable to other jurisdictions.

For jurisdictions interested in adapting this practice to their own context, some of the biggest challenges experienced in implementing this referral process were surgeon buy-in and patient buy-in. Surgeons feared that streamlining surgical and non-surgical consults would lose them business, but the use of a surgical champion was effective in getting other surgeons on board. Patients are often skeptical about choosing the next-available-surgeon option, since they are unsure of the quality of care they will receive from their allocated surgeon. Encouragement of physicians proves crucial in easing patients' concerns about their quality of care. Physicians assure their patients that they will receive comparable quality of care and in the event that the patient is dissatisfied, the patient can be rerouted to another specialist. However, the patient satisfaction surveys clearly demonstrate that rerouting is rarely necessary.

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External Source: http://www.gtarehabnetwork.ca/uploads/File/bpd/2008/bpd2008-pres-6d.pdf

Saskatchewan's Clinical Practice Redesign (CPR)

LOCATION:	Saskatchewan	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice is a set of tools and methodologies that improve access to care, communications, office processes, and effectiveness between office settings and other health care providers. Launched in Saskatchewan in 2007, this program aims to help health care professionals enhance communication, streamline office processes and make the best use of everyone's time.

PRACTICE DESCRIPTION:

As part of the Saskatchewan Surgical Initiative, the Saskatchewan Medical Association (SMA), the provincial Health Quality Council, and the Ministry of Health launched a joint initiative in 2007 called the Saskatchewan Clinical Practice Redesign (CPR). This program helps health care professionals enhance communication, streamline office processes, and make the best use of everyone's time, thus creating a more manageable workplace and the opportunity to provide quality care sooner. CPR is a set of tools and methodologies that improve access to care, communications, office processes, and effectiveness between office settings and other health care providers. Physicians can access and modify the CPR tools to meet their own needs and address their unique challenges. Some CPR tools include strategies for:

- Allocation of time for scheduled appointments
- No-show management
- Reminder calls for patients

Physicians enrolled in the program have the opportunity to discuss challenges in their practice with a designated CPR coach, and design a tailored action plan to enhance the efficiency of day-to-day office processes. Overall, CPR is structured to achieve four main objectives:

- improve the patient experience
- improve access and efficiency within practice settings
- improve access and efficiency among practice settings
- improve the staff experience

IMPACT:

CPR has been used in a variety of practices and clinics. It includes an online system, TransformMyPractice.ca, where physicians and surgeons can track and measure their progress. One example of successful CPR implementation is in the Regina Qu'Appelle Health Region Sleep Disorders Clinic. After CPR was introduced, patients were asked for feedback on their experience. Survey results indicate that in 2010/2011, 62% of patients in this sleep clinic reported great satisfaction in their clinical experience after the implementation of CPR tools.

Interviews with other patients revealed their satisfaction with their access to care. For example, an SMA news release profiled a patient who required rapid access to care after a leg injury. He was very impressed with how quickly he was able to set up an appointment and receive the treatment he needed through the Advanced Access program, which is part of CPR. He attributed his positive experience to his physician's participation in advanced booking and CPR. Physicians have also been pleased with their experience, saying that CPR has helped them better prioritize and manage their cases to enhance patient flow and reduce wait times. Most surgeons have even expressed an interested in CPR services to be expanded.

APPLICABILITY/TRANSFERABILITY:

Although components of CPR, such as the Advanced Access program, have been previously implemented in the United Kingdom, the United States, and elsewhere in Canada (Nova Scotia), Saskatchewan is the first jurisdiction to implement CPR as a holistic approach to patient care and quality improvement across health care services.

CPR implementation has spread across the province. As of March 2012, 63 clinics in Saskatchewan—involving roughly 100 clinicians and 350 staff—are actively using this innovative practice. Numerous sites have expressed interest in CPR and are currently recruiting CPR coaches to help them better identify how CPR can improve their practices.

Transferability of this practice is possible. However, the needs of each clinic's specific characteristics, including patient load and demographics, should be considered. In addition, the broader thinking of physicians and staff with respect to offering same-day access and striving for lower (or no) wait times should also be taken into account.

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

- Government of Saskatchewan. (2012, March). *The Sooner, safer, smarter newsletter*. http://www.health.gov.sk.ca/s3-mar-2012
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- Saskatchewan Medical Association. *Clinical practice redesign (CPR)* [Project Website]. https://www.sma.sk.ca/Default.aspx?cid=838&lang=1&pre=view

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External Source: https://www.sma.sk.ca/Default.aspx?cid=838&lang=1&pre=view

Advanced Access for Family Physician Appointments in Manitoba

LOCATION:	Manitoba	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice aims to reduce concerns about the length of time patients waited for appointments with family physicians and about overuse of emergency departments. Launched in 2007 in Manitoba, the goal is to elimiate patient wait times to get an appointment and minimize the amount of time each patient spends at an appointment.

PRACTICE DESCRIPTION:

Starting in 2007, Advanced Access was implemented in Manitoba to reduce concerns about the length of time patients waited for appointments with family physicians and about overuse of emergency departments within the province. Advanced Access was created in the United States by Dr. Mark Murray, a family physician, and has been rolled out to numerous clinics in the US and in over 30 other countries including in many Canadian provinces. The goal of Advanced Access is to eliminate patient wait times to get an appointment and minimize the amount of time a patient spends at an appointment.

Implementing Advanced Access was a unique journey for each clinic in Manitoba. Clinics develop and access individual efficiency goals and timelines for implementation depending on their assessment of need and capacity. Clinic staffs work collaboratively with experts to learn how to implement Advanced Access principles, measure their progress, and share ideas and knowledge that will result in the best patient health care. Manitoba Health has contracted experts to provide the training for Advanced Access in the province, and a train-the-trainer model is being used to expand the training capacity.

Through the government-sponsored training program, since 2007 staff in more than 50 clinics have been trained to implement Advanced Access. Manitoba's goal is to support 75% of primary care clinics in Manitoba with Advanced Access training and implementation by 2015. At this time, Advanced Access is also being rolled out to regional health authority programs (mental health, chronic disease management) that also rely on appointments.

IMPACT:

Training clinic improvement teams in Advanced Access methodology takes place over a 12- to 14-month period. As part of the training, each clinic gives a presentation on pre- and post-training wait times. Currently, Manitoba Health does not collect ongoing wait time data from participating clinics. The province is working on strategies to address this issue and plans a formal evaluation of the first four phases of the program (2007–2012) in 2013/14.

Although aggregate patient outcome data on access and wait times is not collected at this time, specific clinics have experienced promising results. Using the Advanced Access model, Manitoba clinics have made significant progress in reducing wait times for appointments through strategies such as

- reducing the types of appointments (e.g., pre-natal, pap smears, routine physical) to two—one long, one short—to allow more flexible scheduling;
- reducing "no shows" through reminder telephone calls;
- stocking all exam rooms with the same equipment to reduce delays caused by clinicians tracking down what they need;
- clarifying roles to allow all team members to work to the full scope of their practice; and
- addressing clinic policy/practice issues, such as ensuring no more than 50% of physicians are scheduled to be away at any one time.

One challenge experienced in Manitoba in implementing Advanced Access is that the eight-day training commitment for members of the improvement team is a barrier to enrolment for some clinics due to workload and/or financial implications. Another is that among clinics participating in the program, some improvement teams find it difficult to gain the staff and

physician support necessary to implement change. In other instances, clinics lost momentum due to staff turnover.

APPLICABILITY/TRANSFERABILITY:

International studies in this field have indicated the successful use of Advanced Access strategies to reduce delays, which in turn leads to improved compliance with prevention guidelines, improved care for patients with chronic illness, and enhanced early detection of serious illness.

Advanced Access is being implemented extensively in Canada. The program has a presence in British Columbia, Saskatchewan, and Alberta, with smaller developments starting in Ontario and Atlantic Canada. Manitoba and Alberta (the AIM Program) worked closely together and implemented very similar Advanced Access programs. Both provinces hired Mark Murray, the developer of Advanced Access, as the lead trainer. Alberta was able to provide Manitoba with tools and consultations on strategy and lessons learned.

ALL CONTENT IS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES

- Fournier, J., Heale, R., & Rietze, L. (2012). “I can’t wait”: Advanced Access decreases wait times in primary healthcare. *Healthcare Quarterly, 15*(1), 64–68. http://www.longwoods.com/content/22763
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Information last updated on: January 28, 2013

External Source: http://www.gov.mb.ca/health/primarycare/access/advancedaccess.html

OsteoArthritis Service Integration System (OASIS)

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Access and Wait Times**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice addresses the fragmentation of osteoarthritis services for non-operative patients. It was launched in 2006 in the Vancouver Coastal Health Authority and since has been implemented in Richmond and North Shore as well.

PRACTICE DESCRIPTION:

Prior to 2006, patients with osteoarthritis (OA) in British Columbia found it challenging to access comprehensive resources for appropriate treatment options, community services, and contacts they can use to facilitate their recovery. In 2006, the Vancouver Coastal Health Authority invited numerous health stakeholders to participate in a new initiative called the OsteoArthritis Service Integration System, or OASIS, to address the fragmentation of OA services for non-operative patients and wait time pressures. OASIS provides a more coordinated approach to care, ultimately giving OA patients (1) advanced access to a consultation with an interprofessional team, followed by (2) access to targeted community programs or surgery consultation if needed, and (3) tailored self-management action plans. The interprofessional team, consisting of physiotherapists, occupational therapists, dietitians, and nurses, is also actively involved in ensuring that the action plans are implemented properly. This initiative links all existing OA services on a searchable List of Community Services and uses electronic software to improve coordination among health care professionals. Further, it increases access to care by speeding up the referral system and by better implementing the electronic medical interface in daily practice. The electronic system also tracks progress and user feedback on the OASIS initiativeand acts as a platform for sharing documents and storing clinical information.

Another key component of OASIS is the emphasis on training and education. Vancouver Coastal Health Authority has created numerous educational materials for patients on OA prevention, statistics, treatment, available services, and self-management. These materials have been translated into languages such as Punjabi and Cantonese to further increase access to care. Also, community educational sessions have been in place since 2006 and continue to be delivered in various locations. These sessions feature discussions on weight management, healthy eating, physical activity, and pain management. OASIS is now a well-integrated program within the Vancouver Coastal Health Authority.

OASIS has the potential to help millions of Canadians suffering from OA. Statistics show that OA is the second most costly disease category in Canada, and that 10% of OA patients suffer from extreme pain. It is forecasted that Canada may experience an increase in OA prevalence in the next decade due to the aging population. Therefore, a program targeted at OA prevention, treatment, and management will become increasingly important in limiting the development and progression of OA.

IMPACT:

When OASIS was launched, only a few family physicians and surgeons participated in the initiative. Within a year, several other specialties were included. As of 2011, over 26,000 client encounters have been reported and over 36,000 referrals have been made to community services. Seventy thousand educational documents have been downloaded from the OASIS website, and over 600 services have been included on the platform. Although OASIS tracks these metrics, there is no formal evaluation or regular reporting of the progress this practice has made.

Successes have been noted on the OASIS website and other OA websites regarding the nature of the assessments and the types of services provided. Services have also expanded their focus from the hip and knee to also include the upper extremities. More work is being done to address management of shoulder- and elbow-related conditions.

Based on personal testimonials from participants, the benefits of OASIS include enhanced relationships with primary care physicians, improved access to services including access to the first available surgeon, improved quality of life and health outcomes, improved use of system resources, and enhanced collaboration among health care professionals including primary care physicians, orthopedic surgeons, rheumatologists, allied health professionals, community stakeholders, caregivers, and

education partners. In addition, OASIS is aligned with other chronic disease management initiatives, thereby providing a complete spectrum of services while repairing gaps in access to services.

APPLICABILITY/TRANSFERABILITY:

OASIS was initially launched in one clinic in Vancouver and has since been implemented in Richmond and the North Shore as well. It is similar to the Multidisciplinary Osteoarthritis Program in Ontario and the team-based care approach to OA in Alberta and therefore positive results are theoretically replicable across Canada. In all three jurisdictions, case managers help OA patients navigate the health care system to connect with appropriate health care professionals and to find appropriate resources for their needs. The three programs in Canada feature interprofessional teams with a clear definition of team roles to avoid overlap of evaluation and management. The pathway consists of a primary care physician making referrals to the rheumatologist who ensures proper diagnosis, after which the patient is directed to an interprofessional team for consultation and direction. This pathway ensures that patients have access to a continuum of care. Education is a key component of all three models of care, all of which focus on communication as a way to promote appropriate educational resources, formulate action plans, and ensure enhanced patient flow through the system.

The process of achieving this model of care relies on several important factors. Firstly, the preliminary team meetings need to be inclusive, since it can be difficult to get everyone at the table and ensure that all representatives are on the same page. Clarification of roles and capacity need to be determined early on, since experimenting with the pathway without defined roles can leave primary care physicians concerned about losing their patients. Additionally, unclear roles can create disorganization whereby patients no longer have access to the first available surgeon. Proper EMR development needs to be in place prior to the onset of practice, with features tested to ensure compatibility among all stakeholders using the system. Lastly, the practice must be well-integrated into other available programs, initiatives, and departments to ensure a continuum of care.

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

- Canadian Medical Association. (2011, December 5). *A collection of referral and consultation process improvement projects*. http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf
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External Source: http://oasis.vch.ca/

Alternative Relationship Plan–Rheumatology Project

LOCATION:	Alberta	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the issue of access to appropriate and timely rheumatology care through effective coordination between health care through central referral and intake. This program was launched in 2006 across the Calgary Health Region.

PRACTICE DESCRIPTION:

Appropriate and timely access to specialized care can be hindered by inefficient communication between health care providers, fragmentation of care, poor coordination, duplication of efforts, and a lack of awareness of available services in the health care system. As a result of these inefficiencies, patients experience longer wait times, more stress with navigating the system, and poorer outcomes in health. In response to growing concerns around access to specialized medical services, Calgary Health Region and Alberta Health Services pooled their resources to establish a $7.4 million grant for innovation in access and triage. The grant, lasting from 2005 to 2007, went to fund Calgary Health Region's groundbreaking Alternative Relationship Plan (ARP) with the Department of Medicine. The ARP hosted 18 innovative practices aimed at improving the access patients and primary care professionals have to specialized medical services, system quality, safety and effectiveness, service integration between primary care and other care providers, and system efficiency and sustainability.

Of these 18 innovative practices, the Rheumatology Project had the broadest scope. Seven full-time allied health professionals were hired to determine how best to redesign the referral process for rheumatology patients, and they went on to put the new model into practice. Central referral and intake was seen as critical to prioritize patient referrals and stream patients to the most appropriate care provider and service. In 2006, Central Intake began in April, the young adults with rheumatic disease (YARD) clinic opened in February, the Urgent Clinic opened in the spring, the Early Rheumatoid Arthritis (RA) Clinic opened in the summer, and the Nurse Practitioner Stable RA Clinic opened in the fall.

The Rheumatology Project formulated a step-by-step process for making and tracking referrals:

1) Referrals are received by a single fax and tracked in the database.

2) Nurse Clinicians triage referrals with the support of a rheumatologist and obtain all additional pertinent information.

3) Patients are booked to the next available rheumatologist based on urgency.

4) Referring physicians are notified about estimated wait time.

5) Rheumatologists notify patients of their appointment date and time.

6) Appropriate cases are directed to specialized clinics.

The Rheumatology Project later served as a guide for the development of a high-level Central Intake and Triage model in the Medical Access to Services (MAS) Project.

IMPACT:

The Rheumatology Project involved all 14 rheumatologists in the Calgary Health Region and resulted in improved access, wait

times, referral management, and coordination of care. The ARP conducted a rigorous project evaluation using an established evaluation framework, indicators, a matrix to quantify relative contributions made by each initiative, and a data grid to identify new databases that needed to be created. The results of the ARP were published in the *2007 Final Evaluation Report*.

As a result of new services, new staff, and the innovation initiatives coming out of the ARP, over 8,600 new patients have improved access to specialized medical services. Early data collected between April 2006 and February 2008 showed a total of 8,338 referrals were made, with 84% made using the Central Triage model. There was a reduction in wait times for routine, moderate, and urgent referrals using the Central Triage model after one year of its implementation, and 158 urgent/semi-urgent patients were seen within 24 days after referral. The wait times for the urgent patients was reduced to an average of two weeks. However, by 2008, the routine referral patients experienced a significant increase in wait times due to the prioritization of urgent cases and a decline in available rheumatologists, since two left their practices and two were on maternity leave. Nevertheless, the evaluation of the Rheumatology Project identified it as an example of how early management of cases using central intake and triage can improve referral quality and the timeliness of access.

The Rheumatology Project also resulted in improvements in communication among health care providers, improved data management and patient scheduling, and overall elimination of duplicated efforts. A total of eight sub-specialty clinics, including an Urgent Rheumatology clinic and a YARD clinic, were also involved and integrated into the referral process. Within 26 days, 106 patients were seen at the Early RA Clinic and 184 new patients were seen in the Nurse Practitioner Clinic.

APPLICABILITY/TRANSFERABILITY:

Although other innovative practices that improve wait times and referrals exist across Canada, the ARP is unique in that it implemented 18 innovation initiatives to transform and integrate specialized medical services. This a broad approach covers the entire continuum of care in both urban and rural settings. The ARP's Rheumatology Project was successful because it secured specialist and divisional buy-in and was supported by staff who have specialty and clerical experience. Appropriate staff selection was key in ensuring that the referral model reflected the experiences of care providers and that individuals with appropriate clinical skills would implement it. To classify urgency and streamlined care appropriately required developing a fully operational database that was linked with the existing electronic medical records. Lastly, it was necessary to establish effective communication and use a communication loop so that all parties were aware of patients' progress through the referral process.

After the Rheumatology Project ended, the Referral and Access Conferences in 2006 and 2007 featured discussions among the stakeholders involved in the project and those about to be involved in the MAS Project. The discussions highlighted these areas of success and the barriers that were experienced throughout the project's implementation. Identifying these characteristics of success as well as the project's challenges with routine wait times made it possible to launch the MAS Project in 2007, which had its own optimized Central Intake and Triage (CAT) model. Their model was expanded to the departments of endocrinology, general internal medicine, and hematology. They successfully identified triage categories, acceptable approximate wait times for each category, and necessary information/documents for triage implementation. They went on to create a CAT booklet that is now used for many specialties, including rheumatology. The MAS Project's *Outcome Assessment Final Report* highlighted many successes, including enhanced communication, better tracking of referral status, the establishment of a high-level information technology plan for automated referrals, satisfaction noted by five of the six Access Improvement Measures (AIM) clinics involved in the project, and an overall decrease in wait times. These successes and the lessons learned through the MAS Project echo those experienced in the APR's Rheumatology Project. The Rheumatology Project's experiences enabled improvements in referral management and facilitated the MAS Project's continued efforts to optimize the implementation of CAT. Given the ARP's success and continued application through the MAS project, this type of broad innovative practice approach is likely transferable to other jurisdictions.

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

Canadian Medical Association. (2011, December 5). *A collection of referral and consultation process improvement projects*. http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf

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Department of Medicine and Medical Services. (September 2007). *Alternative relationship plan innovative initiatives: Final evaluation report*. http://www.departmentofmedicine.com/documents/dom/reports/innovation_report_07.pdf

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External Source: http://www.departmentofmedicine.com/documents/dom/reports/innovation_report_07.pdf

Primary Outreach Services in British Columbia

LOCATION:	British Columbia	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses supported housing and emergency shelter residents' overall health by delivering clinical services on-site, improve residents' access to health services, create a strong partnership model in delivering health services, and reduce non-urgent hospital emergency department visits. Implemented in the Vancouver Coastal Health Authority since 2007, the program targets individuals who are chronically homeless, live chaotic lifestyles, and have multiple chronic health conditions, including mental health conditions and addiction.

Practice Description:

In 2007, Vancouver Coastal Health Authority (VCH) created Primary Outreach Services (POS) to deliver a full range of integrated primary care, mental health services, and addiction services to residents in supported housing and emergency shelters. The objectives of the program were to improve residents' overall health by delivering clinical services on-site, improve residents' access to health services, create a strong partnership model in delivering health services, and reduce non-urgent hospital emergency department visits. POS are provided to clients who live in the downtown core and the downtown eastside. They serve clients who are housed in supportive low threshold housing or are chronically homeless and need clinical interventions. As of 2012, the program was in 19 supported housing sites and nine emergency shelters and was supporting over 1,205 individuals. These sites primarily house individuals who are chronically homeless, live chaotic lifestyles, and have multiple chronic health conditions, including mental health conditions and addiction.

POS are provided by interprofessional clinical housing teams (CHT) that include a physician, nurse practitioner, nurses, case manager, and other health care workers. Services include medication management; wound and skin support; management of chronic disease problems such as diabetes, mobility issues, hepatitis C, and HIV/AIDS; mental health and addiction assessment and treatment; and relationship building, connection, and decrease in stigma and social isolation. The CHT acts as the primary point of care integration for acute care, community partners, and family and social agencies.

A nurse practitioner, family physician, and nurse hold clinics at housing sites on certain days of the week, and ongoing care and support are provided by case managers, nurses, counsellors, and health care workers who help patients get to their medical appointments or access community resources. In addition, non-profit organizations that manage the housing and shelter sites are funded by VCH to have on-site tenant support workers who maintain a safe and secure environment; link tenants with medical, mental health, and addiction treatment and social/community services; and assist patients with basic living skills.

IMPACT:

The program was evaluated in 2008 and 2010. Both quantitative and qualitative methods were used to evaluate the practice. The quantitative components utilized a pre-test/post-test design. The qualitative component included conducting interviews and focus groups with service providers and administrators/managers.

The results of the initial evaluation of the CHT (2008) showed that the CHT was able to connect with 74% of clients living in the initial eight sites. POS teams increased health service access—41% percent of clients had not accessed any VCH health services in the 12 months prior to the CHT contact. Thirty percent of clients seen six or more times by CHT were referred to other VCH health services. In clients seen six or more times by CHT, visits to the emergency department had decreased by 30%. CHT interventions also reduced semi/non-urgent emergency department visits by 55% among previously high-frequency users.

Results of the 2010 POS evaluation showed that in the 120-day period after initiation of POS treatment, clients had 20% fewer emergency department visits compared to before POS treatment. The greatest reduction was with the most frequent users of the emergency department, who had 58% fewer visits. Urgent visits declined by 22% overall, while less urgent visits decreased by 15%.

Non-profit organization partners and other health providers identified POS as a successful model to reach individuals who have

challenges connecting with health services. The program received a VCH award in Interprofessional Practice. Factors that contributed to the program's success are leadership to implement change in care delivery, resources made available to create outreach teams, and personal characteristics of team members, which include adaptability, flexibility, being solution focused, and being respectful of clients and tenant support workers. Challenges included making the teams diverse to meet the needs of clients and communicating to make other care providers aware of the role of the teams and how they can work together. What worked was the ability of teams to build relationships with clients that made clients more willing to receive health services. The key lesson learned is that meeting people where they are geographically, emotionally, and mentally improves access to services and reduces utilization of emergency departments.

APPLICABILITY/TRANSFERABILITY:

The program has not been replicated elsewhere, but it may have informed or inspired intensive home-based treatment programs such as those for mental health and for patients discharged from hospital with complex care needs.

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Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative

LOCATION:	British Columbia	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses child health inequities through a publicly funded, community-based primary health care and specialist pediatrics service designed to meet the needs of children, youth, and families living in Vancouver's inner-city neighbourhoods. BC Children's Hospital developed the Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative in 2007 as a means to promote access to health care for all.

PRACTICE DESCRIPTION:

In recent years, understanding and addressing child health inequities has become a priority for research and practice. As pathways of influence on children's health and development extend beyond the biomedical domain, the emergent literature recognizes that new approaches to integrated care are needed to promote access to health care.

BC Children's Hospital developed the Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative in 2007. The RICHER initiative is a publicly funded, community-based primary health care and specialist pediatrics service designed to meet the needs of children, youth, and families living in Vancouver's inner-city neighbourhoods. The family's particular needs are taken into consideration when providing health care services, which are linked to specialized health care services and their community-based support networks. The primary focus of the initiative is on at-risk children, since their material and social circumstances often make them more likely to suffer the consequences of delayed development and poor health. Lack of access to appropriate health care further compounds their vulnerabilities, as it compromises continuity of care and interferes with timely referrals for assessment and treatment.

The goal of RICHER is to reduce child health inequities while improving children's access to primary, secondary, and tertiary health care. The RICHER initiative provides regularly scheduled and easily accessible primary health care outreach clinics and specialized pediatric health services. RICHER is integrated with community infrastructure, and services are delivered in community spaces (e.g., daycares, schools, community centres). Through intersectoral partnerships, typical health services are complemented by services and community-based resources, many of which assist clinicians to address social determinants of health. Nurse practitioners are the point of care primary health care providers who work with clinical support from pediatricians and other specialists who provide pediatric outreach consultation. Services include assessment, treatment, and follow-up of common, predictable health conditions; episodic illness care; mental health screening and referral to appropriate resources; and developmental screening and referral for assessment at Sunny Hill Health Centre for Children. The initiative complements existing tertiary and health promotion programs. It incorporates elements of social and community pediatric approaches to care delivery. The initiative works in collaboration with Vancouver Coastal Health Authority, established community and tertiary health care services, and existing community-based organizations. The intersectoral model of service delivery is unique in its collaborations among primary health care, community organizations, and public health, and its link to specialty and tertiary services.

The nurse practitioners are employed by BC Children's Hospital, and the specialist services are administered through BC Children's Hospital with funding from the BC Medical Services Plan. BC Children's Hospital provides the administrative infrastructure (clinical bookings, records) and community partners provide the venues for the clinical programs.

IMPACT:

Funding has been obtained for ongoing research to evaluate the RICHER initiative. Funding support has been provided by the Canadian Institute of Health Research—Partnerships for Health Services Innovation, the Michael Smith Foundation for Health Research, the BC Medical Services Foundation, and the Canadian Nurses Foundation. Research results demonstrate that the RICHER model of engagement not only effectively fosters access for families with multiple forms of disadvantage but also improves outcomes by empowering parents to become more active participants in care.

In 2010, a structured questionnaire was administered to families receiving clinical services from RICHER. The purpose of the survey was to examine whether the program was reaching the target population and to consider patients' experiences of primary health care. The survey incorporated standardized measures that reflected the key components of primary health care: access, continuity (informational, relationship, and management continuity), interprofessional communication, patient activation, and patient empowerment. Analyses of the survey data show that the RICHER approach does foster access to primary care for children and families facing significant poverty and multiple forms of social and material vulnerability, including family instability, housing challenges, and food insecurity. Moreover, the children accessing RICHER clinical programs have considerably higher rates of complex health conditions and developmental challenges than would be expected in a typical population. Parents also reported that, through engagement with RICHER clinicians, they acquired knowledge of their child's health condition, and felt well prepared to manage their child's condition, navigate the health care system, and mobilize needed supports and information. A major cornerstone of RICHER's success hinges on access and continuities of care and the formation and maintenance of relationships with individuals, community partners, and secondary and tertiary providers.

APPLICABILITY/TRANSFERABILITY:

The RICHER initiative builds on the insights of the social pediatrics approach developed by Dr. Gilles Julien to remove barriers to access, and thereby improve health and educational outcomes for inner-city children and youth. It also builds on research that has (1) demonstrated the impact of marginalization and exclusion on child and family health over the life course, (2) identified conditions that mitigate the impact of adversity on child health and development, and (3) identified the processes of care that are associated with improved health outcomes for populations vulnerable because of their social and material circumstances.

Content was adapted from the following sources and relevant websites:

http://www.healthcouncilcanada.ca/content.php?mnu=4&mnu1=34#Presentations

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External Source: http://www.bcchildrens.ca/Services/SpecializedPediatrics/RICHERInitiative/default.htm

An Interprofessional Model of Care That Integrates Musculoskeletal Ambulatory Services

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice was developed In response to the Ontario Wait Time Strategy to implement an interprofessional approach to improve access and care for patients requiring hip and knee replacement. The Advanced Practice Physiotherapist (APP) was introduced in 2006, leveraging existing health human resources to provide independent, comprehensive physical assessments for triage and post-operative follow up.

PRACTICE DESCRIPTION:

In response to the Ontario Wait Time Strategy, Sunnybrook's Holland Orthopaedic & Arthritic Centre implemented an interprofessional approach to improve access and care for patients requiring hip and knee replacement. The innovative role of an Advanced Practice Physiotherapist (APP) was introduced in 2006, leveraging existing health human resources to provide independent, comprehensive physical assessments for triage and post-operative follow up. The program has since evolved into a comprehensive hip and knee arthritis care strategy with community linkages. The successful team-based approach has now been transferred to shoulder and spine specialty clinics, which have been similarly gridlocked by a growing aging population, deficits in primary care, and a high volume of non-surgical patients.

Combining current research and input from all stakeholders (patients, surgeons, and administrative and leadership groups), system-wide changes were made using a nine-step framework and quality improvement methodology, specifically, *Plan-Do-Study-Act*. The following core program elements have been put in place:

- centralized referral intake using an electronic referral tracking system;
- a clearly defined role for an APP, with a three-month residency training program and surgeon evaluation;
- medical directives extending the physiotherapist's scope of practice to order diagnostic tests;
- referral triage and initial assessment by APPs within target time frames;
- selective referral to surgeons based on defined criteria;
- same-day preoperative health screening for surgical candidates;
- an emphasis on patient education, optimization, and choice of surgeon;
- post-operative follow-up and long-term surveillance by APPs;
- enhanced post-operative patient support and education; and
- community partnerships to support healthy active living.

IMPACT:

A structure-process-outcome framework is utilized to evaluate key program metrics as well as the impact of the role of the APP. The referral tracking system provides critical reports on Wait 1 (time from referral to assessment).

Results of formal research demonstrate that team-based care utilizing APPs can reduce wait times, improve care, and maintain high patient satisfaction. All referrals are triaged within two business days and patients are seen for initial assessment within three weeks of referral. Over 200 patients are seen per month for initial assessment by APPs, of whom 30% are diverted to conservative care. Wait 1 times are below the Toronto Centre LHIN target of 90 days. The number of surgical cancellations has dropped. In 2011, APPs performed over 4,500 post-operative follow-up visits for patients with primary joint replacement. Patient satisfaction is high: a sample of over 800 patients post–joint replacement completed the validated Visit-Specific Questionnaire (VSQ-9) in both surgeon and APP clinics. APPs scored either significantly higher ($p \leq 0.004$) or similarly to surgeons. Formal evaluation of the piloted shoulder program revealed similar findings. A pilot is underway in the spine program examining the level of agreement between surgeon and APP on the patient's need for surgical consultation and patient satisfaction. Streamlining referral management, shifting traditional practice boundaries, and extending the scope of appropriate medical

personnel improves musculoskeletal care and reduces burden. Engaging patients and all levels of staff in program improvement is critical to success.

APPLICABILITY/TRANSFERABILITY:

We have hosted numerous interprofessional teams seeking solutions to excessive wait times with limited health human resources and have been invited to deliver presentations across Canada to spread the change. Published results have sparked international dialogue, further demonstrating the transferability of core program elements. Sunnybrook's program is a highly acknowledged practice that is helping to shape musculoskeletal care delivery in a challenging economic time.

Content developed from the following sources and relevant websites:

Robarts, S., Kennedy, D., MacLeod, A. M., Findlay, H., & Gollish, J. (2008). A framework for the development and implementation of an advanced practice role for physiotherapists that improves access and quality of care for patients. *Healthcare Quarterly, 11*(2), 67-75; Kennedy, D. M., Robarts, S., & Woodhouse, L. (2010). Patients are satisfied with advanced practice physiotherapists in a role traditionally performed by orthopaedic surgeons. *Physiotherapy Canada, 62*(4), 298-305.

www.sunnybrook.ca

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External Source: http://www.sunnybrook.ca

Specialized Rehabilitation Outpatient Program

LOCATION:	Alberta	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Rehabilitation	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice focuses on outpatient redesign efforts targeted to increase access, improve service coordination across the care continuum, alignment of patients' needs to interventions, and use of the right mix of service providers. In January 2011, Glenrose Rehabilitation Hospital (GRH) in Edmonton, Alberta, redesigned its adult and geriatric outpatient services to support a province-wide initiative to improve inpatient flow.

PRACTICE DESCRIPTION:

In January 2011, Glenrose Rehabilitation Hospital (GRH) in Edmonton, Alberta, redesigned its adult and geriatric outpatient services to support a province-wide initiative to improve inpatient flow. Alberta Health Services had challenged GRH to admit five new patients per day to improve access to acute care. The outpatient redesign efforts targeted increased access, improved service coordination across the care continuum, alignment of patients' needs to interventions, and use of the right mix of service providers. The new Specialized Rehabilitation Outpatient Program (SROP) differs from traditional rehabilitation models in seven key areas: (1) service is organized by the World Health Organization (WHO) International Classification of Function (ICF) model—care is focused on function, not diagnosis; (2) person-centred services focused on "function for meaning full living"; (3) strengthened collaborative, interprofessional practice; (4) use of standardized practices and processes; (5) continuous decision-making based on qualitative and quantitative data; (6) development of a Rehabilitation Navigator; and (7) development and implementation of an Interprofessional Student Service. The role of the Rehabilitation Navigator is to oversee the outpatient care continuum, link with the patient and family before in-patient or clinic discharge, initiate goal setting with the patient/family, work with the GRH team and patient to identify a treatment plan, support the team in managing ongoing care needs, link with community partners, and act as the key contact for patient/family, GRH, and community supports. The objectives of the Interprofessional Student Service are to increase access to student clinical placements, support interprofessional collaborative practice, and increase access to GRH outpatient services. Discipline-specific supervisors oversee two to six intermediate to advanced students and supervise student caseloads. Prior to the outreach redesign, programs were organized by diagnosis; there was insufficient use of staff time, duplication in coordination responsibilities, no population-based outcomes measurement, and no oversight of care continuum; staffing coverage was problematic; and there was reduced flexibility to meet patient care needs.

An Outpatient Redesign Steering Committee was established under senior administrative and medical leadership to oversee the redesign, implementation, and evaluation of the expanded outpatient service in consultation with service leaders and front-line staff. This committee commissioned the formation of the SROP Working Group to support implementation at the operational level based on work plans and timelines, patient needs, flow algorithms, individual vs. group interventions, standardized protocols and processes, organizational infrastructure, and performance evaluation measures.

IMPACT:

Formal evaluation is currently underway, and a logic model and data matrix have been developed. Challenges identified early included a lack of a standardized ambulatory outcomes data set; inadequate infrastructure and support related to information technology, communication to staff, space for new clinicians and enhanced clinical care, and nursing coverage. Cultural change and the establishment of the organizational infrastructure and associated supports have been critical to the success of this initiative. Several factors played particularly important roles. These included the timely recruitment of key personnel, building standardized processes, and continuous communication and engagement with staff and physicians to identify and resolve issues and concerns in a timely way. Key accomplishments include greater interprofessional collaboration, the identification and implementation of outcome measures, and better access to rehabilitation technology. A critical component of the success of this service design is the development of the Rehabilitation Navigator role. In addition, the new service model supports the continuation of patient health, wellness, and participation through partnerships with health and non-health community services.

APPLICABILITY/TRANSFERABILITY:

Current plans are underway to expand SROP to include the pediatric population and to extend the Rehabilitation Navigator role

to include case management for complex (surgical, trauma) pediatric patients. In consultation with community partners, the model is also being expanded to support continued home living for older adults across the Edmonton area.

Content developed from the following sources and relevant websites:

http://www.healthcouncilcanada.ca/content.php?mnu=4&mnu1=34#Presentations

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Hamilton Family Health Team—Mental Health Program

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice was initially established in recognition that primary care physicians play a central role in delivering mental health care, often with minimal support from mental health services. Since 1994, the Hamilton Family Health Team (formerly Hamilton Health Service Organization) Mental Health Program (HFHT-MHP) has successfully integrated mental health counsellors and psychiatrists into the offices of 150 family physicians in 81 practices across the City of Hamilton.

PRACTICE DESCRIPTION:

Since 1994, the Hamilton Family Health Team (formerly Hamilton Health Service Organization) Mental Health Program (HFHT-MHP) has successfully integrated mental health counsellors and psychiatrists into the offices of 150 family physicians in 81 practices across the City of Hamilton. In 2006, addiction specialists and child mental health professionals were added to the program, serving selected practices. The program was initially established in recognition that primary care physicians play a central role in delivering mental health care, often with minimal support from mental health services. In addition, many individuals fail to seek or receive mental health services when needed, and primary care may be the only opportunity for identifying these problems and initiating treatment. The goals of the HFHT-MHP are to improve access to care, enhance the care experience for patients and providers, improve health outcomes, and increase capacity for primary care. The HFHT-MHP increases access by integrating mental health counsellors and psychiatrists into the practice team. They can see any individual with a mental health problem where the family physician requires assistance with little delay, and provide advice and ongoing support to the primary care team. They also assist primary care physicians to increase their skills and comfort in managing mental health problems, partly by being able to introduce evidence-based practices into their discussion of cases they have seen or informal case reviews. Mental health counsellors are permanently attached to the practices—1 FTE for every 7,200 patients—and a psychiatrist visits a half day per family physician per month. The program uses a “stepped” approach in a shared care model and emphasizes short-term care, although individuals can be seen on an ongoing or intermittent basis. Regular communication allows for better coordinated care and care plans. The model also offers opportunities for case discussions and reviews, continuing education in a brief case-based approach, early detection and intervention, relapse prevention and monitoring of individuals after an episode of treatment is completed, family interventions, and improved access to care, especially for people from ethno-cultural communities.

IMPACT:

Data on referrals, outcomes, and processes of care are collected routinely. An external evaluation of the program was done as part of the 2006 Primary Health Care Transition Fund.[1] Data from the first five years of the program demonstrated that it had improved access to mental health services by 1,100%, especially in underserved communities. It had also reduced the use of secondary and tertiary in-patient and out-patient services by 10% and 70% respectively, compared to the year before the program started. This improvement has been maintained over a 15-year period. The program demonstrated improved outcomes for individuals with mental health problems, better coordination of care, reduced system fragmentation, improved communication, and reduced wait times for services. It is more convenient, comfortable, and less stigmatizing for people using the service, and it has high provider and consumer satisfaction ratings, although this is based on descriptive data, and comparative data from other local mental health services are not routinely collected.

APPLICABILITY/TRANSFERABILITY:

The HFHT-MHP model has been adopted by other programs in Canada and in other countries and has become the prototype for the integration of specialized services within family health teams in Ontario. Program staff participated in the development of a 1997 position paper on shared mental health care in Canada,[2] which led to the establishment of the Collaborative Working Group on Shared Mental Health Care, a joint committee with representation from the Canadian Psychiatric Association and the College of Family Physicians of Canada. The program received a significant achievement award from the American Psychiatric Association in 1999.

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1. Vingilis, E., Paquette-Warren, J., Kates, N., Crustolo, A.-M., Greenslade, J., & Newman, S. (2007). Descriptive and process evaluation of a shared primary care program. *The Internet Journal of Applied Health Sciences and Practice, 5*(4). Retrieved from: http://ijahsp.nova.edu

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External Source: http://www.hamiltonfht.ca/i-am-a-patient/mental-health

Home First

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses the issue of of Alternate Level of Care (ALC) patients waiting for beds in long-term care facilities. In the last few years, Ontario has developed a Home First program that sends patients back to their communities and homes with intensive case management.

PRACTICE DESCRIPTION:

Canadian provinces and territories are looking for ways to manage the issue of Alternate Level of Care (ALC) patients. In Ontario, the problem has been particularly acute due to large waiting lists—and long waits—for beds in long-term care facilities. In the last few years, Ontario has developed a Home First program that sends patients back to their communities and homes with intensive case management. Clients receive several weeks of enhanced home care support, allowing seniors to see how well they manage at home before they make decisions about where they wish to live long-term. Home First allows seniors to make this potentially life-altering decision over time and in a familiar setting, rather than in a stressful and disorienting hospital environment.

Home First is as much a health care management philosophy as a program. Under Home First, transferring a patient from a hospital to a long-term care home is considered as a last resort only after other community options have been explored. This is better for patients and helps to reduce the demand and wait list for long-term care facilities. Home First was introduced in Ontario by the Mississauga- Halton Local Health Integration Network (LHIN) in 2008. The LHIN has invested significantly in expanding community support services for vulnerable seniors who were referred to long-term care after a hospitalization, but who could be cared for appropriately and safely in their own homes with enhanced home care services.

These types of improvements can lead to cost savings, improved flow through the system, and improved quality of life for many seniors. Over a two-year period, Home First programs for seniors in the Mississauga-Halton region have enabled 2,500 people to go home with support instead of staying longer in the hospital or being moved into long-term care.

All LHINs across Ontario are currently implementing Home First, although each is at a different stage of development. Each LHIN and Community Care Access Centre (CCAC) determines the types of services and hours allotted to Home First clients, based on availability of resources and services within the region. A Home First Implementation Guide and Toolkit was produced in February 2011 by the advisory body for the LHINs (see www.lhincollaborative.ca).

External Source: http://www.lhincollaborative.ca/Page.aspx?id=1902