Health Innovation Portal:
Archive of Innovative Practices

Theme: **Access and Wait Times (Vol. 2)**

January 2014

Health Council of Canada
Conseil canadien de la santé

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:	40 results out of 80

1. Saskatoon Primary Health Bus

Implementation Year: Tuesday, December 9, 2008 - 15:45	Location: Saskatchewan	Practice Website: http://www.saskatoonhealthregion.ca/your_health/ps_primary_health_health_bus.htm

SNAPSHOT:

This innovative practice improves access to care in low-income neighbourhoods. The practice was launched in Saskatoon, Saskatchewan, and involves nurse practitioners and paramedics.

CONTACT INFORMATION:

Sheila Achilles, Director Primary Health and Chronic Disease Management Primary Health St. Paul's Hospital 1702-20th Street West Saskatoon, SK S7M 0Z9 Telephone: (306) 655-5806

2. Health Care Connect

Implementation Year: Wednesday, December 9, 2009 - 15:00	Location: Ontario	Practice Website: http://www.health.gov.on.ca/en/ms/healthcareconnect

SNAPSHOT:

This innovative practice assists patients who do not have a consistent primary care provider, especially patients with high needs for care, to obtain the support of one.. The practice was launched throughout Ontario and involves nurse "care connectors," based in Community Care Access Centres, who attach patients to family physicians and nurse practitioner-led clinics. The initiative is voluntary for patients and providers.

CONTACT INFORMATION:

ServiceOntario, Infoline Telephone: 1-866-532-3161

3. Access Registries (Guichet d'accès pour la clientele sans médecin de famille)

Implementation Year: Tuesday, December 9, 2008 - 14:30	Location: Quebec	Practice Website:

SNAPSHOT:

This innovative practice links unattached (orphan) patients to family physicians willing to accept new patients. The practice was launched in the 95 local areas across Quebec and involves registry nurses and a family physician coordinator for each area.

CONTACT INFORMATION:

Johanne Caseault Conseillère en affaires intergouvernementales Direction des affaires intergouvernementales et de la coopération internationale Ministère de la Santé et des Services sociaux 1005, chemin Ste-Foy, 1er étage Québec (Québec) G1S 4N4 Téléphone: (418) 266-5838 Télécopieur: (418) 266-8755

4. Express Chemotherapy Clinic

Implementation Year: Wednesday, November 27, 2013 - 09:45	Location: Ontario	Practice Website: http://www.sickkids.ca/Nursing/Nursing-Excellence/2010-Nursing-Excellence-Awards/2010%20Award%20Recipient%20Profiles/NEA2010-HeamONC-clinic.html

SNAPSHOT:

This innovative practice expedites chemotherapy services for children managing acute lymphoblastic leukemia. This Express Clinic was developed as a pilot project in 2004 at the Hospital for Sick Children in Toronto and is still in practice today. Using resource reallocation, this model maximizes health human resources and efficiency of care without increasing costs.

CONTACT INFORMATION:

Name: Eleanor Hendershot Title: Clinical Nurse Specialist-Nurse Practitioner; Lecturer Organization: The Hospital for Sick Children; University of Toronto Email address: eleanor.hendershot@sickkids.ca Telephone number: 416-813-7515 Information last updated on: July 15, 2013

5. System-Wide Case Management

Implementation Year: Wednesday, November 26, 2008 - 14:15	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=7573

SNAPSHOT:

This innovative practice improves the coordination of care for persons managing chronic illness. The system-wide case management model was first launched in the Calgary region in Alberta in January 2008 as an 18-month pilot project. At that time, seven case managers were hired; within a year, over 200 clients were enrolled in the program. While the model has changed from its original scope and patient population targets, system-wide case management is still in practice in community care settings in the Calgary Region.

CONTACT INFORMATION:

Name: Barbra LeMarquand-Unich Title: Executive Director (Interim) Organization: Integrated Seniors and Continuing Care (Calgary Zone) Email address: barbra.lemarquand-unich@albertahealthservices.ca Telephone number: 403-943-0252 Information last updated on: August 8, 2013

6. Supporting Aboriginal Seniors at Home (SASH), Southwest Ontario Aboriginal Health Access Centre

Implementation Year: Friday, November 26, 2010 - 10:15	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice provides culturally safe care to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. In doing so, the practice addresses disparities between the life expectancy and the incidence of chronic disease for Aboriginal and non-Aboriginal seniors. It was launched in Ontario at an Aboriginal Health Access Centre, and involved a nurse practitioner, a senior's health advocate, and a patient navigator.

CONTACT INFORMATION:

Name: Barb Chrysler Title: Manager, Primary Care Organization: Southwest Ontario Aboriginal Health Access Centre Email address: bchrysler@soahac.on.ca Telephone number: (519) 289 0352 Information last updated on: September 23, 2013

7. Adapting the Non-Insured Health Benefits (NIHB) program to meet the needs of First Nations elders – Policy Tools, Pharmaceutical Medication and Rural/Remote Travel.

Implementation Year: Saturday, November 26, 2011 - 10:00	Location: New Brunswick, Newfoundland & Labrador, Nova Scotia, Prince Edward Island	Practice Website:

SNAPSHOT:

This innovative practice addresses the need for improvement in FNIHB's programs and services in the Atlantic region, to better meet the needs of Elders and improve their health and wellbeing. The Strategic Plan for Atlantic First Nations Elder Care was launched in January 2011. FNIHB Atlantic works collaboratively with

the Mi'kmaq Maliseet Atlantic Board to implement the plan.

CONTACT INFORMATION:

Name: Louise Cholock Title: Director, NIHB Organization: Health Canada, First Nations and Inuit Health Branch, Atlantic Region Email address: Louise.Cholock@hc-sc.gc.ca Telephone number: (902) 426-2519 Information last updated on: October 7, 2013

8. Pooled Referrals to Specialist Care in Saskatchewan

Implementation Year: Thursday, October 7, 2010 - 14:45	Location: Saskatchewan	Practice Website: http://www.sasksurgery.ca/provider/pooledreferrals.html

SNAPSHOT:

This innovative practice addresses the issue of improving access to and decreasing wait times for specialist services by matching the flow of referrals to the capacity of specialists through a standardized, centralized referral process. The program launched in Saskatchewan in June 2010 and has now expanded to 20 specialist practices in the province.

CONTACT INFORMATION:

Name: Ron Epp Title: Senior Project Manager Organization: Saskatchewan Surgical Initiative Email address: repp@health.gov.sk.ca Telephone number: 306-787-7261

9. MRI Process Improvement Project: Improving patient access to imaging services

Implementation Year: Tuesday, October 7, 2008 - 14:00	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of improving patient access to magnetic resonance imaging (MRI) services through improvements to MRI administrative processes. Between October 2008 and March 2012, all Ontario-based MRI facilities have participated in this program.

CONTACT INFORMATION:

Name: Nahi Siklos, Senior Project Manager Organization: University Health Network Email address: nahi.siklos@uhn.ca Telephone number: (416)-603-5800 ext: 2911

10. The Mental Health Engagement Network: Providing Patients Access to Personalized Health Records via Smartphone Technology

Implementation Year: Tuesday, October 9, 2012 - 14:00	Location: Ontario	Practice Website: http://publish.uwo.ca/~cforchuk/MHEN/side.html

SNAPSHOT:

This innovative practice addresses the issue of providing mobile patient-centred care for individuals diagnosed with a mental illness. The practice was launched in London, Ontario, and involved 55 mental health care professionals.

CONTACT INFORMATION:

Name: Cheryl Forchuk Title: Lead Investigator Organization: University of Western Ontario/Lawson Health Research Institute Email address: cforchuk@uwo.ca Telephone number: (519) 685-8500 ext. 77034

11. Intensive Outpatient Rehabilitation Program for Stroke Survivors and Limb Amputees

Implementation Year: Friday, October 7, 2011 - 14:00	Location: British Columbia	Practice Website: http://www.viha.ca/adult_rehab_services/outpatient_programs/iorp.htm

SNAPSHOT:

This innovative practice addresses the need to increase access to rehabilitation services for stroke or limb amputees through an interprofessional team supporting patients to reintegrate in their community. This practice was initiated in October 2011 in two communities in the Vancouver Island Health Authority (VIHA).

CONTACT INFORMATION:

Name: Marci Ekland, Manager Rehab, Services and Regional OP Program Organization: Vancouver Island Health Authority Email address: marci.ekland@viha.ca Telephone number: (250) 755-7681 ex 52333

12. Group Medical Visits: An Initiative to Improve Access, Efficiency, and Health Outcomes among Patients with Chronic Disease

Implementation Year: Tuesday, October 7, 2008 - 13:15	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of increasing the efficiency of family practices and improving the health outcomes and treatment experience of patients with chronic disease. The initiative was launched in family practices across British Columbia, and each session typically involves family physicians, allied health professionals, and medical office assistants.

CONTACT INFORMATION:

Name: Liza Kallstrom Title: Lead, Content and Implementation, Practice Support Program Organization: BC Medical Association Email address: lkallstrom@bcma.bc.ca Telephone number: 604-638-2854

13. A GP for Me: An Initiative to Match British Columbians with Family Doctors

Implementation Year: Wednesday, February 3, 2010 - 11:00	Location: British Columbia	Practice Website: http://www.agpforme.ca/

SNAPSHOT:

This innovative practice addresses the issue of strengthening the primary health care system and improving health outcomes by helping people who want a family doctor to get one. The pilot project was launched in British Columbia in three communities and involved approximately 300 family physicians.

CONTACT INFORMATION:

Name: Jonathan Agnew Title: Executive Director, Practice Support & Quality Organization: BCMA Email address: jagnew@bcma.bc.ca Telephone number: (604) 638-2833

14. CareOregon's The Productive Ward (Releasing Time to Care)

Implementation Year: Wednesday, February 4, 2009 - 01:00	Location: International	Practice Website: http://www.careoregon.org/TransformingHealthcare/ReleasingTimetoCare.aspx

SNAPSHOT:

This innovative practice aims to improve nurses' workflow in order to increase the amount of time dedicated to direct patient care. Originally developed in the United Kingdom, the practice was launched in four hospitals in Oregon, United States, and involved a chief nurse executive, a nurse manager from a showcase unit, a program facilitator, and one or two staff nurses from a showcase unit.

CONTACT INFORMATION:

Name: Barbara Kohnen Adriance Title: Manager, Governance and Business Plan Development Organization: Care Oregon Email address: kohnenb@careoregon.org Telephone number: 503-416-3675 Information last updated on: July 2, 2013

15. High Acuity Response Team (HART)

Implementation Year: Tuesday, March 2, 2010 - 00:30	Location: British Columbia	Practice Website: N/a

SNAPSHOT:

This innovative practice addresses the provision of mobile intensive care to rural hospitals that do not have critical care services in an effort to stabilize and sustain patient care and, when necessary, transport patients to a higher level of care. The practice was launched in British Columbia in one health region, Trail, and involved six critical care nurses, a basic life-support ambulance team, and, occasionally, a respiratory therapist.

CONTACT INFORMATION:

Name: Brent Hobbs Title: Regional Director, Patient Transportation Services Organization: Interior Health Email address: Brent.Hobbs2@interiorhealth.ca Telephone number: 250-870-5758 Information last updated on: July 2, 2013

16. Canadian Pediatric Surgical Wait Times (CPSWT) Project

Implementation Year: Sunday, February 3, 2013 - 00:30	Location: National	Practice Website: http://www.ccyhc.org/work_surgical_projects.html

SNAPSHOT:

This innovative practice addresses the issue of pediatric surgical wait times by providing a comprehensive, comparable prioritization wait-time information system for this population. The practice was launched in 15 pediatric academic health sciences centres across Canada and involved surgeons, information technology (IT) staff, and project site coordinators.

CONTACT INFORMATION:

Name: Dr. James G. Wright Title: Surgeon-in-Chief, Department of Surgery Organization: The Hospital for Sick Children Email address: james.wright@sickkids.ca Telephone number: 416.813.5018

17. The Sherbourne Health Centre Infirmary: Cancer care for homeless or underhoused populations

Implementation Year: Wednesday, March 2, 2011 - 00:45	Location: Ontario	Practice Website: http://www.sherbourne.on.ca/programs/infirmary.html

SNAPSHOT:

This innovative practice addresses the issue of housing individuals who are homeless or underhoused and who have cancer or other acute medical conditions. The practice was launched in Ontario in one clinical setting in Toronto and involves a coordinated team of the Community Care Access Centre (CCAC), oncologists, and Sherbourne Health Centre staff.

CONTACT INFORMATION:

Name: Dr. Laura Pripstein Title: Medical Director Organization: Sherbourne Health Centre Telephone number: 416-324-5064 Information last updated on: June 14, 2013

18. All-Access Dentistry: Specialized Geriatric Dental Services

Implementation Year: Wednesday, March 2, 2011 - 00:45	Location: Ontario	Practice Website: http://www.runnymededentalcentre.com/

SNAPSHOT:

This innovative dental practice addresses the issue of enhancing access to oral care for people with limiting physical, medical, or cognitive conditions. The clinic aims to smoothly integrate dental clinic services for a spectrum of patients, including the most complex cases. The practice was launched in Ontario in January 2011 in an independently owned specialized dental clinic operating in a hospital setting.

CONTACT INFORMATION:

Name: Dr. Natalie Archer Title: Organization: Runnymede Dental Centre Email address: runnymededental@drarcher.ca Telephone number:

416-763-2000 Information last updated on: May 1 2013

19. Burntwood CHRC Advanced Access and Clinical Practice Redesign

Implementation Year: Friday, February 1, 2008 - 00:00	Location: Manitoba	Practice Website: http://www.gov.mb.ca/health/primarycare/access/advancedaccess.html

SNAPSHOT:

This innovative practice addresses the issue of wait times and the need for access to early diagnosis and treatment for patients. The practice was launched in Manitoba and is implemented throughout 30 clinics with the aim of 75 per cent of primary care clinics to be trained in Advanced Access by 2015. This practice involves as few as two and as many as 14 staff including physicians, nurses, nurse practitioner, dietitian, family counsellor, midwife, health promotion staff, risk factor coach, Aboriginal liaison workers and various support staff working in access improvement teams.

CONTACT INFORMATION:

Name: Jo-Anne Lutz Title: Director, Primary Care Clinics Organization: Northern Health Region Email address: jlutz@brha.mb.ca Telephone number: 204-677-1796 Information last updated on: April 15, 2013

20. Transitioning Patients between BC Cancer Agency and Vancouver – Acute Services

Implementation Year: Tuesday, February 3, 2009 - 00:30	Location: British Columbia	Practice Website: http://www.vch.ca/home/

SNAPSHOT:

This innovative practice addresses how best to facilitate patient transfers between regional health authorities.

CONTACT INFORMATION:

Name: Sue Fuller Blamey Title: Corporate Director, Quality & Safety Organization: Provincial Health Services Authority Email address: sue.fuller-blamey@bccancer.bc.ca Telephone number: 604-877-6198 or 604-788-3175 Information last updated on: March 27, 2013

21. Specialist Directory

Implementation Year: Tuesday, February 3, 2009 - 00:30	Location: Saskatchewan	Practice Website: https://www.sma.sk.ca/Default.aspx?cid=642&lang=1

SNAPSHOT:

This innovative practice aims to increase access to care and decrease wait times by showing patients that they can access equally qualified specialists with shorter wait times.

CONTACT INFORMATION:

Name: Ron Epp Title: Senior Project Manager Organization: Saskatchewan Ministry of Health Email address: ron.epp@gov.sk.ca Telephone number: 306-787-7261 Information last updated on: March 24, 2013

22. Collaborative Emergency Centres (CECs)

Implementation Year: Monday, February 7, 2011 - 00:45	Location: Nova Scotia	Practice Website: http://novascotia.ca/health/betterCareSooner/

SNAPSHOT:

This innovative practice aims to provide enhanced health care and expanded access to primary health care through collaborative teams that include physicians, nurse practitioners, registered nurses (RN), and paramedics in each community.

CONTACT INFORMATION:

Name: Dr. John Ross MD, FRCPC Title: Emergency Physician, Professor, Department of Emergency Medicine, Dalhousie University Provincial Advisor on Emergency Care, Department of Health, Nova Scotia Organization: Dalhousie University Email address: john.ross@dal.ca Telephone number: (902) 473-2164

23. Process Improvement Initiative in Endoscopy

Implementation Year: Wednesday, February 3, 2010 - 00:00	Location: Newfoundland & Labrador	Practice Website: http://www.centralhealth.nl.ca/

SNAPSHOT:

This innovative practice is a provincial wait time strategy for endoscopy services.

CONTACT INFORMATION:

Name: Tracy MacDonald Title: Regional Wait Time Manager Organization: Central Health Email address: Tracy.macdonald@centralhealth.nl.ca Name: Judy Budgell Title: Provincial Wait Time Consultant – Access & Clinical Efficiency Division Organization: Department of Health and Community Services, Government of Newfoundland and Labrador Email address: judy.budgell@centralhealth.nl.ca

24. Orthopedic Central Intake Project

Implementation Year: Tuesday, February 9, 2010 - 00:00	Location: Newfoundland & Labrador	Practice Website: http://www.cfhi-fcass.ca/Libraries/Taming_of_the_Queue_English/2012Poster-OrthopedicCentralIntakePoster.sflb.ashx

SNAPSHOT:

This innovative practice aims to facilitate the referral of orthopedic patients to the next available surgeon, keeping track of the referral status, and involving all health care providers throughout the process.

CONTACT INFORMATION:

Name: Michelle Alexander Title: Project Lead, Orthopedics Organization: Eastern Health Email address: michelle.alexander@easternhealth.ca Telephone number: 709-777-1320 Information last updated on: March 24, 2013.

25. Path to Care: Referral and Wait Time Measurement and Management

Implementation Year: Wednesday, February 3, 2010 - 00:45	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/

SNAPSHOT:

This innovative practice aims to improve access and reduce health care service and referral wait times through a province wide program. This practice was launched in Alberta in 2010 and aims to develop and implement provincially adjudicated referral standards.

CONTACT INFORMATION:

Name: Allison Bichel, MPH MBA Title: Executive Director Access Organization: Alberta Health Services Email address: allison.bichel@albertahealthservices.ca Telephone number: 403-617-6642

26. Nova Scotia Breast Screening Program – Wait Time Reporting

Implementation Year: Wednesday, February 3, 2010 - 00:15	Location: Nova Scotia	Practice Website: http://breastscreening.nshealth.ca/

SNAPSHOT:

This innovative practice addresses the issue of performance measurement by reporting on nine indictors related to wait times and breast screening. Launced in

Nova Scotia in 2010, results are provided to the public via the provincial wait times website.

CONTACT INFORMATION:

Name: Ryan Duggan Title: Data Analyst/Project Co-ordinator Organization: Nova Scotia Breast Screening Program Email address: Ryan.Duggan@cdha.nshealth.ca Telephone number: 902-488-0839

27. myDDSNetwork Collaborative Model for Dentistry Referrals

Implementation Year: Friday, February 3, 2012 - 00:15	Location: National	Practice Website: http://www.ereferralpilot.com/

SNAPSHOT:

This innovative practice addresses the need to support the exchange and collaboration of personal health information (PHI) between dental providers. Launched at the end of 2012, all dentists in Canada now have access to a standardized referral and consultation platform to exchange PHI.

CONTACT INFORMATION:

Name: Dr. Jeff Glaizel Title: President and CEO Organization: myDDSnetwork Ltd. Email address: drjeff@myddsnetwork.com Telephone number: 416-579-9679

28. The Arthritis Alliance of Canada's National Musculoskeletal Models of Care Working Group and Master Worksheet

Implementation Year: Tuesday, February 1, 2011 - 00:30	Location: National	Practice Website: http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf

SNAPSHOT:

This innovative practice addresses the need for health care professionals across Canada to deliver the most efficient models of care (MoCs) for musculoskeletal (MSK) patients. The working group was launched in 2011 with the purpose of determining the importance and applicability of MoCs in treating MSK conditions and then to devise a strategic framework that is both evidence-based and consensus-based.

CONTACT INFORMATION:

Name: Dr. Cyril B. Frank Title: Lead, Models of Care Working Group Organization: The Arthritis Alliance of Canada Email address: cfrank@ucalgary.ca Telephone number: 403-220-6881

29. Shared Care Strategy for Patients with Chronic Diseases—Patients in Care, Providence Health Centre

Implementation Year: Thursday, February 4, 2010 - 00:45	Location: British Columbia	Practice Website: http://www.healthcouncilcanada.ca/tree/symposium2012/C1_CareCoordinationWorkshop_Wilson_EN.pdf

SNAPSHOT:

This innovative practice consisted of several projects all aimed at facilitating a seamless patient experience through better collaboration between health care providers. Launched in April 2010 in two health authorities in British Columbia, the core of initiatives are to strengthen relationships between family practitioners (FPs) and specialists to ensure that referrals are timelier and to avoid duplicating effort and resource utilization.

CONTACT INFORMATION:

Name: Margot Wilson Title: Director, Chronic Disease Management Strategy Organization: Providence Health Care Shared Strategy Email address: mwilson@providencehealth.bc.ca Telephone number: 604-682-2344 ext. 66522

30. Spine Pathway Project

Implementation Year: Tuesday, February 3, 2009 - 00:45	Location: Saskatchewan	Practice Website: http://www.health.gov.sk.ca/back-pain

SNAPSHOT:

This innovative practice aims to increase medical training in screening methods, establish spine centres dedicated to effective screening of lower spine pathologies, and develop a system to offer appropriate management resources for lower back pain and injuries. Launched by the government of Saskatchewan in 2009, the end goals of this initiative are to provide appropriate patient care to those with lower back pain and injuries and to increase the amount of time available for specialists to perform other much-needed spinal surgeries.

CONTACT INFORMATION:

Name: Brad Waddell Title: Project Manager, Research and Clinical Pathways Development Organization: Ministry of Health, Acute and Emergency Services Branch Email address: brad.waddell@health.gov.sk.ca Telephone number: (306) 787-2424

31. Youth Transitions to Adult Care in BC

Implementation Year: Wednesday, February 1, 2012 - 00:15	Location: British Columbia	Practice Website: https://www.bcma.org/youth-transitions-initiative

SNAPSHOT:

This innovative practices facilitates the successful transition of patients from pediatric to adult care involves the provision of uninterrupted, coordinated, developmentally appropriate, and psychologically sound health care. In June 2011, the British Columbia Medical Association's (BCMA) Council on Health Economics and Policy approved a project on youth transition in BC.

CONTACT INFORMATION:

Name: Jonathan Agnew Organization: British Columbia Medical Association Email address: jagnew@bcma.bc.ca

32. Transformation by Design in Ontario

Implementation Year: Tuesday, February 3, 2009 - 00:30	Location: Ontario	Practice Website: http://www.providence.on.ca

SNAPSHOT:

This innovative practice addreses the need to fundamentally transform the way hospitals deliver health care in order to improve patient flow, given that the organization was being confronted with an increased acuity of patients in the health care system. Launched in Providence Healthcare in Ontario, the project's aim was to create a new model for improved patient flow that would in turn also improve quality of care. Improvements are focused on managing two transitions in a patient's journey to wellness: the transfer from an acute care hospital to the Providence in-patient rehabilitation care, and the transfer from in-patient to home with outpatient clinic support.

CONTACT INFORMATION:

Name: Heidi Hunter Title: Quality Improvement Manager Organization: Providence Healthcare Email address: hhunter@providence.on.ca Telephone number: 416-285-3666, ext. 4424

33. Virtual Ward, South East Toronto Family Health Team

Implementation Year: Thursday, February 3, 2011 - 00:30	Location: Ontario	Practice Website: http://www.cadth.ca/products/environmental-scanning/environmental-scans/environmental-scan-27

SNAPSHOT:

This innovative practice targets older adults with complex health needs that are re-admitted to hospital at a higher than average rate than the rest of the population. To better serve the needs of this complex patient population, a virtual ward (VW) was embedded in the South East Toronto Family Health Team (SETFHT), located across the road from the Toronto East General Hospital (TEGH) in 2011. The goals of the program are to provide this population with improved follow-up after hospital discharge, to identify and assist the growing population of unattached patients who do not have access to primary care, and to admit these patients to a VW to assist with transition back home from hospital.

CONTACT INFORMATION:

Name: Dr. Thuy-Nga (Tia) Pham Title: Lead Family Physician Organization: South East Toronto Family Health Team Email: thuynga.pham@utoronto.ca

34. Integrated Discharge Planning

Implementation Year: Wednesday, February 2, 2011 - 00:45	Location: Ontario	Practice Website: http://www.headwatershealth.ca/

SNAPSHOT:

This innovative practice is a framework for discharge planning to streamline processes and improve system navigation for clients and their families. Beginning as a one-year pilot project in 2011 between the Headwaters Health Care Centre (HHCC) and the Central West Community Care Access Centre (CCAC) in Ontario, the programs success has led to the recent adoption of this role and partnership into standard practice.

CONTACT INFORMATION:

Name: Mary Wheelwright Title: Program Director, Rehabilitation, Medicine and Complex Continuing Care Organization: Headwaters Health Care Centre Email address: mwheelwright@headwatershealth.ca

35. Integrated Comprehensive Care at St. Joseph's

Implementation Year: Friday, February 3, 2012 - 00:45	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice is a collaborative model of care that integrates the transition of patients from the hospital to the community. Launched in St. Joseph's Healthcare, Hamilton and St. Joseph's Home Care, Hamilton, in March 2012, the objectives of the project are to explore the benefits of integrated case management and to evolve the existing case management model into a patient-centred model that follows the patient across the continuum of care.

CONTACT INFORMATION:

Name: Carolyn Gosse Organization: St. Joseph's Healthcare, Hamilton Email address: cgosse@stjosham.on.ca

36. Canadian Medical Association's Referral and Consultation Process Toolbox

Implementation Year: Wednesday, February 10, 2010 - 00:45	Location: National	Practice Website: http://www.cma.ca/referrals

SNAPSHOT:

This innovative practice addresses the challenges experienced on both ends of a patient referral that are common for all physicians in all areas of the country; examples include insufficient communication between primary and specialty care, inefficient triage processes, or referral requests sent to the wrong specialist. In October 2010, Health Canada agreed to support the CMA to investigate possible solutions to problems such as these, with assistance from the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (Royal College).

CONTACT INFORMATION:

Name: Kelly Higdon Title: Senior Health Economist Organization: Canadian Medical Association Email address: kelly.higdon@cma.ca Telephone number: 1-800-663-7336 x 2208

37. Rapid Access to Consultative Expertise (RACE)

Implementation Year: Wednesday, February 3, 2010 - 00:45	Location: British Columbia	Practice Website: www.RACEconnect.ca

SNAPSHOT:

This innovative practice aims to redesign the collaboration between specialists and family physicians (FPs) with respect to the development, implementation,

sustainability, and spread of FP-to-specialist interactions to improve population health outcomes, improve patient and provider experiences, and reduce per capita system costs. Launched in early 2010 in BC's Providence Health Care, the Rapid Access to Consultative Expertise (RACE) model ensures telephone calls from FPs are routed directly to a specialist's cellphone or pager for "just in time" advice.

CONTACT INFORMATION:

Name: Margot Wilson Title: Director, Chronic Disease Management Strategy Organization: Providence Health Care Email address: mwilson@providencehealth.bc.ca

38. Ontario's Centre for Family Medicine Mobility Clinic

Implementation Year: Monday, February 1, 2010 - 00:00	Location: Ontario	Practice Website: http://family-medicine.ca/events-and-clinics/clinics/mobility-clinic/

SNAPSHOT:

This innovative practice facilitates increased access for mobility-impaired patients to family physicians; improves care for patients with mobility challenges; promotes awareness of mobility issues through education; and develops further clinical, education, and research projects. In operation since January 2010, the Centre for Family Medicine Family Health Team established a fully accessible, interprofessional primary health care Mobility Clinic in Kitchener, Ontario.

CONTACT INFORMATION:

Name: Dr. James Milligan Organization: Centre for Family Medicine Family Health Team Email address: james.milligan@medportal.ca Telephone number: 519-783-0022

39. Partners in Care Initiative

Implementation Year: Thursday, February 4, 2010 - 00:30	Location: British Columbia	Practice Website: https://www.bcma.org/partners-care-initiative

SNAPSHOT:

This innovative practice addresses the pressures and increasing challenges in the health care system call for transformation and system redesign. In April 2010, Providence Health Care partnered with the British Columbia Shared Care Committee (a joint committee of the BC Ministry of Health and the BC Medical Association) in collaboration with Vancouver Coastal Health (VCH) to facilitate collaboration between family physicians and specialists in regions throughout the province. Their aims were to improve and transform care for patients with complex chronic conditions, and to support and maintain the locus of care for chronic disease management in the community.

CONTACT INFORMATION:

Name: Margot Wilson Title: Director, Chronic Disease Management Strategy Organization: Providence Health Care Email address: mwilson@providencehealth.bc.ca Telephone number: 604-682-2344, extension 66522

40. Building Access to Specialist Care through e-Consultation: The Champlain BASE Project

Implementation Year: Wednesday, February 3, 2010 - 00:45	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice addresses the need to improve patient care by increasing primary health care providers' access to specialists.

CONTACT INFORMATION:

Name: Dr. Clare Liddy Title: Physician and Assistant Professor Organization: University of Ottawa and The Ottawa Hospital Email address: cliddy@bruyere.org Telephone number: 613-889-1016 Information last updated: November 14, 2012

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Saskatoon Primary Health Bus

LOCATION:	**Saskatchewan**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	

Snapshot: This innovative practice improves access to care in low-income neighbourhoods. The practice was launched in Saskatoon, Saskatchewan, and involves nurse practitioners and paramedics.

Practice Description:

A 2006 study examining health disparities by neighbourhood in Saskatoon showed that low-income neighbourhoods have a higher than average use of health care, higher burdens of illness (including mental disorders, diabetes, chronic obstructive pulmonary disease, coronary artery disease, chlamydia, gonorrhea, hepatitis C), higher rates of teen births, and greater likelihood of low birth weights. Primary health care managers in Saskatoon Health Region recognized that residents of these neighbourhoods (primarily First Nations people, Métis, immigrants, and refugees) could not access primary care easily. To address this concern, they converted a recreational vehicle to serve as a mobile clinic with a fully equipped examination room. The Health Bus, which is staffed by nurse practitioners and paramedics, operates daily to provide primary care services to patients at various locations that are convenient to the residents. Services include blood pressure and blood sugar checks, diagnosis and treatment of common illness and injuries, testing for sexually transmitted infections, provision of free condoms, pregnancy testing, suturing and suture removal, wound care, management of chronic conditions, disease prevention, health education, advocacy, and referral. A community advisory committee helps guide Health Bus operations.

Impact:

The Saskatoon Health Region has tracked program utilization and demographic information of users. During the 2011/12 calendar year, 2,777 patients visited the bus (Saskatoon Health Region, 2012). The majority of visits were for integumentary or ENT conditions. The service was most heavily used by women and by people in the 0–9 and 20–59 age groups.

This innovative practice has been implemented since 2008 and does not have a completed evaluation at this time. 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. Early evidence suggests mobile clinics improve screening for chronic conditions (diabetes and hypertension) and coordination of care (Conference Board of Canada, 2012).

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 commitment to unique interprofessional primary health care teams; investment of resources for primary health care services to a small number of people; and engagement of community members in discussions of the scope of services and location of the bus.

The Health Bus has not been adapted from another jurisdiction. Three mobile primary care clinics designed to serve patients in rural and northern Manitoba communities who do not have a family physician are scheduled for implementation in 2013.

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

This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

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Canadian Health Services Research Foundation. (2010). Saskatoon Health Bus. In *Casebook of primary healthcare innovations: Picking up the pace.* Ottawa, ON: Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/CasebookOfPrimaryHealthcareInnovations.sflb.ashx

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External Source: http://www.saskatoonhealthregion.ca/your_health/ps_primary_health_health_bus.htm

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Health Care Connect

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

Snapshot:

This innovative practice assists patients who do not have a consistent primary care provider, especially patients with high needs for care, to obtain the support of one.. The practice was launched throughout Ontario and involves nurse “care connectors,” based in Community Care Access Centres, who attach patients to family physicians and nurse practitioner-led clinics. The initiative is voluntary for patients and providers.

Practice Description:

Due to the substantial numbers of Ontarians with no regular primary care provider (often called *unattached patients*), the Ministry of Health and Long-Term Care launched the Health Care Connect program in February 2009 to link the two. Unattached patients can register for Health Care Connect (or be registered by a substitute decision-maker) either by telephone or online. Registration includes the completion of a brief health questionnaire to determine the registrant’s level of need for primary care services. The questionnaire content is based on research on the determinants of primary care need conducted at the McMaster University Centre for Health Economics and Policy Analysis; it includes self-assessed health status, chronic health conditions, activity limiting disability, mental health status, and body mass index. The patient’s registration information is forwarded to a “care connector nurse” based in the local Community Care Access Centre, who attempts to identify a family physician or nurse practitioner-led clinic in the registrant’s community that is accepting new patients. Priority for linkage is given to registrants identified as having the highest need for services. Primary care physicians who accept a high-needs patient receive bonus payments for enrolling the patient and for the patient’s first year of care.

Impact:

This innovative practice has been in place since 2009. While the practice 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.

The Ministry of Health and Long-Term Care has tracked program utilization and results (connection of patients to a primary care provider) overall and by local health integration network (LHIN) since the program’s inception. By June 30, 2013, 279,072 patients had registered with the program, of whom 79.1% (78.9% of those with high needs) were matched with a provider. Attachment rates have varied among the 14 LHINs from 45.6% (North West) to 95.6% (Hamilton Niagara Haldimand Brant).

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

Applicability/Transferability

Access registries have also been established in Quebec (2008), New Brunswick (2013), and Alberta. However, the practice informant was unable to identify which practice came first and if there was collaboration among the provinces.

Health Care Connect has been implemented throughout Ontario. The local success of the program is dependent on obtaining the buy-in of stakeholders through consultations; marketing the initiative to patients; educating primary care providers about the initiative; and the capacity, expertise, and willingness of primary care providers to accept new patients.

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

This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

http://www.health.gov.on.ca/en/ms/healthcareconnect/pro/

Breton, M., Ricard, J., & Walter, N. (2012). Connecting orphan patients with family physicians: Differences among Quebec's access registries. *Canadian Family Physician, 58*(9),921–922. Retrieved from http://171.66.125.180/content/58/9/921.full

Fowler, S. (2013, August 8). *New patient registry matches 800 people with doctors.* Retrieved from http://www.cbc.ca/news/canada/new-brunswick/story/2013/08/08/nb-patient-registry-doctor.html

External Source: http://www.health.gov.on.ca/en/ms/healthcareconnect

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Access Registries (Guichet d'accès pour la clientele sans médecin de famille)

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

Snapshot: This innovative practice links unattached (orphan) patients to family physicians willing to accept new patients. The practice was launched in the 95 local areas across Quebec and involves registry nurses and a family physician coordinator for each area.

Practice Description:

To address the issue of orphaned patients, the Ministère de la Santé et des
Services sociaux and the Fédération des médecins omnipraticiens du Québec implemented 95 access registries to improve access to family physicians. The program is managed through the 95 local health networks (Centres de la Santé et des Services sociaux (CSSSs)) by registry nurses and medical coordinators. These coordinators are family physicians who are remunerated for the role and are accountable to the regional department of family medicine (Département regional de medicine générale). Patients seeking a family physician register by telephone with the local CSSS. A registry nurse contacts callers "within a few days or weeks" by telephone to complete the registration. The nurse assesses the client's health in relation to 14 types of vulnerability defined by the Quebec health insurance board (Régie de l'assurance maladie du Québec), such as diabetes, chronic obstructive pulmonary disease, and mental health conditions.

Family physicians who agree to accept orphan patients through the registry receive a lump-sum amount for each patient they accept ($100 for each non-vulnerable patient and $200 for each vulnerable patient). Local areas have considerable latitude regarding the resourcing and operation of the registries, resulting in substantial variation across the province. In the absence of clear guidelines, some registries only accept vulnerable patients, while others register all applicants regardless of their health status. Some prioritize pregnant women; others do not. Some family physicians register patients who they have already accepted into the practice.

Impact:

This innovative practice was first implemented in 2008 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance 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

Access registries have been implemented in all 95 of Quebec's local health and social service networks. Further, research indicates that Access registries have also been established in Ontario (2009), New Brunswick (2013), and Alberta.

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This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

Breton, M., Ricard, J., & Walter, N. (2012). Connecting orphan patients with family physicians: Differences among Quebec's access registries. *Canadian Family Physician, 58*(9), 921–922. Retrieved from http://171.66.125.180/content/58/9/921.full

Fowler, S. (2013, August 8). New patient registry matches 800 people with doctors. *CBC News New Brunswick*. Retrieved from http://www.cbc.ca/news/canada/new-brunswick/story/2013/08/08/nb-patient-registry-doctor.html

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Express Chemotherapy Clinic

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

SNAPSHOT: This innovative practice expedites chemotherapy services for children managing acute lymphoblastic leukemia. This Express Clinic was developed as a pilot project in 2004 at the Hospital for Sick Children in Toronto and is still in practice today. Using resource reallocation, this model maximizes health human resources and efficiency of care without increasing costs.

PRACTICE DESCRIPTION:

Children receiving chemotherapy, and their families, must make ongoing visits to the hospital, at which time they are subject to long registration processes; lag times associated with obtaining laboratory results, patient assessment, and preparation of chemotherapeutic agents; and the consequences of constrained nursing resources and physical space relative to patient volumes. To reduce the impact of these hospital visits on attending patients, the Express Chemotherapy Clinic was developed to increase overall efficiency of health human resources, timeliness, and quality of care.

To bring the Express Chemotherapy Clinic into practice, a program planning committee comprised primarily of nurses established patient eligibility criteria, determined appropriate protocols and treatment plans, fostered interdepartmental collaboration, developed a plan for communication between staff and families, ensured presence of medical coverage, and negotiated use of physical space. During the introductory phases of the new clinic, physicians and nurses were briefed on patient eligibility criteria and expected protocols. Strategies for fast-tracking the system include having the physician or nurse practitioner write chemotherapy orders ahead of time for the pharmacy to fill by 4:00 pm the day prior to the patient's clinic visit, establishing a rapid registration process, scheduling the physical space when nurses are underutilized (between 8:30 am and 10:00 am daily), and checking patient blood counts ahead of time to ensure appropriateness of scheduled visit.

IMPACT:

This pilot project ran for one year (2004 to 2005) and served a total of 75 patients, with an average of four patients scheduled every day. Evaluation was conducted throughout—each member of the interprofessional team completed a survey, and then families were interviewed separately by a research nurse. There was a 61% response rate among the families, of whom 58% had received care prior to the introduction of the Express Clinic and therefore could thus draw some comparison to changes in care received.

In response to perceptions of efficiency, 89% of families reported receiving chemotherapy in a timely fashion. In response to perceptions of quality of care, the majority of respondents reported that the Express Clinic decreased the sense of burden on the rest of the clinic. In response to perceptions of impact on lifestyle, the feedback on the Express Clinic's ability to reduce the impact of ongoing hospital visits on everyday lifestyle was overwhelmingly positive. From the interprofessional team care providers, 11 registered nurses, five contact nurses, four physicians, two nurse practitioners, five registration clerks, and three pharmacists completed the survey. The majority of staff reported that the redistribution of tasks did not increase their overall workload.

While the program continues to record clinic flow details for internal management purposes, no formal data collection has been conducted or produced for external dissemination since the program's initial implementation in 2004.

APPLICABILITY/TRANSFERABILITY:

This innovative practice has not been adapted from another jurisdiction. While it has not been expanded to other jurisdictions, the express model has expanded to two other areas in the division: the intravenous treatment room and the day hospital. In these settings the streamlined triage system allows direct registration for eligible patients rather than them going through the outpatient clinic. Sustainability for this model is strong given that no additional funding is required based on the reallocation of resources. Its success in improving overall efficiency of care and operational feasibility is demonstrated through the continuity of the pilot project 10 years later and its broader application. Management of the Express Clinic report still receiving informal

inquires about enabling this model of care in other settings in Canada and the United States; however, there is no formal documentation on this external impact factor. An important consideration that affects the transferability of this model is patient volume relative to existing human and physical resources.

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Publications:

Hendeshot, E., Murphy, C., Doyle, S., Van-Clieaf, J., Lowry, J., & Honeyford, L. (2005). Outpatient chemotherapy administration: Decreasing wait times for patients and families. *Journal of Pediatric Oncology Nursing, 22*(1), 31–37. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15574724

Personal Communications:

Hendershot, E. (interviews, August 20, 2013).

External Source:

http://www.sickkids.ca/Nursing/Nursing-Excellence/2010-Nursing-Excellence-Awards/2010%20Award%20Recipient%20Profiles/NEA2010-HeamONC-clinic.html

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System-Wide Case Management

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

SNAPSHOT: This innovative practice improves the coordination of care for persons managing chronic illness. The system-wide case management model was first launched in the Calgary region in Alberta in January 2008 as an 18-month pilot project. At that time, seven case managers were hired; within a year, over 200 clients were enrolled in the program. While the model has changed from its original scope and patient population targets, system-wide case management is still in practice in community care settings in the Calgary Region.

PRACTICE DESCRIPTION:

In its initial stages as a pilot program, the system-wide case management was designed to serve four patient population groups: multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), mental health related to brain injury, and dementia. Two roles were designed to deliver the services of the system-wide case management program. The first was the case manager, who was responsible for overseeing patients' navigation throughout their care pathway. Core components of the case managers' work included patient intake, assessment, care planning, evaluation, reassessment, discharge, and transition. Case managers were considered as experts in available treatment and program options, bridging services for particularly complicated cases, and improving communication through the development of a report system between patient, care project managers, and providers. The second role was the project manager, who was responsible for overseeing the work of the case manager. The two roles worked together to enable broader care management models that include advocacy, building relationships, education, connecting resources, and working directly with other health care team members. Specific roles were dependent on the setting context, resources, and needs of patients/clients.

Once the project surpassed its pilot phase, the costs of running these services were absorbed into the general operations budget of Alberta Health Services. However, the program underwent significant changes from 2009 to 2012 due to broader provincial restructuring efforts. The project manager role was discontinued towards the end of 2008. In addition, the program currently exists for dementia management only, as this was the patient population group that was identified as benefiting the most from these services relative to human resources input.

IMPACT:

To assess the qualitative impact of this pilot project, nearly 100 interviews were conducted with clients, informal caregivers, families, health care professionals, system-wide case managers, and working group members at the midpoint and endpoint of the pilot phase in February 2009. Among respondents, there was consensus around improved access to and integration of services for patients and their families. Acute care data were also collected, but due to sample size and lack of comparison group no quantitative analysis was possible with the given data set. (The terms of continuity of the initiative had to balance out the positive impact assessments with resource allocation projections.)

APPLICABILITY/TRANSFERABILITY:

The system-wide case manager position is similar to other positions, such as patient navigators or care coordinators, in Canada. However, this initiative is distinctively based on its specific population targets and its evaluation framework. The evaluation framework was informed by the Calgary Health Region's Framework for Case Management, Case Management for Continuing Care Clients, the System-wide Case Management Project Charter, and McMaster University's Case Management Workshop Workbook.

Key factors identified as contributing to the success of this program include collaborative partnerships, clinical practice support, staffing, service provision, target populations, goals, outcomes, and appropriate caseloads. As the program continues, program managers have emphasized the need for greater standardization of the guidelines for client intake and assessment; care planning, evaluation, reassessment; and discharge planning particularly. A province-wide evaluation of case management is due to come out in March 2014.

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

Publications

Trojan, L., & Armitage, G. D. (2009). *Evaluation report: System-wide case management*. Health Systems & Workforce Research Unit, Calgary Health Region. Retrieved from

http://www.albertahealthservices.ca/Researchers/if-res-hswru-case-management-report-2009.pdf

Personal Communications:

LeMarquand-Unich, B. (interview, August 8, 2013).

External Source: http://www.albertahealthservices.ca/services.asp?pid=service&rid=7573

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Supporting Aboriginal Seniors at Home (SASH), Southwest Ontario Aboriginal Health Access Centre

LOCATION:	Ontario	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice provides culturally safe care to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. In doing so, the practice addresses disparities between the life expectancy and the incidence of chronic disease for Aboriginal and non-Aboriginal seniors. It was launched in Ontario at an Aboriginal Health Access Centre, and involved a nurse practitioner, a senior's health advocate, and a patient navigator.

PRACTICE DESCRIPTION:

The Supporting Aboriginal Seniors at Home (SASH) program offers culturally based services designed to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. The program targets First Nations, Inuit, and Métis seniors and their family members. It was established in 2010 and is supported by Aging at Home funding. It was developed in consultation with Aboriginal community members, drawing on models of care that support the delivery of culturally appropriate and culturally safe care.

Staff assigned to the SASH program includes a nurse practitioner, a seniors health advocate, and a patient navigator, as well as a cultural safety trainer and management staff. The nurse practitioner provides primary care and chronic disease management services to seniors at the clinic, in community centres, or in seniors' homes. The seniors health advocate assists seniors to access community and social services. The patient navigator helps clients find their way through the complex hospital system. The SASH team works with the health care team to develop a client-centred care plan that incorporates traditional healing and culturally safe practices. The cultural safety trainer educates organizations in the region on the provision of culturally safe care, and builds their capacity to work well with Aboriginal patients. Chronic disease management services focus on helping people stabilize, improve, develop better self-management skills, and, in some cases, recover. The team supports clients, caregivers, and families in their interactions with health practitioners, and arranges interpretation and translation services as needed. They connect clients and their families with traditional Aboriginal healers, and counsel clients and their families to ensure that they understand their care plan while in hospital. Team members participate in discharge planning for their clients, helping them transition from hospital settings to home, arranging follow-up care, and connecting them with a comprehensive and holistic range of resources and supports. The team works closely with local organizations and hospitals, and the patient navigators have taken on a community development role, meeting with organizations and bands to better understand service pathways in the region.

The SASH program provides care that is different than what is typically available to Aboriginal seniors. It incorporates a spiritual component in its approach to treatment and wellness, and patients are able to access traditional services. It uses a patient-centred model, and staff members go above and beyond to provide exceptional programming and ensure that patients' comprehensive needs are taken into account.

IMPACT:

The SASH program was implemented in 2010 and has not completed an evaluation at this time. However, the program is now implementing results-based accountability processes. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. These include increased use of primary care services and reduced use of emergency department services, increased access to appointments with specialists, improved identification and management of chronic disease, and increased movement of people into recovery from addiction. The program is also building the capacity of organizations and practitioners to work well with Aboriginal seniors and provide culturally appropriate and safe care. Linkages between the program and other organizations (in particular, non-Aboriginal organizations) are strengthening.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that SASH had adapted from and were unaware if the practice was used as a model elsewhere. Components of the model have been adopted by a local CancerCare program. Lessons learned that might affect the applicability or transferability of the practice include the importance of community development and partnership, and the importance of attending to human resources issues. Staff members must be comfortable working in community settings; comfortable working with networking and promotion activities; and capable of working well with people with mental health issues, addiction issues, and other complicated medical conditions. Staff must also understand the ways of the communities they are working in, and be resourceful about how to address basic needs in areas such as food, housing, and economic security.

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Personal Communications:

Chrysler, B. (interview and feedback, August 7, 2013). [Southwestern Ontario Aboriginal Health Access Centre].

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Adapting the Non-Insured Health Benefits (NIHB) program to meet the needs of First Nations elders – Policy Tools, Pharmaceutical Medication and Rural/Remote Travel.

LOCATION:	New Brunswick, Newfoundland & Labrador, Nova Scotia, Prince Edward Island	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for improvement in FNIHB's programs and services in the Atlantic region, to better meet the needs of Elders and improve their health and wellbeing. *The Strategic Plan for Atlantic First Nations Elder Care* was launched in January 2011. FNIHB Atlantic works collaboratively with the Mi'kmaq Maliseet Atlantic Board to implement the plan.

PRACTICE DESCRIPTION:

Elders have expressed growing concerns about the programs and services of the FNIHB-Atlantic region. As part of a new *Strategic Action Plan for Atlantic First Nations Elder Care,* FNIHB - Atlantic is working to improve existing programs and services through a co-management (i.e., shared decision-making) committee with the Atlantic First Nations Chiefs, called the Mi'kmaq Maliseet Atlantic Health Board. In 2007, the Board established priorities that included Elder care. The focus of the strategic plan includes identifying and supporting local options to keep First Nations elders in the community for as long as possible, as well as addressing cultural competency, quality of care, and access to family for those who are admitted to long-term care facilities off reserve.

A first priority was to look at policies and requirements associated with the NIHB program; they are established mainly at the national level and cannot be easily changed. The program was reviewed from the perspective of whether the region had any flexibility to make changes for the benefit of elders' health and well-being.

A "policy lens" tool was created called the Elder Care Assessment Tool (ECAT). The process began with identifying what aspects of the program are within the region's discretion to design or modify, taking into consideration the elders' concerns and their health and well-being needs. In a pilot test, the Tool was applied to the medical transportation component of the NIHB program. One of several issues that elders had identified was the requirement for pre-approval to cover the travel costs of "non-medical" escorts - usually a family member or friend - to travel with them to appointments. Prior to the review, all First Nations people required pre-approval for every single appointment. For Elders with complex health needs and multiple doctors, or whose first language is not English, this could mean a lot of paperwork. As a result of applying the Tool, it was learned that while a regional branch of FNIHB could not remove the pre-approval requirement, there was some flexibility to change the procedure for people with chronic health problems or translation needs. Now, they only need to seek pre-approval once a year to have a non-medical escort accompany them to all their appointments. Also, there was a change to the request form so that it was clearer, with easy-to-answer questions, enabling staff to quickly determine whether someone is eligible.

Another area requiring improvement was Elders' access to prescribed medications. Some medications are covered automatically, but others need to be approved for coverage by the NIHB Drug Exception Centre in Ottawa. A pharmacist is required to call to initiate the review, and then the Drug Exception Centre will send paperwork to the health professional who prescribed the medication. Sometimes there is a breakdown in the process - for example, pharmacists don't call the Drug Exception Centre to ask for a review, or prescribers don't fill out the paperwork. The result is that the elder is denied coverage for the medication, and they must pay for it themselves or have their band pay with money from another program.

FNIHB-Atlantic looked at the medications that were rejected for payment to identify the top medications being requested, and learned that most were approved once they were reviewed at the Drug Exception Centre. In those instances where the pharmacist didn't call, the regional pharmacist in the FNIHB office contacted the pharmacies and reminded them about the

process. The regional pharmacist also sent the results of this work to a pharmacy working group at NIHB headquarters in Ottawa, and this contributed to some drugs being moved to the category where they are covered automatically (called open benefits). The regional pharmacist also created formularies that identified appropriate substitutions for common medications, so that if someone is prescribed a drug that requires a call to the Drug Exception Centre, pharmacists can choose an alternate that is automatically covered by NIHB.

IMPACT:

This innovative practice was implemented in January 2011 and does not have a completed evaluation at this time. A pilot in the NIHB medical transportation component was conducted and the recommendations are in the process of being implemented. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. The ECAT has made a difference: it simplified process and paperwork for non-medical escorts and fewer medications were declined for coverage. Also, it became clear that FNIHB-Atlantic did in fact have flexibility to adjust the procedure for medical transportation, and to think creatively about what else could be done to increase flexibility, while at the same time adhering to national policies. The Tool is still in its infancy, but already FNIHB-Atlantic staff and First Nations partners are developing a strong sense of shared commitment to and responsibility for elders' health. The regional office has committed to completing at least one program review per year. A review of the Aboriginal Diabetes Initiative is underway, other program areas requiring improvement will be identified, and together with quality improvement initiatives taking place within FNIHB nationally, changes to the way the FNIHB Atlantic region works and changes to policies and programs are beginning to be implemented.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that FNIHB Atlantic had adapted from and were unaware if the practice was used as a model elsewhere. However, specific lessons learned from this practice include: partnership and joint working group with First Nations; New Elder Care Assessment Tool used to review policies and procedures; Flexibility for regional office to make changes to procedures while still working within overall national policies.

Problems with FNIHB programs and services have been discussed across the country but no other region appears to be taking this kind of approach to making improvements, making it a unique effort that others across the country are interested in knowing more about. Other than a small contract of $10,000 for a literature review in the early stages of the plans development, no other resources are attached to the plan or the tool itself.

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Personal Communications:

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Pooled Referrals to Specialist Care in Saskatchewan

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

SNAPSHOT: This innovative practice addresses the issue of improving access to and decreasing wait times for specialist services by matching the flow of referrals to the capacity of specialists through a standardized, centralized referral process. The program launched in Saskatchewan in June 2010 and has now expanded to 20 specialist practices in the province.

PRACTICE DESCRIPTION:

Pooled referrals in Saskatchewan began in 2010 as part of the Saskatchewan Surgical Initiative, a collaborative effort by government, health organizations and providers and patients to offer "sooner, safer, and smarter" surgical care.

As one aspect of "sooner" care, pooled referrals were introduced to address the uneven distribution of patients among surgeons and to maximize the use of all surgeons. When a group of specialists pool their referrals, patients are assigned to the next available consultant in the group who has the required expertise to treat the referring condition. This approach maximizes the use of all the specialists in a group evenly, leading to faster access for patients.

Referral Management Services (RMS), a new division of Saskatchewan HealthLine, offers specialist groups a centralized intake service for pooled referrals across the province. By outsourcing the referral process to this provincial service, specialist groups can ensure referrals and notifications are managed using a streamlined process. RMS confirms receipt of the referral with the referring physician and contacts the patient within two weeks for an appointment. Specialists receive regular reports about the types of medical conditions being handled, the length of patient waits, and other information that can be used to manage future demand and further improve health care delivery.

A 36-page implementation guide was developed to provide surgical specialists with a basic process for introducing pooled referrals into their practice. It can be accessed at http://www.sasksurgery.ca/provider/pooledreferrals.html

IMPACT:

A key outcome of pooled referrals is rebalancing the distribution of surgical cases among specialists in a health system. The pooled referral approach is being formally evaluated by the Saskatchewan Health Quality Council. The evaluation includes surveying patients, referring physicians, and specialists. Initial survey results have shown positive outcomes. Some of the benefits of pooled referrals include:

For patients

- may choose to consult with a specific surgeon or the first available specialist;
- wait times are redistributed and equalized among specialists;
- appointments are made through a standardized process that provides better notifications; and
- reduction of anxiety associated with waiting.

For referring practitioners

- no need to research specialists' subspecialties, since the referral is redirected through RMS; and
- a standard referral process saves physicians time in referring to specialists.

For specialists

- distributes the stream of patients among all specialists, thus decreasing pressure on certain practices while ensuring business and job security for others;
- better control of their practice and the ability to select subspecialties;
- improved communication through a standardized, central referral process; and
- increased data on referrals and associated wait times that support continuous improvement efforts

The pooled referral program expanded provincially following a successful pilot run with the obstetrics and gynecology specialist group in Regina. During the five-month pilot project, the average wait times decreased from 44 to 24 days, with 43% of patients choosing to go with the next available specialist.

Groups participating in pooled referrals also gather data about patient numbers, conditions being referred, and how long each patient waits to be seen. This provides specialists and administrators with important information, such as the level of demand for different specialists, helping the system to ensure there are enough specialists to meet the needs of the population.

The government expects the program to cost $200 000 a year, and anticipates that the long-term benefits will outweigh the program's cost.

APPLICABILITY/TRANSFERABILITY:

Pooled referrals were introduced in the province as part of the Saskatchewan Surgical Initiative. However, pooled referrals are not a new concept. Pooling has been applied successfully by numerous industries and businesses, including other health systems. The United Kingdom's NHS has used this approach for over a decade. In 2010, Saskatchewan health care leaders toured the NHS to learn more about how pooled referrals can significantly reduce and sustain lowered patient wait times.

To date, 20 specialty groups have begun pooling referrals throughout Saskatchewan. These groups include services such as general surgery, orthopedics, obstetrics and gynecology, and cardiovascular specialities. The provincial government has committed to pooling all surgical practices (approximately 47 groups) in the province by March 31, 2016.

This practice is being implemented elsewhere in Canada, including in Manitoba, Alberta, and some Atlantic provinces. Pooled referrals can be used by specialist groups that are either co-located or geographically dispersed, and can be adapted for a variety of payment models.

PRACTICE WEBSITE http://www.sasksurgery.ca/provider/pooledreferrals.html

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External Source: http://www.sasksurgery.ca/provider/pooledreferrals.html

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MRI Process Improvement Project: Improving patient access to imaging services

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

SNAPSHOT: This innovative practice addresses the issue of improving patient access to magnetic resonance imaging (MRI) services through improvements to MRI administrative processes. Between October 2008 and March 2012, all Ontario-based MRI facilities have participated in this program.

PRACTICE DESCRIPTION:

The MRI Process Improvement Program (MRI-PIP) is a Lean Six Sigma initiative that focuses on creating sustainable improvements in MRI processes by optimizing the use of existing staff and equipment at all participating facilities in Ontario.

The program uses Lean Six Sigma methodology, which is a strategic approach that strives to improve processes and reduce variation by eliminating problematic areas in the process and standardizing the flow of services. The methodology focuses on adding value to the patient and empowering staff and clinicians to improve patient care. It emphasizes the importance of data in developing solutions.

The MRI-PIP focuses on process improvement in the following areas:

• Booking Process: streamlining the process and decreasing the wait time from the time an MRI requisition is received by the MRI facility to the point when an appointment is booked and the patient is notified of the appointment;

• Scheduling System: improving the allocation of MRI resources to reflect the demand of each patient population and the resource constraints in the system; and

• Patient Flow on Day of Exam: streamlining the process on the day of exam, thus maximizing scanner time.

IMPACT:

Overall, MRI-PIP has made a positive impact on the landscape of MRI delivery in Ontario. Results include the following:

• 80% of sites improved their 90th percentile wait times with a combined provincial decrease of 1920 days (or an average of 36 days per site);

• 78% of sites increased their average monthly volumes with a combined provincial increase of 5275 exams (or an average of 98 exams per site);

• 80% of sites increased their rate of patients scanned per hour equal to an additional 54 patients per day across the province, or approximately 20,000 patients per year without increasing resources;

• 500 health care professionals and hospital leaders were trained in quality improvement methodologies and tools; and

• 93% of sites continued to track performance measures, while 75% of sites continued to meet to discuss these measures.

APPLICABILITY/TRANSFERABILITY:

Lean Six Sigma process methodology is used in programs throughout much of Canada, but the Ontario-wide MRI-PIP strategy is the first of its kind in Canada. A similar MRI process program exists at the Akron Children's Hospital in Ohio, although it was done in isolation from Ontario's provincial program. The Akron Children's Hospital's MRI scheduling project won a Lean Six Sigma program award in June 2011 for outstanding health outcomes.

EXTERNAL LINKS: http://www.mritoolkit.ca/

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The Mental Health Engagement Network: Providing Patients Access to Personalized Health Records via Smartphone Technology

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

SNAPSHOT: This innovative practice addresses the issue of providing mobile patient-centred care for individuals diagnosed with a mental illness. The practice was launched in London, Ontario, and involved 55 mental health care professionals.

PRACTICE DESCRIPTION: Approximately one fifth of Canadians will experience a mental illness during their lifetime, yet accessing continuous, supportive care can be challenging. Only about one individual in five with mental illness receives professional help.

The Mental Health Engagement Network (MHEN) is a two-year research project launched in September, 2011, through the London Health Sciences Centre, St. Joseph's Health Care, Community Mental Health Care Services, and the Canadian Mental Health Association. This project introduces, delivers, and evaluates the effectiveness of using web and mobile technologies to provide continuous, supportive health care services to individuals living in the community with a mental illness.

Through the MHEN project, 400 individuals with mental illness and 55 mental health care professionals receive hand-held devices (smartphones/tablets) programmed with a Lawson Health Research Institute SMART record, a mental health application with a personalized health record and interactive tools. The SMART record was developed in partnership with TELUS health. Canada Health Infoway, a not-for-profit organization funded by the federal government is funding the MHEN project.

Through the Lawson SMART record, individuals have access to their personal health information, including current and past medications, diagnosis, medical history, care provider contact information, and assessments. In addition, individuals can receive prompts and reminders, track health status indicators, create and manage activity plans, and exchange messages with their care provider.

This project combines technology with common recovery strategies for people living with mental illness. The program's research team anticipates that access to up-to-date, personalized health information will empower patients to actively participate in the management of their health, improve access to the mental health care system, and provide coordination of care. In addition, they believe that the use of smart technology in mental health has the potential to improve quality of life and reduce health care costs incurred by emergency department visits and hospital admissions.

IMPACT:

The MHEN project began in September 2011, and will conclude in November 2013. Individuals received the MHEN intervention through a staggered implementation approach in August 2012 and March 2013. While no formal evaluation has occurred to date, data will be collected during survey interviews at four time points (baseline, six, 12, and 18 months post implementation) and focus group sessions. Data collected will measure health status, well-being, quality of life, empowerment, social and justice service use, perceptions of technology, and usability of the MHEN tools. Initial results are scheduled to be available by fall 2013. The MHEN project will also perform economic, policy, ethical, and effectiveness analyses to provide evidence-based recommendations about the use of smart technologies in mental health care.

APPLICABILITY/TRANSFERABILITY:

The Mental Health Engagement Network has not been adapted from another jurisdiction and has not been implemented elsewhere. However, this project is expected to grow through a partnership with The Sandbox Project (an organization committed to improving the health of children and youth) to include an offering for children and youth experiencing depressive

symptoms. This project is expected to launch in September 2013.

A lesson learned by the research team is the importance of engaging key stakeholders (community, clinical, and consumer) in the development and implementation of a new service delivery model. To ensure successful implementation and adoption, end-users must be engaged from the onset to address the target population's needs.

PRACTICE WEBSITE: http://publish.uwo.ca/~cforchuk/MHEN/side.html

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External Source: http://publish.uwo.ca/~cforchuk/MHEN/side.html

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Intensive Outpatient Rehabilitation Program for Stroke Survivors and Limb Amputees

LOCATION:	British Columbia	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Rehabilitation	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need to increase access to rehabilitation services for stroke or limb amputees through an interprofessional team supporting patients to reintegrate in their community. This practice was initiated in October 2011 in two communities in the Vancouver Island Health Authority (VIHA).

PRACTICE DESCRIPTION:

The Intensive Outpatient Rehabilitation Program (IORP) has clinics in Victoria and Nanaimo for patients with moderate levels of impairment following a stroke and for patients with limb amputation. The six- to eight-week outpatient rehabilitation program offers an alternative to traditional hospital-based in-patient rehabilitation by allowing patients to live at home and access community facilities for services. The interprofessional team offering the program includes physiotherapy, registered nursing, occupational therapy, social work, rehabilitation assistants, unit clerks, speech and language pathology, prosthetics, and physiatry.

The IORP team screens patients (referred by general practitioners) for admission to the program and then works with the in-patient care team to transition patients to outpatient care, where they can access the rehabilitation services at community facilities.

IMPACT:

The VIHA collected outcomes data at the end of one year and reported that:

- 129 patients were enrolled in the IORP;
- in-patient rehabilitation length of stay for those patients enrolled in IORP decreased by
  - 11 days for patients with stroke in Nanaimo;
  - 8 days for patients with amputation in Nanaimo; and
  - 8 days for patients with amputation in Victoria.
  - roughly 2,490 in-patient days were saved, resulting in over $2.5 million in cost avoidance; and
  - functional independence measures at discharge, for both patient groups, exceeded the 2009/2010 national average for patients leaving high-intensity in-patient rehabilitation units.

The outcome data indicate that an intensive, interprofessional outpatient rehabilitation program can effectively meet the needs of these patient groups in a cost-effective manner. Ongoing evaluations will continue during the implementation of this care model as it spreads across the Vancouver Island Health Authority.

APPLICABILITY/TRANSFERABILITY:

VIHA has chosen to continue the IORP and expand the criteria to include other complex patient groups across the health authority. Expansion of this type of program is an integral component of IORP's strategic plan. Similar programs are offered in the United States. An IORP program also exists at the Woodstock Hospital in Woodstock, Ontario. The Woodstock Hospital IORP reports positive outcomes for patients enrolled, with a formal evaluation being planned for the future.

PRACTICE WEBSITE: http://www.viha.ca/adult_rehab_services/outpatient_programs/iorp.htm

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Other:

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External Source: http://www.viha.ca/adult_rehab_services/outpatient_programs/iorp.htm

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Group Medical Visits: An Initiative to Improve Access, Efficiency, and Health Outcomes among Patients with Chronic Disease

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

SNAPSHOT: This innovative practice addresses the issue of increasing the efficiency of family practices and improving the health outcomes and treatment experience of patients with chronic disease. The initiative was launched in family practices across British Columbia, and each session typically involves family physicians, allied health professionals, and medical office assistants.

PRACTICE DESCRIPTION:

For most chronic conditions there are symptoms that all patients share, common lifestyle and dietary countermeasures they can take, and information they all need to have or know. Yet patients often do not receive all the information necessary to manage their disease in a typical 15-minute one-on-one visit with their family physician. Group Medical Visits (GMVs) allow patients to receive care, education, and advice from their family physician in a supportive group environment. Rather than having to repeat the same information for each patient, physicians relay information once to the group and then spend time going into depth about disease management. Strict confidentiality among patients is a requirement and patients sign a letter of agreement prior to participation.

GMVs are one of seven learning modules available to physicians in British Columbia through the Practice Support Program (PSP), an initiative that provides training and support for physicians and their medical office assistants to improve clinical and practice management and enhance the delivery of primary health care for patients. The PSP began as an initiative of the General Practice Services Committee (GPSC), a partnership of the BC Ministry of Health and the BC Medical Association. The PSP now receives additional direction, support, and funding from the Shared Care Committee and the Specialist Services Committee.

GMVs provide social support, but they differ from typical support groups in that sessions tend to be more educational and medical questions are encouraged. The program is intended to save time for practitioners and give patients a platform to share knowledge and gain confidence in managing their own health. The GPSC anticipates this program will offer sustained benefits to both patients and doctors by improving access to health care professionals, decreasing wait times, and improving efficiency.

IMPACT:

An evaluation of the PSP learning modules was conducted from data collected over the first three years of the program and published in *BMC Medical Education*. A total of 887 GPs and 405 Medical Office Assistants (MOAs) provided feedback upon completing the learning modules. For the GMV module, most GPs agreed that their patients liked the peer learning (79%), liked the self-management support (80%), and were satisfied with their care (76%). Some 77% of GPs agreed that group visits allowed them to use a team-based approach to care, although 46% agreed that scheduling them was difficult. Some 60% said they planned to make group visits an ongoing part of their practice.

In May 2013, the fifth annual evaluation of the PSP's learning modules was released. Thirty-two GPs attended GMV modules in their fifth year and supplied feedback. The majority agreed their patients liked the peer learning (77%) and self-management aspects of the program (82%). Going forward, a small majority (58%) of GPs agreed that they would make GMVs part of their ongoing practice, and 52% agreed that it was difficult for the MOAs to schedule group visits. An assessment of the costs and savings of this practice has not been completed at this time.

APPLICABILITY/TRANSFERABILITY:

This practice builds on the success of the original GMV initiatives in Colorado and California. GMVs have been implemented by health care systems internationally, and they have consistently received high satisfaction ratings from patients and providers. In Canada, Alberta and Saskatchewan are also offering GMVs following the experience in British Columbia.

This model of care has also spread to other patient groups. In Smithers, BC, GMVs are held monthly for patients with dementia and their caregivers. In Vancouver, GMVs for Cantonese-speaking patients have been implemented to help patients with cholesterol issues learn better dietary habits. The practice is also being taken up by other health care professionals. In Vancouver, psychiatrists have incorporated GMVs into their outpatient practices and observed positive results. Lastly, nurse practitioners are increasingly using GMVs to deliver primary health services to people with chronic disease.

While the practice is applicable to other settings, there are some challenges that affect the transferability of GMVs. Many physicians' offices are too small, requiring an outside space to hold GMVs. This can become an additional logistical and sometimes a cost barrier to offering the service. The time involved in organizing the GMVs may also deter some physicians from offering them regularly.

PRACTICE WEBSITE: n/a

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A GP for Me: An Initiative to Match British Columbians with Family Doctors

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

SNAPSHOT: This innovative practice addresses the issue of strengthening the primary health care system and improving health outcomes by helping people who want a family doctor to get one. The pilot project was launched in British Columbia in three communities and involved approximately 300 family physicians.

PRACTICE DESCRIPTION:

The premise for this innovative practice is that a strong primary care system with a foundation of continuous doctor-patient relationships leads to better health outcomes for patients. As of 2013, however, approximately 176,000 British Columbians are looking for a family physician. A GP for Me aims to provide all British Columbians who want a family doctor with access to one, and to better support and reward family physicians who commit to delivering long-term care for their patients.

A three-year pilot project, A GP for Me was launched in June 2010 and involved three Divisions of Family Practice in White Rock-South Surrey, Prince George, and the Cowichan Valley. A GP for Me facilitates community-based professional networks of family physicians, health authorities, and community partners to work together to develop plans for improving local primary care capacity, including mechanisms for finding doctors for patients who are looking for one.

A GP for Me will not be an instant solution for everyone who is looking for a doctor now. However, over time it is expected to improve the primary care system by establishing ongoing patient-physician relationships. Once these relationships exist it is possible to introduce more efficient ways to care for patients, such as phone consultations over routine matters. Phone consultations save time for physicians and give them the option of taking on new patients. A GP for Me also provides incentives for doctors to take on patients with complex health conditions, such as cancer, severe disabilities, or mental health challenges.

The program is funded by the General Practice Services Committee (GPSC), a collaboration between the BC Medical Association and the Ministry of Health.

IMPACT:

Results from the pilot project have been collected and published on the initiative’s website. Collaborative local efforts at the three sites produced new primary care clinics, increased physician recruitment, expanded family practice capacity, and developed more interprofessional teams. As a result, since 2010 more than 9,400 patients have found family doctors. In White Rock, the initiative matched 4,500 people with family doctors, thereby eliminating the wait for a family doctor. The Cowichan Valley Division of Family Practice found primary care providers for 1,100 patients. In Prince George, 3,800 patients were matched with family doctors, and a new clinic opened in July 2012 to provide regular care to patients without a family doctor.

The expansion of A GP for Me province-wide is being supported by $132.4 million in funding. The funding is available on two levels:

- $40 million over three years to Divisions of Family Practice to improve primary care capacity locally and evaluate the number of people looking for doctors; and
- $60.5 million over two years towards increasing the efficiency of individual practices, including fees for phone consultations and for taking on new patients, with different fees for average versus complex patients.
- The remaining $31.9 million is being allocated towards supporting existing care by family physicians in hospitals.

APPLICABILITY/TRANSFERABILITY:

Based on the success of the pilot, A GP for Me expanded province-wide in April 2013.

A GP for Me is part of the General Practice Services Committee's suite of programs—including the Practice Support Program—that aim to improve the care patients receive and how doctors deliver it. Based on the success of the pilot program, A GP for Me is being implemented in divisions of family practice throughout BC. So far, 20 divisions are involved at various stages in applying for funding to participate in A GP for Me. Some of those have started a rigorous assessment and planning process as a first step in defining the extent of the issue in their regions. After this, an implementation plan will be submitted to enable the participating divisions to try innovative approaches to find primary care providers for traditionally 'hard to attach' people.

It is too early to evaluate the results of this program in other areas, but there is the potential for the positive results in the initial 3 pilot sites to be replicated throughout the province. The GPSC website provides a variety of supports and resources for both patients and physicians interested in learning more about the program, including billing tutorials and a FAQ section.

PRACTICE WEBSITE:

http://www.agpforme.ca/

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

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CareOregon's The Productive Ward (Releasing Time to Care)

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

SNAPSHOT: This innovative practice aims to improve nurses' workflow in order to increase the amount of time dedicated to direct patient care. Originally developed in the United Kingdom, the practice was launched in four hospitals in Oregon, United States, and involved a chief nurse executive, a nurse manager from a showcase unit, a program facilitator, and one or two staff nurses from a showcase unit.

PRACTICE DESCRIPTION:

Nurses all work with the mission of delivering excellent patient care. However, they are often confronted with numerous barriers that inhibit them from dedicating their time fully to their mission. Several hospitals in Oregon, United States were surprised to learn that, on average, nurses were spending just 27% to 54% of their time on direct patient care. In addition they were being interrupted from 70 to 330 times per shift. Consequently, in May 2010, CareOregon (a health plan with 9, 500 members among 14 Oregon counties) introduced a new open-source initiative called Releasing Time to Care (RT2C).

RT2C is a structured and modular lean-based, innovative methodology designed by nurses to help front-line hospital nursing staff redesign and streamline their workflow. It has four core objectives: (1) improve patient safety and reliability of care, (2) improve patient experience, (3) improve staff well-being, and (4) improve efficiency of care. It translates into time and cost savings that can be directly invested into patient care in order to improve workflow and patient outcomes.

The program uses visual tools to track patient falls, pressure ulcers, hospital-associated infections, staff injury, or whatever quality measures the unit team chooses. It is unit-based in order to preserve the unique culture in a unit while standardizing nurse processes.

The RT2C collaborative hosts regular discussions and training sessions to educate health care professionals on how to implement the initiative and tailor it to their ward's needs. CareOregon provides a program that consists of two days of classroom training followed by one day visiting demonstrations sites, four months of web-based support throughout the implementation of the training, and a train-the-trainer course for the hospital staff responsible for spreading the program across the hospital's other wards.

IMPACT:

RT2C features real-time progress in the form of the Know How We Are Doing (KHWD) boards displayed in every participating wing. These boards post ongoing results on several measurable outcomes and are checked several times a week in group board meetings in order to have real-time assessment of progress and to redefine goals/action plans that are best suited for their ward. It also facilitates data transparency with patients and caregivers, who are encouraged to provide written feedback on the wall regarding their experiences.The results of this performance improvement initiative are featured in videos, written media, and testimonials on the CareOregon website, as well as an article in the newspaper *The Oregonian*. The practice and its evaluation were also presented at the BC Quality Forum.

In one pilot ward (5G), reorganizing the ward and making the workspace more patient-friendly decreased patient falls rate by 53% from 2009 to 2010. Reorganization and enhanced communication also released 36 hours of nursing time that was reallocated into direct patient care. Consequently, there was an increase in self-reported patient experience, and patient satisfaction with the initiative went up to 98% in 2010. According to hospital efficiency audits, with planned changes such as further reorganization of supplies, preparation of vacant rooms for incoming patients, and switching to snap-on gowns in the emergency department, the 5G ward is forecasted to release and reallocate another 250 hours of nursing time in the upcoming year.

Lastly, there are several published videos and written articles on CareOregon's website that feature positive testimonials from

nurses, patients, and other health care professionals who describe the improvement they have experienced since the implementation of RT2C in their wards.

APPLICABILITY/TRANSFERABILITY:

RT2C was developed by the NHS Institute for Improvement and Innovation in the UK in 2008. It was later adopted by OregonCare, which acts as a centre for disseminating RT2C practices and training to other US centres. It has since been implemented in more than 17 hospitals across 13 countries including Canada, where hospitals in the Vancouver Coastal Health Authority and throughout the province of Saskatchewan are currently implementing the practice. These hospitals are already experiencing improvements in staff and patient satisfaction, reductions in falls, and other positive outcomes. Nurses from Oregon's hospitals gather on a quarterly basis as part of the RT2C collaborative to learn from one another and exchange best practices.

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High Acuity Response Team (HART)

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

SNAPSHOT: This innovative practice addresses the provision of mobile intensive care to rural hospitals that do not have critical care services in an effort to stabilize and sustain patient care and, when necessary, transport patients to a higher level of care. The practice was launched in British Columbia in one health region, Trail, and involved six critical care nurses, a basic life-support ambulance team, and, occasionally, a respiratory therapist.

PRACTICE DESCRIPTION:

Interior Health (IH) is responsible for delivering comprehensive health care services to a population of 750,000 residents in southern British Columbia. The British Columbia Ambulance Service (BCAS) provides basic life support services to this remote region by ground ambulance, along with the provincial air transport system. However, due to long distances, mountain ranges, severe weather, and limited clinical resources in rural hospitals, the resident health care providers often have to accompany critical patients to a higher level of care, leaving their patients without health care professionals for hours at a time.

To ensure that higher-acuity patients receive optimal care in a rural context, IH developed a flexible-deployment, hospital-based High Acuity Response Team (HART). Interior Health supports HART in partnership with BC Ambulance Services so that HART teams can attend to acute patients at rural and remote health sites by either stabilizing them to avoid transfer or transporting them to a higher level of care.

The program currently staffs one HART member 24/7 at three regional referral centres across Interior Health. HART members are typically registered nurses (RNs) who have specialized training and equipment that allow them to provide expert inter-facility transport services at rural/remote facilities. HART members are required to integrate into their base hospitals, where they deliver critical care outreach (CCO) and other clinical support services when not on transport. Specialized respiratory therapists (RTs) are available on call to the HART program and are typically involved 38% of the time in cases requiring advanced critical monitoring and intervention.

As a core component of HART, clinicians are required to record all in-hospital and out-of-hospital response activity in an electronic data registry. This information includes a staff-initiated quality assurance audit, in which clinicians have the opportunity to identify areas of success and opportunities for improvement, thus empowering staff to take an active role in developing of the program. End-users of the HART service also have an opportunity to provide feedback to HART. All documentation is then reviewed by the clinical team Leader and the base medical director for quality of care, documentation, operational benchmarking, and communication issues. The clinical team leader and local medical director then provide feedback to the HART clinicians, and may also use their findings to identify opportunities for further professional development and operational efficiency.

IMPACT:

In over 1,000 transfers to date, HART is meeting the performance benchmark for patient delivery 88% of the time. When working in the base hospitals, HART responded to a total of 1,027 rapid response requests based on the Early Warning Signs screening tool. With further analysis using standardized Early Warning scores, the program hopes to answer the question of whether HART improves the physiological stability of patients in its care.

IH spends about $800,000 annually per hospital base team to deliver this service.

APPLICABILITY/TRANSFERABILITY:

After Trail, the program was launched in Cranbrook, Kamloops, and Penticton. Success stories were also prevalent in the other sites, such as two burn victims in Lytton saved due to HART's response team. The HART teams throughout Interior Health have done more than 211 transports in the first year of implementation and have reported a positive reception from the medical community.

High priorities for the program include (1) exploring opportunities to optimize communication and coordination between the sending facility, BCAS, and HART in an effort to improve response times and patient outcomes; (2) expanding the service to proposed HART catchment areas, such as Vernon; (3) increasing the scope of practice to include pediatric patients; (4) formalizing in-hospital rapid response outreach services across all HART bases; and (5) further developing cross-pollination of RN skill sets.

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

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Petruk, T. (2012, January 18). A HART that saves lives. *KamloopsThisWeek.com*. Retrieved from http://www.kamloopsthisweek.com/community/137598273.html

External Source: N/a

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Canadian Pediatric Surgical Wait Times (CPSWT) Project

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

SNAPSHOT: This innovative practice addresses the issue of pediatric surgical wait times by providing a comprehensive, comparable prioritization wait-time information system for this population. The practice was launched in 15 pediatric academic health sciences centres across Canada and involved surgeons, information technology (IT) staff, and project site coordinators.

PRACTICE DESCRIPTION:

Canadian children and youth represent more than one quarter of the population. Children and youth often require surgery at critical stages of development. Delaying surgery could have lifelong and permanent impact. The Canadian Pediatric Surgical Wait Time Project (CPSWT) developed a prioritization system for surgery called the Paediatric Canadian Access Targets for Surgery (P-CATS) that encompasses 867 diagnoses in 11 surgical disciplines.

P-CATS was developed for clinicians by clinicians (specifically pediatric surgeons from Canadian pediatric centres). The advantage has been to create clinically relevant and useful access targets for clinical decision-making in the management of wait times (i.e. “to do the right case at the right time”). Since pediatric surgery is highly specialized, a common methodology has also allowed hospitals to collaborate to identify areas of common need and leverage possible solutions.

P-CATS was developed by expert panels of over 100 pediatric surgeons from all surgical subspecialties across Canada. Using this methodology, children with the same diagnosis are assigned the same priority (i.e. access target wait time) regardless of where they live in Canada. By attaching one priority to each diagnosis and using consistent priorities across all surgical subspecialties, P-CATS generate data that are less prone to variance in practice.

The CPSWT Project was funded by Health Canada through contribution agreements under the Health Care Policy Contributions Program from January 2007 to March 2011. For the following two years, the project was self-sustaining through participating Site contributions. The project ended on March 31, 2013.

Agreements were negotiated and work had begun to transition the CPSWT Project. As of April 1, 2013, the decision-to-treat date, surgery date, and P-CATS code for completed pediatric surgical cases across Canada can be submitted to the Canadian Institute for Health Information (CIHI) through the Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) abstracts. The Canadian Association of Paediatric Health Centres–Canadian Paediatric Decision Support Network (CAPHC–CPDSN) has agreed to create reports for their members that will be published in their annual report.

IMPACT:

At the national level, the CPSWT database represents the only source of comprehensive comparable pediatric surgical wait time information from across Canada. The data from January 2012 to December 2012 demonstrated that, on average, 31% of pediatric patients received surgery past their access targets (i.e. acceptable wait times).

In Ontario, hospitals participating in the project have reduced the percentage of children exceeding acceptable wait times by using this system to prioritize cases by acuity and redistribute resources to address their specific areas of need. At one hospital P-CATS is used by individual surgeons to prioritize patients on their surgical lists. At another hospital, P-CATS is used to allocate operating room (OR) time among surgical divisions. Finally, at a third hospital, P-CATS is used to determine the greatest need for additional OR time. With additional funding from the Ministry of Health and Long-Term Care in Ontario, the overall out-of-window rate dropped from 46% to 15%. Using common standards also enabled participating hospitals to share learning.

The CPSWT Project was given the Gold Leadership Award by the Institute of Public Administration of Canada for its vision, innovation, leadership, and collaboration.

APPLICABILITY/TRANSFERABILITY:

The value of the project has been recognized by many provinces across Canada, and a total of 24 hospitals in Alberta (3 sites), British Columbia (4), Manitoba (2), Newfoundland and Labrador (1), Nova Scotia (1), Ontario (8), Quebec (4), and Saskatchewan (1) are now participating in this approach. For example, British Columbia's Ministry of Health has adopted P-CATS to measure wait times for all pediatric surgeries in that province. The Patient Access Registry of Nova Scotia (PAR-NS) incorporates P-CATS-coded pediatric information from the IWK Health Centre for approximately 70% of Nova Scotia's pediatric surgery cases. Finally, in a recent initiative in Alberta, P-CATS is being considered as a model to develop similar targets for adults.

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Publications:

Wright, J.G., & Menaker, R.J. (2011). Waiting for children's surgery in Canada: The Canadian Paediatric Surgical Wait Times project. *Canadian Medical Association Journal, 183*(9), E559–E564.

Other:

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External Source: http://www.ccyhc.org/work_surgical_projects.html

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The Sherbourne Health Centre Infirmary: Cancer care for homeless or underhoused populations

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

SNAPSHOT:

This innovative practice addresses the issue of housing individuals who are homeless or underhoused and who have cancer or other acute medical conditions. The practice was launched in Ontario in one clinical setting in Toronto and involves a coordinated team of the Community Care Access Centre (CCAC), oncologists, and Sherbourne Health Centre staff.

PRACTICE DESCRIPTION:

The Sherbourne Health Centre Infirmary is a short-term cancer care unit where people of all ages who are homeless or underhoused may stay while recovering from an acute medical condition, illness, or injury. The Infirmary program provides a safe space where clients are able to rest and recover in a comfortable, supportive environment.

Health care is provided by an interprofessional team including consulting physicians, nurses, and a case manager for homeless and underhoused persons. It operates seven days a week, 24 hours a day, providing recuperative and holistic health care to clients who are expected to recover in a short period of time from a medical condition and do not require hospital care. Whenever possible, morning admissions are preferred so that clients can have a smooth transfer or transition into the program. The initiative has produced integrated care from a coordinated team to ensure a seamless transition between hospital (when care is no longer need), shelter, and infirmary settings.

The Sherbourne Health Centre Infirmary program is intended to augment already existing health care available through hospital and community sites. The intent of the program is to enhance the recuperative or recovery options for people who are homeless or underhoused, with a focus on individuals with health issues requiring short-term stays. The Infirmary program is not intended to replace other needed forms of health care such as emergency or urgent assessment, crisis, mental health, or addiction services.

IMPACT:

There is no formal evaluation of the practice at this time, but personal accounts, internal program measures, and observation indicate positive outcomes.

Since 2011, 20 homeless people—men and women aged 30 to 70, with different types of cancer and varying prognoses—have received treatment. In 2012, the Sherbourne Health Centre was announced as an Innovation Award Winner by the Cancer Quality Council of Ontario for developing this practice to provide chemo and radiation therapies to individuals experiencing homelessness, or those with no real “home.” These patients face significant barriers to accessing mainstream treatment. Even those in shelters or rooming houses lack a sufficiently safe or hygienic environment, and cannot appropriately dispose of the toxic chemotherapeutic waste. The Infirmary has enabled Ontario oncologists to confidently implement treatment plans for a number of homeless or vulnerably housed individuals who may otherwise have been refused treatment or struggled to fit into care options.

APPLICABILITY/TRANSFERABILITY:

The Sherbourne Health Centre Infirmary Program has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings.

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

Sherbourne Health Centre. (n.d.). *Infirmary program referral guide 2009/2010*. Retrieved from http://www.sherbourne.on.ca/PDFs/inf-guide/referralguide.pdf

Association of Family Health Teams of Ontario. (2012, December 6). Sherbourne and North York FHTs honoured for their work by Cancer Quality Council of Ontario. [News Release]. Retrieved from http://www.afhto.ca/news/sherbourne-and-north-york-fhts-honoured-for-their-work-by-cancer-quality-council-of-ontario/

Goar, C. (2013, April 25). Sherbourne Health Centre improves cancer care for Toronto's homeless. *Toronto Star*. Retrieved from http://www.thestar.com/opinion/commentary/2013/04/25/sherbourne_health_centre_improves_cancer_care_for_torontos_homeless_goar.html

Cancer Quality Council of Ontario. (n.d.). *Award recipients 2012*. Retrieved from http://www.cqco.ca/cms/One.aspx?portalId=89613&pageId=253500

External Source: http://www.sherbourne.on.ca/programs/infirmary.html

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All-Access Dentistry: Specialized Geriatric Dental Services

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

SNAPSHOT:

This innovative dental practice addresses the issue of enhancing access to oral care for people with limiting physical, medical, or cognitive conditions. The clinic aims to smoothly integrate dental clinic services for a spectrum of patients, including the most complex cases. The practice was launched in Ontario in January 2011 in an independently owned specialized dental clinic operating in a hospital setting.

PRACTICE DESCRIPTION:

The Runnymede Dental Centre (RDC) provides access to oral care and offers a branch of dentistry for people with physical, medical, or cognitive conditions that limit their ability to receive routine dental care. The dental centre provides patient-focused dental care to Runnymede patients, staff, and the broader community, and opened at the Runnymede Health Centre (RHC) in January 2011.

The RDC objectives are to improve access to care and to offer quality dental services to all in need. The clinic is designed to meet the unique challenges and needs of patients who require specialized care, and does so through specialized equipment and processes. The office operatories are uniquely outfitted with Hoyer Lift wheelchair transfer equipment and air-compressed floating dental chairs, and they are set up for patients on continuous oxygen. The new dental clinic has space for a support person or family member to accompany patients while they undergo treatment, as well as moveable dental chairs. Unlike the stationary dental chairs in most dental clinics, these seats can be moved aside in the treatment room. This is particularly beneficial for patients with specialized wheelchairs that tilt and recline, as it allows them to be treated in their wheelchair without being moved. RDC also helps coordinate patient appointments and offers shuttle services to patients in the community, fostering independence and convenience for those unable to attend on their own.

An initial oral pre-screening and assessment is offered to patients at no charge. Following the assessment, the dental centre provides written treatment recommendations and a cost breakdown of services. Payment arrangements for dental services are between the dentist and the patient or substitute decision-maker.

Since 2012, RDC has been raising awareness of its unique services and increasing the size of the practice, targeting RHC patients, staff, and members of the community. Additionally, the dental clinic and RHC have been working together on a strategic plan to ensure that all new admissions and their alternative decision-makers are informed of and given access to the on-site dental care services. The RDC is in a stage of informing and offering dental care services to surrounding long-term care facilities (LTCs), nursing homes, and independent living residents.

IMPACT:

This innovative dental practice was implemented in January 2011 and does not have a completed formal evaluation at this time. However, RDC has received significant positive feedback, and observations suggest that this practice has the potential for positive outcomes on health.

The practice meets the needs of the community—it was the numerous requests by patients, alternative decision-makers, and staff that prompted RDC to start building relationships and offer specialized, comprehensive dental services in a hospital setting. Patient and provider testimonials indicate that accessing the clinic has increased patient quality of life. The RDC has been successful in providing oral health care to a population that would otherwise be unable to access this type of care due to physical or medical limitations. The importance of a mouth free of disease, infection, and plaque is of paramount importance for heart health and overall health. Patients report increased comfort and accessibility during the dental visit, improved oral hygiene, and satisfaction with their appearance, sociability, and the sense of community in the clinic.

The plaque scores and the disease, pain, and infection findings have dramatically decreased since RDC began servicing RHC patients on a part-time basis in 2011. A second important impact is that oral hygiene awareness has significantly improved since the opening of RDC. For example, RDC has organized annual training sessions on oral care for all RHC staff. Thus, with improved awareness and education, a greater number of patients in RHC and the community are learning about the importance of oral health and prevention, as well as accessing dental services regularly rather than on an emergency basis.

Finally, frequent preventative visits and examinations provide comfort and cost savings, and help minimize emergency visits and unnecessary pain and discomfort. The set-up costs, systems, and training for such a specialized clinic are greater than a general dental practice, so the key is growing the clinic and increasing awareness.

APPLICABILITY/TRANSFERABILITY:

Given the success of RDC in its RHC setting, a similar clinic is being established in downtown Toronto. Although this second clinic does not have the same facilities or equipment as the hospital setting, the approach to providing integrated oral health care for a diverse population of patients has been adapted. The original practice at RDC is also growing as awareness about its specialized services increases. Additionally, RDC is looking to provide mobile dental services to bedridden in-patients at the RHC.

RDC has received many requests for information from outside long-term care and other facilities about the importance of oral health and to offer their residents the clinic's services. Expanding this practice beyond its original setting will help improve accessibility to dental care for LTC facilities, increase LTC staff training in the important of oral health, and promote regular dental visits as an important component of disease prevention and health promotion.

The greatest challenge for RDC remains accessing and informing those who could most benefit from the services offered by RDC—such as LTC-facility residents and patients unable to obtain independent transportation—and advising them of the choices available for their care.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communications:
Archer, N. (interview, review, and feedback, May 1, 2013). [Runnymede Dental Centre].

Alternative Profiles:

Other:
Archer, N. Content developed from an abstract submission to the Health Council of Canada's National Symposium on Integrated Care (2012).

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

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Burntwood CHRC Advanced Access and Clinical Practice Redesign

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

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

SNAPSHOT: This innovative practice addresses the issue of wait times and the need for access to early diagnosis and treatment for patients. The practice was launched in Manitoba and is implemented throughout 30 clinics with the aim of 75 per cent of primary care clinics to be trained in Advanced Access by 2015. This practice involves as few as two and as many as 14 staff including physicians, nurses, nurse practitioner, dietitian, family counsellor, midwife, health promotion staff, risk factor coach, Aboriginal liaison workers and various support staff working in access improvement teams.

PRACTICE DESCRIPTION:

Advanced access is about helping primary care clinics make practice changes so that patients can see a physician or other primary care practitioner at a time convenient for them. The goal is to significantly reduce wait times for services, so that clinics can provide earlier diagnosis and treatment to patients.

The Burntwood Community Health Resource Centre (BCHRC) created in 2000, was plagued with long waits for appointments, at times up to two to three months, and many complaints from community members trying to make an appointment. The BCHRC serves a population of approximately 45,000 in the Northern Health Region of Manitoba. The centre is a multidisciplinary clinic consisting of physicians, nurses, nurse practitioner, dietitian, family counsellor, midwife, health promotion staff, risk factor coach, Aboriginal liaison workers and various support staff.

In January 2008, the BCHRC started the Advanced Access project with Manitoba Health. One of their aims was to decrease the wait for an appointment, with a goal of same-day access in June of that year. Another aim was to increase office efficiency and decrease the wait time once a patient arrived for his or her appointment. The following measures were put into place to monitor progress: delays for long and short appointments demand for and availability of appointments, clinics activity, no-shows, and cycle times (the time from when a patient first arrives for an appointment until they leave the clinic). This innovative practice also aims to keep bottom-line costs down by eliminating unnecessary and duplicate services.

IMPACT:

Following the implementation of the Advanced Access project, many changes have been noted with a particular focus on quality improvement. The number of access-related complaints from patients has dropped to 0. The number of patients unassigned to a primary care provider has dropped from over 2,000 to less than 200. Delay for appointments has dropped so most providers have appointments available for the same or next day. Continuity of care, or seeing the same primary care provider, has improved. The clinic has been able to see more people each year as a result of decreased no-shows and improved use of available appointments. The demands on the walk-in clinic have decreased because patients can now get appointments with their usual health care provider.

There is no cost for clinics to apply for and take Advanced Access training. Manitoba Health has received funding to support clinic training. However, fee-for-service clinics should expect some upfront costs from the need to dedicate resource time to the training and implementation of Advanced Access. Most clinics experience a return on these upfront costs, because once Advanced Access is implemented, it has demonstrated increased billings due to improved office efficiency and the reduction in patient "no shows".

APPLICABILITY/TRANSFERABILITY:

The success of advanced access has been gaining momentum across other provinces in Canada. The BCHRC success

illustrates some unique challenges faced by serving a remote northern region. The BCHRC staff are working with other facilities in the region and provinces to spread their success.

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

Primary Care – Advanced Access: Success Stories http://www.gov.mb.ca/health/primarycare/access/docs/burntwood.pdf

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

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Transitioning Patients between BC Cancer Agency and Vancouver – Acute Services

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

SNAPSHOT:

This innovative practice addresses how best to facilitate patient transfers between regional health authorities.

PRACTICE DESCRIPTION:

The Provincial Health Services Authority (PHSA) and Vancouver Coastal Health (VCH) in British Columbia collaborated on an initiative from 2009 to 2013 to improve patient transfer processes between two of their organizations. This initiative was developed after a patient safety event occurred with a patient who was being transferred from Vancouver General Hospital (VGH) to BC Cancer Agency (BCCA) for an outpatient radiation therapy appointment. The patient transfer occurred after regular clinic hours when there was minimal staff around, and a newly hired casual nurse was transporting the patient to a different and unfamiliar agency. A number of communication and care issues arose along the way. Leaders, educators, physicians, and front-line staff from both organizations met to review the transfer process. They conducted a failure modes effects analysis to identify the defective process stages and their root causes, to score the severity and probability of recurrence, and to identify solutions to mistake-proof the process and evaluate measures over time.

The following 12 failure modes were identified: (1) lack of communication about patient needs; (2) lack of pain management plan prior to transfer; (3) nurse unaware of care plan; (4) no medication with transfer; (5) unclear physician's orders; (6) no seven rights of medication administration; (7) no after-hours policy for retrieving medication at BCCA; (8) nurse uneducated about BCCA radiation therapy protocol; (9) no policy for VCH nurse to give medications at BCCA; (10) VCH nurse unaware of BCCA procedure for radiation therapy; (11) no communication back to sending hospital from BCCA; and (12) no physician follow-up post-procedure.

A number of recommendations/solutions were identified and implemented to address these failure modes. They included: (1) staff at VGH and BCCA need to communicate verbally and in writing prior to patient transfer; (2) VGH staff need to contact the physician prior to transfer if a patient's condition changes; (3) VGH staff should receive education on the radiation therapy procedure; (4) the BCCA Medical Advisory Committee needs to discuss the appropriate use of verbal orders; (5) patients require a pain management plan prior to being transferred; (6) intra-facility policies are needed regarding the authority of VGH nurses to give medications at BCCA and after-hours medication procurement at BCCA; (7) education is needed regarding the seven rights of medication administration; (8) a protocol is needed for giving medications after-hours at BCCA; (9) BCCA needs to communicate back to the sending facilities; and (10) a PHSA Handovers Framework should be created.

The PHSA Handovers and Transitions Framework that has been created addresses three types of handover: internal, external, and intra-agency/health authority. Each PHSA agency or service must include in their processes and procedures the following core elements: standard mechanism of transfer, patient/caregiver involvement, interactive communication, comprehensive information, review of previous history, documentation, and minimal interruptions. BC Cancer Agency staff telephone the sending hospital 48 hours in advance to complete a Patient Care Information checklist to find out about the patient and request a nurse escort if required. The BCCA staff also complete a Communication Handover Form to return with the patient if the patient has received medication or has had an adverse event while at the BCCA. Vancouver – Acute Services developed a clinical practice document on transfer of patients for tests/procedures. It expands the use of the checklist beyond BCCA and identifies when accompaniment is required and what to consider when using clinical judgement to establish requirements in other scenarios.

IMPACT:

Since the recommendations/solutions were implemented in 2009, there has been a 60% drop in the number of BCCA transition events from an average 240 in fiscal year 2008/2009 to 100 in fiscal year 2012/2013. The number of transition events specific to

transitions from other facilities to the BCCA outpatient areas decreased from 75 in fiscal year 2008/2009 to 5 in fiscal year 2012/2013. There have been no new critical patient safety events since 2009 when the process was implemented, and there has been a significant drop in the number of non-critical safety events.

Mock accreditation surveys are conducted at the BCCA every six months. These include reviewing the transition form process, collecting a number of forms that have been completed per centre, and discussing/reviewing with front-line staff to ensure the BCCA process is still in place and meeting the needs of staff and patients. Staff report that there has been a significant reduction in the number of communication gaps and inappropriate transfers of patients arriving without a member of the sending hospital staff. There have also been regular quarterly meetings with a number of the sending hospitals (or host hospitals for the BCCA) to ensure the processes and checklists remain in place. Each organization has had to do a re-education of the processes and checklist every six months to ensure that the improvements are sustained.

APPLICABILITY/TRANSFERABILITY:

The Transfer Checklist, a key tool of the Transition Framework, was rolled out in October 2012 to Fraser Health Authority at the Abbotsford Regional Hospital and Cancer Centre and at Surrey Memorial Hospital. There are plans to invite all of the other BC health authorities to roll out this process. An evaluation of the process shows that since getting Fraser Health involved, the number of patient safety events has decreased from 15 per year in Abbotsford Centre in 2009 to 1 since the October 2012 implementation.

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Content was adapted from the following sources and relevant websites:

Other:

BC Cancer Agency website: http://www.bccancer.bc.ca/default.htm

Provincial Health Services Authority website: http://www.phsa.ca/default.htm

External Source: http://www.vch.ca/home/

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Specialist Directory

LOCATION:	Saskatchewan	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice aims to increase access to care and decrease wait times by showing patients that they can access equally qualified specialists with shorter wait times.

PRACTICE DESCRIPTION:

In 2009, Saskatchewan's Ministry of Health launched its Specialist Directory to physicians. A year later, after the Patient First Review, the directory was launched to the public. The Specialist Directory provides detailed information on Saskatchewan's surgical practices and associated wait times. Although it was created with the intention of improving patients' experience in navigating the health care system, the initial directory lacked a patient focus. There were over 100 pages of unsearchable information describing the practice of each of the province's 200 surgeons. Consequently, the Saskatchewan Medical Association, Saskatchewan Ministry of Health, eHealth Saskatchewan, and Saskatchewan Senior Medical Officers got together to discuss how best to enhance the Specialist Directory to make it completely user-friendly and accessible.

Areas for improvement were identified through rigorous testing and discussions with urban and rural focus groups that consisted of family physicians, surgeons, and patient volunteers. The patient volunteers were given instructions to find certain specialists, such as their local specialist with the shortest wait time. Similar exercises were conducted with physicians, all of which led to the identification of utilization barriers. The feedback from the focus groups was assembled into a single user requirements document that was used as the basis for change. A survey of other jurisdictions' directories identified British Columbia's Surgical Wait Times website as a resource that best met user requirements. After consultation with BC's Ministry of Health, BC agreed to share their vendor, CGI group Inc., to complete Saskatchewan's website redesign. The redesign took eight weeks to complete, after which the prototype was showcased to selected physicians and advisors for feedback. After government endorsement, the Specialist Directory was made public with a media campaign in early 2012.

IMPACT:

The changes made to the directory have resulted in widespread use of the website by patients, enhanced coordination among available patient/service registries, improvements in both patient and physician satisfaction, and reduced wait times. The site received 2,162 hits on release followed by an average of 250 to 300 hits per week. Access to local surgical services has been improved for rural care practices. The launch and implementation of the new directory resulted in a 57% decrease in wait times that exceed 18 months and a 44% decrease in wait times that exceed 12 months.

Since the directory is linked to numerous registries, such as the Provider Registry, it has been constantly updated with an 80% automated approach to provide patients with the most up-to-date information. The information added has been integrated with the rest of the directory and has been organized such that patients can look up information by procedure, surgeon name, or geographic location. It has also been useful in making physicians aware of all referral options by updating them about new practising surgeons and specialists.

APPLICABILITY/TRANSFERABILITY:

The enhancement of the Specialist Directory required the collaboration of many health specialists, Information Technology (IT) specialists, patients, and advisors over a short period of time. The experience in putting together the website brought to light the lack of available information on all physicians and specialists. It was not until all providers were contacted and their information was solicited that the IT staff could start their website redesign. Moreover, using the existing directory framework and engaging vendors with experience in successful website design proved to be crucial in completing the project in a timely manner.

A component of the directory highlights pooled referral groups, which promotes the next-available-surgeon approach in referral making. This approach has been used successfully in other jurisdictions, such as Ontario, Alberta, and Newfoundland and

Labrador. Similar to these jurisdictions' referral practices, Saskatchewan has integrated non-surgical specialists into the directory to enhance access to care for those patients opting for medical management of disease. Similar directories for referrals exist in the Netherlands, Alberta, Ontario, and Nova Scotia. However, to date only in Saskatchewan has this type of directory been fully opened to the public, although Nova Scotia plans to do this with its Surgeon Directory. This indicates that having a specialist directory is a highly transferable practice across jurisdictions, with successful results being reported from the Netherlands and Ontario.

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

Alternative Profiles:

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

Other:

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External Source: https://www.sma.sk.ca/Default.aspx?cid=642&lang=1

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Collaborative Emergency Centres (CECs)

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

SNAPSHOT: This innovative practice aims to provide enhanced health care and expanded access to primary health care through collaborative teams that include physicians, nurse practitioners, registered nurses (RN), and paramedics in each community.

PRACTICE DESCRIPTION:

Improving access to primary health care and emergency services is one of Canada's top health priorities. In Nova Scotia, many had to wait for weeks to see their family physician, and rural emergency departments were frequently closed. Collaborative Emergency Centres (CECs) were first recommended as a way of making emergency care a seamless part of primary health care. CECs provide enhanced health care and expanded access to primary health care through collaborative teams that include physicians, nurse practitioners, registered nurses (RN), and paramedics in each community. Care is available 24 hours a day, seven days a week. The professionals in the CECs are appropriately trained, experienced, and have the equipment to provide care to patients. The first CEC was announced in April 2011 and opened in Parrsboro in July 2011.

Collaborative Emergency Centres are part of Nova Scotia's Better Care Sooner plan to provide consistent, safe, quality care. The services available in CECs are designed to match the needs of the community.

CECs provide patients with access to

- same- or next-day medical appointments for urgent matters;
- a team approach to health care that is focused on patient specific needs;
- extended hours and expanded services for primary health care (call 811 to speak to an RN); and
- 24/7 access to emergency care by highly trained professionals.

CECs are funded by the Government of Nova Scotia. In December 2011, it was announced that the government will invest $6.8 million to establish more CECs across the province.

The development of CECs is innovative in that they target rural communities in which emergency departments provide limited services that are not always available when needed. The CEC model includes after-hours care that is provided 24/7 via online physicians who work with the RN and paramedic on site in case of emergency.

IMPACT:

The Nova Scotia Cochrane Resource Centre found that there is limited scientific literature on the concept of CEC-type models as a health care delivery model. Further, a lack of evidence is available on the impact of alternative models of after-hours care. However, telephone triage and advice lines similar to Nova Scotia's 811 model do appear to reduce medical workload and to have the potential to reduce costs.

Although there is no formal evaluation of this innovative practice, most CECs in Nova Scotia are reporting positive outcomes. Patients are reporting that there is more flexibility in the system and it's a little easier to see providers for prescription renewals and other services.

APPLICABILITY/TRANSFERABILITY:

It was initially recommended that 14 rural communities be considered for CECs. Since the first CEC was opened in July 2011, further CECs have opened in Springhill, Tatamagouche, Pugwash, Annapolis Royal, and Musquodoboit Harbour. In the 2013 fiscal year, CECs in Musquodoboit Valley and New Waterford will also be opened, bringing the total to eight CECs. Phase 3 of the CEC implementation plan will see as many as six more communities get a CEC.

Other jurisdictions, including Saskatchewan and PEI, have consulted Nova Scotia on implementing CECs. As of March 2013, Saskatchewan has committed $4.3 million to developing CECs and PEI has announced that it will establish its first CEC in Alberton. This suggests that the practice is applicable to other jurisdictions, but results are still forthcoming about whether this model is having a positive impact in their communities. Components and variations of this practice also exist at the international level.

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

Publications:

Ross, J. (2010, October). *The patient journey through emergency care in Nova Scotia: A prescription for new medicine.* Retrieved from
http://www.gov.ns.ca/dhw/publications/Dr-Ross-The-Patient-Journey-Through-Emergency-Care-in-Nova-Scotia.pdf

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External Source: http://novascotia.ca/health/betterCareSooner/

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Process Improvement Initiative in Endoscopy

LOCATION:	Newfoundland & Labrador	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice is a provincial wait time strategy for endoscopy services.

PRACTICE DESCRIPTION

In 2010, the Newfoundland and Labrador Department of Health and Community Services announced a provincial wait time strategy for endoscopy services to review the system's current capacity and its ability to deal with the increased volumes that the new screening program would generate. The Central Health Regional Endoscopy Waitlist Management Working Group assists in the development of a regional strategy to manage wait lists in order to improve access and reduce wait times for endoscopy services. The Centre for Research in Healthcare Engineering (CRHE) was engaged to assist with the process. They leveraged the use of the Colonoscopy Process Improvement Toolkit (from the 2010 Colorectal Cancer Screening Program) to assist hospitals in dealing with increased demand for services. Through staff interviews, processes from booking to discharge were mapped and evaluated. Analysis of data over a six-month period revealed inefficiencies in procedure scheduling, and it was discovered that a high volume of patients did not attend their scheduled endoscopy appointments (850 "no shows" in 6 months).

Strong leadership from physician champions led to the implementation of changes, such as central intake of referrals, a one-room-per-physician model in the endoscopy suite, standardized patient surveillance forms, and streamlined recovery processes. By implementing central intake of referrals, Central Health was better able to evaluate referral practices and measure referral volumes. True demand for services was determined through validating the wait list. Established guidelines were used to standardize the referral form and processes. Access was improved by redesigning patient flow and implementing a two-room model (two physicians, two rooms). Decision-makers and staff took ownership and implemented and evaluated recommendations. To improve accessibility and reduce existing wait times, several options were presented to the Regional Endoscopy Waitlist Committee. The following options for increasing clinic capacity were evaluated: (1) increase physician capacity by adding three physicians to the endoscopy service and implementing the two-room model; (2) redesign patient flow to prepare patients for the procedure in the waiting room and walk patients to the procedure room to eliminate patients being admitted to the "bed" prior the procedure; and (3) implement a process to book all urgent cases when the referral is received.

The option approved was a new process to book referrals. All referrals (excluding urgent cases) are entered into a pending list that forms the basis of the booking process. Booking for new patients accommodates referral volume by type, next available, and physician specific requests. Wait times are calculated from an electronic scheduling module based on timely entry of referrals. Physicians screen all referrals based on standardized urgency bands.

IMPACT:

Evaluation of the Process Improvement Initiative in Endoscopy includes an annual analysis of performance data. The Department of Health and Community Services collaborated with Central Health to develop key performance indicators to measure efficiency, accessibility, and effectiveness. With respect to referral rates (urgent and non-urgent combined), the number of people waiting for colonoscopies decreased from 1,139 in December 2011 to 864 in December 2012, while the number of colonoscopy referrals went up from 14 in December 2011 to 43 in December 2012. There were also significant improvements in accessibility rates for urgent colonoscopies over the one-year period: colonoscopies (50th percentile) went from 30 to 18 from 2011 to 2012, while colonoscopies (90th percentile) went from 237 to 29 in the same time period.

APPLICABILITY/TRANSFERABILITY

Implementation successes will be spread to the three remaining urgency bands, a second referral site, and other services within Central Health.

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Content was adapted from the following sources and relevant websites:

Other:

- Newfoundland & Labrador Department of Health and Community Services. (2011, March 4). Progress continues in addressing wait times for health care services [News Release]. Retrieved from http://www.releases.gov.nl.ca/releases/2011/health/0304n02.htm
- MacDonald, T. & Budgell, J. (2013, March). *Leadership and sustainable change: A process improvement initiative in endoscopy*. Poster session presented at the Taming of the Queue, Ottawa, ON.
- http://www.health.gov.nl.ca/health/

External Source: http://www.centralhealth.nl.ca/

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Orthopedic Central Intake Project

LOCATION:	Newfoundland & Labrador	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

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

SNAPSHOT:

This innovative practice aims to facilitate the referral of orthopedic patients to the next available surgeon, keeping track of the referral status, and involving all health care providers throughout the process.

PRACTICE DESCRIPTION:

Before 2011, the people of Newfoundland and Labrador had difficulties accessing appropriate and coordinated access to orthopedic surgical consultations. In response to complaints regarding excessively long wait times, inefficient referral practices, and poor patient satisfaction, Eastern Health invited numerous health care stakeholders to discuss ways of revamping the orthopedic referral system to increase access to care, decrease wait times, and streamline the referral process. After many discussions among stakeholders, visits to other jurisdictions with central intake processes in place, and consulting the national benchmarks on joint replacement surgery wait times, the Eastern Health created the Orthopedic Central Intake (OCI) Project. The primary goal of this initiative, which launched in 2010, is to develop a central intake algorithm that can refer patients—on an urgency basis—to the next available surgeon, keep track of the referral status, and involve all health care providers throughout the process. The OCI involved seven orthopedic surgeons, 316 physicians at the Eastern Health, and numerous allied health staff in all aspects of the process design, pilot implementation, and outcome analysis.

After the budget was submitted in November 2010, the project lead engaged stakeholders in discussions to establish a common understanding of central intake. This understanding was used to formulate a single-entry patient referral form that was put into use in April 2011. Working groups identified key performance indicators and have been evaluating the impact of the new referral system within existing structures and identifying areas for improvement. The OCI is currently in the last year of its three-year plan and outcome measurement is ongoing.

IMPACT:

The OCI resulted in improvements in wait times, streamlined the referral process, and enhanced communication between health care providers. The stakeholders contributed to the development of detailed algorithms to guide decision-making, standardized the triage criteria, clearly defined the orthopedic demand for a next available surgeon across all sub-specialties, and improved the transparency for reporting timely data on access and wait times.

Key performance indicators were identified across the continuum of care in order to measure efficiency, accessibility, appropriateness, and effectiveness. The findings are published in evaluation reports and presentations. Positive impacts include decreases in wait times being reported. For high-priority referrals, a median wait of 325 days was reduced to 91 days (a 72% reduction); for routine referrals, the median was reduced to 179 days (a 45% reduction). The indicators also reveal a compliance rate of 80% with 63% of family doctors using the next available surgeon method.

These efforts to improve access to care complemented the Government of Newfoundland and Labrador's commitment to reducing wait times for joint replacement surgeries in 2011, which strengthens the government's 2012 Strategy to Reduce Hip and Knee Joint Replacement Surgery Wait Times.

APPLICABILITY/TRANSFERABILITY:

For planners and jurisdictions interested in adapting this practice into their own setting, the success of the OCI lies in the proper identification of change management principles. Process change started with the involvement and early engagement of key stakeholders with appropriate clinical and health service backgrounds. This was followed by the development of a shared vision

on what the central intake process would look like in the context of their regional health authority and orthopedic specialty. Emphasis was later put on communication for buy-in, followed by engagement of stakeholders in providing feedback and formulating an action plan that all stakeholders would be on board with.

Information Technology (IT) development was also crucial to the success of this project; stakeholders noted that multiple database systems already existed but had limited capacity to collect and measure all the relevant outcomes. Hence, ensuring that a proper electronic database system was created, managed, and incorporated into daily practice required collaboration between health care providers and IT support staff throughout the design and implementation phases of the project.

Current plans include the development of clinical guidelines for non-surgical interventions and an interprofessional team—including surgical and non-surgical staff—working together to achieve a more coordinated, accessible, and appropriate approach to health care delivery. A similar type of initiative to create benchmarks and reduce wait times for surgery has been implemented in Saskatchewan in isolation. Therefore, transferability of the OCI to other jurisdictions is possible provided there is strong IT support and communication between all staff involved.

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Publications:

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

Newfoundland and Labrador. (2012). *A strategy to reduce hip and knee joint replacement surgery wait times in Newfoundland and Labrador*. Retrieved from
http://www.health.gov.nl.ca/health/wait_times/orthopedic_wait_times_strategy.pdf

External Source:
http://www.cfhi-fcass.ca/Libraries/Taming_of_the_Queue_English/2012Poster-OrthopedicCentralIntakePoster.sflb.ashx

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Path to Care: Referral and Wait Time Measurement and Management

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

SNAPSHOT: This innovative practice aims to improve access and reduce health care service and referral wait times through a province wide program. This practice was launched in Alberta in 2010 and aims to develop and implement provincially adjudicated referral standards.

PRACTICE DESCRIPTION:

Path to Care: Referral and Wait Time Measurement and Management is a province-wide initiative to improve access and reduce health care service and referral wait times in Alberta. The initiative evolved partly from Alberta's Wait Time Management Initiatives, which supported the province's research and development on access improvement from 2007 to 2010. It also has roots in Alberta's work on the Transformational Improvement Program (TIPs)–Improving Access, Reducing Wait Times, which is part of *Alberta's 5-Year Health Action Plan* (2010 to 2015).

Path to Care is in year 2 of a five-year program. The specific objectives of the program are to improve access and reduce wait times; implement service redesign across common processes that affect access across primary care, the five zones, and Strategic Clinical Networks within Alberta; standardize the elements of referral and triage criteria across program areas; establish consistent operational policies regarding service response times, and patient and provider communication; increase transparency of service delivery and wait times; and improve request tracking and status reporting.

The specific program related to referral management includes redesigning services; developing provincially adjudicated referral standards and access targets by population or care pathway; and automating the referral process through e-referral. This work addresses current challenges with respect to variable referral and communication processes (i.e., lack of standardized referral processes and lack of transparency about the status of referrals); capacity management issues related to matching service supply and demand; and lack of automation of the referral process.

Alberta Health Services (AHS) is beginning a clinical engagement and design phase to define Alberta's e-referral experience. A web portal will be used to automate the referral process. In the short term, Alberta Netcare Portal (ANP) users will be able to create and manage referrals within Netcare; long-term plans include integrating ANP with clinical applications such as EMR, scheduling systems, and the patient portal. AHS will do a limited production roll out of e-referral provincially for hip and knee surgery, breast cancer, and lung cancer starting in November 2013. These clinical pathways were chosen because provincially adjudicated guidelines for them already exist, they have already done business process re-engineering, and they have clinical champions. A business case and implementation plan for provincial deployment of the e-referral and wait time platform beyond the limited production toll out is currently being developed.

IMPACT:

The evidence for the effectiveness and efficiency of electronic referrals comes primarily from international case studies, since no systematic reviews or randomized controlled trials have been published to definitively quantify the impact of electronic referral systems. It suggest that electronic referrals have helped eliminate the risks associated with manual workflow processes and have significantly reduced inefficiencies in the health care system, duplication, and transcription errors. Almost all e-referral initiatives have resulted in improved access to services, increased capacity of the health care system, and reduced wait times for patients.

A formal program evaluation of Alberta's Path to Care, including a benefits realization/return on investment analysis is being developed. The evaluation will look at the impact of Path to Care across the quality dimensions (access, appropriateness, acceptability, efficiency, safety, and effectiveness).

APPLICABILITY/TRANSFERABILITY:

AHS is building on work done to reduce variability in the referral process and automate it in, for example, the United States (San Francisco General Hospital, Cook County Health and Hospital System, Boston Medical Centre, Harvard University/Partners Health System), Denmark (MedCom-Projects), Australia (Australia Capital Health), and New Zealand (Hutt Valley District Health Board).

The AHS's referral management process has not been implemented elsewhere. The initiative is theoretically applicable and transferable elsewhere.

Content adapted from the following sources and relevant websites:

- Alberta Health Services. (2012). *Closed loop referral management in Alberta: Draft white paper*. Edmonton, AB. (Internal Document).
- Alberta Health Services. (2012). *Path to Care: Opportunity assessment* [Internal Document].
- Bichel, A. (personal communication: interview and feedback, December 11, 2012). [Alberta Health Services]

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Nova Scotia Breast Screening Program – Wait Time Reporting

LOCATION:	Nova Scotia	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:		FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the issue of performance measurement by reporting on nine indictors related to wait times and breast screening. Launced in Nova Scotia in 2010, results are provided to the public via the provincial wait times website

PRACTICE DESCRIPTION:

The Canadian Breast Cancer Screening Initiative (CBCSI) has a national wait time performance indicator for diagnostic interval. The Nova Scotia Breast Screening Program (NSBSP) has extended its wait time reporting beyond diagnostic interval. It reports on nine indicators that monitor a patients' real wait time experience along the entire breast health continuum, from screening to surgery. The indicators include: (1) date from when a first-time client calls central booking to the date of screening appointment; (2) date from screening mammogram to the date of work-up mammogram; (3) date from screening mammogram to the date of finalized report; (4) date from finalized report to date of work-up mammogram; (5) date from when a requisition is received to date of an urgent or semi-urgent diagnostic mammogram; (6) date from most recent breast-related diagnostic imaging procedure to date of needle core biopsy; (7) date from screening mammogram to date of needle core biopsy; (8) date from work-up mammogram to date of needle core biopsy; and (9) date from needle core biopsy to breast cancer surgery. Results are provided to the public via the provincial wait times website and directly to managers and staff within breast imaging departments. Sites are shown their performance relative to the national target, the provincial average, and all other sites. The NSBSP captures data at a level where it is able to break the national indicator into specific waits and identify where bottlenecks may exist along the clinical trajectory.

IMPACT:

The NSBSP adopted the use of retrospective analysis to improve the dissemination of wait time information. Typically the 50th (median) and 90th percentiles are calculated for each indicator over a 3-month calendar quarter. Often wait time reporting is seen as a measure for public transparency. The NSBSP took the opportunity to share wait times information directly with health care personnel. This level of engagement has proven successful, as personnel are more conscientious of the targets they are being measured against. Also, poor performing sites are more apt to approach the NSBSP, seeking ways to improve performance.

Breaking wait time indicators into smaller component waits has also helped to improve wait times. Specific personnel (e.g. radiologists) "own" certain wait times (e.g. reporting time), meaning their performance is the key factor of that component wait. As a result, a sense of ownership and responsibility to the wait times has developed in personnel across the province. Since the introduction of regular wait time reporting to all breast imaging departments in Nova Scotia, there has been a noted improvement in wait times and a decrease in the variability across sites.

In the 4th quarter of 2010, just as this practice began, it took 41 days for 90% of patients in Nova Scotia to have a work-up mammogram after an abnormal screen. As of the 4th quarter of 2012 this wait has been reduced to 26 days for 90% of patients in Nova Scotia.

APPLICABILITY/TRANSFERABILITY:

To date, the NSBSP is not aware of this approach being formally implemented in any other setting.

This practice has brought awareness of patient wait times and wait time targets to front line health care providers delivering the services being measured. Regardless if presenting wait time information alone doesn't improve performance, having the information readily available is the first step to invoking positive change and creating an environment that fosters new ideas from all levels of the organization.

Although the reporting of median and 90th percentiles was not novel, the dissemination of breast imaging wait time information directly to health care providers was an approach piloted in Nova Scotia.

Content was adapted from the following sources and relevant websites:

- http://waittimes.novascotia.ca
- Duggan, R. Content developed from an abstract submission for the Health Council's National Symposium on Integrated Care (2012).

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Information last updated on: April 12, 1013

External Source: http://breastscreening.nshealth.ca/

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myDDSNetwork Collaborative Model for Dentistry Referrals

LOCATION:	National	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need to support the exchange and collaboration of personal health information (PHI) between dental providers. Launched at the end of 2012, all dentists in Canada now have access to a standardized referral and consultation platform to exchange PHI.

PRACTICE DESCRIPTION:

In dentistry, the referral process is still largely paper based which limits the completeness and timeliness of patient information that can be provided to other practitioners within the circle of care.

In 2008, myDDSnetwork was released to support the exchange and collaboration of personal health information (PHI) between dental providers. The objectives of the network were; to improve patient care, to improve continuity of care in a multi provider setting, reduce the cost and time of delivery of care and to enable real time clinical knowledge transfer of PHI in a secure, regulatory compliant environment.

The Canadian Dental Association (CDA) recognized the needs of oral health professionals to have a standardized digital environment to share clinical information including radiographs. At the end of 2012 myDDSnetwork was implemented in a partnership with the CDA, Canada Health Infoway, Continovation Services Inc. (CSI) and myDDSnetwork Ltd. All dentists in Canada will now have access to a standardized eReferral and eConsultation platform to exchange PHI. On ramping of all Canadian dentists and their care teams is ongoing.

myDDSnetwork takes existing office processes with respect to the referral/consultation process and mimics them in a real time digital environment. The network can be used in all dental offices covering the entire spectrum from fully paper based to paperless. myDDSnetwork can support patient access to their own referral information.

IMPACT:

The CDA eReferral and eConsultation project will have an ongoing benefits evaluation. There will be a formal benefits evaluation at the end of 2013.

APPLICABILITY/TRANSFERABILITY:

The dental referral model is very similar to the current generalist to specialist relationship in the medical system and the current allied health care to medical professional relationship. myDDSnetwork's authentication process, clinical workflow tools and roles based permissions can be adapted and adopted to enable collaboration of PHI between any and/or all healthcare practitioners, patients and stakeholders.

The myDDSnetwork platform has been used to support the exchange of PHI between hospitals and doctor's offices electronic medical records in Ontario
Future expansion of the current myDDS model will be supporting the sharing of PHI with different users such as patients and industry stakeholders. From a workflow perspective integration with practice management systems will be supported.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

- Glaizel, J. Content developed from an abstract submission for the Health Council's National Symposium on Integrated Care (2012).

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

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The Arthritis Alliance of Canada's National Musculoskeletal Models of Care Working Group and Master Worksheet

LOCATION:	National	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for health care professionals across Canada to deliver the most efficient models of care (MoCs) for musculoskeletal (MSK) patients. The working group was launched in 2011 with the purpose of determining the importance and applicability of MoCs in treating MSK conditions and then to devise a strategic framework that is both evidence-based and consensus-based.

PRACTICE DESCRIPTION:

Musculoskeletal (MSK) conditions are highly diverse and costly; therefore, numerous models of care (MoCs) have been proposed and adopted across Canada to address the need for more targeted care. However, the emergence of so many models has led to less efficient practices and to the need for a more systematic approach to health care delivery. Numerous stakeholders in health care, including the Arthritis Alliance of Canada and the Canadian Orthopedic Association, have formed a working group to share expertise and discuss the scope of MSK MoCs offered across the nation. The purpose of the working group has been to determine the importance and applicability of MoCs in treating MSK conditions and then to devise a strategic framework that is both evidence-based and consensus-based. This framework will enable health care professionals across Canada to deliver the most efficient MoC.

The MSK MoCs Working Group began in 2011, and met regularly during that year. The first meeting was important in establishing both the importance of MoCs in MSK treatment as well as in garnering the support of key national leaders. Their first task was to ensure that there was a common understanding of existing MoCs and agreement on the importance of MoCs in MSK treatment. Once the support of key national leaders was obtained, the group focused on formulating systematic criteria upon which the framework would be devised. The consensus-based framework was then validated before gaining national endorsement from the federal government.

IMPACT:

The working group found it challenging to develop the framework given the vast number of existing MoCs and the current gaps in health care delivery. Nevertheless, the group successfully established basic criteria for the framework and garnered national support for creating the framework and advocating its endorsement. The stakeholders achieved an evidence-based framework that led to the formation of a Master Worksheet. The Master Worksheet helps model developers assess the completeness of MoCs, suggest improvements, and assess readiness for expansion. It also outlines the key elements of a successful MoC, which physicians can use to create their own personalized models.

The Master Worksheet was pilot tested in April 2012 and received positive feedback from experts with experience in MoC usage and development. The worksheet highlights elements such as conducting public needs assessment, establishing local partnerships, and ensuring that the MoC is evidence-based. Advice on common language usage and addressing the relationships among quality, access, and cost are also addressed in this resource.

APPLICABILITY/TRANSFERABILITY:

Several working groups in Europe (e.g., in Italy and Spain) focus on musculoskeletal injuries, but those initiatives are related to occupational health and do not focus on MoCs. Other working groups, such as the Musculoskeletal Network's Paediatric Rheumatology Working Group in Australia, focus on a more specific disease in a particular region of the country as opposed to national level. Canada's National Musculoskeletal Models of Care Working Group is the first group that has adopted a national, cross-jurisdictional approach to improving cooperation and coordination for optimal MSK care delivery. The Master Worksheet

developed by this group can be used for the planning, development, or formative evaluation of proposed MoCs, locally, provincially/territorially, and nationally. It can also be used to identify the appropriateness of disseminating information on particular MoCs.

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

- National Musculoskeletal Models of Care Working Group. (2012, Fall). *Tool for developing and evaluating models of care.* http://www.arthritisalliance.ca/docs/bod/201211272330_moc_EN.pdf
- 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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Information last updated on: March 4, 2013

External Source:
http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf

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Shared Care Strategy for Patients with Chronic Diseases—Patients in Care, Providence Health Centre

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

SNAPSHOT: This innovative practice consisted of several projects all aimed at facilitating a seamless patient experience through better collaboration between health care providers. Launched in April 2010 in two health authorities in British Columbia, the core of initiatives are to strengthen relationships between family practitioners (FPs) and specialists to ensure that referrals are timelier and to avoid duplicating effort and resource utilization.

PRACTICE DESCRIPTION:

Ensuring maximum patient satisfaction is the ultimate goal of any health care provider. It requires a multi-pronged approach that focuses on timely access to care, an organized communication model, improving health outcomes, and ensuring that patients can manage their condition independently after hospital discharge. The health care community of British Columbia has recognized the need to devise a more organized and coordinated approach to health care delivery. In April 2010, the Shared Care Committee—a partnership of the BC Medical Association and Ministry of Health—Providence Health Care (PHC) and Vancouver Coastal Health launched a two-year joint initiative to establish a shared care approach to delivering health services to patients with complex chronic conditions. The purpose of this initiative was to facilitate a more comfortable and accessible experience for patients with chronic diseases by focusing on improving health outcomes, reducing per capita costs, and improving communication. The core of this initiative was strengthening relationships between family practitioners (FPs) and specialists to ensure that referrals are timelier and to avoid duplicating effort and resource utilization.

The initiative consisted of several projects all aimed at facilitating a seamless patient experience through better collaboration between health care providers. The first of these projects, the Rapid Access to Consultative Expertise (RACE) telephone advice line, is a telephone technology that allows FPs rapid access to specialists and thereby avoid unnecessary wait times, ER visits and face-to-face consultations. FPs can choose from a list of specialty services and have their call routed directly to the specialist's pager to ensure rapid consultations. Similarly, an acknowledgement of referral mechanism was put in place to promote a more effective telephone-based referral system for FPs with an emphasis on ensuring the timely receipt of the referral. These efforts were also elaborated on to include Shared Care Planning, a line of communication between FPs and specialists following the consult, which was not in practice prior to this initiative. Finally, the self-management project was designed to engage patients in establishing their own health goals and action plan. This patient-centred approach provides a more tailored and effective plan for self-management.

A highly organized implementation plan was devised. It included several diverse stakeholder groups and advisory groups that met multiple times per year to discuss a wide range of topics from IT support to physicians' opinions on the feasibility of the communicative model in their daily practice.

IMPACT:

The Shared Care strategy is evaluated through individual evaluations of each of its component projects, rather than as whole strategy. Each project was first put through the Plan-Do-Study-Act Cycle of prototype design, trials, and implementation, to observe its efficacy and determine gaps in the framework at round-table discussions. A formal evaluation of each project was conducted to qualitatively and quantitatively assess the initiative's success and impact on patient outcomes.

As an example, the RACE project was formally evaluated using measures such as questionnaires, online surveys, and interviews with the FPs and specialists. These two groups of health care providers generally found RACE to be an excellent tool that filled the gap in communication. The online survey indicated that 90% of FPs and specialists were aware of RACE and of those who participated in the RACE trial, 95% would recommend it to their colleagues. They noted that it reduced their patients'

emergency department visits (32% avoided visits), reduced face-to-face consultations with specialists (60% avoided consultations), and reduced unnecessary specialist referrals, and 83% believed it helped manage their health care delivery. Overall, RACE was effective at enhancing timely communication between FPs and specialists, given that of the more than 600 calls that were logged by 2012, 80% were answered within 10 minutes. The RACE system has won the Institute of Public Administration of Canada /Deloitte Public Sector Leadership Award, and the Health Employers Association of British Columbia Top Innovation Gold Apple Award.

The Shared Care Strategy is correlated with an increased referral acknowledgement to 77%; similar gains were observed in management of care using Share Care Planning. Interviews with patients have brought to light their satisfaction with their quality of care and improved navigation through the medical system. The trials have demonstrated that a coordinated approach using effective models of communication can enhance the patient's journey, improve emergency department flow, reduce costs (by up to $200 per call), and increase specialty capacity.

APPLICABILITY/TRANSFERABILITY:

The success of this initiative has encouraged more participation and utilization in BC. The RACE project was piloted in the cardiology unit; given its success, it was then expanded to 11 specialty services in 2012. The acknowledgement of referral system has been successfully implemented in several Providence Health Care chronic disease clinics, private specialty clinics, and broader provincial programs. Share Care Planning has been implemented both regionally and provincially and overall, the Shared Care Strategy innovative practice initiative has engaged over 1500 FPs and 200 specialists.

Although there are other referral practices being implemented across Canada and internationally, many of them are led by nurse specialists. The Share Care Strategy is the only initiative that provides GPs and their patients with direct real-time telephone access to specialists, and is a practice that could be adopted in other provinces and territories.

Content was adapted from the following sources and relevant websites:

http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf

http://www.healthcouncilcanada.ca/tree/symposium2012/C1_CareCoordinationWorkshop_Wilson_EN.pdf

https://www.bcma.org/rapid-access-consultative-expertise-race-program

http://www.youtube.com/watch?v=TQyKe0CKh_A

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Information last updated on: February 22, 2013

External Source: http://www.healthcouncilcanada.ca/tree/symposium2012/C1_CareCoordinationWorkshop_Wilson_EN.pdf

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Spine Pathway Project

LOCATION:	Saskatchewan	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to increase medical training in screening methods, establish spine centres dedicated to effective screening of lower spine pathologies, and develop a system to offer appropriate management resources for lower back pain and injuries. Launched by the government of Saskatchewan in 2009, the end goals of this initiative are to provide appropriate patient care to those with lower back pain and injuries and to increase the amount of time available for specialists to perform other much-needed spinal surgeries.

PRACTICE DESCRIPTION:

Spine conditions are highly diverse and can be treated through medical or surgical intervention. Although there are over 900 spine conditions, many severe and benign spine conditions present highly similar symptoms, making diagnoses rather difficult. Physicians in Saskatchewan have identified this problem in spine condition assessments and recognized that through proper screening interventions, 80% of patients with spine conditions can avoid unnecessary surgery and be treated with medical interventions instead. As a result, the government of Saskatchewan launched the Spine Pathway Project in 2009 to increase medical training in screening methods, establish spine centres dedicated to effective screening of lower spine pathologies, and develop a system to offer appropriate management resources for lower back pain and injuries.

The initial phase of the project included the development of physician training modules including an online course that received continuing medical education recognition. This was followed by the establishment of Spine Centres and the formation of appropriate benchmarks and clinical studies to assess progress. This involved the development of a classification-based system used to determine the level of care and severity of condition for each patient. In 2010, online courses and training modules were released, and Spine Centres were opened a year later in Regina and Saskatoon. These Spine Centres are equipped with an interprofessional team dedicated to providing the most appropriate treatment for each patient referred.

The end goals of this initiative are to provide appropriate patient care to those with lower back pain and injuries and to increase the amount of time available for specialists to perform other much-needed spinal surgeries. This will help to decrease wait times for specialists and increase access to diagnostic resources. This initiative is the first of its kind in Canada and shows promise in increasing access to care and providing patient-centred primary care to those with spine conditions.

IMPACT:

The Spine Pathway Project is an ongoing initiative that has demonstrated preliminary success and potential for expansion. The physician-training course and materials, which have been recognized by the CME, have been completed. To date, 900 of the 2,000 anticipated primary care providers (PCPs) in Saskatchewan have been trained. There are ongoing efforts to develop online training modules for chronic pain conditions along with chronic pain assessment forms. The Spine Centres have been opened and new lower spine assessment modules have been completed and implemented by the primary care physicians involved. Benchmarks and clinical studies on the flow processes and outcomes have been established. The course has a 95% satisfaction rate from the PCPs who have participated to date.

The reduction in spinal surgeries and diagnostic studies has resulted in decreased wait times and increased access to diagnostic resources such as MRIs. About 36% of all MRIs prior to the launch of this initiative were conducted for lower back pain and injuries. It has been observed that removing 100 patients from this MRI waiting list reduces the waiting time for the rest of the patients by one week.

In 2011, the journal *Spine* published a systematic review on clinical pathways that included a case study discussion on the Saskatchewan Spine Pathway Project. This review suggested that the Spine Pathway Project was an innovative initiative for spine screening, since it incorporated appropriate training modules, used financial incentives to drive successful patient care, addressed screening measures at the primary care level rather than at the specialist level, and used a classification-based system of referral. The review encourages further development of the clinical pathway to include evidence-based guidelines as well as further evaluation of its ongoing success.

APPLICABILITY/TRANSFERABILITY:

There are likely many similar pathways worldwide (e.g., Spinal Taskforce for the Department of Health, National Health Service, United Kingdom) but most have not been published in peer-reviewed journals. In Saskatchewan, to date only two specialized Spine Centres have been opened to facilitate referrals. Although other clinical pathways exist for lower back pain, the Spine Pathway Project is the only practice that is inclusive of all types of lower back pain and that includes all the defining features of a modern care pathway—clear objectives, facilitation of communication between physicians and patients, coordination of care, continued monitoring of outcomes, and adequate funding. With the proper funding supports and clinician champions, this practice is likely transferable to other jurisdictions.

Content adapted from the following sources and relevant websites:

Fournier, D.R., Dettori, J.R., Hall, H., Hartl, R., McGirt, M.J., & Daubs, M.D. (2011). A systematic review of clinical pathways for lower back pain and introduction of the Saskatchewan Spine Pathway. *Spine, 36*(21 Suppl), S164–171. doi: 10.1097/BRS.0b013e31822ef58f

https://www.spinepathwaysk.ca/home

http://www.gov.sk.ca/news?newsId=4d8a0b8c-367f-42eb-8587-43bc3b58432b

http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf

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Information last updated on: February 29, 2013

External Source: http://www.health.gov.sk.ca/back-pain

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Youth Transitions to Adult Care in BC

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

SNAPSNOT: This innovative practices facilitates the successful transition of patients from pediatric to adult care involves the provision of uninterrupted, coordinated, developmentally appropriate, and psychologically sound health care. In June 2011, the British Columbia Medical Association's (BCMA) Council on Health Economics and Policy approved a project on youth transition in BC.

PRACTICE DESCRIPTION:

With improved treatment and care, approximately 90% of pediatric patients with complex or chronic illness will now reach age 20. However, unsuccessful transition of these patients to adult care is associated with the risks of accelerated mortality and morbidity. Although British Columbia has historically provided ad hoc transition services, there has been no consistent and overarching provincial mandate or widespread knowledge of available resources. Ensuring successful transition from pediatric to adult care involves the provision of uninterrupted, coordinated, developmentally appropriate, and psychologically sound health care. This requires systematic and collaborative solutions with buy-in from all levels of key stakeholders across the province.

Consultation with key stakeholders revealed that many believed that youth transition was being addressed successfully. However, consultation with clinicians suggested they were challenged without formal transition planning strategies and long-term care plans, and they were largely unaware of programs and resources available to them.

To ensure that all pediatric patients aging into adult care would be successfully transitioned in British Columbia, stakeholders have taken a two-pronged approach toward policy and program delivery. In June 2011, the British Columbia Medical Association's (BCMA) Council on Health Economics and Policy approved a project on youth transition in BC. In January 2012, the BCMA identified an expert project group to conduct a thorough review of existing literature, analyze existing policy, and develop recommendations in consultation with stakeholders (clinicians, administrators, allied health professionals, health authorities, and government). Dissemination plans for the final paper include collaboration with stakeholders and advocacy at senior levels of health authorities and the Ministry of Health. Key recommendations include a family physician from birth, in addition to other care providers; individualized transition plans for graduating patients; and development of identification and ongoing tracking systems. Funding and support was obtained through various BCMA initiatives, including the Specialist Services Committee and the Shared Care Committee.

At the level of program delivery, BC Children's Hospital (BCCH) developed ON TRAC as a clinical pathway tool. This was used as a foundation to expand the program's mandate to provide transition services province-wide. To achieve this goal, a number of elements were identified: the development of youth-friendly and developmentally appropriate clinical care; interprofessional integration, support, education, and skills training for health care providers; and information and access to resources for patients, families, and providers. Tools and resources are in development at BCCH, in collaboration with health authorities and care centres. Advisory groups are developing an overarching Transition Clinical Pathway/Plan for use in pediatric-to-adult settings. Youth engagement is being maximized in all project areas. Funding for this project was secured through the BCMA and other sources.

IMPACT:

Evaluation of the BCMA's policy advocacy efforts is ongoing. The rate of adoption of the policy recommendations is the identified outcome measure. Qualitative analysis of the collaboration with key stakeholders will be conducted in 2013.

Long-term evaluation of each ON TRAC initiative is planned. Future evaluations include: review of the uptake of formal transition planning using clinical practice guidelines and provider training; evaluation of the process of medical transfer document creation and reception; and quantitative analysis of pediatric patient attachment to general practitioners.

Success of the ON TRAC and BCMA initiatives depends on widespread adoption, dissemination, and promotion of resources

available to key stakeholders and clinicians.

APPLICABILITY/TRANSFERABILITY:

The BCMA's policy development process and the ON TRAC program initiatives are highly transferable to other provinces and countries. At this time, The Hospital for Sick Children in Ontario has implemented some of the tools derived from ON TRAC.

Content adapted from the following sources and relevant websites:

http://ontracbc.ca/

Smith, D. F., MacNeily, A., Whitehouse, S., & Woodfield, W. (2012). Closing the gap: Youth transitioning to adult care in BC. Vancouver, BC: British Columbia Medical Association.

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

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Information last updated on: December 21, 2012

External Source: https://www.bcma.org/youth-transitions-initiative

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Transformation by Design in Ontario

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

SNAPSHOT: This innovative practice addreses the need to fundamentally transform the way hospitals deliver health care in order to improve patient flow, given that the organization was being confronted with an increased acuity of patients in the health care system. Launched in Providence Healthcare in Ontario, the project's aim was to create a new model for improved patient flow that would in turn also improve quality of care. Improvements are focused on managing two transitions in a patient's journey to wellness: the transfer from an acute care hospital to the Providence in-patient rehabilitation care, and the transfer from in-patient to home with outpatient clinic support.

PRACTICE DESCRIPTION:

Providence Healthcare in Toronto, Ontario, needed to fundamentally transform the way it delivered health care in order to improve patient flow, given that the organization was being confronted with an increased acuity of patients in the health care system. Alternate Level of Care (ALC) patients at Providence Healthcare occupied 28% of hospital beds in 2009, which was restricting the organization's ability to respond to pressures from partner acute care hospitals that had significant ALC patients waiting for rehabilitation. For more than a year, Providence Healthcare has sustained an average of 12% of hospital beds occupied by ALC patients. Patients were also experiencing too many inefficient transitions and handoffs as they moved from acute care through rehabilitation and then back home. As a result, the organization implemented a multi-year project—Transformation by Design—in January 2010. The project's aim was to create a new model for improved patient flow that would in turn also improve quality of care. Improvements are focused on managing two transitions in a patient's journey to wellness: the transfer from an acute care hospital to the Providence in-patient rehabilitation care, and the transfer from in-patient to home with outpatient clinic support. The project also included the remodelling of the hospital unit and staffing changes.

The first pilot teams for the project included one stroke and neuro rehabilitation unit (low tolerance patients) and the outpatient stroke clinic. Over 200 staff, patients, and families participated in the pilot project design, implementation, measurement, and sustainment. Front-line staff developed, tested, and implemented the improvements throughout the project, which included 29 process changes to manage transitions and handoffs. Six staffing model changes, 12 new therapy spaces to support the philosophy of "rehab everywhere, always, one patient at a time," and new measurement and sustainment models were developed to improve patient flow. Improvements are focused on managing flow during three stages in the patient's journey: (1) from acute care to Providence, (2) in-patient at Providence, and (3) from in-patient to home and outpatient clinic. Specifically, some of the changes include:

- ensuring that the right patient is admitted to the right bed at the right time via the new Patient Flow Coordinators, who meet the patient in acute care before they arrive at Providence
- regular bedside patient "huddles" with the care team
- no more transfers—patients stay in the same room to which they were first admitted
- trial run—patients experience at least one outing and one home pass before they are discharged home
- improved family physician connection prior to discharge
- expanded outpatient services
- smoother transition from in-patient therapy to outpatient therapy—patients meet with the care team in the outpatient clinic before their discharge
- no more four-person rooms
- space for self-directed rehabilitation
- bright, spacious therapy rooms

The implemented processes were funded with internal reallocations within Providence Healthcare's funding envelope. Remodelling of the clinical spaces was achieved in partnership with the Providence Healthcare Foundation.

IMPACT:

Ongoing evaluation of the project consists of patient surveys, staff surveys, collection of lessons learned from project leads and stakeholders, and measurement of key patient flow indicators. The results of the pilot were 20% overall increase in staff satisfaction from pre- to post-implementation of the changes, 83% of staff agreed that staffing changes help patients and improve patient flow, 82% of staff agreed that the remodelled spaces support the concept of “rehab everywhere, always, one patient at a time” and are satisfied with the overall design, and 90% of patients agreed that the environment helped them achieve their rehabilitation goals. Some of the patient flow indicator improvements from fiscal year 2009/10 to 2011/12 were an increase in the number of admissions (141 to 204), an increase in the percentage of patients discharged home (69.4% to 74.5%), an improved length of stay efficiency (0.37 to 0.5), a decrease in average length of stay from 74 to 56 days, and an increase in the percentage of patients returning to the stroke and neuro clinic in fewer than 60 days post-discharge home (17.2% to 26.9%).

APPLICABILITY/TRANSFERABILITY:

Due to the success of the pilot, the project has been successfully spread to and sustained by two additional units: Orthopaedic and Amputee Rehabilitation and Geriatric Rehabilitation. The goal is to spread the project to all six units of Providence Healthcare by 2015.

Content adapted from the following sources and relevant websites:

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

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Information last updated on: November 26, 2012

External Source: http://www.providence.on.ca

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Virtual Ward, South East Toronto Family Health Team

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

SNAPSHOT: This innovative practice targets older adults with complex health needs that are re-admitted to hospital at a higher than average rate than the rest of the population. To better serve the needs of this complex patient population, a virtual ward (VW) was embedded in the South East Toronto Family Health Team (SETFHT), located across the road from the Toronto East General Hospital (TEGH) in 2011. The goals of the program are to provide this population with improved follow-up after hospital discharge, to identify and assist the growing population of unattached patients who do not have access to primary care, and to admit these patients to a VW to assist with transition back home from hospital.

PRACTICE DESCRIPTION:

Older adults with complex health needs in the East York area of Toronto are re-admitted to the Toronto East General Hospital (TEGH) at a higher than average rate for Toronto, Ontario. To better serve the needs of this complex patient population, a virtual ward (VW) was embedded in the South East Toronto Family Health Team (SETFHT), located across the road from the TEGH. The VW involves a partnership among the SETFHT, TEGH, the Toronto Central Community Care Access Centre (CCAC), Toronto Emergency Medical Services (EMS), and the Ontario Telemedicine Network (OTN). The VW started enrolling patients in 2010, and the Toronto Central CCAC joined the collaborative group in 2011.

The goals of the program are to provide this population with improved follow-up after hospital discharge, to identify and assist the growing population of unattached patients who do not have access to primary care, and to admit these patients to a VW to assist with transition back home from hospital. The aim of the program is to improve continuity of care and reduce rates of emergency department visits and hospital re-admissions for patients who, at the time of discharge, are deemed high risk for re-admission. The SETFHT includes physicians who are accepting new patients, and thus the VW service is available for unattached/orphan patients, established SETFHT patients, and other high-risk patients of the TEGH catchment area who have a family doctor outside the Family Health Team.

The VW is managed by a physician assistant who works as the clinical case manager and is supported by an interprofessional team that includes a supervising physician, care navigator, pharmacist, nurse practitioner, mental health and addictions counsellor, and CCAC care coordinator. A physician assistant meets with the patient the day before discharge from hospital and assesses whether they are at high risk of re-admission using the LACE index. Patients over the age of 65 with a LACE score greater than 9 are enrolled in the VW, and those without a family doctor are attached to one at the SETFHT. A case management approach is taken. The VW monitoring includes daily phone calls, remote monitoring of vital signs with emphasis on health education and self-management, daily rounds by the physician assistant and the VW physician, home visits as required, weekly review of patients and updated progress notes on the hospital electronic system, and weekly case conferences with the interprofessional team. For very complex patients, the care coordinator engages more intensely with the SETFHT team with the goal to develop an integrated, shared care plan for support. This may include a joint home visit through the SETFHT-CCAC Integrated Home-Based Primary Care Program; that is, a member of SETFHT may do a home visit to a homebound, complex patient together with CCAC and Toronto EMS community paramedics.

IMPACT:

Although the VW model has been in place for two years, there was no formal funding until recently to do a full-scale evaluation of the program. Nevertheless, outcome measures have been collected, including health care utilization (e.g., 30-day readmission rates, physician assistant time spent monitoring, drop-out rates, length of stay, number of visits to FHT, CCAC services); surveys (e.g., health status—SF-12, use of health services, patient experience/satisfaction using NRC Picker questions); clinical indicators as per Quality Improvement and Innovation Partnership measures for chronic obstructive pulmonary disease, congestive heart failure, and diabetes; and quality improvement measures regarding process and outcomes

as part of the Ontario Ministry of Health MRP-QI Collaborative involvement.

A program evaluation has been funded by the Ontario Ministry of Health and Long-Term Care through the Primary Health Care System Program. This evaluation will use a mixed methods approach to explore the impact of the program on patients' experience; the VW health provider's experience; patient attachment to a primary care physician and hospital utilization (re-admission and emergency department visits); and its scalability to other family health teams in Ontario. The research study is being conducted from April to December 2012. Early anecdotal evidence from key stakeholders of the SETFHT VW program is very positive.[1]

A BRIDGES grant ("Bridging Care for Frail Older Adults: A Study of Innovative Models Providing Home-based Care in Toronto") from the Departments of Family Medicine and Medicine at the University of Toronto will be used to evaluate the VW's home visit program. The Toronto Central CCAC will be evaluating their own work under the Integrated Client Care Project. The specific objectives of this study are to improve access and build capacity for the provision of primary, specialty, and community care for homebound older adults; study the effectiveness of innovative home-based primary care models in improving patient, caregiver, team, and system outcomes; and inform the development of toolkits to support scalability and dissemination of best practices and build system capacities and networks that support home-based care and training opportunities.

The Toronto Central CCAC will also be undergoing a multi-year evaluation of the partnership among the different sectors. Preliminary stakeholder meetings with other family health teams suggest that under Ontario's Excellent Care for All Act, the VW program directly addresses the focus on patient-centred care and reduces avoidable hospital re-admissions. This is of direct interest particularly to communities where family health team physicians are also the physicians staffing the emergency departments and hospitals in their local communities.

APPLICABILITY/TRANSFERABILITY:

Virtual wards were founded in the United Kingdom in 2007, and were established within the Primary Care Trusts. The effectiveness of VWs in reducing hospitalizations in Britian is currently under investigation by the Nuffield Trust. The results of these initiatives are expected to be published in 2012. The UK uses a population-based risk evaluation tool to identify patients at risk for hospital admission in order to prevent admission in the first place, whereas the SETFHT VW uses the LACE index to identify patients at high risk for re-admission.

Trillium Health Partners and their associated Department of Family Medicine and Family Health Team are working on developing a similar primary care VW, as is the Prince Edward Family Health Team in Picton, Ontario. These VWs will be implemented in late spring 2013.

Content was adapted from the following sources and relevant websites:

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

Law, M. (2012). *Evaluation of the primary care virtual ward model: Preliminary progress report.* Toronto, ON: Ontario Ministry of Health and Long-Term Care. Retrieved from
http://www.uwo.ca/fammed/csfm/siiren/documentation/AHRQ_Virtual_Ward_PreliminaryReport_Law_31Mar2012.pdf

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Information last updated on: December 6, 2012

External Source: http://www.cadth.ca/products/environmental-scanning/environmental-scans/environmental-scan-27

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Integrated Discharge Planning

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

SNAPSHOT: This innovative practice is a framework for discharge planning to streamline processes and improve system navigation for clients and their families. Beginning as a one-year pilot project in 2011 between the Headwaters Health Care Centre (HHCC) and the Central West Community Care Access Centre (CCAC) in Ontario, the programs success has led to the recent adoption of this role and partnership into standard practice.

PRACTICE DESCRIPTION:

The Transitional Case Manager role is the result of an innovative partnership between Headwaters Health Care Centre (HHCC) and the Central West Community Care Access Centre (CCAC) in Ontario. It began as a one-year pilot project in 2011, but its success has led to the recent adoption of this role and partnership into standard practice. Together the organizations have developed a new framework for discharge planning to streamline processes and improve system navigation for clients and their families. Historically, discharge planning at the hospital did not begin until late in the client's stay, and only involved the CCAC at time of discharge. This did not allow for optimal planning and resourcing to occur, which led to unidentified needs and gaps in service for clients once they returned to the community.

The new model supports the Home First philosophy and discharge planning by beginning discharge coordination at the time of hospital admission. It acknowledges that both organizations are accountable for discharge planning and transition, and uses the skills and expertise of both partners to ensure optimal transition from acute care to the community. The Transitional Case Manager role combines both discharge coordination and case management. The focus is on patient navigation and smooth hospital transitions, which include supporting the client flow in and out of the hospital through ambulatory care services, surgery, and repatriation of clients to and from HHCC. The role supports linking clients to other community agencies through increased awareness of CCAC services and information sharing at the time of discharge. The project encompassed the full age spectrum and continues to address multiple populations, from pediatrics through geriatrics. The complex chronic care population consumes the majority of the attention of the Transitional Case Manager and interprofessional team.

IMPACT:

The pilot project was evaluated. From 2010/11 to 2011/12, outcome measures that demonstrated improvement included an increase in the percentage of clients discharged home from hospital (72% to 76%), a decrease in the length of hospital stay (16.3 to 13.4 days for complex continuing care patients in Assess and Restore beds), and an increase in the number of clients discharged home with CCAC support (22% to 31%). The client and family benefits of this model included reduced duplication in sharing of information, a common language and approach across hospital and CCAC, and consistency in coordination and seamless handoffs leading to smooth transition back into the home. This initiative also resulted in an increased appreciation of the partners' roles and expertise in discharge and transition planning.

APPLICABILITY/TRANSFERABILITY:

Although interest has been expressed and the success of the concept has been demonstrated, there have been no replications of this practice to date.

Content was adapted from the following sources and relevant websites:

http://www.ccac-ont.ca/Content.aspx?EnterpriseID=5&LanguageID=1&MenuID=1

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

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Information last updated on: December 5, 2012

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

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Integrated Comprehensive Care at St. Joseph's

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

SNAPSHOT: This innovative practice is a collaborative model of care that integrates the transition of patients from the hospital to the community. Launched in St. Joseph's Healthcare, Hamilton and St. Joseph's Home Care, Hamilton, in March 2012, the objectives of the project are to explore the benefits of integrated case management and to evolve the existing case management model into a patient-centred model that follows the patient across the continuum of care.

PRACTICE DESCRIPTON:

St. Joseph's Health System (SJHS) is engaged in a pilot project on the feasibility of an innovative model of care that directly integrates the transition of patients from the hospital to the community. St. Joseph's Healthcare, Hamilton and St. Joseph's Home Care, Hamilton, both members of SJHS, are collaborating on this initiative, and patient enrolment began in March 2012. Patients from the following clinical domains are included in the project: elective total hip and knee replacement, thoracic surgery, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The objectives of the project are to explore the benefits of integrated case management and to evolve the existing case management model into a patient-centred model that follows the patient across the continuum of care.

Integral to the success of this project is the role of the Integrated Care Coordinator (ICC). The ICC coordinates transitions of care throughout the patients' journey, and is responsible for exchanging knowledge related to their respective health conditions and the continuum of services and resources to enhance client self-management and quality of care. The ICC follows patients through the various care settings to ensure continuity of care, working collaboratively with all existing providers of care in the hospital and the community. The ICC coordinates the process with the selected patients at their point of entry to St. Joseph's Heathcare Hamilton, i.e. prior to their elective surgery (total joint replacements and thoracic surgery), or upon presentation to the emergency department at St. Joseph's Healthcare, Hamilton (chronic diseases). A process mapping exercise was used to ensure the team understood the entire journey from the patient's perspective, and could best design an improved, integrated transition process. An integrated electronic health record was developed and has been implemented. This provides the entire team with real-time remote access to the integrated patient record. The team members can securely access the patient record remotely via tablets, laptops, or desktop computers. Patients also have access to a member of the team 24 hours a day, 7 days a week. Patient concerns can then be directed to the most appropriate member of the health care team. Timely access to a knowledgeable team member who can view their home care history from their time of discharge has prevented a number of emergency department visits.

IMPACT:

An independent program evaluation is being conducted by the Program for Assessment of Technology in Health (PATH). The evaluation includes an assessment of clinical outcomes for patients; system concerns such as quality, throughput, and efficiency (length of stay, readmissions, emergency room visits); patient concerns (accessibility, satisfaction, and continuity of care); and comparison with the existing model of care, including their respective costs. A patient satisfaction questionnaire is administered to patients at the time of discharge and 60 days post-discharge from hospital. The questionnaire at time of discharge is focused on pre-hospital and in-patient care, while the latter questionnaire is focused on transitions home and home care.

To date, the project has demonstrated success with respect to integrated team collaboration in the care of each patient. The project has also resulted in more efficient home visits, with a 50% reduction in the time it takes to complete a home visit. The integrated electronic health record has been a key enabler for delivering care in a timely and efficient way in the community. An integrated care plan has been developed for each patient group, with engagement and feedback from hospital and home care providers. Patient satisfaction with the process is very high, and they note in particular the collaboration of team members and access to a central point of contact.

APPLICABILITY/TRANSFERABILITY:

If successful, this model of Integrated Comprehensive Care will create the conditions for bundled funding and care. The bundled

care model encourages health care providers to maximize quality and efficiency, because the provider absorbs the cost of unnecessary hospital days, complications, and readmissions. This offers the potential of a faster, better, cheaper model of care. SJHS believes that implementation on a greater scale could free up valuable resources to allow Community Care Access Centres in Ontario to offer case management to the more chronic and complex patients in the health care system.

Content was developed based on the following sources and relevant websites:

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

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Canadian Medical Association's Referral and Consultation Process Toolbox

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

SNAPSHOT: This innovative practice addresses the challenges experienced on both ends of a patient referral that are common for all physicians in all areas of the country; examples include insufficient communication between primary and specialty care, inefficient triage processes, or referral requests sent to the wrong specialist. In October 2010, Health Canada agreed to support the CMA to investigate possible solutions to problems such as these, with assistance from the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (Royal College).

PRACTICE DESCRIPTION:

There are a multitude of challenges experienced on both ends of a patient referral that are common for all physicians in all areas of the country. Examples of these challenges include insufficient communication between primary and specialty care, inefficient triage processes, or referral requests sent to the wrong specialist. In October 2010, Health Canada agreed to support the CMA to investigate possible solutions to problems such as these, with assistance from the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (Royal College).

Through this project, considerable research was undertaken on various ways access to specialty care can be improved. It has been found that there are plenty of referral / consultation process improvement activities occurring in Canada but the proverbial wheel is continually being reinvented, because knowledge about successful initiatives is not well known.

In an effort to raise awareness and spread knowledge about successful referral and consultation process improvement initiatives it was decided to develop an online resource called the Referral and Consultation Process Toolbox, containing useful data on these successful initiatives.

The toolbox is a web-based resource on http://www.cma.ca/referrals and includes "tools" that any stakeholder involved in the administration and/or delivery of health care can use to address challenges experienced with referrals in their jurisdiction. The intention is to provide information on how referral and consultation process improvement activities across the country were conducted, enabling others to replicate their success.

On the main page of the toolbox visitors will find a document containing summaries of nearly 30 such initiatives. Most were gathered for a Multi-Stakeholder Summit held in late 2011. Further information on some of these projects, as well as data gathered on additional projects since the Summit, can be found on the various pages within the Toolbox.

This online resource is currently a work in progress. It was launched June 14th, 2012 with the Intraprofessional Communications tool containing information on activities geared towards improving communication between primary and specialty care. On November 9th two new tools were added on the topics of Measuring "Wait One" and on Central Intake activities. The final tool, Physician Directories, is expected to be released in January 2013. This toolbox is being updated regularly, as additional effective referral improvement activities or tools are discovered.

Each tool group includes links to other websites about specific activities on referral and consultation process improvement that have already been done elsewhere. Two "How to" guides have been developed: one on creating referral request forms and one on establishing a central intake system. A third guide on creating physician directories will be launched when this tool is released.

Overall, the referral and consultation processes described on the toolbox webpages will help stakeholders improve bilateral intra-professional communication by:

o Helping family physicians make more appropriate and informative referrals

o Assisting consulting specialists with providing sufficient information back to family physicians

o Encouraging more efficient use of physician and administrative staff time when processing referrals

o Facilitating more timely access to specialty care

IMPACT:

Funding from Health Canada will end on March 31, 2013, at which time a formal evaluation of the success of this project will be conducted. The Referral and Consultation Process Toolbox is the project's main deliverable. Success will be difficult to evaluate at this early stage given the short time frame that this toolbox has been available online, and considering the amount of time that many of these projects require for implementation.

However, several parties from various parts of Canada have already expressed appreciation for the information they have found in the toolbox and have indicated their intentions of using this newfound knowledge in their own jurisdictions.

APPLICABILITY/TRANSFERABILITY:

The resources provided in the Toolbox can be used to replicate successful initiatives involving referral and consultation process improvements that have already been implemented.

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External Source: http://www.cma.ca/referrals

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Rapid Access to Consultative Expertise (RACE)

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

SNAPSHOT: This innovative practice aims to redesign the collaboration between specialists and family physicians (FPs) with respect to the development, implementation, sustainability, and spread of FP-to-specialist interactions to improve population health outcomes, improve patient and provider experiences, and reduce per capita system costs. Launched in early 2010 in BC's Providence Health Care, the Rapid Access to Consultative Expertise (RACE) model ensures telephone calls from FPs are routed directly to a specialist's cellphone or pager for "just in time" advice.

PRACTICE DESCRIPTION:

In early 2010, a partnership was formed between Providence Health Care (PHC) and the Shared Care Committee (SCC, a joint committee of the BC Ministry of Health Services and the BC Medical Association) in collaboration with Vancouver Coastal Health (VCH) to

1) identify gaps in the care process for patients with chronic diseases, and

2) develop and test prototypes for improvement that are transferable and scalable.

The goal of the overall project was to redesign the collaboration between specialists and family physicians (FPs) with respect to the development, implementation, sustainability, and spread of FP-to-specialist interactions to improve population health outcomes, improve patient and provider experiences, and reduce per capita system costs. In the Rapid Access to Consultative Expertise (RACE) model, telephone calls from FPs are routed directly to a specialist's cellphone or pager for "just in time" advice.

Based on encouraging results from a PHC pilot project in which FPs could page a cardiologist, RACE allows FPs to call one number, choose from a selection of specialty services, and speak to the specialist usually within a few minutes. The prototype began with five specialty areas and thus far has grown to include 14 specialty areas in response to the needs of FPs. Application of a powerful tool for accelerating improvement that uses a series of testing Plan-Do-Study-Act (PDSA) cycles allowed the team to trial and refine change ideas prior to implementation. RACE is a novel strategy to enhance patient care.

Compensation for physicians is via fee for service billing. While any FP could call any specialist prior to the implementation of RACE, it was on a "catch me if you can" basis, and there was no guarantee that a specialist could be contacted or would call back in a timely manner. The RACE line provides structure to promote easy accessibility while allowing for sustainability through an organized rotation. Patients may have their health care issue dealt with in their FP's office instead of needing to see a specialist. This often renders face-to-face consultation or referral to an emergency department unnecessary.

IMPACT:

Formal structured evaluation was conducted in three phases by Scott Lear, Associate Professor, Faculty of Health Sciences, Simon Fraser University and Pfizer/Heart and Stroke Foundation Chair in Cardiovascular Prevention Research at St. Paul's Hospital. The methodology was based on qualitative interviews/focus groups and quantitative surveys.

Results include

- > 2500 calls were made to the RACE line over the first two years (June 2010–June 2012);
- 78% of calls are answered within 10 minutes;
- 90% of calls are answered within 60 minutes;
- 90% of calls are < 15 minutes in length;
- 60% of calls avoid a face-to-face consult with a specialist; and
- 37% of calls avoid an emergency department visit.

Evaluation results indicate RACE contributes to knowledge transfer, improved clinical judgment, and overall improvement in office efficiencies for family physicians. RACE decreases unnecessary consults and emergency department visits, and provides "just in time" advice for FPs to care for their patients, often while the patient is still in the office. Both specialists and FPs have embraced the advice line as shown by the request from FPs for additional services and by the request from specialists who wish to participate in the service.

The evaluation was designed to provide data that can be analyzed/evaluated using the Triple Aim framework developed by the Institute for Healthcare Improvement (IHI). The IHI developed the Triple Aim approach to improve population health, enhance the health care experience of patients, and reduce per capita costs.

APPLICABILITY/TRANSFERABILITY:

In June 2010 the RACE model began with five specialty areas. Over the two-year period the model has expanded to include 14 specialty areas. Specialists from across the Vancouver Coastal Health (VCH) region participate in the RACE line. The cardiology RACE line is expanding to include specialists from Fraser Health Authority along with the VCH cardiologists. This service will provide support for over 2500 FPs in the two health authorities.

Work is currently underway to develop a provincial structure for telephone advice for the specialty areas in which the majority of specialists are clustered in the southwestern area of BC. Child psychiatry and chronic pain RACE services provide support to FPs across the province. A rheumatology RACE line will soon be providing a provincial service.

Through this initiative, PHC has taken provincial leadership in shared care. While the prototypes were designed to address the PHC/Vancouver medical environment, the objective is to develop strategies that are scalable and transferable throughout the province in differing medical contexts.

Based on the RACE model, Northern Health Authority has initiated a RACE-like telephone advice line for cardiology. Vancouver Island Health Authority is currently exploring what model of telephone advice would best fit the needs of their FPs.

Although this work involves simple concepts, the solutions and prototypes involved in changing work processes can be complex. The success of this project has provided PHC with a clear structure and process to address other patient transition points where the interface between specialty care and FP care is critical. The achievements serve as a source of system innovation both internally and externally across the health regions and the Ministry of Health.

Content developed from the following sources and relevant websites:

http://www.youtube.com/watch?v=TQyKe0CKh_A

https://www.bcma.org/rapid-access-consultative-expertise-race-program

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External Source: www.RACEconnect.ca

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Ontario's Centre for Family Medicine Mobility Clinic

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

SNAPSHOT: This innovative practice facilitates increased access for mobility-impaired patients to family physicians; improves care for patients with mobility challenges; promotes awareness of mobility issues through education; and develops further clinical, education, and research projects. In operation since January 2010, the Centre for Family Medicine Family Health Team established a fully accessible, interprofessional primary health care Mobility Clinic in Kitchener, Ontario.

PRACTICE DESCRIPTION:

Mobility impairments that require the use of assistive devices such as wheelchairs challenge patients to access primary health care and result in significant care gaps, high risk for adverse health events, and a variety of complications. Access to care is compromised by poorly designed physical spaces, lack of appropriate equipment, and limited knowledge of the care needs of people with mobility impairments. To address these challenges, the Centre for Family Medicine Family Health Team (FHT) established a fully accessible, interprofessional primary health care Mobility Clinic in Kitchener, Ontario. This was done in collaboration with the Ontario Neurotrauma Foundation (ONF) and the University of Waterloo–Schlegel Research Institute for Aging (RIA). The clinic was in the development phase from July to December 2009 and became fully operational in January 2010.

The objectives of the Mobility Clinic are to increase the access mobility-impaired patients have to family physicians; improve care for patients with mobility challenges; promote awareness of mobility issues through education; and develop further clinical, education, and research projects. Referrals to the Mobility Clinic are accepted primarily from rostered patients of the Centre for Family Medicine FHT. The Mobility Clinic is comprised of an interprofessional team, including a family physician, chiropractor, occupational therapist, social worker, nurse, pharmacist, and physiotherapist. There is a dedicated Mobility Clinic for one half day per week, and the services of the clinic are accessible for an additional four days per week. There are dedicated rooms and equipment (e.g., lift, high-low exam tables, scale) at two sites. A comprehensive interprofessional assessment is conducted and a plan of care is developed to be implemented within a shared care approach. Follow-up is done by telephone, return visit, and/or house calls. Results are communicated to the regular family physician.

The Mobility Clinic has established links with key stakeholders in the community: SCI Ontario (Spinal Cord Injury Ontario) has referred spinal cord–injured patients who did not have a family physician, and collaboration with the YMCA will produce an exercise program that is accessible for those with physical disabilities. The Mobility Clinic has been funded in part by the ONF, Schlegel RIA, and the Centre for Family Medicine.

IMPACT

Mixed quantitative and qualitative methods have been used to evaluate the Mobility Clinic program. Patient satisfaction interviews and surveys, health professional and learner satisfaction surveys, and interviews with key stakeholders and team members have been conducted. Patients were extremely satisfied with the clinic; they reported improved access to care, thought that their care providers were knowledgeable, and felt safe accessing the building and specialized equipment. Effects on patients included improved access to comprehensive assessment and interprofessional care, as well as improved quality of care and health outcomes.

Referring health professionals were very satisfied with the clinic, reporting that it had a positive impact on availability of consultation support. Learners were very satisfied with the educational experience from the clinic. For referral sources, the clinic contributes to reduced burden of care and increased capacity for managing patients with mobility issues. Health system impacts included timely access to local care and reduced use of acute and long-term care. Leadership support for the family health team, partnership with the Canadian Paraplegic Association (now SCI Ontario), accessible space and equipment, and flexibility to meet patient needs were identified as key factors contributing to the success of the clinic. Challenges to implementation were related to managing increasing demands for service, the broad range of mobility issues addressed by the clinic, and system

issues such as inaccessible laboratories, diagnostic imaging centres, and specialist offices. The study results indicate that accessible interprofessional mobility clinics within primary health care settings can support capacity building to improve patient access to care and enhance quality of care.

APPLICABILITY/TRANSFERABILITY:

The Ontario Neurotrauma Foundation and the Kitchener-Waterloo site of McMaster University have expressed a keen interest in developing a training program for primary health care providers to assist them in developing sustainable mobility clinics across the province. The Mobility Clinic is currently part of the clinical curriculum of training for family residents of the Kitchener-Waterloo site of McMaster's Department of Family Medicine. Based on the Memory Clinic model at the Centre for Family Medicine (a primary health care multidisciplinary clinic that successfully manages patients with cognitive impairment within a primary health care setting, which has been implemented in 30 FHTs across Ontario), the goal is to disseminate this model to other teams. Currently, this dissemination is in the feasibility and process development stages.

Content developed from the following sources and relevant websites:

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

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Partners in Care Initiative

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

SNAPSHOT: This innovative practice addresses the pressures and increasing challenges in the health care system call for transformation and system redesign. In April 2010, Providence Health Care partnered with the British Columbia Shared Care Committee (a joint committee of the BC Ministry of Health and the BC Medical Association) in collaboration with Vancouver Coastal Health (VCH) to facilitate collaboration between family physicians and specialists in regions throughout the province. Their aims were to improve and transform care for patients with complex chronic conditions, and to support and maintain the locus of care for chronic disease management in the community.

PRACTICE DESCRIPTION:

Pressures and increasing challenges in the health care system call for transformation and system redesign. Shared care models present opportunities for collaborative and innovative solutions that allow patients to benefit from specialist expertise in real time while maintaining the benefit of continuity of care from family physicians.

In April 2010, Providence Health Care partnered with the British Columbia Shared Care Committee (a joint committee of the BC Ministry of Health and the BC Medical Association) in collaboration with Vancouver Coastal Health (VCH) to facilitate collaboration between family physicians and specialists in regions throughout the province. Their aims were to improve and transform care for patients with complex chronic conditions, and to support and maintain the locus of care for chronic disease management in the community. Funding for the initiative was provided by the Shared Care Committee and Providence Health Care. The goals of the Partners in Care initiative was to simplify the patient and health care provider journey, to improve health outcomes, to reduce per capita health care costs, and to strengthen the relationship between primary care and specialists. The initiative aims to increase access to specialists through telephone advice programs and to expedite referral and re-referral processes, with a focus on improving communication, knowledge translation, and role clarification for family physicians and specialists.

A team of family physicians, specialists, patient representatives, clinical/administrative leaders, and quality improvement and change specialists was established to develop processes to address the identified areas of work. Prototypes include developing a multispecialty telephone advice line for family practitioners (Rapid Access to Consultative Expertise: RACE); identifying key elements of a comprehensive referral form, including implementing a process for acknowledging referral receipt; identifying and testing key elements and format of a consult; developing and implementing a process for bidirectional communication between specialists and family physicians following a consult; and testing and implementing a set of questions to assist patients with self-management. While these prototypes were designed to address the urban environment, the objective was to develop strategies to scale throughout BC in differing medical contexts. These teams are able to develop, test, and implement new processes and systems, and, in many cases, build on successful models of care being used elsewhere by members of the Partners in Care initiative. To date, more than 1,500 family physicians and over 200 specialists are involved in the Partners in Care initiative, with work underway at numerous sites across BC.

IMPACT:

Evaluation of the Partners in Care initiative has involved qualitative and quantitative methods, and has been guided by the Institute for Healthcare Improvement's Triple Aim program. Evaluation included surveys and interviews with family physicians, specialists, and decision-makers, as well as focus groups with patients. Findings indicate there have been fewer unnecessary face-to-face specialist consults (60%) and fewer emergency department visits (32%) in the VCH region. Seventy-seven percent of family physicians report that the new referral process improved care, 81% felt the shared care planning tool improved care, and 83% state the telephone advice line improved care for their patients.

APPLICABILITY/TRANSFERABILITY:

Several of the prototypes developed through the Partners in Care initiative have been scaled out regionally and provincially. The RACE telephone advice line currently includes 14 specialty services that received a total of 2,500 calls over the first two years.

The acknowledgement of referral prototype has been implemented in several Providence Health Care chronic disease clinics, and in several specialty private offices. It has also been rolled out provincially and implemented in provincial programs. The shared care planning prototype has been implemented in several Providence Health Care chronic disease clinics, and is being shared regionally and provincially. The prototypes and the process of development are scalable to differing medical contexts.

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Relevant websites:

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

External Source: https://www.bcma.org/partners-care-initiative

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Building Access to Specialist Care through e-Consultation: The Champlain BASE Project

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

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 need to improve patient care by increasing primary health care providers' access to specialists.

PRACTICE DESCRIPTION:

Since access to specialist care remains a major barrier to patients and providers of primary health care in Canada, new integrated ways of providing access to specialist advice and care are needed. The Champlain BASE (Building Access to Specialists through e-Consultation) project was developed and piloted in a large health region in Eastern Ontario in 2010/11. It is a collaborative project between The Ottawa Hospital, the Bruyère Research Institute, the Champlain Local Health Integration Network (LHIN), and the Winchester District Memorial Hospital.

The goal of the project is to improve patient care by increasing primary health care providers' access to specialists. In the current system, primary health care providers access specialists through a formal consult or referral request that is sent via mail, fax, or phone, and which involves the patient visiting the specialist. An electronic system of consultation using an existing secure web-based regional platform (a collaboration site using Microsoft SharePoint) was developed. Primary care physicians (from rural and urban areas) were eligible to enrol in the pilot and had access to 17 specialty services through the system. Primary health care providers could send patient-specific consultation questions to a speciality service through the site before determining whether a referral was necessary.

Primary health care providers use a standardized template that prompts them to provide key data and attach information (such as test results and images) for the consult. The consult is then assigned to a specialist who is expected to provide a response within one week. The specialist may provide a specific response to the question, thus avoiding the need for a specialist visit; request additional information before providing advice; or recommend a formal referral be made, along with any diagnostic tests or treatment that should be done before the visit to the specialist. If a referral is necessary, the patient goes on the usual waiting list, though not necessarily with the specialist who provided the consultation.

Funding for the pilot project was provided by the Ontario Hospital Academic Medical Association alternate funding plan. Technical and operational support was provided by the Champlain LHIN and the Bruyère Research Institute.

IMPACT:

The implementation process was evaluated using a mixed methods approach that used both quantitative survey data and qualitative interviews and focus groups. A total of 188 e-consult requests were processed during the pilot phase. Dermatology, endocrinology, cardiology, and internal medicine were the most popular specialities. Results showed an overall high level of satisfaction with the system by both primary health care providers and specialists. The specialist community was particularly enthusiastic and supportive of this type of service, as it reduces unnecessary referrals and allows for easy bi-directional communication with the primary health care provider. The most noted benefits of the e-consult included improved access by avoiding face-to-face consultations or re-consultations, and reduced delays—that is, the provision of more timely access for patients.

As of June 2012, there were 150 primary health care providers registered, including 12 nurse practitioners. A total of 417 e-consult requests were processed, and 330 cases completed. Thirty-eight percent of primary health care providers indicated that they were able to confirm a course of action that they had originally had in mind for the patient, and 58% got good advice for a new or additional course of action. In 43% of cases, a referral that had been contemplated by a primary health care

provider was avoided.

APPLICABILITY/TRANSFERABILITY:

The Champlain BASE e-consult service continues to be developed based on feedback from evaluation surveys. The service continues to be expanded to include more speciality groups, and its use in follow-up consultations is being explored. The next phase of the project involves further expansion across the Champlain LHIN and replication in three other Ontario LHINs. Beyond that, it is expected that there will be a major expansion of e-consultation as part of a broader provincial e-Referral strategy.

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