



Health Innovation Portal: Archive of Innovative Practices

Theme: **Chronic Disease Management**

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:	Chronic Disease Management	FRAMEWORK CATEGORY:	All
HEALTH SECTOR:	All	SEARCH RESULTS:	42 results out of 64

1. Eastern Health Chronic Disease Prevention and Management Emergency Department Pilot Project

Implementation Year: Friday, December 9, 2011 - 14:45	Location: Newfoundland & Labrador	Practice Website:
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SNAPSHOT:

This innovative practice decreases emergency department (ED) visits and increases patient satisfaction among frequent ED users with chronic health conditions. The practice was launched in St. John's, Newfoundland and Labrador, with a half-time primary health care nurse. In February 2013, a full-time community health nurse was added to provide case management services.

CONTACT INFORMATION:

Alice Kennedy VP – Eastern Health Room 125, VP1, Veterans Pavilion 100 Forest Road St. John's, NL A1A 1E5 Telephone: 709-777-7200 Email: alice.kennedy@easternhealth.ca

2. Advanced Clinician Practitioner in Arthritis Care Program (ACPAC)

Implementation Year: Sunday, November 27, 2005 - 09:30	Location: Ontario	Practice Website: http://chronicdiseases.ca/arthritis/
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SNAPSHOT:

This innovative practice aims to improve the competencies of advanced clinical practitioners delivering care for patients with arthritis. The interprofessional program was launched in 2005 at St. Michael's Hospital, in collaboration with the Hospital for Sick Children in Toronto, and now has over 37 graduates working in diverse clinical settings across Ontario.

CONTACT INFORMATION:

Name: Dr. Katie Landon BScPT, MSc, PhD or Dr. Rachel Shupak MD, FRCP(C) Title: Program Director-General Organization: Advanced Clinician Practitioner in Arthritis Care, St. Michael's Hospital Email address: k.lundon@cogeco.ca Information last updated on: August 1, 2013

3. Culturally Competent Collaborative Practice Model for Chronic Disease Management

Implementation Year: Friday, November 26, 2010 - 09:45	Location: Saskatchewan	Practice Website:
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SNAPSHOT:

This innovative practice aims to improve quality of life and health care delivery for First Nations people with chronic disease, through better linkages between provincial and on-reserve services and enhanced service delivery on-reserve. Launched in 2010, this practice included collaboration among Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program) and three First Nations communities including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation.

CONTACT INFORMATION:

Name: Sandy Hassler Title: Collaborative Practice Coordinator (retired) Organization: n/a Email address: s.hassler@sasktel.net Telephone number: 306 736-9099 Information last updated on: October 10, 2013



4. Bringing chronic disease self-management to rural and remote regions in Rocher-Percé

Implementation Year: Saturday, November 26, 2011 - 09:45	Location: Quebec	Practice Website: http://interestsante.ca/participation-au-4e-rendez-vous-de-la-gestion-des-maladies-chroniques.php
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SNAPSHOT:

This innovative practice improves the effectiveness of chronic disease management in rural remote regions. Established in 2011 and funded for two years, this practice involved an interprofessional team of nurses, dietitians, and kinesiologists who worked collaboratively with physicians.

CONTACT INFORMATION:

Name: Tim Sutton **Title:** Kinesiologist **Organization:** The Centre de santé et des services sociaux du Rocher-Percé **Email address:** tim.sutton.pabok@SSSS.gouv.qc.ca **Telephone number:** 418-680-3307 **Information last updated on:** September 25, 2013

5. Heart Healthy Kids (H2K)

Implementation Year: Saturday, October 7, 2006 - 13:15	Location: Nova Scotia	Practice Website: http://maritimeheartcenter.ca/h2k-program
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SNAPSHOT:

This innovative practice addresses the impact of sedentary behaviour and physical inactivity on the health of children and youth. This practice was launched as a school-based program in Nova Scotia in 2006. It involved one paid staff member, many adult volunteer supervisors, and student peer mentors.

CONTACT INFORMATION:

Name: Becky Spencer **Title:** Programs Manager **Organization:** Maritime Heart Centre **Email address:** becky@maritimeheartcenter.ca **Telephone number:** (902) 446-3669

6. 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:
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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

7. VivoSpace: Using social media for chronic disease management

Implementation Year: Monday, November 1, 2010 - 00:45	Location: British Columbia	Practice Website: http://www.magic.ubc.ca/pmwiki.php?n=Projects.E-HealthCare
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SNAPSHOT:

This innovative practice addresses the use of social media marketing as a platform for chronic disease management. The practice was launched in British Columbia at the University of British Columbia and involved two graduate students, a web designer, two primary investigators, and over 100 pilot users for prototyping.



CONTACT INFORMATION:

Name: Noreen Kamal **Title:** PhD student and Quality Leader **Organization:** BC PSOC and UBC **Email address:** noreenk@ece.ubc.ca, nkamal@bcpsqc.ca
Telephone number: N/A **Information last updated on:** July 8, 2013

8. Bounce Back: Reclaim Your Health

Implementation Year: Sunday, February 3, 2008 - 00:30	Location: British Columbia	Practice Website: www.bouncebackbc.ca
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SNAPSHOT:

This innovative practice addresses the issue of mild to moderate depression in primary care patients by using self-help materials and telephone health coaching. It was launched in British Columbia in 2008.

CONTACT INFORMATION:

Name: Title: Organization: Canadian Mental Health Association, British Columbia Division **Email address:** bounceback@cmha.bc.ca **Telephone number:** 604-688-3234 **Information last updated on:** July 4, 2013

9. The Sherbourne Health Centre Infirmiry: 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/infirmiry.html
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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

10. Primary Musculoskeletal Provider

Implementation Year: Thursday, February 3, 2011 - 00:00	Location: Ontario	Practice Website: http://www.chiropractic.on.ca/HealthPolicy/inter-professional-collaboration/research-and-projects.aspx
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SNAPSHOT:

This innovative practice addresses the issue of wait times for referrals to orthopedic surgeons and neurosurgeons by introducing a chiropractor assessment to the process.

CONTACT INFORMATION:

Name: Andrea Prashad **Title:** Health Policy Manager **Organization:** Ontario Chiropractic Association **Email address:** aprashad@chiropractic.on.ca **Telephone number:** 416-860-7188 **Information last updated on:** April 9, 2013

11. Integrated Care for Individuals with Severe and Persistent Mental Illness

Implementation Year: Wednesday, February 9, 2011 - 02:15	Location: British Columbia	Practice Website:
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SNAPSHOT:

This innovative practice aims to provide individuals with severe and persistent mental illness access to integrated care teams.



CONTACT INFORMATION:

Name: John Braun **Title:** Manager of Case Management, Residential and Rehab Services **Organization:** Vancouver Island Health Authority **Email address:** john.braun@viha.ca **Telephone number:** 250-370-8562 **Information last updated on:** Apr 10, 2013

12. Strong and Steady Falls Prevention Program

Implementation Year: Wednesday, February 11, 2009 - 00:30	Location: Ontario	Practice Website:
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SNAPSHOT:

This innovative practice aims to prevent falls by offering seniors setting-appropriate, individually tailored, progressive activities to improve balance and strength

CONTACT INFORMATION:

Name: Anne McKye **Title:** Occupational Therapist, Seniors Health Services **Organization:** Trillium Health Partners **Email address:** anne.mckye@trilliumhealthpartners.ca **Telephone number:** 905-848-7580 ext. 2520 **Information last updated on:** April 16, 2013

13. Readmission Reduction Program through Payment Systems (USA)

Implementation Year: Friday, February 10, 2012 - 00:00	Location: International	Practice Website: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
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SNAPSHOT:

This innovative practice aims to reduce readmission rates in hospitals by changing the in-patient prospective payment system (IPPS).

CONTACT INFORMATION:

Name: Jonathan Blum **Title:** Deputy Administrator and Director **Organization:** Center for Medicare **Email address:** Jonathan.Blum@cms.hhs.gov **Telephone number:** 202-690-6301 DC | 410-786-4164 Baltimore

14. Community Stroke Rehabilitation Team (CSRT)

Implementation Year: Wednesday, February 4, 2009 - 00:15	Location: Ontario	Practice Website: http://www.sjhc.london.on.ca/stroke-rehabilitation-programs/community-stroke-rehabilitation-team
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SNAPSHOT:

This innovative practice aims to facilitate patients' functional recovery and reintegration into the community post-stroke through rehabilitation services. The practice was launched in the South West LHIN (Ontario) on April 1, 2009 with three collaborative teams (composed of eight members each).

CONTACT INFORMATION:

Name: David Ure **Title:** Coordinator, Community Stroke Rehabilitation Team **Organization:** St. Joseph's Health Care, London **Email address:** david.ure@sjhc.london.on.ca **Telephone number:** 519-685-4292 x.42615

15. Primary Care Memory Clinics: An Innovative, Integrated Model of Care to Improve Capacity and Quality of Health Care for Seniors in Family Practice

Implementation Year: Friday, February 3, 2006 - 00:15	Location: Ontario	Practice Website: http://www.ncbi.nlm.nih.gov/pubmed/20977435
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SNAPSHOT:

This innovative practice was created to resolve dementia care gaps in primary care by offering a clinic where service is targeted at allowing for quick and accurate assessment of memory loss in patients. The Primary Care Memory Clinic was established in 2006 in the Centre for Family Medicine Family Health Team (FHT) in



Kitchener, Ontario.

CONTACT INFORMATION:

Name: Linda Lee **Organization:** Centre for Family Medicine Family Health Team **Email address:** joelinda5@rogers.com **Telephone number:** 519-783-0023

16. Self-Advocacy For Everyone (SAFE) Toolkit

Implementation Year: Tuesday, February 8, 2011 - 00:30	Location: Manitoba	Practice Website: http://www.safetoask.ca/safetoolkit/index.html
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SNAPSHOT:

This innovative practice focuses on engaging patients and encouraging individuals to take ownership of their health care by educating them on a number of topics through a patient safety toolkit. Launched in Manitoba in 2011, the program offers information, tips and resources that can help people learn to be more involved in their health care.

CONTACT INFORMATION:

Name: Dawn White **Title:** Consultant **Organization:** Manitoba Institute for Patient Safety **Email address:** dwhite@mbips.ca **Telephone number:** (204) 927-6471

17. Bridging General and Specialist Care (BGSC) Project

Implementation Year: Tuesday, February 5, 2008 - 00:30	Location: Manitoba	Practice Website:
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SNAPSHOT:

This innovative practice streamlines the referral process among health care providers in Manitoba. Launched in 2008, the program focused on developing IT software and finalizing criteria for effective referrals.

CONTACT INFORMATION:

Name: Brie DeMone **Title:** Executive Director **Organization:** Health System Innovation, Manitoba Health **Email address:** Brie.DeMone@gov.mb.ca **Telephone number:** 204-788-6475

18. 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
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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

19. OsteoArthritis Service Integration System (OASIS)

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

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

CONTACT INFORMATION:

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

20. Alternative Relationship Plan–Rheumatology Project

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

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

CONTACT INFORMATION:

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

21. Physician Integrated Network (PIN) Initiative

Implementation Year: Friday, February 3, 2006 - 00:45	Location: Manitoba	Practice Website: http://www.gov.mb.ca/health/primarycare/pin/index.html
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SNAPSHOT:

This innovative practice facilitates systematic improvements in the delivery of primary care among fee-for-service physician groups. Launched in Manitoba in 2006, this program rewards quality processes in primary care, not health outcomes.

CONTACT INFORMATION:

Organization: Manitoba Health, Physician Integrated Network Initiative **Email address:** pinsupport@gov.mb.ca **Telephone number:** (204) 788-6423

22. 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
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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

23. Practice Support Program

Implementation Year: Saturday, February 3, 2007 -	Location: British Columbia	Practice Website: http://www.gpscbc.ca/psp/practice-support-program
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SNAPSHOT:

This innovative practice addresses the inadequate number of family physicians working in full service family practice. Launched by the BC Medical Association and the Ministry of Health in 2007, this program focuses on practice support for family physicians, specialist physicians and medical office assistants (MOAs) that is centred on improving clinical and practice management, capacity, patient care, and professional satisfaction for physicians.

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

24. Spine Pathway Project

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

25. Integrated Client Care Program (ICCP) for Older Adults with Complex Needs

Implementation Year: Thursday, February 3, 2011 - 01:00	Location: Ontario	Practice Website: http://www.ccac-ont.ca/Upload/on/General/ICCP_Older_Adults_with_Complex_Needs.pdf
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SNAPSHOT:

This innovative practice aims to implement and evaluate practical models of integrated care for specific complex needs populations: older adults with complex needs, medically fragile children, and palliative clients. Launched since early 2011, the Toronto Central Community Care Access Centre (TC-CCAC) in partnership with the Toronto Central Local Health Integration Network (TC-LHIN) has been leading this collaborative, LHIN-wide, multi-year strategy and change initiative.

CONTACT INFORMATION:

Name: Jodeme Goldhar **Title:** Lead, Health System Integration for Complex Populations and Primary Care **Organization:** Toronto Central Community Care Access Centre **Email address:** jodeme.goldhar@toronto.ccac-ont.ca

26. Red Deer Primary Care Network—Chronic Disease Management Program

Implementation Year: Tuesday, February 3, 2009 - 00:30	Location: Alberta	Practice Website: http://www.reddeerpcn.com/OurPrograms/OurPrograms/Default.aspx
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SNAPSHOT:

This innovative practice addresses that 30% of the population with chronic disease account for 60% of direct health care costs in Alberta. In response, the Red Deer Primary Care Network (RDPCN) developed and implemented an integrated chronic disease management strategy to improve health outcomes and reduce costs. RDPCN used a health promotion philosophy to design an integrated approach to preventing and managing chronic disease. Adapting the expanded chronic care model, chronic disease management programs are integrated with community-based health promotion strategies.

CONTACT INFORMATION:



Name: Lorna Milkovich Title: Executive Director Organization: Red Deer Primary Care Network Email address: Lorna.Milkovich@rdpcn.com

27. 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
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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

28. 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
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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

29. Red Deer Primary Care Network's Health Basics Program

Implementation Year: Wednesday, February 3, 2010 - 00:00	Location: Alberta	Practice Website: http://www.reddeerpcn.com
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SNAPSHOT:

This innovative practice address self management and patient accountability of weight loss and active living. Launched in Alberta's Red Deer Primary Care Network in 2010, the program offers public group sessions for eight weeks that allow people to integrate healthy living into their lifestyle.

CONTACT INFORMATION:

Name: Lorna Milkovich Title: Executive Director Organization: Red Deer PCN Email address: lorna.milkovich@rdpcn.com Telephone number: 403-343-2605

30. An Innovative Behavioural Outreach Service and Day Program for Persons with Acquired Brain Injury and Challenging Behaviours

Implementation Year: Thursday, February 3, 2000 - 01:00	Location: Ontario	Practice Website: http://www.westpark.org/Services/ABICommunityOutreachService.aspx
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SNAPSHOT:



This innovative practice targets survivors of acquired brain injury (ABI), that show behavioural changes which adversely affect their relationships with family members, friends, co-workers, and others. The Acquired Brain Injury Behaviour Services at West Park Healthcare Centre, in Toronto, Ontario, provides community outreach behaviour therapists to help survivors, their families, and caregivers learn strategies to manage challenging behaviours following an ABI.

CONTACT INFORMATION:

Name: Gary Gerber **Title:** Clinical Director, Acquired Brain Injury Behaviour Services **Organization:** West Park Healthcare Centre **Email address:** gary.gerber@westpark.org **Telephone number:** 416 243-3600 2615

31. Cudworth Health Council in Saskatchewan

Implementation Year: Wednesday, February 2, 2011 - 01:00	Location: Saskatchewan	Practice Website: http://www.townofcudworth.com/Community%20Newsletter%20may%202012%20(2).pdf
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SNAPSHOT:

This innovative practice addresses the need to promote active engagement of individuals and communities in planning, reviewing, and implementing strategies that both maintain and improve the health and well-being of citizens. The Saskatoon Health Region (SHR) developed a community engagement process to enable community members living in the Town of Cudworth and surrounding area to influence, design, implement, and evaluate health services in their community.

CONTACT INFORMATION:

Name: Pat Stuart **Title:** Manager Primary Health **Organization:** Saskatoon Health Region **Email address:** pat.stuart@saskatoonhealthregion.ca **Telephone number:** 306-655-5364

32. 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/
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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

33. Alberta Healthy Living Program

Implementation Year: Tuesday, February 1, 2011 - 00:00	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/
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SNAPSHOT:

This innovative practice aims to help individuals with or at risk of developing chronic diseases to adopt healthy lifestyles and ultimately improve their quality of life. Adopted by the Alberta Health System in 2011, the program's model calls for an integrated, community-based chronic disease management program.

CONTACT INFORMATION:

Name: Lene Jorgensen **Title:** Decision Support and Evaluation Lead **Organization:** Alberta Health Services **Email address:** Lene.Jorgensen@albertahealthservices.ca **Telephone number:** 403-560-0872

34. Partners in Care Initiative

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

35. Interprofessional Model of Practice for Aging and Complex Treatment (IMPACT Plus)

Implementation Year: Monday, February 6, 2012 - 00:30	Location: Ontario	Practice Website: http://www.building-bridges.ca/projects/impact-plus/
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SNAPSHOT:

This innovative practice addresses patients with chronic, multiple co-morbidities, as they are the fastest-growing sector of Ontario's population, accounting for more than 40% of the province's health care costs. Currently these patients are most often treated with serial visits to disconnected providers who use single-disease management models, which are inadequate to address complex conditions. The Sunnybrook Family Practice Unit developed the concept of the IMPACT Clinic in 2009, which is designed to integrate care by physically bringing together patients, caregivers, and providers in real time and space to assess the medical, functional, and psychosocial needs of the patient and jointly develop a patient-centred care plan.

CONTACT INFORMATION:

Name: Dr. Pauline Pariser **Title:** Physician **Organization:** Taddle Creek Family Health Team **Email address:** paulinepariser@sympatico.ca **Telephone number:** 416-960-1366

36. Hamilton Family Health Team—Mental Health Program

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

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

CONTACT INFORMATION:

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

37. Cancer Care Ontario's Provincial Patient and Family Advisory Council

Implementation Year: Wednesday, February 3, 2010 - 00:45	Location: Ontario	Practice Website: http://ocp.cancercare.on.ca/strategic_priorities/patient_experience/
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SNAPSHOT:

This innovative practice addresses one of the strategic priorities of the Ontario Cancer Plan III (2011–2015) is to “continue to assess and improve the patient experience.” In 2010, CCO introduced, Engaging Survivors to Improve Patient Experiences throughout the Cancer Journey—a patient engagement project (PEP) supported by the Canadian Foundation for Healthcare Improvement. Through this project, a provincial Patient and Family Advisory Council (PFAC) was established to provide a forum in which patients, family members, and caregivers could provide feedback and direction to CCO and its staff on various programs related to improving the patient experience.



CONTACT INFORMATION:

Name: Esther Green **Title:** Provincial Head, Nursing and Psychosocial Oncology Organization: Cancer Care Ontario **Email address:** esther.green@cancercare.on.ca **Telephone number:** 416-971-9800, ext. 2278

38. Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)

Implementation Year: Friday, February 3, 2006 - 00:45	Location: Quebec	Practice Website: http://www.prismaquebec.ca/cgi-cs/cs.waframe.index?lang=2
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SNAPSHOT:

This innovative practice addresses many of the challenges of delivering comprehensive health care services to an aging population. In 2006, a model of integrated care called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) was launched throughout Quebec.

CONTACT INFORMATION:

Name: Hebert Rejean **Title:** Principal Investigator **Organization:** PRISMA **Email address:** rejean.hebert@USherbrooke.ca **Telephone number:** (819) 821-5112 **Last updated:** N/A

39. The Stanford Chronic Disease Self-Management Program

Implementation Year: Wednesday, February 3, 2010 - 01:00	Location: International	Practice Website: http://patienteducation.stanford.edu
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SNAPSHOT:

This innovative practice is designed to address generic issues typically faced by people with chronic disease, but adaptations have also been developed for a range of specific populations. Launched in British Columbia in 2010, the program forms part of the provincial "Patients as Partners" strategy, which coordinates the planning and evaluation of self-management initiatives.

CONTACT INFORMATION:

40. The 5As

Implementation Year: Monday, February 2, 2009 - 02:00	Location: National	Practice Website: http://www.ahrq.gov/clinic/tobacco/5steps.htm
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SNAPSHOT:

This innovative practice addresses the need for self management support for a range of chronic health issues from diabetes to depression. Assess, Advise, Agree, Assist, Arrange: these five steps make up a communication and action cycle known as "the 5As" that health care providers can use to help patients make challenging changes in their lives.

CONTACT INFORMATION:

Name: N/A **Title:** N/A **Organization:** Agency for Healthcare Research and Quality **Office of Communications and Knowledge Transfer** **Email address:** <https://info.ahrq.gov> **Phone number:** (301) 427-1104.

41. Co-creating Health

Implementation Year: Saturday, March 3, 2007 - 15:00	Location: International	Practice Website:
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SNAPSHOT:

This innovative practice addresses chronic disease management by drawing on an integrated approach. Co-creating Health began in 2007 with local primary health care and specialist services in eight communities.

CONTACT INFORMATION:

42. Patients as Partners

Implementation Year: Saturday, February 2, 2002 - 00:30	Location: British Columbia	Practice Website: http://www.impactbc.ca/patients-as-partners
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SNAPSHOT:

This innovative practice addresses the need to help patients constructively share both positive and negative experiences as a voice for improvement to ensure patient experiences can inform system, program, and practice improvements. Patients as Partners is both a policy and philosophy of the British Columbia Ministry of Health. It offers an opportunity for patient engagement in redesign through the partners who deliver Integrated Primary and Community Care.

CONTACT INFORMATION:

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Eastern Health Chronic Disease Prevention and Management Emergency Department Pilot Project

LOCATION:	Newfoundland & Labrador	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

Snapshot: This innovative practice decreases emergency department (ED) visits and increases patient satisfaction among frequent ED users with chronic health conditions. The practice was launched in St. John's, Newfoundland and Labrador, with a half-time primary health care nurse. In February 2013, a full-time community health nurse was added to provide case management services.

Practice Description:

In keeping with its chronic disease prevention and management strategy, Eastern Health mounted a pilot project to assess whether the implementation of intensive chronic disease case management by a primary health care nurse decreases ED visits and improves patient satisfaction for patients 50 years or older who have presented to the ED five or more times in a 12-month period with a CTAS score of 3, 4, or 5. The nurse reviews the client's demographic and medical information to confirm the presence of at least one chronic disease and contacts the client to explain the program. On consent, an intensive case management plan is implemented. The plan includes:

- in-home nursing assessment;
- education related to the patient's chronic disease(s), self-management skills, and medication management (including medication reconciliation);
- development of an alternate plan of care other than an ER visit for non-urgent/non-emergent issues;
- falls prevention;
- referral to or consultation with other health care providers or programs; and
- follow-up by the nurse by phone and/or home visits.

Impact:

As of August 2013, 32 patients had participated in the program. The Eastern Health Research Department conducted an initial evaluation of this initiative in November 2012. That evaluation found a 14 % decrease in the number of ER visits, as well as high levels of patient satisfaction with the program (Gallant 2013). In August of 2013, the Eastern Health Research Department completed a second evaluation, which included 28 of 32 enrolled patients. The evaluation indicated a 27% decrease in the number of ER visits during the intervention year, an average reduction of 2.4 visits per patient per year. The reduction appeared to be largely in visits coded as CTAS 5.

While an assessment of the costs and savings of this practice has not been completed at this time, the Eastern Health Research Department has recommended an evaluation to determine the effects of the Emergency Room Pilot Project on ER visit frequency, chronic disease self-management, cost benefit/effectiveness, and post-intervention ER visits, and to determine the recruitment rate which will improve program efficiency.

Applicability/Transferability:

The practice informant did not identify other specific practices that the Eastern Health Chronic Disease Prevention and Management Emergency Department Pilot Project had been adapted from and was unaware whether it had been used as a



model elsewhere. Lessons learned from this specific practice suggest that success is dependent on extracting information in a timely manner on patients visiting the ER, a timely consent management process, building strong relationships with the acute care sector, and engaging ER clinicians in the initiative.

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VP – Eastern Health

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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.

Eastern Health. (2012). *Chronic disease prevention and management strategy*. Retrieved from <http://www.easternhealth.ca/WebInWeb.aspx?d=3&id=1487&p=981>

Gallant, D. (April 2013). *Primary health care chronic disease prevention & management emergency room (ER) pilot project summary*. St. John's, NL: Eastern Health.



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Advanced Clinician Practitioner in Arthritis Care Program (ACPAC)

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to improve the competencies of advanced clinical practitioners delivering care for patients with arthritis. The interprofessional program was launched in 2005 at St. Michael's Hospital, in collaboration with the Hospital for Sick Children in Toronto, and now has over 37 graduates working in diverse clinical settings across Ontario.

PRACTICE DESCRIPTION:

The ACPAC program was developed to address issues related to the accessibility to arthritis care specialist services for people living with rheumatoid arthritis and osteoarthritis, and to shift towards a more patient-centred, interprofessional approach to care delivery. The goal of the ACPAC program is to provide comprehensive, advanced education in rheumatology and orthopedics by optimizing the scope of existing health human resources. This post-licensure, academic and clinical-education training program targets physical therapists, occupational therapists, and advanced nurses wishing to advance their knowledge and practice in musculoskeletal/arthritis care. The standardized curriculum, which is offered by over 90 multidisciplinary faculty members in Ontario, applies rigorous training and evaluation standards. Individuals who go through the program receive a certificate of completion from the Department of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto. Graduates of this program are expected to provide effective triage, advanced history taking and physical examination, interpretation of laboratory and diagnostic imaging, early detection/initiation of treatment monitoring and follow-up, assessment of appropriate medications and complications, and patient education in the context of musculoskeletal disorders with the goal of improved overall efficiency of care.

To date, the Ontario Ministry of Health and Long-Term Care has provided the majority of the ACPAC program's funding, supplemented by individual tuition fees. The program is endorsed by the Arthritis Alliance and the Canadian Rheumatology Association. Other key stakeholders include The Arthritis Society, industry, and academia (Continuing Education and Professional Development, Faculty of Medicine, University of Toronto).

IMPACT:

Impact assessments have been targeted at health care providers participating in the program. These assessments involve continuous feedback surveys administered to ACPAC students at baseline, midpoint, and at six and 12 months after graduation. Outcome measures were designed prior to the implementation of the program and have helped to inform the program design for subsequent years. Particular areas of interest for these evaluations include determining changes in necessary role competencies, developing best practice standards, and identifying barriers and enablers for recent graduates carrying out their new roles in diverse clinical settings.

From surveys conducted and published in 2011, 100% of graduates were satisfied with the program and found it highly relevant to their clinical practice. System-level evaluations have indicated improvements in access, particularly in rural and remote regions, perceived impact on patient outcomes, and opportunities for further role promotion and expansion. Extensive health services evaluation of ACPAC program graduates can be found in the ACPAC System Level Outcome Report (<http://www.stmichaelshospital.com/pdf/programs/acpac-executive-summary.pdf>), which was presented to the Ontario Ministry of Health and Long-Term Care in January 2012.

The ACPAC program has won a number of awards, including the Colin Woolf Award for excellence in course development from the Department of Continuing Education Professional Development in 2007, the Ted Freedman Award for excellence in design and delivery of formal, post-licensure health care education training in Ontario in 2008, and the Innovations in Human Health Resources Award from the Ontario Ministry of Health and Long-Term Care in 2009.

APPLICABILITY/TRANSFERABILITY:



Based on the positive impact reported since the ACPAC program's implementation, another five-year commitment of financial support from the Ontario Ministry of Health and Long-Term Care and in-kind support from the identified stakeholders is currently being sought. During this transition time, the Arthritis Society has generously funded the program for 2013/2014. The focus will be on developing a national framework for standardized post-licensure training in arthritis care, maintaining the University of Toronto as the central site, and potentially expanding affiliations with other academic sites to establish branches in western and eastern Canada. As this program continues to evolve, areas to address will include barriers faced at institutional and professional regulatory levels, access to and efficiency of care, and cost indicators. In terms of facilitators, medical directives and administrative support have been reported to help overcome legal issues in order to have the most appropriate care provider delivering the services required, reducing direct dependency on physicians and increasing overall system efficiency. Program directors emphasize the importance of the trickle-down effect of ACPAC graduates, whose presence has the potential to change the way arthritis care is delivered in their respective places of practice across diverse clinical settings.

CONTACT INFORMATION:

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Information last updated on: August 1, 2013

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

Publications:

Landon, K., Shupak, R., Reeves, S., Schneider, R., & McIlroy, J.H. (2009). The Advanced Clinician Practitioner in Arthritis Care program: An interprofessional model for transfer of knowledge for advanced practice practitioners. *Journal of Interprofessional Care*, 23(2), 198–200. Retrieved from <http://informahealthcare.com/doi/pdf/10.1080/13561820802379987>

Alternative Profiles:

Chronic Disease Management. (n.d.). *ACPAC: Advanced Clinician Practitioner in Arthritis Care program 2013–2014*. Retrieved from www.chronicdiseases.ca/arthritis

Personal Communications:

Landon, K. (emails, August 1, 2013).

External Source: <http://chronicdiseases.ca/arthritis/>



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Culturally Competent Collaborative Practice Model for Chronic Disease Management

LOCATION:	Saskatchewan	HEALTH THEME:	Aboriginal Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to improve quality of life and health care delivery for First Nations people with chronic disease, through better linkages between provincial and on-reserve services and enhanced service delivery on-reserve. Launched in 2010, this practice included collaboration among Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program) and three First Nations communities including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation.

PRACTICE DESCRIPTION:

In 2010, three partners came together to begin the first ever Kidney Health Education and Targeted Screening Program. The partners were Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program). Three First Nations community partners were asked to participate including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation. This pilot project had the following goals: improved coordination of care of individuals with chronic disease, improved client outcomes, increased access to chronic disease management, increased community capacity and improved self-care management.

Each community had two days of screening where approximately twenty-five people were screened per day. In total, 150 people were screened for chronic disease and educated about ways to keep themselves healthy. Each participant signed a consent form that explained the purpose of the program and what would occur that day and a pre-survey was completed to assess prior knowledge. A health data form was filled out to collect information and record test results, and a copy was also given to the participant in the form of a "kidney report card." Tests were administered including blood pressure, random glucose, A1c, estimated glomerular filtration rate, urinalysis, weight, body mass index, percentage of body fat and waist circumference.

After the tests were completed the participants met with a nurse from the Chronic Kidney Disease program to discuss their results and ask any questions. The nurse provided health advice for optimal kidney function and well-being. Follow-up screening was done in 2011 following the same process.

IMPACT:

There was evidence in the follow-up surveys of the health changes that people were making. They were exercising more, losing weight and decreasing fat and salt consumption, quitting smoking and regularly monitoring their blood glucose and blood pressure and taking their medications. There was also improved coordination and increased access to chronic disease management. Further evaluations are forthcoming.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that the Collaborative Practice Model had adapted from and were unaware if the practice was used as a model elsewhere. However, specific lessons learned from this practice include: repeat screening of clients; regular meetings and foundation for collaboration established to improve coordination of care; client education sessions and engagement of local leadership increased community capacities, and client input contributed to improved self-care management. Challenges that impacted the program included: staff turnover and shortages, heavy workloads prevented staff from dedicating time to the project; and, it was difficult at times to coordinate activities with the Regional Health Authority due to their staff shortages and constraints.

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Information last updated on: October 10, 2013

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

Personal Communications:

Hassler, Sandra (interview and feedback, June 2013). [Collaborative Practice Project].

Other

Petruka, P. and Bassendowski, S. (April 2013). Innovative Collaborative Practice Models to Managing Home Care Clients. Saskatchewan Region.

Lytle, K. (no date). Strengthening the Bridge: Continuing Prevention of Chronic Disease in Saskatchewan First Nations. The Kidney Foundation of Canada, Saskatchewan Branch.



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Bringing chronic disease self-management to rural and remote regions in Rocher-Percé

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

SNAPSHOT: This innovative practice improves the effectiveness of chronic disease management in rural remote regions. Established in 2011 and funded for two years, this practice involved an interprofessional team of nurses, dietitians, and kinesiologists who worked collaboratively with physicians.

PRACTICE DESCRIPTION:

The population in Rocher-Percé is scattered along a vast coastline, making it a difficult population to service. Approximately 60% of clients are seniors, and chronic diseases are a significant problem given risk factors such as obesity, hypertension, high cholesterol levels, sedentary lifestyle, alcohol abuse, and smoking. Accessing treatment—especially for cardiovascular disease, pulmonary disease, diabetes, and renal disease—is a problem. There is a small team at the health centre (the Centre de santé et des services sociaux du Rocher-Percé) with limited capacity and resources. Specialized resources are far away in Montreal, Quebec City, or Rimouski. The Chandler Hospital emergency department was overloaded, which was costly for the health centre. In addition, programs were not operating efficiently given that there were separate clinics and staff for diabetes, cardiac problems, lung, and renal problems; chronic diseases were not being addressed holistically and staff were not communicating.

An industry representative met with the health centre director to discuss a funding opportunity, in partnership with the Quebec government, for new and innovative chronic disease programs. With the goal of transforming an outdated, siloed, and reactive service delivery model, a proposal based on the internationally recognized Chronic Care Model (www.improvingchroniccare.org) was submitted and accepted. The focus was on bringing services closer to clients in their communities through a partnership and team-based model, and on teaching patients to understand their health, and to take responsibility and control, with team support.

An intensive three-month holistic program was created. Instead of looking at a patient's conditions on an individual basis and developing a different treatment plan for each condition, the interprofessional team (dietitian, registered nurse, and kinesiologist) develops a single treatment plan to address all the conditions effectively. With a referral from the doctor and follow-up communication where the team reports information such as blood pressure and diabetes status, medication and other adjustments are made.

The program includes a healthy lifestyle focus (exercise, good nutrition) and patients are educated (in groups) to better understand their health situation. Patients are seen twice a week at a clinic or at a local gym in their community—similar to a mobile clinic. It's very intensive; for example, staff review daily eating habits with clients, who bring in their food products so labels can be read together. The goal is to make individuals proactive in their treatment so they understand why a particular food is or is not a good choice. Exercise, nutrition, how chronic diseases affect the body, and medication management are all part of the teaching. Clients also receive written information to take away. After the three month program is completed, the team is available for support but not regular care, making staff available to start up a new group.

This kind of intensive follow-up is typically only available in specialized health centres, which are typically far away and difficult to access for patients. It is important for rural and remote regions to offer this kind of program.

IMPACT:

A formal evaluation is due later in 2013. In the interim, positive results are seen from discussions with staff and monitoring of patients. Patients' conditions are improving with reduced use of medication, reduced levels of hypertension, lower cholesterol levels, better-controlled diabetes, weight loss, and a change of lifestyle including less smoking. As a result, fewer specialized services are required including surgery.



Feedback from physicians suggest this program is having positive results as patients are seen less frequently. The program was funded for two years initially, and that ended in January 2013. However, given the success of the program, the health centre decided to permanently integrate the different chronic disease programs into one. As a result, the program continues to operate, since the reallocation of time and money have allowed staff to spend more time with clients.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that CDPM had adapted from and were unaware if the practice was used as a model elsewhere. However, there has been considerable interest in the program. The Government of Quebec is interested in adopting the program across the province. And the Government of Canada, specifically the First Nations and Inuit Home and Community Care (FNIHCC) program, is also interested because they believe it is applicable to rural and remote First Nations and Inuit communities. An important lesson is that an intensive program that empowers clients and focuses on a holistic approach to chronic disease makes a difference. Key components for success included partnerships (in this case with industry, the provincial government, and local gyms), interprofessional team-based care, and an approach that was based on a best practice model.

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Information last updated on: September 25, 2013

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

Personal Communications:

Sutton, T. (interview and feedback, 2013). [The Centre de santé et des services sociaux du Rocher-Percé].

Publications

Taking charge of health in the territory of Rocher-Percé: An offer of services in chronic disease care adapted to rural and remote regions. (2012, September). Presentation Notes]. Retrieved from <http://interestsante.ca/files/interdisciplinaritegestiondesmaladieschron...>

Improving Chronic Illness Care. (n.d.). *The Chronic Care Model*. Retrieved from www.improvingchroniccare.org

External Source: <http://interestsante.ca/participation-au-4e-rendez-vous-de-la-gestion-des-maladies-chroniques.php>



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Heart Healthy Kids (H2K)

LOCATION:	Nova Scotia	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the impact of sedentary behaviour and physical inactivity on the health of children and youth. This practice was launched as a school-based program in Nova Scotia in 2006. It involved one paid staff member, many adult volunteer supervisors, and student peer mentors.

PRACTICE DESCRIPTION:

The Heart Healthy Kids (H2K) program was launched in Halifax, Nova Scotia, in 2006. It is a school-based program, targeting children in grades 4, 5, and 6 in the Halifax region. The program involves one paid staff member and many adult volunteer supervisors; each school site has a community champion and three to five additional volunteers. The program has the following components:

- **A team-based physical activity challenge.** Participants log their daily physical activity, which is converted into kilometres in a virtual journey across Canada. The challenge is to be the team travelling the longest distance over the school year.
- **H2K Club** (also known as H2K lunches). These are weekly or biweekly lunchtime events that include **peer mentoring** and team building opportunities. Peer mentors are selected and trained at an in-school workshop to be team leaders in the physical activity challenge. H2K Clubs include a team meeting while the participants eat lunch, where peer mentors take attendance, discuss goals, and facilitate discussion about new activities or nutritional foods participants have tried. After the team meeting, participants engage in a series of active games, which are supervised by adult volunteers but facilitated by the peer mentors.
- **Monthly H2K assemblies.** Maritime Heart Centre staff or program volunteers visit each school to hold an assembly with H2K participants to keep them motivated. Progress is recognized and goals are reviewed. Sometimes there are guest speakers or group activity challenges.
- **Semi-annual education sessions.** These share information on heart anatomy and physiology, nutrition, smoking prevention, and risk factor modification. The content conforms to the Nova Scotia Department of Education's Curriculum Outcomes. Volunteer health professionals or students deliver these sessions.

This program is considered to be innovative for its peer mentoring component; it reduces the need for extensive involvement of adult volunteers, fosters student leadership, and allows children to relate positively to each other and to physical activity. The program started as a research project, with funding from the Nova Scotia Health Research Foundation. The Maritime Heart Centre and the Division of Cardiac Surgery provide in-kind support for one full-time program manager. In the 2012/13 school year, seven schools participated in H2K, involving nine Community Champions, 50 H2K Club volunteers, and more than 700 students, including 117 peer mentors. H2K participants logged physical activity of nearly 200 million steps, or 135,000 kilometres.

IMPACT:

This program is being run at a relatively low cost due to its heavy use of volunteers. There are many student and parent testimonials that speak to the positive reception of this program. As well, there has been a multi-year research study to support the program's development. A 2009/2010 pilot study in one school showed that the H2K program, with student peer mentoring, resulted in a 17% increase in physical activity levels. Thereafter, a larger study conducted in 2010/2011 involved a control group and a larger sample size of nearly 800 students in 10 schools. Five control schools received the standard H2K program, involving the physical activity challenge and education sessions. The same program, with the addition of peer mentoring, was run in five intervention schools to determine the difference associated with peer mentoring. In all control and intervention schools, the following outcomes were measured: physical activity (through daily pedometer use and website tracking), education (through pre- and post-session testing), height, weight, waist circumference, and cardiovascular fitness (determined using the



PACER shuttle run test to calculate maximal oxygen consumption). The results showed that while there were improvements in heart health knowledge in both groups, only the intervention schools showed statistically significant increases in their activity (of more than 1,000 steps per day on average) and maximum volume of oxygen uptake, suggesting that peer mentoring is associated with improvement in daily activity levels and cardiovascular fitness. Further, a qualitative sub-study indicated that the experience of peer mentoring was perceived positively. Participants believed peer mentoring to be enjoyable and felt that it affected participants' activity levels because peer mentors acted as helpers and supporters, organizers and administrators, and expanders of social networks. Peer-reviewed publications are currently in preparation to present the scientific data in the academic literature.

APPLICABILITY/TRANSFERABILITY:

The H2K program has not been adapted from another jurisdiction—it was developed by researchers at the Maritime Heart Centre. The initiative is theoretically applicable and transferable to other settings, such as schools in rural communities. The research included focus groups and interviews with peer mentors, parents, and teachers to evaluate the peer mentoring experience. Peer mentoring was received positively was thought to encourage physical activity. The later phases of the H2K multi-year research study focused on further program refinement (e.g., for sustainability, a program volunteer structure using community champions was developed) in 2011/2012, and then on pilot testing the refined program in more schools. Province-wide implementation of the program is planned for the next three to five years. Lessons learned in refining the program for broader implementation include that peer mentoring shows promise as a valuable health promotion tool, that the school-based environment offers opportunity to reach populations of children, and that development of a sustainable volunteer model is critical to the success of program expansion and impact on health.

PRACTICE WEBSITE: <http://maritimeheartcenter.ca/h2k-program>

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Information last updated on: June 27, 2013

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

Personal Communication:

Spencer, R. (interview, June 27, 2013; review, July 11, 2013). [Maritime Heart Centre].

Other:

Jollymore, M. (May 16, 2012). 'Heart Healthy Kids' yields real gains in children's fitness. In Capital Health Research Services Newsletter, Focus on Cardiac Surgery. Retrieved from <http://www.cdha.nshealth.ca/system/files/sites/391/documents/focus-cardi...>

Heart and Stroke Foundation and the Canadian Cardiovascular Society. (2012, October 29). Nova Scotia research team proves peer pressure can be used for good. [News Release]. Retrieved from <http://www.heartandstroke.nb.ca/site/apps/nlnet/content2.aspx?c=kplPKZOyFkG&b=8453823&ct=12490643&printmode=1>

Maritime Heart Centre. (2013). *H2K: Heart Healthy Kids!* [Project Web Pages]. <http://maritimeheartcenter.ca/h2k-program>

Spencer, R.A. (May 7, 2012). Comparing quantitative and qualitative data to determine the impact of peer-mentoring on physical activity in the Heart Healthy Kids Program. Unpublished presentation at the Dalhousie Cardiac Research Day.

External Source: <http://maritimeheartcenter.ca/h2k-program>



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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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Information last updated on: July, 2013

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

Publications:

Barber, C., & Kallstrom, L. (2011). Vancouver psychiatrists incorporate group medical visits into patient care. *BC Medical Journal*, 53(6), 299.

MacCarthy, D., Kallstrom, L., Kadlec, H., & Hollander, M. (2012). Improving primary care in British Columbia, Canada: Evaluation of a peer-to-peer continuing education program for family physicians. *BMC Medical Education*, 12, 110–122.

Other:

Kadlec, H., & Hollander, M. (2013). Evaluation of the Practice Support Program.

General Practice Services Committee. (2009). *Innovative group medical visits benefit both dementia patients and their caregivers*. Retrieved from http://www.gpsc.bc.ca/media/success-stories#Success_Story-Blouw



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VivoSpace: Using social media for chronic disease management

LOCATION:	British Columbia	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the use of social media marketing as a platform for chronic disease management. The practice was launched in British Columbia at the University of British Columbia and involved two graduate students, a web designer, two primary investigators, and over 100 pilot users for prototyping.

PRACTICE DESCRIPTION:

The self-management of chronic diseases has been recognized as an important determinant for improved health outcomes, and self-management of one's health has been shown to be of vital significance in avoiding illness. However, self-management has many limitations, since it is dependent on the individual's ability and motivation to maintain healthy life choices. Existing self-management strategies have been adopted for short periods of time and often lack sustainability.

Social networks and online communities have been identified as critical motivators in helping individuals achieve positive health outcomes, especially in disease-focused studies. The objective of the VivoSpace project is to understand how online social networks can be designed to motivate positive health behaviour change.

The first step in the initiative is to understand the motivators for using online social networks and for health behaviour change. This understanding forms a basis for the development of the ABC (Appeal, Belonging, Commitment) framework that outlines key components necessary for VivoSpace. The ABC framework stratifies the motivational determinants into three dimensions: appeal, which contains all the individual determinants (what makes an individual a user); belonging, which contains all the socially based determinants (what factors support the frequent use of social media); and commitment, which are the temporal aspects to behaviour change (what helps ensure continued use of the social network). The pilot project explores health behaviour and personal health management goals for people with specific chronic diseases and for healthy people.

IMPACT:

The development of the VivoSpace prototype has been tracked and evaluated at several stages. The initial protocol was published in a peer-reviewed journal and progress on the prototype has been shared in MITACS and BC Quality Forum presentations.

After completing a literature review, the first step was to determine what motivates users to access the social media platform. A paper/online questionnaire had 104 user respondents, and the results show good agreement with the determinants. The majority of responders noted that their motivation to use online social networks are to get information, to maintain connection with people, and for convenience, rather than to learn about oneself and to gain social enhancement. These determinants helped shape the paper prototype. Eleven people were interviewed on the usability of this prototype; they were pleased by the socialization of health information and were eager to have more group health activities and health challenges to further engage users. They also noted concerns with the potential risk of privacy. These comments were taken into consideration when creating the medium fidelity prototype, which was more interactive and featured tools such as the dashboard, where patients can track daily caloric intakes, etc. This prototype progressed through a laboratory evaluation in which 36 adults piloted the prototype. Results from the final evaluation of the high-fidelity prototype are still being gathered.

APPLICABILITY/TRANSFERABILITY:

VivoSpace 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:

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External Source: <http://www.magic.ubc.ca/pmwiki.php?n=Projects.E-HealthCare>



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Bounce Back: Reclaim Your Health

LOCATION:	British Columbia	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses the issue of mild to moderate depression in primary care patients by using self-help materials and telephone health coaching. It was launched in British Columbia in 2008.

PRACTICE DESCRIPTION:

Cognitive behavioural therapy (CBT) is an intervention for mild to moderate depression that is not readily accessible for primary care patients in Canada, particularly in rural areas. As one strategy to address this issue, the government of British Columbia has funded a mental health promotion and intervention initiative called Bounce Back: Reclaim Your Health. This initiative, which is operated by the BC Division of the Canadian Mental Health Association, is currently being offered throughout British Columbia.

The target group of the Bounce Back program is adults with mild or moderate depression, low mood, or stress, with or without anxiety. This mental health service is available to patients in their own homes. The program provides two forms of support: a *Living Life to the Full* video on DVD and workbook-based telephone coaching, available in English and Chinese (Mandarin or Cantonese). The video provides practical advice on how to recognize and address depressive symptoms.

Trained telephone coaches support patients (in English or Cantonese) in using the self-help materials. Coaches assist in teaching problem-solving and other skills to overcome patients' difficulties, including inactivity, unhelpful thinking, worry, and avoidance. Telephone coaches are non-specialists who are trained and monitored by a registered psychologist. A primary care physician's referral is required for the telephone coaching component of the program. To be eligible for referral, patients must be assessed by the PHQ-9 tool and have a score of 5 to 19, with no contraindications for low-intensity cognitive behavioural intervention. Family physicians may claim a community patient conferencing fee from the government if they consult with a Bounce Back coach as part of collaborative care planning.

This practice is innovative in that it expands access to mental health services and promotes mental health literacy, especially in rural areas.

IMPACT:

This innovative practice was implemented in 2008. It is based on a cognitive behavioural therapy approach, which the Canadian Network for Mood and Anxiety Treatments Clinical Guidelines recommend as a treatment for depression. A three-phase implementation evaluation (2011) of the Five Areas Approach (which informed the Bounce Back Program) was carried out by Jeanne Legare and Associates, covering the period from June 2008 to March 2010. As well, the program asks participants to complete a short online survey to provide program feedback. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. The Canadian Institutes for Health Research and the Canadian Mental Health Association have funded research for a randomized controlled trial in 2013 to evaluate (1) whether the program is more effective than usual treatment by general practitioners; and (2) whether the program's results can be attributed to the telephone coaching component. A secondary objective is to assess the cost-effectiveness of the telephone support. The research is being conducted in BC and in pilot sites in Alberta.

APPLICABILITY/TRANSFERABILITY:

The *Bounce Back: Reclaim Your Health* program content was developed in part from the work of **Dr. Chris Williams' Living Life to the Full** program, which includes an educational DVD and a self-help book first published in 2006 called ***Overcoming Depression and Low Mood: A Five Areas Approach***. The content of these self-help materials was adapted to a BC context for use in the Bounce Back program.

There was a staged roll-out of the program in BC. It was launched in five Interior communities in June 2008, and by April 2010 it



was providing service to the whole province. By the end of October 2010, over 49,000 DVDs had been distributed and over 9,100 participants had been referred for telephone coaching. The program has established a Participant Advisory Committee (PAC), involving former program participants, to provide suggestions, feedback, and recommendations on how to improve the Bounce Back program across the province.

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Publications:

BC Ministry of Health. (2011, June 10). *Self-management support: A health care intervention*. Retrieved from <http://www.selfmanagementbc.ca/uploads/What%20is%20Self-Management/PDF/Self-Management%20Support%20A%20health%20care%20intervention%202011.pdf>

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External Source: www.bouncebackbc.ca



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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 needed), 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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Sherbourne Health Centre. (n.d.). *Infirmery 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/>

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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/infirmery.html>



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Primary Musculoskeletal Provider

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice addresses the issue of wait times for referrals to orthopedic surgeons and neurosurgeons by introducing a chiropractor assessment to the process.

PRACTICE DESCRIPTION:

Patients who have chronic, recurrent low back pain (LBP) and who do not respond to usual physician care are a particular challenge for family physicians and the health care system. They are cited as the most common reason for referrals to orthopedic surgeons and neurosurgeons. The specific anatomic cause of back pain is often very difficult to define, and only a small percentage of patients have an identifiable underlying cause. Most patients with LBP improve with conservative management and do not require advanced imaging. Evidence-based conservative care for most LBP patients emphasizes patient education, activation, and therapeutic exercise. Various guidelines also include analgesics and other pain management strategies, such as manual care.

Interprofessional collaborative models involving chiropractors are currently in place in a number of Ontario primary health care settings. In 2011/2012, the Ontario Chiropractic Association partnered with the Ministry of Health and Long-Term Care (MOHLTC) and other external stakeholders to design, implement, and evaluate a consulting chiropractor role in primary care. This project was part of the MOHLTC's initiative to address barriers to the provision of high-quality, appropriate care for LBP in Ontario.

The pilot test model of care introduced an assessment clinic for LBP patients in four family physician offices in Ontario. A chiropractor performs a 30-minute assessment with a patient who has been identified as having LBP and is referred by the primary health care provider. The family physician in collaboration with the chiropractor and patient determine the care plan. The outcome of the assessment is advice and decision support provided to the physician and the inherent knowledge transfer that takes place between providers.

IMPACT:

The objective of this pilot project was to test the feasibility, acceptability, and value of this model of care in the Ontario context. A mixed methods approach was used, including semi-structured interviews, clinical practice guideline concordance surveys, and reflective surveys with both the chiropractors and family physicians. Some patient-level data were collected via a graded chronic pain scale questionnaire, clinical notes, and the patient satisfaction survey following each visit.

It was found that the consulting chiropractor appeared to influence decisions the family physicians made regarding how to manage LBP patient cases. Specifically, the chiropractor influenced physicians' decisions about the appropriateness of advanced imaging and/or a referral to specialist, and their understanding of patient self-management and education strategies. There was strong evidence that physicians benefited from the knowledge transfer, since they reported higher levels of confidence in dealing with similar cases in the future.

The majority of participating providers and patients reported high levels of satisfaction in relation to this model of care. Patient satisfaction was at 94%. Provider satisfaction was even higher, with all physicians interviewed making reference to the value of referring their LBP patients to the assessment clinic. The clinic's value was in providing quicker access and faster diagnosis of patients. Additionally, the majority of primary health care providers perceived the assessment and management of LBP patients in the clinic as being of higher quality.

Participation in the program also increased physicians'

- confidence in assessing and managing LBP patients;



- knowledge of appropriate imaging and specialist referral for LBP patients (which may account for the decrease in referrals for imaging and specialists);
- identification and management of psycho-social variables for LBP patients; and
- awareness and understanding of the role exercise and physical activity can play in managing LBP patients.

In addition, chiropractors reported an increase in their knowledge of medication management for LBP patients.

The results of this project demonstrate that effective interprofessional primary health care triage and management of LBP patients can result in provider and patient satisfaction, and can improve how the health system manages patients with lower back pain.

APPLICABILITY/TRANSFERABILITY:

This program was an original design that was not based on any existing model.

Negotiations are underway for an expanded Phase II of the project, with the aim of moving beyond the pilot phase and spreading the program to multiple settings. The collaborative consulting chiropractic model developed in this program can be readily applied in other jurisdictions that want to introduce a primary musculoskeletal provider in the primary health care setting.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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Rogers, J. (2012, April 30). *Consulting chiropractor role in primary care demonstration project* [Executive Summary]. Toronto: Centre for Effective Practice. Retrieved from https://d2oovpv43hgkeu.cloudfront.net/Collaboration/Primary-Care-Demonstration-Project-Executive-Summary-April-30_2012.pdf

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External Source: <http://www.chiropractic.on.ca/HealthPolicy/interprofessional-collaboration/research-and-projects.aspx>



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Integrated Care for Individuals with Severe and Persistent Mental Illness

LOCATION:	British Columbia	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice aims to provide individuals with severe and persistent mental illness access to integrated care teams.

PRACTICE DESCRIPTION:

In September 2011, two integrated care teams (ICTs) were developed on Vancouver Island to help individuals with severe and persistent mental illness to graduate from secondary Mental Health and Addiction Services (MHAS) case managers and psychiatrist to a family physician who monitors the clients' mental health treatment in the primary health care setting with support of ICT colleagues. The focus of this initiative was to decrease stigma, provide knowledge exchange between psychiatrists/case managers and family physicians, increase the confidence clients and family physicians have in working together on mental health challenges, and increase the capacity of the secondary mental health system to focus on patients who need specialized mental health support. Funding for the pilot project was time-limited and provided by the Ministry of Health.

To design and implement the model, a working group that included secondary and primary care physicians, family and patient representatives, managers, and front-line staff was formed. Weekly meetings were held to develop the program structure and process. In the model, each ICT consists of a psychiatrist, nurse case manager, client, and family physician working closely to enable successful transfer of care. The psychiatrist and nurse case manager are based in a community setting separate from the secondary MHAS to support closer links with family physicians and for ongoing support and knowledge exchange.

IMPACT:

Success of the program during the pilot led to ongoing funding through the Vancouver Island Health Authority. Regular feedback via surveys and focus groups was gathered from patients, clients, staff, and family practitioners to evaluate the implemented program. Clients were tracked with respect to their use of medical and psychiatric emergency departments and psychiatric in-patient units. Ongoing evaluation and outcome measures are being developed and tracked. As well, a complete evaluation framework for the program is under development and is close to implementation.

Between September 2011 and March 2012, results for program use include that there were 113 new referrals to the two ICTs and 55 admissions; and that there are 42 current clients. With regards to discharges, there have been eight discharges back to a general practitioner, four back to a mental health centre (two required service and two requests by clients); and one to another health program. Based on survey results, there was a high degree of satisfaction with the program on all levels—clients, physicians, and staff. Clients saw their referral to the team as evidence of progress in their mental health recovery. They felt less stigmatized and better able to manage self-care. Clients pointed to the prompt response of the ICT nurse as a crucial factor in preventing relapse; the nurse's timely communication with both the client and the family physician facilitated this. Overall, family physicians felt satisfied with their skills in working with these clients and the involvement of the other members of the ICT. Additionally, the pilot demonstrated a small reduction in contacts with emergency departments—one ICT client had one emergency department contact for medical concerns.

Uptake of the program was originally slower than expected due to concerns about the service being a pilot project, concerns of case managers related to increased acuity of caseloads once stable patients graduated, and unfamiliarity of this new model of support. It was clearly evident that ongoing and clear communication between secondary and primary health care services is vital to the success of such a program.

APPLICABILITY/TRANSFERABILITY:



The program allows each local area to adopt the model to their local needs, suggesting that this model of support has a high degree of applicability and transferability in any region where mental health programs want to increase integrated care between secondary mental health services and primary care physicians.

The learnings from these two ICTs are being used in the development of two additional ICTs, which will be implemented in a more rural setting in Central and North Vancouver Island.

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Other:

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



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Strong and Steady Falls Prevention Program

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT:

This innovative practice aims to prevent falls by offering seniors setting-appropriate, individually tailored, progressive activities to improve balance and strength.

PRACTICE DESCRIPTION:

In November 2009, the Mississauga Halton Local Health Integration Network (LHIN) allocated funding to hospitals within the region through the Ontario Government's Aging at Home Strategy, to expand an existing falls prevention program at one hospital to multiple hospitals across the region. The expanded programs, known as "Strong and Steady", in operation since February 2010, offer a six-week exercise and education program (with two, 2-hour sessions per week) to frail older adults in the community who have fallen or who are at risk for falls.

At one hospital, through an innovative partnership, the program was located in a local community centre and a follow-up exercise program, known as "Stronger and Steadier" was created and is offered by the community centre to graduates of Strong and Steady. The impetus for this partnership was to increase the likelihood that older adults participants would strengthen their commitment to physical activity and sustain their gains made during the six-week program.

The combined program offered by Trillium Health Partners, Mississauga Hospital site (Strong and Steady) and The City of Mississauga, Recreation and Parks (Stronger and Steadier) illustrates how the integration of existing specialized geriatric services with community partners and can enhance the sustainability of gains. Utilizing best practices and an inter-professional team, the program includes clinic and individual consultations, goal setting, educational curriculum, balance and strength training and linkages to community services including outreach/in-home consultations and therapeutic physical activity programs such as Stronger and Steadier.

IMPACT:

The program has been evaluated through quantitative and qualitative methods, with data collection at program completion, three months, and six months post program involvement. The value of a community partnership to benefit participants' outcomes and enhance sustainability has also been reviewed.

Outcome measures from Strong and Steady include Berg Balance Scale, reduction in falls, increase in participants' knowledge on falls prevention and increase in recreational physical activity levels measured on the Phone FITT. Recreation physical activity scores were significantly increased from baseline to program completion as well as three and six months post program ($p=0.005$) and there was a significant decrease in the frequency of falls at completion and post program compared to baseline.

Results from participant feedback surveys and focus groups are in alignment with the quantitative findings and provided insight into how elements of the program were effective in facilitating recreation physical activity and reducing barriers to maintaining physical activity levels. Lessons learned include the benefits of having both programs in the same location with similar timeframe and cost as well as strong linkage in program content. Participants who did not live in the vicinity of the community centre reported the need for further programs of a similar nature to be available in their neighborhood. Participation in Stronger and Steadier has enabled some older adults to be physically active and maintain this activity, when they otherwise were not.

APPLICABILITY/TRANSFERABILITY:

Stronger and Steadier is now offered out of two different community centres and a third is offering an aquatic version of the program. This model is theoretically transferable to any region.

For planners and jurisdictions interesting in adapting this practice, the success of the hospital based falls prevention program is



greatly enhanced by partnership with the local community centre. It provides an exceptional service for a wide range of older adults with varying chronic conditions that have impacted their physical activity. The success of this model has led to development of further community follow-up programs and is now being copied at the other falls prevention programs within the LHIN.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

McKye, A. & Bernick, L et al. Content developed from an abstract submission for the Health Council's National Symposium on Integrated Care (2012).

http://www.trilliumhealthcentre.org/programs_services/seniors_health_services/documents/Falls_Prevention_29-08-11.pdf

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Readmission Reduction Program through Payment Systems (USA)

LOCATION:	International	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to reduce readmission rates in hospitals by changing the in-patient prospective payment system (IPPS).

PRACTICE DESCRIPTION:

Hospital readmissions in North America are receiving increasing attention as a largely correctable source of poor quality care and excessive spending. According to a 2009 U.S. study, nearly 20% of Medicare beneficiaries are rehospitalized within 30 days after discharge, at an annual cost of \$15 to \$25 billion.

In 2012, the Affordable Care Act (ACA) in the U.S. was modified when a new section was added to the Social Security Act establishing the Hospital Readmissions Reduction Program. This change requires the Centers for Medicare & Medicaid Services (CMS) to reduce payments to in-patient prospective payment system (IPPS) hospitals that have excess readmissions. The change was effective for hospital discharges beginning on October 1, 2012.

In the FY 2012 IPPS final rule, CMS finalized the readmission measures for acute myocardial infarction, heart failure, and pneumonia. It also finalized how excess readmission ratios will be calculated. These ratios will be used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a hospital within 30 days of a discharge from the same or another hospital. The readmission ratios represent a hospital's readmission performance compared to the national average for the hospital's patients with AMI, HF, and PN. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum to calculate these excess readmission ratios. The excess readmission ratio adjusts for clinically relevant factors such as patient demographic characteristics, comorbidities, and frailty. Finally, the CMS policy is to use three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For fiscal year 2013, the excess readmission ratio is based on discharges occurring during the three-year period of July 1, 2008 to June 30, 2011.

Although the maximum penalty is set at 1% for 2013, eventually reaching 3% of a hospital's Medicare payments, the CMS implementation reduces the potential penalties in aggregate to only 0.2% of national Medicare payments in 2013. Payments for hospitals with below-average rehospitalization rates for all three conditions will not change. Eventually, CMS plans to expand this program to include other common diagnoses for which readmissions are theoretically preventable, boosting the financial effects.

IMPACT:

CMS has estimated, under the Hospital Readmissions Reduction Program, that for FY 2013 Medicare IPPS operating payments will decrease by approximately \$300 million (or 0.3%) of the total Medicare IPPS operating payments.

CMS data show that about 2,200 hospitals face a penalty in FY 2013, and more than 270 of them will get docked the maximum penalty of 1% for FY 2013 (over 12%). CMS stated in the final rule issued in August 2012 that it estimates the program to result in a \$280 million decrease in payments to hospitals.

On February 28, 2013, CMS's Jonathan Blum, Acting Principal Deputy Administrator and Director of the Center for Medicare, informed the Senate Finance Committee the 30-day all-cause hospital readmission rate dropped to 17.8% in the last quarter of 2012 after averaging about 19% over the last five years.

APPLICABILITY/TRANSFERABILITY:

The CMS readmissions penalty policy has drawn the attention of hospitals and stimulated similar approaches among other payers, with readmission rates emerging as a quality marker in public reporting programs. Some limitations to this innovative



practice include the inability of hospitals to submit additional corrections related to the underlying claims data, or to add new claims to the data extract used to calculate the ratios during the review and correction process. The practice also fails to reward hospitals that improve.

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Information last updated on: April 8, 2013

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

Publications:

- Berenson, R.A., Paulus, R.A., & Kalman, N.S. (2012). Medicare's readmissions-reduction program—A positive alternative. *New England Journal of Medicine*, 366, 1364–1366. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMp1201268>

Other:

- Dorland Health. (2013, April 17). Improving medication management, reducing readmissions [Webinar]. http://www.dorlandhealth.com/webinars/Medication_Management_Reducing_Readmissions/#about

External Source:

<http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>



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Community Stroke Rehabilitation Team (CSRT)

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice aims to facilitate patients' functional recovery and reintegration into the community post-stroke through rehabilitation services. The practice was launched in the South West LHIN (Ontario) on April 1, 2009 with three collaborative teams (composed of eight members each).

PRACTICE DESCRIPTION:

2010 Canadian Best Practice Recommendations for Stroke Care indicate that, "After leaving hospital, stroke survivors must have access to specialized stroke care and rehabilitation services appropriate to their needs." A gap analysis completed in 2007 showed that only 14.5% of acute stroke clients in the South West LHIN accessed community or ambulatory rehabilitation services. Hospital and community partners came together to address this gap by designing a program that would help patients continue their functional recovery and rehabilitation journey post-stroke, and reintegrate into the community.

An advisory group consisting of hospital, CCAC, rehabilitation and stroke network representatives designed a specialized team approach, affiliated with the rehabilitation program and district stroke centre, with CCAC providing initial, safe transition from hospital to home. In June 2008, the South West LHIN, as part of the Aging at Home Initiative, confirmed funding for the three specialized Community Stroke Rehabilitation Teams that provide therapy in a variety of settings, including the home, for adults recovering from stroke. Partnering very closely with the CCAC and primary care providers, the Community Stroke Rehabilitation Teams are providing integrated, individualized care for stroke survivors in the community. Services became available in early 2009.

Three Community Stroke Rehabilitation Teams (CSRT) were established, with the goal of providing post-hospital community-based rehabilitation services.

The CSRT team members work collaboratively with service providers in the community to make sure clients have the therapy, education, and support they need to live independently. The team assesses clients who have had a stroke and make recommendations for healthy living to help reduce the chance of another stroke or serious health problem. Each team consists of 8 members: a registered nurse, physiotherapist, occupational therapist, speech language pathologist, social worker, therapeutic recreation specialist, and rehabilitation therapists/facilitators who each contribute different expertise to help rehabilitate the patient in the community. This is a trans-disciplinary approach using rehabilitation professionals and support personnel that maximizes the shared competencies of each member.

IMPACT:

In 2011-12, the Community Stroke Rehabilitation Team saw 19% of new stroke clients living in the South West LHIN. For the 2012-2013 period, the three teams have provided services to over 400 new clients.

A mixed methods (quantitative and qualitative) evaluation approach was employed to assess the impact of the CSRT in 2012. Changes in admission, discharge and 6-month follow-up data (Functional Independence Measure™ (FIM), Stroke Impact Scale (SIS), Hospital Anxiety and Depression Scale and Caregiver Assistance Scale) were analyzed using paired t-tests. Surveys and interviews were used to gain perspectives from clients, caregivers and key stakeholders.

Early results of the evaluation include:

Quantitative: Statistically significant functional improvements were noted from admission to discharge. Clients reported fewer depressive symptoms and caregivers reported providing less assistance. All improvements were maintained by 6 month follow-up appointments.



Qualitative: The team achieved client-related objectives of improved functional recovery, reduction of caregiver burden, and community reintegration. Health system improvements included long term care avoidance, improved access to rehabilitation in the community, and reduced length of hospital stay, emergency room visits, and hospital readmissions.

System Impact: Overall flow improved, with one of the affiliated inpatient rehabilitation programs noting a 32% decrease in Alternate Level of Care days, 18% decrease in average length of stay and 44.9% decrease in days waiting for admission to rehab. A recent review of 4 fiscal years (2008-09 to 2011-12) showed a 27.8% decrease in length of stay from 43.1 days in 2008-09 to 31.1 days in 2011-12. Of note, there was no corresponding negative impact on the Functional Independence Measure change by a shorter length of stay and the percentage of patients discharged home was not reduced. There has been a corresponding 17.5% increase in admissions. Because the length of stay was shorter, the inpatient stroke program at Parkwood was able to admit more patients more quickly, related to the introduction of CSRT to facilitate earlier discharge. The improved wait time has been sustained at 1-2 days maximum.

Currently, an analysis of the Community Stroke Rehabilitation Team database is being completed to provide a more detailed understanding of the service provided by the teams and outcomes experienced by the clients. Additional analysis will include all cases, rather than a small sample. Additionally, an economic analysis is being completed to determine the costs/savings related to the Community Stroke Rehabilitation Team. Recruitment of 200 Community Stroke Rehabilitation Team clients has been completed, while recruitment of the controls continues.

APPLICABILITY/TRANSFERABILITY:

The Community Stroke Rehabilitation Team is based on the results of a pilot completed in 2004, the results of which are summarized in the final report *Stroke Rehabilitation Pilot Project Southwestern Ontario, A Regional Stroke Rehabilitation System: From Vision to Reality*. In its current form, the CSRT provides specialized team rehabilitation services that are directly related to client-centered goals. This service model could be transferred to brain injury outreach, geriatric rehabilitation as well as to other chronic diseases populations such as COPD and CHF in this and other Local Health Integration Networks.

Other communities have expressed interest in adapting the CSRT model. A pilot project is set to start this year in the Hamilton Niagara Haldiman Brant LHIN using a model similar to the Community Stroke Rehabilitation Team.

Some lessons learned that may be useful when adapting or replicating this model include:

- A database allowed the collaborative teams to continuously monitor, evaluate and improve service delivery.
- Support from the stroke network provided best practice resources, education, and knowledge translation.
- A strong relationship with community stakeholders is necessary to facilitate appropriate and timely referrals.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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

Publications

- Stroke Rehabilitation Pilot Project Southwestern Ontario:
http://strokenetworkseo.ca/public/pdf_docs/SWOntStrokeRehabPilotProjectfinal.pdf

Websites

- Community Stroke Rehabilitation Team – About Us:
<http://www.sjhc.london.on.ca/stroke-rehabilitation-programs/community-stroke-rehabilitation-team/about-us>



- Community Stroke Rehabilitation Team – How We Work:

<http://www.sjhc.london.on.ca/stroke-rehabilitation-programs/community-stroke-rehabilitation-team/how-we-work>

External Source: <http://www.sjhc.london.on.ca/stroke-rehabilitation-programs/community-stroke-rehabilitation-team>



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Primary Care Memory Clinics: An Innovative, Integrated Model of Care to Improve Capacity and Quality of Health Care for Seniors in Family Practice

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice was created to resolve dementia care gaps in primary care by offering a clinic where service is targeted at allowing for quick and accurate assessment of memory loss in patients. The Primary Care Memory Clinic was established in 2006 in the Centre for Family Medicine Family Health Team (FHT) in Kitchener, Ontario.

PRACTICE DESCRIPTION:

Primary care physicians will be increasingly challenged to meet the health care needs of an aging population. Yet, today's seniors who have complex chronic conditions receive suboptimal quality of care, which results in profound impacts on health system utilization and quality of life for these seniors and their families. Dementia has been described as the most difficult chronic condition to manage, and data from the Canadian Institute of Health Information show that dementia results in over 30% of Alternate Level of Care (ALC) hospitalization days. These data also show that hospitalization costs for this group are among the highest, at \$19,302 per hospitalization. Interventions designed for complex chronic conditions have generally been specialist-oriented and poorly integrated into the primary care management of the patient.

The Primary Care Memory Clinic is an innovative model established in 2006 in the Centre for Family Medicine Family Health Team (FHT) in Kitchener, Ontario. The clinic was created to resolve dementia care gaps in primary care by offering a clinic where service was targeted at allowing for quick and accurate assessment of memory loss in patients. Shortly thereafter a training program was developed to assist other FHTs to establish their own independent memory clinics.

The Primary Care Memory Clinic is demonstrating that integration of interprofessional teams led by family physicians can strengthen the role of primary care to better manage memory loss due to dementia. This approach has the potential to improve health outcomes and care coordination, and ensure the use of geriatric specialist and system resource is more efficient.

IMPACT:

A mixed quantitative and qualitative evaluation of the 15 clinics using the Primary Care Memory Clinic model was conducted. It included patient and health professional satisfaction surveys, surveys measuring practice changes in training program participants, chart audits, and interviews with clinic staff and patients.

Across all of the clinics, 582 patients were assessed over a period of one to 35 months. They were seen in a more timely manner (83% seen within two months of referral) than if referred to a specialist (whose wait time is typically six to eight months). The majority of patients received a diagnosis of mild cognitive impairment (27%) or dementia (40%). Rate of referrals for specialist consultation was just 9%, which is consistent with ideal models of chronic disease management and which suggests increased capacity in primary care for dementia care. Patients and caregivers were satisfied with the care received, as were referring physicians, who reported increased capacity to manage dementia as a result of the clinic and reduced burden of care with the availability of "in-house" consultation support. Results have been published in peer reviewed journals (Lee.L, et al).

Independent chart audits conducted by geriatricians verified quality of care. Practice changes reported by clinic members included the increased use of standardized tools, and increased knowledge and confidence regarding dementia assessment and management.

This study demonstrated that primary care-based memory clinics are an effective strategy to ensure timely access to quality



assessment and to manage dementia, with positive impacts on health service utilization and quality of dementia care.

APPLICABILITY/TRANSFERABILITY:

The memory clinic model of care may be implemented in other jurisdictions and can be adapted to existing resources in FHTs. To date, similar memory clinics have been established in 32 primary care settings in southern Ontario.

Additionally, the interprofessional model of care and the associated training program may be adapted to improve the primary care management of other complex chronic conditions of seniors that are associated with disproportionately high use of health care resources.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCE:

- Lee, L. Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care (2012).
- Lee, L et. al. *Enhancing dementia care: a primary care-based memory clinic*. Pub Med, October 2010.
<http://www.ncbi.nlm.nih.gov/pubmed/20977435>

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External Source: <http://www.ncbi.nlm.nih.gov/pubmed/20977435>



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Self-Advocacy For Everyone (SAFE) Toolkit

LOCATION:	Manitoba	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice focuses on engaging patients and encouraging individuals to take ownership of their health care by educating them on a number of topics through a patient safety toolkit. Launched in Manitoba in 2011, the program offers information, tips and resources that can help people learn to be more involved in their health care.

PRACTICE DESCRIPTION:

In 2011, the Manitoba Institute for Patient Safety (MIPS) launched the Self-Advocacy For Everyone (SAFE) patient safety toolkit. The SAFE toolkit has information, tips, and resources that can help people learn to be more involved in their health care. The toolkit aims to:

- promote clear, common messages to the public and health care providers on patient safety topics
- provide a patient safety resource for Manitobans
- promote an approach to health care delivery that involves patients and families as key members of their health care team

The SAFE toolkit includes information on 13 key patient safety topics in summary and full-version formats, and a Leader's Guide. The 13 topics are: Know Your Patient Rights, Prepare for Surgery, Choose Your Patient Advocate, Prevent Falls, Know Your Healthcare Plan, Know the Process When Harm Happens, Access Your Medical Records, Know the Patient Safety Contacts, Talk with Your Doctor, Know the Steps in Stating Your Concerns, Work with Your Pharmacist, Know Some Patient Safety Definitions, and Prepare Your Stay in Hospital.

The SAFE toolkit is unique in that it focuses specifically on patients and encourages individuals to take ownership of their health care by educating them on the above 13 topics. The toolkit was developed as part of Phase 3 of the 'It's Safe to Ask' initiative in collaboration with the MIPS's Patient Advisory Committee and many others who provided feedback on this public awareness/education tool. Further, a group of representatives of the Seniors Advisory Council attended a focus group to review and enhance the toolkit's Leader's Guide, which is used to inform potential leaders about the toolkit's content and resources, and how to implement public information sessions. The Leader's Guide also increases the number of leaders offering structured sessions and discussions to Manitobans about patient safety topics. MIPS continues to promote the SAFE toolkit and work with community groups interested in promoting patient safety awareness at grassroots levels in Manitoba.

Funding assistance for the It's ' Safe to Ask' initiative, from which the toolkit originated, was provided by AstraZeneca, the Winnipeg Foundation, the Canadian Patient Safety Institute, the College of Physicians and Surgeons of Manitoba, and the Manitoba Medical Services Foundation.

IMPACT:

The toolkit was presented at conferences for provincial senior resource coordinators and at the Alzheimer Society conference. Staff also made presentations to community support groups, such as the Canadian National Institute for the Blind's (CNIB) Steinbach support group. Health care staff in the regions engaged communities in patient safety activities related to the toolkit such as at community booths in shopping malls and pharmacies, lunch and learn sessions, health fairs, mobile patient safety sessions, and newspaper articles.

Given the fairly recent implementation of this tool, no formal evaluation has been conducted to date. However, the SAFE Patients Blog contains several personal accounts and informal observations on the usefulness of certain topics (including "Talk with Your Doctor and Choose Your Patient Advocate"). Patients report that they are taking components of the SAFE toolkit and bringing them to their physician visits, which helps them keep track of future appointments, and also gives them a sense of control and encourages them to ask questions. Clinicians who have come across patients using the SAFE toolkit information



(such as the medication history card) find this tool helpful, especially when meeting with first-time or out-of-province patients.

APPLICABILITY/TRANSFERABILITY:

Somewhat similar tools are in place across Canada with respect to reconciling medications. However, these tools are targeted to clinicians, whereas the SAFE toolkit is patient-centred. The SAFE toolkit has not been implemented elsewhere, but is likely transferable to other jurisdictions given its well-developed topic information and Leader's Guide. Successful implementation of this innovation requires strong patient and family engagement as well as clinician leadership in providing education.

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

- Manitoba Institute for Patient Safety. (2011). *It's safe to ask: Self-Advocacy For Everyone (SAFE)*. <http://www.safetoask.ca/safetoolkit/index.html>
- *S.A.F.E Patients Blog*. (2013). http://www.mbips.ca/wp/safe_patients_blog/
- Manitoba Institute for Patient Safety. (2011). *Annual report 10/11*. <http://www.mbips.ca/wp/wp-content/uploads/2011/07/long-annual-report-web-version-final.pdf>
- Manitoba Institute for Patient Safety. (2012). *Annual report 11/12*. http://www.mbips.ca/wp/wp-content/uploads/2012/06/mips-annual_report-2011-2012.pdf
- Byrd, J. & Thompson, L. (2008). "It's Safe to Ask": Promoting patient safety through health literacy. *Healthcare Quarterly* 11, 91–94. Retrieved from <http://www.longwoods.com/content/19656>
- Colquhoun, M. (2006). *Medication reconciliation: The "new" GSK—What have we learned?* [Presentation Notes]. [http://www.saferhealthcarenow.ca/EN/events/PreviousEvents/Documents/Medication%20Reconciliation%20and%20Surgical%20Site%20Infection%20\(2006\)/Session%203/The%20New%20Medication%20Reconciliation%20Getting%20Started%20Kit%20-%20What%20Have%20We%20Learned.pdf](http://www.saferhealthcarenow.ca/EN/events/PreviousEvents/Documents/Medication%20Reconciliation%20and%20Surgical%20Site%20Infection%20(2006)/Session%203/The%20New%20Medication%20Reconciliation%20Getting%20Started%20Kit%20-%20What%20Have%20We%20Learned.pdf)

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External Source: <http://www.safetoask.ca/safetoolkit/index.html>



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Bridging General and Specialist Care (BGSC) Project

LOCATION:	Manitoba	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice streamlines the referral process among health care providers in Manitoba. Launched in 2008, the program focused on developing IT software and finalizing criteria for effective referrals.

PRACTICE DESCRIPTION:

BGSC is viewed as an innovative practice that streamlines the referral process in Manitoba.

Ensuring timely access to quality health care requires coordination among health care professionals and effective communication tools that can be easily used in clinics day-to-day. The Bridging General and Specialist Care Project (BGSC) was launched as an information technology (IT) consultation and referral system in May, 2008. BGSC facilitates timelier and more appropriate coordination between family physicians and specialists. The goal of this initiative was to streamline the consultation and referral process while also ensuring that patients get referred to the right specialist at the appropriate time. BGSC is a novel approach to clinical referral pathways in that it uses electronic record technology as a platform for sharing clinical information, medical history, and medication history with a target specialty. BGSC was funded by Health Canada, Manitoba Health, and Healthy Living; stakeholders included physicians, specialists, IT staff, and clinical office staff.

This two-year initiative was delivered in two parts. The first wave (May to December 2008) focused on developing the IT software and finalizing the criteria for referral, the required tests, and the clinical data to be entered into the software. Enough information needed to be uploaded for the physician and the specialist to agree on the appropriate treatment option. The software confirms whether all information to meet the established criteria has been uploaded, and suggests what additional information to include if the criteria are not met. These criteria were disseminated to other health care interest groups for feedback. The IT system also monitors wait times to ensure that patients who do not get access to care within the guaranteed time are referred to another specialist immediately. Six specialty areas were included in the first wave, and seven more were added in the second wave (January and February 2010).

IMPACT:

The Government of Manitoba reported on the progress and effectiveness of the initiative in its reports and presentations. Data were taken from surveys given to health care professionals before and after the intervention period as well as more informal interviews with family physicians. From 2009 to 2010, 78% of the 1,002 referrals were accepted and only 19% of appointment dates were set later than the target deadline. In the following year, 902 more referrals were made. A total of 177 family physicians and nurses were involved as well as 55 specialists. The physicians said they liked the recommendations provided by the IT system and were pleased that the system reflected their local needs rather than adopting a “one size fits all” policy. The specialists also preferred to use the BGSC system rather than traditional methods. The system would benefit from including a wider variety of specialties and from better integration with other electronic medical devices.

APPLICABILITY/TRANSFERABILITY:

The transition from wave 1 to wave 2 increased the spread of utilization and the variety of specialties included. Health care professionals reported better coordination and communication with a wider variety of specialists, and all sites had overall positive results with the software. Although somewhat similar practices exist in the United States and the United Kingdom, the BGSC project has an innovative set of inputs and established criteria that provide patient-centred treatment options. It is also the only initiative of its kind in Canada. The BGSC project could be implemented in other provinces and territories, but only for high-volume, routine referrals that meet its specific information and testing requirements.

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



- Canadian Medical Association. (2011, December 5). *A collection of referral and consultation process improvement projects*.
http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf
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- Manitoba Health. (n.d.). *Bridging general and specialist care* [Project Website].
<http://www.gov.mb.ca/health/bgsc/index.html>

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

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External Source:

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



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OsteoArthritis Service Integration System (OASIS)

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

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



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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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



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Alternative Relationship Plan–Rheumatology Project

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

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

PRACTICE DESCRIPTION:

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

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

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

- 1) Referrals are received by a single fax and tracked in the database.
- 2) Nurse Clinicians triage referrals with the support of a rheumatologist and obtain all additional pertinent information.
- 3) Patients are booked to the next available rheumatologist based on urgency.
- 4) Referring physicians are notified about estimated wait time.
- 5) Rheumatologists notify patients of their appointment date and time.
- 6) Appropriate cases are directed to specialized clinics.

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

IMPACT:

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



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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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



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Physician Integrated Network (PIN) Initiative

LOCATION:	Manitoba	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice facilitates systematic improvements in the delivery of primary care among fee-for-service physician groups. Launched in Manitoba in 2006, this program rewards quality processes in primary care, not health outcomes.

PRACTICE DESCRIPTION:

The Physician Integrated Network (PIN) is a multi-phase primary care renewal initiative in Manitoba. The goal of PIN is to facilitate systematic improvements in the delivery of primary care among fee-for-service physician groups. Fee-for-service physicians account for 76.9% of family physicians in the province. The four key objectives of PIN are to improve access to primary care, to improve primary care providers' access to and use of information, to improve the work life of all primary care providers, and to demonstrate high-quality primary care, with a focus on chronic disease management.

Phase 1 of the PIN initiative began in 2006 with 4 demonstration sites. Phase 2 was launched in September 2008, by which time 13 clinics were participating in the initiative. In August 2011, this phase was extended to August 2015 and is now referred to as Phase 2+. There are currently 12 sites continuing to participate. This includes 142 physicians, which represents 14.2% of all fee-for-service family physicians in Manitoba. PIN is a demonstration project—Manitoba Health works with the collaborating sites to explore and test new initiatives that could be implemented more broadly on a provincial basis.

Physicians that participate in PIN have access to quality-based incentive funding (QBIF). QBIF is a made-in-Manitoba approach to physician compensation that rewards quality processes in primary care, not health outcomes. It is being trialed within the PIN initiative as an opportunity to explore the potential of a blended model for compensating physicians that considers both the quality of services provided (pay-for-performance) and the volume of services delivered (fee-for-service). QBIF has been designed to incentivize physicians for achievement in prevention, risk-factor identification, comprehensive chronic disease management, and continuity of care. Funding is tied to the clinic's performance on primary care quality indicators related to prevention, diabetes management, asthma management, congestive heart failure management, hypertension management, coronary artery disease management, and trial depression screening indicators. These primary care quality indicators are based on a set of evidence-based measures originally developed by the Canadian Institute for Health Information, in collaboration with clinical experts. Participating clinics use an electronic medical record (EMR) system that reminds physicians when someone is overdue for a required test or procedure so that patients receive the right care at the right time. The EMR also allows clinics to track their performance on the primary care quality indicators so they can ensure they are meeting targets and providing optimal care.

The amount of funding available to each clinic is based on the number of patients who attend that clinic as their regular place of care. The amount of funding actually paid is based on the clinic's individual

performance on primary care quality indicators. QBIF is also linked to "clustered achievement" on primary care quality indicators, and to how well the clinic performs comprehensive chronic disease management. QBIF provides clinics with resources to implement practice changes that contribute to PIN objectives, such as establishing interprofessional teams. To participate in PIN, clinics agree to specific deliverables: implementation of their practice change plans, regular reporting on progress (i.e. EMR data extraction every quarter), and participation in evaluation and indicator development for PIN practices and to measure quality of care provincially.

IMPACT

The PIN initiative was evaluated throughout the demonstration period. Each phase of the project was evaluated using a pre- and post- design. The evaluation was designed to measure the impact of PIN on patient care and patient and provider satisfaction in relation to each of PIN's four objectives. The evaluation includes several lines of evidence: a provider survey, a patient survey, analysis of EMR data, and interviews with PIN stakeholders.

In December 2012, Manitoba Health released the findings of the Phase 2 PIN evaluation. PIN has been most beneficial in



improving primary care physicians' access to and use of information by increasing their awareness of clinical practice guidelines and enabling monitoring of PIN compliance through EMR data. Moreover, there has been success in providing greater quality primary care and chronic disease management. In Phase 2 clinics, there were increases in all indicator clusters, as well as individual indicators from Time 1 to Time 2. To illustrate, in the diabetes indicator cluster (comprised of all seven individual diabetes indicators), all diabetes indicators had an increase in proportions over time, in particular foot exams (37% to 64%) and nephropathy screening (52% to 75%). Over time, all hypertension indicators had an increase in proportion, with the full fasting lipid profile screening (62% to 73%) and obesity/overweight screening (68% to 79%) having the highest increases, followed by fasting blood sugar test (67% to 77%) and testing to detect renal disease (73% to 83%).

APPLICABILITY/TRANSFERABILITY

The QBIF model was developed based on evidence and knowledge about pay-for-performance approaches in other jurisdictions (e.g., British Columbia, Ontario) and countries (e.g., the UK's Quality and Outcomes Framework, and Australia's Practice Incentive Program).

In conjunction with the regional health authorities, Manitoba Health has launched a new initiative to establish primary care networks (PCNs) in the province. PIN has informed the development of the PCN, particularly with respect to access to care and providing quality chronic disease management. PCNs are about teams of care providers (located in the same office or connected virtually online) working together to plan and deliver services for a geographic area or specific community or population. Services in PCNs will build on the work of PIN, and will focus on prevention and coordinated disease management, including the identification and reduction of chronic disease risk factors such as physical inactivity and tobacco use. The Physician Master Agreement, negotiated between Manitoba and Doctors Manitoba, includes five new chronic disease management tariffs—diabetes, asthma, congestive heart failure, coronary artery disease, and hypertension. These tariffs were introduced to help physicians spend more time with complex patients, and to acknowledge the link between comprehensive chronic disease management and better patient health.

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External Source: <http://www.gov.mb.ca/health/primarycare/pin/index.html>



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



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Practice Support Program

LOCATION:	British Columbia	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the inadequate number of family physicians working in full service family practice. Launched by the BC Medical Association and the Ministry of Health in 2007, this program focuses on practice support for family physicians, specialist physicians and medical office assistants (MOAs) that is centred on improving clinical and practice management, capacity, patient care, and professional satisfaction for physicians.

PRACTICE DESCRIPTION:

British Columbia, like the rest of Canada's jurisdictions, has encountered challenges in delivering high quality primary care to its patients. The challenge stems from an inadequate number of family physicians (FPs) working in a full-service family practice. In order to improve patient care while also increasing job satisfaction among FPs, BC's health experts from the BC Medical Association and the Ministry of Health created the General Practice Services Committee (GPSC) in 2003. The GPSC underwent consultations with 1000 FPs across the province on Professional Quality Improvement Days (PQIDs) to discuss solutions to problems including decreasing professional morale and lack of support in handling more complex patients. In 2007, the GPSC launched the Practice Support Program that focuses on practice support for FPs, specialist physicians and medical office assistants (MOAs) that is centred on improving clinical and practice management, capacity, patient care, and professional satisfaction for physicians.

In addition to the support from GPSC, PSP now receives additional direction, support, and funding from the Shared Care Committee and the Specialist Services Committee (also partnerships between the BCMA and Ministry of Health).

Practice Support Program (PSP) services include practice coaching, supporting QI initiatives and providing structured learning support (modules). The modules include three paid half-day sessions of group learning followed by a 6-8 weeks action period where physicians aim to use the skills they acquired in their respective clinical practices. Further training sessions are integrated into the action sessions as part of the PSP's Plan-Do-Study-Act Cycle. The cycle is used to try out new practices and test for their effectiveness before embarking on macro-scale implementation. Practice Support team members visit the PSP participants throughout their action periods to ensure ongoing professional support and guidance in implementing new tools in day-to-day medicine. The program is delivered through PSP Regional Support Teams in BC's five health authorities. All clinical PSP content is accredited for continuing medical education.

Modules include:

- Advanced Access and Office Efficiency
- Group Medical Visits (Patient Self-Management/Health Literacy)
- Chronic Disease Management
- Adult Mental Health
- Child and Youth Mental Health
- End-of-Life
- Musculoskeletal
- Shared System of Care(COPD, heart failure)

IMPACT:

As of March, 2013, PSP has worked with over 2900 FPs (representing approximately 70 percent of active FPs in the province)

to improve patient care and professional satisfaction. PSP is currently developing an innovative strategy to support specialists and this initiative will be launched in 2013/2014.



Published evaluation findings, from a survey of 887 GPs and 405 MOAs over the first three years of the PSP, indicate consistently high satisfaction ratings and perceived impact on GP practices and patients, regardless of physician characteristics (gender, age group) or work-related variables (e.g., time worked in family practice). Participants reported reduced patient wait times, better patient care and a more satisfying work environment. More specifically, practices that participated in the PSP Advance Access Learning module reduced appointment wait times from 5.2 to 1.8 days, and over 87% of participants developed a Chronic Disease Management (CDM) patient registry and believed the CDM module improved patient care. Further, 94% of GPs felt more comfortable helping patients who required mental health care after attending the Adult Mental health module, and 76% of MOAs reported improved working relationships overall.

APPLICABILITY/TRANSFERABILITY:

Many European countries, especially the Netherlands, have developed physician-sponsored education initiatives for quality improvement in health care. However, aside from the Australian General Practice and Education Training Program, there are few large-scale (provincial/territorial/national level) continuing medical education initiatives that are centered on government and physician collaboration. Given its success and structure, this innovative focus on practice support should translate well to other provinces and territories.

Content was adapted from the following sources and relevant websites:

<http://www.gpsc.bc.ca/psp/contact>

<http://www.sscbc.ca/content/about>

<http://www.mybettermedicare.ca/primary-care-practice-support-in-british-columbia.html>

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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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Integrated Client Care Program (ICCP) for Older Adults with Complex Needs

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to implement and evaluate practical models of integrated care for specific complex needs populations: older adults with complex needs, medically fragile children, and palliative clients. Launched since early 2011, the Toronto Central Community Care Access Centre (TC-CCAC) in partnership with the Toronto Central Local Health Integration Network (TC-LHIN) has been leading this collaborative, LHIN-wide, multi-year strategy and change initiative.

PRACTICE DESCRIPTION:

Since early 2011, the Toronto Central Community Care Access Centre (TC-CCAC) in partnership with the Toronto Central Local Health Integration Network (TC-LHIN) has been leading a collaborative, LHIN-wide, multi-year strategy and change initiative. This initiative is to implement and evaluate practical models of integrated care for specific complex needs populations: older adults with complex needs, medically fragile children, and palliative clients. The strategy for older adults is a Toronto-based initiative that ensures that all older adults with complex needs are a part of an integrated community model of care by aligning and leveraging existing resources, bringing together sectors from across the health system, and building capacity to be more responsive to clients and their caregivers. The approach is focused on functional integration at the point of care and is designed to improve quality while ultimately bending the cost curve for some of the system's most complex and costly clients. Through a quality improvement approach to evaluation, key lessons have been identified in relation to the critical success factors for health system integration and the key components for successful integration at the point of care.

IMPACT:

Integration at the point of care involves wrapping care around clients and their families and creating interprofessional teams. At the heart of this work is understanding the players involved in a client's care and bringing them together at the point of care for shared assessments and planning that is centred on the goals of clients and their families. Since its inception, a number of key innovations have demonstrated significant value and are driving sustainable solutions across the TC LHIN. Noteworthy innovations include:

- care coordinators providing intensive case management focused on system navigation, bringing together interorganizational and interprofessional care teams to ensure wrap-around care and smooth transitions;
- primary care engagement with CCAC care coordinators working hand in hand with primary care providers in family health teams, Community Health Centres, and large neighbourhood communities with solo-primary care physicians;
- the EMS-CCAC partnership to support smooth transitions by creating the ED Transfer Package and team communication flagging systems and acute care repatriation;
- acute care with new flagging systems for high-risk clients and virtual case conferences between the community and acute-care providers; and
- engagement with community pharmacists to move to a single pharmacy for each client, and dedicated training to support caregivers based on experience-based problem-solving techniques.

APPLICABILITY/TRANSFERABILITY:

The first generation of ICCP has successfully transitioned the local health system into a level of readiness for transformative change and has embarked on a large-scale expansion. As Ontario continues to face significant challenges in achieving value and sustainability through system-wide integration, this Toronto-based model is moving the local health system towards a scalable model for integration while also delivering grassroots impact.

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Information last updated on: January 25, 2013

Content adapted from the following sources and relevant website:

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

External Source: http://www.ccac-ont.ca/Upload/on/General/ICCP_Older_Adults_with_Complex_Needs.pdf



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Red Deer Primary Care Network—Chronic Disease Management Program

LOCATION:	Alberta	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses that 30% of the population with chronic disease account for 60% of direct health care costs in Alberta. In response, the Red Deer Primary Care Network (RDPCN) developed and implemented an integrated chronic disease management strategy to improve health outcomes and reduce costs. RDPCN used a health promotion philosophy to design an integrated approach to preventing and managing chronic disease. Adapting the expanded chronic care model, chronic disease management programs are integrated with community-based health promotion strategies.

PRACTICE DESCRIPTION:

It is estimated that 30% of the population with chronic disease account for 60% of direct health care costs in Alberta. To respond to population data and family physician needs, Red Deer Primary Care Network (RDPCN) developed and implemented an integrated chronic disease management strategy to improve health outcomes and reduce costs. RDPCN used a health promotion philosophy to design an integrated approach to preventing and managing chronic disease. Adapting the expanded chronic care model, chronic disease management programs are integrated with community-based health promotion strategies. Physician-referred patients are seen by interprofessional practice teams (family nurse, mental health counsellor, pharmacist) located in physician offices to facilitate collaboration, continuity of care, and coordination. Evidenced-based care algorithms (e.g., diabetes, smoking cessation) were developed that emphasize a patient-centred self-management approach.

The team refers patients to community and health resources for help with income support, diabetes care, housing, and other needs. Patients are referred to primary care network group programs (including Health Basics CHOICES, a lifestyle management program; Happiness and Anxiety Groups; and Strong and Steady (falls prevention)). Interprofessional staff teams lead group programs (e.g., the Health Basics team comprises nurses, kinesiologists, and dietitians). Patients who attend groups are followed up in family physician clinics. Patients and their families, along with staff, are encouraged to participate in RDPCN's community-based health promotion activities (such as virtual treks, outdoor gyms, and biking). Subsidies are provided for those in need.

IMPACT:

Formative and summative evaluation supports the continuous quality improvement and results assessment of patient services and programs. In 2011/12, 90% of referred complex chronic care patients (n=1578) were coached by team members. On average, patients presented with 4.3 chronic conditions. Each patient received six interventions, including referral to community resources. Case consultations between RDPCN staff and physicians doubled for complex patients; 30% of these patients were cross-referred to other primary care network programs. Patient feedback was positive regarding attributes of self-management: involvement in action/care planning (>90%), confidence in improving health (>80%), and awareness of RDPCN staff collaboration in their care (90%). The network's patient population had reduced emergency department visits and hospitalizations.

APPLICABILITY/TRANSFERABILITY:

Transferable programs include Happiness, Health Basics CHOICES, and Strong and Steady groups. Community activity partnerships include outdoor gyms, virtual treks, and complex care algorithms. RDPCN recognizes that health is a partnership among patients, families, health professionals, health organizations, and communities that deliver health care services that promote better health, improved chronic disease outcomes, and reduced health care costs.

Content was adapted from the following sources and relevant websites:

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



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External Source: <http://www.reddeerpcn.com/OurPrograms/OurPrograms/Default.aspx>



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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

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.

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



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



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Red Deer Primary Care Network's Health Basics Program

LOCATION:	Alberta	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice address self management and patient accountability of weight loss and active living. Launched in Alberta's Red Deer Primary Care Network in 2010, the program offers public group sessions for eight weeks that allow people to integrate healthy living into their lifestyle.

PRACTICE DESCRIPTION:

This is a facilitated, dynamic group program for people who want to lose weight and become more active. It was designed using a health promotion approach, and has been running for almost three years. It is based on the concept that people have reasonable knowledge of what they should be doing, but have not been successful at translating this knowledge into action. The Health Basics program helps people integrate simple key concepts into their lifestyle. It is very engaging, interactive, and fun.

Self-management and patient accountability are enacted through participants setting individual goals and sharing their progress and challenges with the group. Through this sharing, participants learn from one another. People learn simple and effective ways to make positive lifestyle choices empowered by the insights that "my choices reveal my priorities" and "small steps lead to big changes." The power of the program is that participants take the time to put themselves first and rebalance their lives. People realize the impact their daily choices have on their health. Participants like the Health Basics program, feel empowered by it, and recommend it to their friends.

The program was developed based on an extensive review of the research and best practices. Every group is evaluated and feedback is used for continuous quality improvement. We also use feedback that patients give to their physicians.

Design:

- Participants attend two-hour facilitated group sessions for eight weeks, with monthly follow-up.
- Each week has three key components: mindset, activity during the session, and nutrition. This holistic program combines self-management, exercise, and nutrition rather than breaking these components down into silos. The philosophy is that people don't live their life in silos and all the concepts come together in their lifestyle. This is also simpler and more cost effective than having three separate programs.

Target audience:

- Adults of any size. We normalize the need to focus on a healthy lifestyle rather than on weight.

IMPACT:

In 2010, upon completing their eight-week program, over 1,000 participants had lost weight, and had achieved an average loss of two inches off their waist and an average loss of 0.8 BMI.

The weight, height, and waist circumference of each participant is measured at baseline, at the end of program, and at monthly follow-up programs (if attended). These are routinely monitored for each group (more than 50 each year). These measures are reviewed at three, six, and 12 months post-program for comparison.

Changes in BMI and waist measure:

- mean decrease in BMI from Week 1 to Week 8: 0.8 ($p = .002$)
- mean decrease in waist measure from Week 1 to Week 8: 2.1 inches ($p = .000$)
- mean decrease in BMI over 12-month period: 5.33 ($p = .01$)



- mean decrease in waist measure over 12-month period: 5.05 inches ($p = .00$)

Changes in physical activity and eating habits:

- 79% of participants (N=519) indicated they had increased their physical activity, especially walking.
- 75% indicated they had changed their eating habits. Changes made included reading food labels, eating breakfast, controlling portion sizes, and eating more fruits and vegetables.

Changes in medication, clothing size, and ease of daily activity:

- 28% indicated their medications had been reduced, particularly those that lower blood pressure and blood sugar
- 67% indicated their clothes fit better and looser. Many had dropped a clothing size.
- 60% had more energy to do routine activities, such as climbing stairs and putting on shoes.

Additional evaluation planned for 2011/12:

- Quality of Life—Physical and Mental Health. Data to be collected pre-workshop and at, three, six, and 12 months after workshop completion. In addition, a quality of life assessment was completed (N=113) at specified time periods up to six months after program completion using the SF12v2 survey tool. Results indicate positive changes from baseline through to three months after program completion in physical and mental health indicators. These reflect people having more vitality, less body pain, improved ability to do daily work, and improved mental health. In general, participants left the program with better health functioning. There was a statistically significant difference in scores of all dimensions from baseline to three months after completion of the program. Six- and 12-month results have not been analyzed yet.

- Self-Efficacy, with a focus on how health habits are changed and maintained. A tool to collect data is currently being developed. Further development will include the incorporation of indicators in a Health Basics Alumni Study, which is currently underway. These have been adapted from the Patient Activation Measures (PAM) and include confidence, action planning, and contributors to health behaviour and lifestyle change. Focus groups are conducted with Health Basics alumni to determine what factors help and hinder behaviour change. Results thus far, which affirm those identified in literature, will inform further tool development.

APPLICABILITY/TRANSFERABILITY:

All group programs embrace the same approach based on self-management and activation, and are grounded in positive psychology. Quality of life assessment, utilizing the same evaluation methods has been conducted with participants in Happiness and Anxiety group programs hosted by PCN. Results from the quality of life assessment indicate positive results in physical and mental health function measures across all PCN group programs that subscribe to the same program delivery principles as Health Basics.

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External Source: <http://www.reddeerpcn.com>



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An Innovative Behavioural Outreach Service and Day Program for Persons with Acquired Brain Injury and Challenging Behaviours

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice targets survivors of acquired brain injury (ABI), that show behavioural changes which adversely affect their relationships with family members, friends, co-workers, and others. The Acquired Brain Injury Behaviour Services at West Park Healthcare Centre, in Toronto, Ontario, provides community outreach behaviour therapists to help survivors, their families, and caregivers learn strategies to manage challenging behaviours following an ABI

PRACTICE DESCRIPTION:

After sustaining an acquired brain injury (ABI), survivors may show behavioural changes that adversely affect their relationships with family members, friends, co-workers, and others. In some instances, ABI survivors display challenging behaviours that can include agitation, aggression, irritability, and feelings of anxiety and depression.

The Acquired Brain Injury Behaviour Services at West Park Healthcare Centre, in Toronto, Ontario, provides community outreach behaviour therapists to help survivors, their families, and caregivers learn strategies to manage challenging behaviours following an ABI. The behaviour therapists work in clients' homes or places of residence, including long-term care homes in the Greater Toronto Area. West Park Healthcare Centre also has a day program for ABI survivors that provides social and educational activities, skills training, community outings, and community case management services. Participants attend the day program two to three days per week for a six-month period, and they are also eligible for limited overnight respite stays. The day program's behaviour and rehabilitation therapists are very experienced in working with ABI clients who exhibit challenging behaviours. Funding for the outreach service that began in 2000 is from West Park Healthcare Centre operating funds. The Toronto Central Local Health Integration Network (LHIN) provides separate funding for the day program, which started in 2009.

The behavioural outreach service and the day program are innovative in addressing the needs of ABI survivors. The outreach service's behaviour therapists work with clients and their family members or caregivers in their home to address challenging behaviours that cause distress and often limit clients' ability to be integrated into their home community. This service is not available in the public sector, and clients' needs cannot be adequately addressed in conventional outpatient office therapy. Service is provided for one year or more to ensure that interventions are effective and are maintained. Intervention strategies are customized to address the needs of each client, as each client's behavioural challenges are unique. The goal of intervention is to decrease behaviours that interfere with family and social relationships and to increase community participation. Outreach services reduce the need for in-patient treatment and pharmacological interventions, and enable clients to remain in their home or place of residence.

The day program accepts clients who exhibit challenging behaviours, including agitation, anger, irritability, and wandering. Clients with significant behavioural impairments are usually excluded from ABI day programs and other community programs due to the lack of expertise in managing clients' challenging behaviours. The overall goal of the day program is to reduce participants' social isolation by providing them with social experiences, training, and opportunities to participate in community activities. Participants are expected to be more likely to pursue productive activities in their home community when they leave the day program.

IMPACT:

Outreach services are clinically evaluated for each client. Goal attainment scaling has shown that most clients successfully achieve service goals. Since each client's challenging behaviour is unique, it has proven difficult to use standardized measures to demonstrate behavioural change. Instead, we examine clinical changes in each client's behaviour over the course of treatment, such as frequency of aggression, episodes of agitation, and frequency of participation in productive activities.



Preliminary data for 19 day program participants on standardized measures show a significant increase in community integration, a significant decrease in family burden, and a decrease in challenging behaviours. Family members were very satisfied with the program. These findings were presented at the Toronto ABI Conference in November 2012.

Clients of the outreach service have been very successful in remaining in their homes or places of residence, such as long-term care homes, since their challenging behaviours have decreased. Very few outreach clients have required in-patient treatment for behavioural disorders. In some instances, clients have been able to return to paid or volunteer work. Although we have not formally measured family burden, many family members have commented on the reduced burden of care that is a direct result of outreach services.

We examined official records of health care utilization for day program participants. Participants were not heavy users of the health care system before enrolling in the program, and there were no noticeable changes found during the six months after enrolment. Case management services have successfully connected participants to community services, including medical care and social services when needed. When participants have completed the day program, the case manager links them to other day programs that are not time limited.

APPLICABILITY/TRANSFERABILITY:

In Canada, there are few public sector outreach services that are directed towards community-resident ABI clients. We are aware of other behavioural outreach service providers in the Greater Toronto Area, but these services are usually time limited and not connected to a facility-based rehabilitation program. Most outreach behavioural services are only available for persons with a developmental disability.

Many ABI day programs exist in Canada. The day program at the West Park Healthcare Centre is unique in accepting participants with challenging behaviours and providing behavioural interventions. For example, the day program has successfully reduced challenging behaviours in participants who display verbal and physical aggression who had been excluded from other day programs. The program has also implemented continence and toileting independence training in participants who had been rejected by other programs. As part of an ABI behavioural rehabilitation facility, day program participants have access to community case management, respite care, and consultation with a psychiatrist.

Neither the ABI behavioural outreach service nor the ABI day program have been replicated elsewhere.

Content developed from the following sources and relevant websites:

<http://www.westpark.org/Services/ABIAdultDayProgram.aspx>

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Information last updated on: December 2012

External Source: <http://www.westpark.org/Services/ABICommunityOutreachService.aspx>



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Cudworth Health Council in Saskatchewan

LOCATION:	Saskatchewan	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need to promote active engagement of individuals and communities in planning, reviewing, and implementing strategies that both maintain and improve the health and well-being of citizens. The Saskatoon Health Region (SHR) developed a community engagement process to enable community members living in the Town of Cudworth and surrounding area to influence, design, implement, and evaluate health services in their community.

PRACTICE DESCRIPTION:

Saskatoon Health Region (SHR) developed a community engagement process to enable community members living in the Town of Cudworth and surrounding area to influence, design, implement, and evaluate health services in their community. SHR was having numerous community discussions regarding threats to funding of local laboratory services, so they invited community members to participate in talking about how the community and health region could work together when talking about health services and healthy communities. The Health Region funded the initiative to get the Council going. No honorariums were given for participation. Out of these discussions, the Cudworth Health Council was established.

The Council members were selected by and from the community. The purpose of the Council is to promote active engagement of individuals and communities in planning, reviewing, and implementing strategies that both maintain and improve the health and well-being of SHR citizens. The key objectives are (1) to develop processes that support communities as active partners in their health and health care services; (2) to partner with communities and key stakeholders to share information and promote understanding of perspectives that might not otherwise be understood; (3) to build capacity through informing and empowering individuals and communities to take more responsibility for and control over their health; (4) to build mutual trust and credibility through the process of engagement; and (5) to promote effective, efficient, and sustainable services that appropriately meet the needs of communities. The core components of the design implementation were assessment, building relationships, community engagement, and communication. Some of the guiding principles used to create the design are paraphrased as follows:

1. Communities will be actively and meaningfully engaged in identifying community needs and participating in key strategic initiatives.
2. Except in circumstances beyond the control of the Saskatoon Regional Health Authority, no decisions shall be made to eliminate, significantly change, or add to existing services without the knowledge of, active input from, and discussion of options with the local Community Health Council. It is understood the Saskatoon Regional Health Authority has the ultimate decision-making authority.
3. SHR and the local communities will openly share information that affects the health and well-being of residents.
4. SHR and the local communities will support healthy living by working together to address priority health promotion and disease prevention strategies.
5. The engagement process must be transparent, legitimate, and official. Community input is valued and the region is committed to providing feedback about its decisions.
6. Participants should be involved in the process as early as possible.
7. The potential for communities to influence decisions must be real.
8. Information must be timely such that sufficient time is allowed to understand and deliberate. Information must be clear, transparent, and easy to understand.
9. SHR resources must be available to support engagement processes.
10. SHR and the Council shall strive to achieve mutually acceptable outcomes.

IMPACT:

This practice has not been formally evaluated. However, a qualitative evaluation has been done with the community through a storytelling format. These are some of the key lessons learned: involve the community in decisions that affect them or their



health; do not make decisions about health planning without involving the community; involve the community as early as possible in conversations about health planning; and use a facilitator to support the process.

Factors affecting success included

- The community and the health region were committed to a dialogue process, and all parties “stayed at the table” to talk through difficult issues.
- The “right” people were present—they had decision-making authority and could commit to a plan of action without having to seek approval elsewhere.
- The senior leadership of the Health Region were kept informed about the process and progress.

APPLICABILITY/TRANSFERABILITY:

Currently, the process and practice have been adapted by two other communities. Each community determines its own Terms of Engagement or Reference. Primary Health has just published a Community Engagement Framework, which provides a detailed explanation of how to engage with communities. There is much provincial interest in adapting the process and practice in other community settings. In fact, community engagement is happening in Wadena, Wynyard, Watrous, Wakaw, and Delisle.

Content developed from the following sources and relevant websites:

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

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External Source: [http://www.townofcudworth.com/Community%20Newsletter%20may%202012%20\(2\).pdf](http://www.townofcudworth.com/Community%20Newsletter%20may%202012%20(2).pdf)



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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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External Source: <http://family-medicine.ca/events-and-clinics/clinics/mobility-clinic/>



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Alberta Healthy Living Program

LOCATION:	Alberta	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to help individuals with or at risk of developing chronic diseases to adopt healthy lifestyles and ultimately improve their quality of life. Adopted by the Alberta Health System in 2011, the program's model calls for an integrated, community-based chronic disease management program

PRACTICE DESCRIPTION

Eighty percent of Albertans over age 45 report having at least one chronic condition, and 35% have two or more. In Alberta, 80% of primary care visits are related to chronic disease care, and two thirds of all hospital admissions via emergency departments are due to an exacerbation of chronic disease. Disease management strategies, such as eating healthy, being physically active, avoiding smoking, and coping emotionally, are similar across most chronic conditions. Given the prevalence of co-morbidities and the commonality in approaches, Alberta Health Services (AHS) has developed an integrated, community-based model for chronic disease that replaces fragmented, single-disease management with integrated care of the whole person. This model has three service pillars: (1) patient education classes (disease-specific and general health topics), (2) self-management support (workshops, tools, and integrated messaging), and (3) supervised exercise (disease-spanning and home- or centre-based). It uses common standards of care and evaluation, as well as a partnership approach among Alberta Health Services, primary care, and the community.

The model for an integrated, community-based chronic disease management program was adopted by AHS in 2011. The program was named the Alberta Healthy Living Program in 2012. Programs have existed across the province since early 2000; they emerged in the former health regions and later joined together under AHS. Most programs were initiated with disease-specific funding, which then evolved into an integrated approach. Currently, programs are funded by chronic disease-management operational funding for each of Alberta's five zones.

The goal of the Alberta Healthy Living Program is to help individuals with or at risk of developing chronic diseases to adopt healthy lifestyles and ultimately improve their quality of life. Specifically, the goals are to improve health-promoting behaviours; improve disease control and patient health outcomes; reduce acute care utilization; and improve access for rural, remote, and diverse populations (specifically, ethno-cultural, Mennonite and Hutterite, Aboriginal, Francophone, and homeless populations). Implementation of the model is currently underway, and mapping of 2011 services shows that they were offered in 108 communities across the province. In the two large urban centres, Calgary and Edmonton, services were offered in 35 and 36 locations respectively.

IMPACT:

A province-wide evaluation of the model to assess outcomes at the patient, system, provider, and community levels is being developed and will support decision-makers in planning for continued implementation and expansion in Alberta. An extensive evaluation framework and logic model have been developed. The AHS is currently working with their Zone stakeholders and the evaluation team to finalize a measurement plan that will be implemented in 2013.

To date, outcome data are available for a comparable regional program (Calgary), which is now part of the broader provincial Alberta Healthy Living Program. Evaluation was done in 2006 on a cohort of 2550 patients and includes the program's impact on quality of life, health indicators (HbA1c in diabetes), and acute care utilization (emergency department visits and in-patient (IP) admissions using available administrative data). The evaluation has shown an average reduction in emergency department visits of 14.3% in the full cohort, and 64% among participants with two or more visits in the previous year. Likewise, there was a 75% reduction in in-patient admissions among participants with two or more admissions in the previous year. Among participants with diabetes, HbA1c was reduced by 0.3, and by 1.26 in those at higher risk (HbA1C>9%) one year post program ($p<.001$). Quality of life was significantly improved at one year on generic scales (RAND 36, $p<.001$) and disease-specific scales (St. George's COPD, $p<.01$).

With numerous successes, challenges, and lessons learned, implementation of this model across Alberta has reduced variations



in care while maintaining the required flexibility to meet local needs and the unique needs of diverse and vulnerable populations. The model's disease-spanning approach has improved integration of chronic disease care and achieved health system efficiencies. It has also increased access to chronic disease care, especially for rural, remote, and vulnerable populations, and improved quality of life for Albertans living with chronic disease.

APPLICABILITY/TRANSFERABILITY:

The Alberta Healthy Living Program is based on the Expanded Chronic Care Model but is a uniquely Alberta approach. The model is sufficiently flexible that it is applicable to other care settings and transferable to other jurisdictions.

Content adapted from the following sources and relevant websites:

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

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Community & Rural, Primary Care & Chronic Disease Management. (2012). *Integrated, community-based chronic disease management program: Appendices*. Unpublished document.

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External Source: <http://www.albertahealthservices.ca/>



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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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Interprofessional Model of Practice for Aging and Complex Treatment (IMPACT Plus)

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses patients with chronic, multiple co-morbidities, as they are the fastest-growing sector of Ontario’s population, accounting for more than 40% of the province’s health care costs. Currently these patients are most often treated with serial visits to disconnected providers who use single-disease management models, which are inadequate to address complex conditions. The Sunnybrook Family Practice Unit developed the concept of the IMPACT Clinic in 2009, which is designed to integrate care by physically bringing together patients, caregivers, and providers in real time and space to assess the medical, functional, and psychosocial needs of the patient and jointly develop a patient-centred care plan.

PRACTICE DESCRIPTION:

Patients with chronic, multiple co-morbidities are the fastest-growing sector of Ontario’s population, accounting for more than 40% of the province’s health care costs. Currently these patients are most often treated with serial visits to disconnected providers who use single-disease management models, which are inadequate to address complex conditions. The Sunnybrook Family Practice Unit developed the concept of the IMPACT Clinic. In 2009, the Taddle Creek Family Health Team, in collaboration with the Sunnybrook Family Practice Unit, developed the IMPACT Plus model of care, which is designed to integrate care by physically bringing together patients, caregivers, and providers in real time and space to assess the medical, functional, and psychosocial needs of the patient and jointly develop a patient-centred care plan. In June 2012, the program became operational at South East Toronto Family Health Team and St. Michael’s Hospital Family Health Team. The primary goal of this model of care is to develop and implement a fully integrated patient- and family-centred care plan for patients at risk of emergency department visits and hospitalization.

The IMPACT Plus model of care targets patients with three or more chronic conditions (or two conditions where at least one is frequently unstable), who are on at least five medications, who have a minimum of one activity of daily living limitation, and who are not homebound or institutionalized. Patients are assessed in real time by an interprofessional team that is comprised of a family physician, community nurse, pharmacist, occupational therapist, dietician, social worker, psychiatrist, general internist, and Community Care Access Centre (CCAC) coordinator. Each team member functions as a clinician, as educator to other team members and trainees, and as co-creator of this interprofessional practice model. Patients who meet eligibility criteria are identified through the clinic’s electronic medical record (EMR) system and are scheduled for a two-hour clinic visit with the entire interprofessional team, as well as family and other caregivers. Patients are assessed by the interprofessional team and as a result of these assessments a comprehensive patient-centred care plan is developed. During the clinic visit, patients also participate in a discussion of a proactive anticipatory care pathway that provides recommended alternatives to hospitalization and emergency department visits. The care plan summarizes the visit and lists the recommendations made to the patient and actions for follow-up. An information package also includes a comprehensive, up-to-date medication list with clear instructions, information about other relevant educational information and resources, and referrals and follow-up appointments. A copy of the care plan is given to the patient/caregiver to take home. A follow-up care plan is also developed for the family physician who assumes ongoing care of the patient.

IMPACT

A pragmatic randomized control trial (RCT) design of the IMPACT Plus model is currently underway. Patients who meet the inclusion criteria are randomly assigned to the IMPACT Plus clinic or to usual care over a six-month period. The primary outcome measures are the rate of emergency department visits and admission to hospital in a one-year period after initial assessment. Secondary outcome measures include patient, caregiver, and health care professional satisfaction (prior to and after initial assessment and within six months after initial assessment); implementation experience; interprofessional team functionality; and changes in the utilization of other resources. A qualitative and economic evaluation of the model will also be conducted.

To date, qualitative interviews have been conducted to evaluate the IMPACT Plus model. The Sunnybrook Family Practice Unit



interviewed 120 patients and found high patient satisfaction and enhanced confidence on the part of caregivers. Primary care providers felt less burdened in caring for the target population. Team members scored high on a 56-item measure of teamwork as compared to scores of 55 family health teams. Taddle Creek Family Health Team interviewed 20 patients and found high patient satisfaction with overall reduction in medication use, diagnostic imaging, and primary care and specialist visits. Some initial barriers in identifying patients and in the reluctance of primary health care providers to present a patient who has been difficult to manage were encountered. However, quality improvements have led to all primary health care providers endorsing the clinic and excellent attendance by all team members and trainees from each discipline. Interviews with primary health care providers confirm they experience support and renewed confidence in managing complex patients.

APPLICABILITY/TRANSFERABILITY

A video has been developed to train other family health teams how to implement the model of care. Ontario family health teams have the interprofessional resources to offer this clinic to other family health teams or solo practitioners in their regions in the same way that the family health team Diabetes Education Programs have served the larger community.

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Relevant websites:

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

External Source: <http://www.building-bridges.ca/projects/impact-plus/>



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Hamilton Family Health Team—Mental Health Program

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

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

PRACTICE DESCRIPTION:

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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



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



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Cancer Care Ontario's Provincial Patient and Family Advisory Council

LOCATION:	Ontario	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses one of the strategic priorities of the Ontario Cancer Plan III (2011–2015) is to “continue to assess and improve the patient experience.” In 2010, CCO introduced, Engaging Survivors to Improve Patient Experiences throughout the Cancer Journey—a patient engagement project (PEP) supported by the Canadian Foundation for Healthcare Improvement. Through this project, a provincial Patient and Family Advisory Council (PFAC) was established to provide a forum in which patients, family members, and caregivers could provide feedback and direction to CCO and its staff on various programs related to improving the patient experience.

PRACTICE DESCRIPTION:

Cancer Care Ontario (CCO) is the provincial agency responsible for continually improving cancer services, and is the government’s cancer advisor. It supports and works closely with Regional Cancer Programs across the 14 Local Health Integration Networks (LHIN) in Ontario. One of the strategic priorities of the Ontario Cancer Plan III (2011–2015) is to “continue to assess and improve the patient experience.” CCO established a Patient Experience Program within the Clinical Programs and Quality Initiatives portfolio to support this goal. There are several work streams in this program, addressing patient experience measurement, patient-reported outcomes, patient navigation, and a patient and family advisory council. In 2010, CCO introduced, *Engaging Survivors to Improve Patient Experiences throughout the Cancer Journey*—a patient engagement project (PEP) supported by the Canadian Foundation for Healthcare Improvement. Through this project, a provincial Patient and Family Advisory Council (PFAC) was established to provide a forum in which patients, family members, and caregivers could provide feedback and direction to CCO and its staff on various programs related to improving the patient experience.

Recently the PFAC updated its Terms of Reference and confirmed its overall purpose: to engage and partner with patients and families from across the province, to gather their advice on advancing a patient-centred approach to the delivery of health care, and to improve the patient experience across the cancer journey. Initially, 16 individuals, cancer survivors or family members, were recruited to become part of the PFAC from nine of the Regional Cancer Programs across the province. Members represented patients with diverse cancer types, and families/caregivers of individuals who had a cancer experience. Membership of the PFAC was expanded in 2012 to include representatives from all 14 LHINs. Members participate in an orientation session, attend bimonthly meetings (minimum six meetings per calendar year), and review and comment on documents circulated electronically between regular meetings and at ad hoc meetings. Since the initial orientation and skills-building workshop in May 2011, the PFAC has met five times and identified several key priority areas.

IMPACT:

Qualitative methods were used to evaluate how the orientation process for PFAC members is prepared, designed, and implemented. Participants found the preparation package adequately improved their understanding of the background information they needed and clarified role expectations of the training session.^[1] Quantitative measures indicated the consistency of members across the province and changes resulting from improvement initiatives. Ongoing evaluations are focusing on determining if the skills learned in the orientation and skills-building component are effective. The PFAC as a tool for engagement has affected patient experience, improved patient quality and provider engagement, and reduced cost by identifying a way to engage and partner for system co-design.

APPLICABILITY/TRANSFERABILITY:

CCO has developed and refined a training toolkit based on the feedback from PFAC members and staff that can be adopted by organizations interested in engaging patients in advisory councils to improve patient experience in the care trajectory. The PFAC model serves as an example for cancer agencies across Canada by having patients and the public helping to drive the design and delivery of seamless, high-quality cancer care. Organizations such as Cancer Care Nova Scotia have developed similar models of patient and family engagement.



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Information last updated on: November 8, 2012

Relevant websites:

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

<http://www.cfhi-fcass.ca/WhatWeDo/Collaborations/PatientEngagement.aspx>

http://m.youtube.com/#/watch?index=1&list=UUm-tze53Qzz2nZzLLVK0mVA&feature=plcp&v=HUZZTpl-rhs&desktop_uri=%2Fwatch%3Fv%3DHUZZTpl-rhs%26list%3DUUm-tze53Qzz2nZzLLVK0mVA%26index%3D1%26feature%3Dplcp

[1] Urowitz, S., Green, E., Friedman, A.F., O'Grady, L., Greenberg, N., Alejandro, J., ... Wiljer, D. (in press). Engaging survivors to improve patient experiences throughout the cancer journey. *Journal of Cancer Education*.

External Source: http://ocp.cancercare.on.ca/strategic_priorities/patient_experience/



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Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)

LOCATION:	Quebec	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses many of the challenges of delivering comprehensive health care services to an aging population. In 2006, a model of integrated care called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) was launched throughout Quebec.

PRACTICE DESCRIPTION

In 2006, about 14% of Quebec's population was over age 65, and more than three-quarters (77%) of seniors had at least one select chronic condition. A model of integrated care called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) was developed to address many of the challenges of delivering comprehensive health care services to an aging population. Seniors who are eligible for services are over age 65, have moderate to severe disabilities, show potential for staying at home, and need two or more services.

The PRISMA model is based on six key elements:

- Coordination of organizations and services: Coordination first occurs at the governance level to bring together health care and social services, then at the management level to coordinate services, and finally at the operational level to bring together an interdisciplinary team.
- A single point of entry: This provides a portal for people to access all the services they need through a single source, rather than expecting them to seek out services from multiple sectors and providers to meet their needs.
- Case management: Case managers provide an initial assessment and are involved with planning and coordination of services with the patient and family. They also act as patient advocates.
- An individualized service plan: This plan is based on the assessment and is developed by the case manager in discussion with the multidisciplinary team, as well as with the client and caregiver.
- A standardized assessment: To evaluate clients' needs and determine the right package of services, a standardized assessment tool (the Functional Autonomy Measurement System, known by its French acronym as SMAF) is used to measure functional independence, communication, and mental functions. This tool is being used in several regions of Quebec to inform financing of long-term care facilities and home care services.
- Electronic records: A computerized clinical chart provides an electronic record that enables communication between the health care team as well as between organizations.

The PRISMA group conducted a four-year study to evaluate the impact of the model on the ability of seniors to remain in their homes. The study found fewer people in the PRISMA program experienced functional decline compared to seniors not in the program, and there were fewer admissions to emergency departments. Satisfaction and empowerment levels were higher among the PRISMA participants compared to seniors not participating in the program.

Since 2005, Quebec's Ministry of Health and Social Services generalized the PRISMA model across the province by merging all public hospitals, long-term care facilities, and home care agencies under single organizations within a region, organized into 95 health and social service centres across the province. The next step in implementation involves functional integration within the merged structures. The PRISMA model has been expanded to other regions in Quebec, and a pilot project has been initiated in France. The PRISMA group is working closely with policy-makers towards a more integrated system in Quebec.

External Source: <http://www.prismaquebec.ca/cgi-cs/cs.waframe.index?lang=2>



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The Stanford Chronic Disease Self-Management Program

LOCATION:	International	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Leading

SNAPSHOT: This innovative practice is designed to address generic issues typically faced by people with chronic disease, but adaptations have also been developed for a range of specific populations. Launched in British Columbia in 2010, the program forms part of the provincial “Patients as Partners” strategy, which coordinates the planning and evaluation of self-management initiatives.

PRACTICE DESCRIPTION:

Living well with chronic disease, regardless of the specific condition or conditions, is the focus of the widely used and studied Chronic Disease Self- Management Program (CDSMP). The program was originally designed to address generic issues typically faced by people with chronic disease, but adaptations have also been developed for a range of specific populations.

Pairs of trained leaders—lay people and/or health care professionals—lead small groups of participants who meet weekly for six 2.5-hour sessions. People with any chronic condition can participate, as can their families, friends, and caregivers. The workshop leaders follow a set plan from a program manual; they do not provide medical advice. Instead, the workshops emphasize practical “how-to” techniques covering exercise and healthy eating; pain and stress reduction; using goals and action plans; problem solving; communicating with family, friends and health care providers; using medication; and dealing with emotions like anger and depression that commonly accompany chronic disease. Peer support among participants is a key component. Developed and licensed by Stanford University in California beginning in the mid-1980s, the CDSMP has proven to be popular and flexible. Today, 24 countries worldwide deliver versions of the program, as do most Canadian provinces and territories

In British Columbia, the CDSMP forms part of the provincial “Patients as Partners” strategy, which coordinates the planning and evaluation of self-management initiatives. Programs are delivered free of charge in community settings such as seniors’ centres, and are also available locally in the Chinese and Punjabi languages. BC is also delivering condition-specific versions for people with chronic pain, diabetes, or arthritis/fibromyalgia. In 2010–2011, 86% of BC residents living in communities with a population of 3,000 or more had access to one of six different self-management programs within 50 kilometres of their residence.

An online version of the generic CDSMP is also delivered in BC and is being considered for implementation in at least one other Canadian jurisdiction. This innovative approach enables people to participate if they cannot, or choose not to, attend in person. Participants can log on whenever they want, since the interaction happens through a bulletin board rather than through real-time chats. Evaluations show that the online version is a viable alternative to the small-group program, with positive outcomes similar to those in other CDSMP studies.

IMPACT

Evaluations from its long, international history of implementation show that both the generic and disease-specific CDSMP can be effective, though with sometimes modest and variable results. A 2011 review of 24 evaluations of the program (including five BC studies) found small to moderate

improvements in participants’ self-efficacy (more confidence about self-managing), psychological health (less stress and depression), and health behaviours (better cognitive symptom management and communication with physicians). Many of these improvements were sustained for up to one year. Like other group self-management programs, the CDSMP has had challenges in recruiting and retaining participants. A great deal of work has gone into adapting the program to reach more people. There is also debate about whether the program leaders should be health professionals or lay people. (Some programs are co-led by a lay person and professional working together; others are led by either one or the other.) Whereas professionals may be better equipped to deliver technical education about chronic disease and be more likely to attract referrals from primary health care



providers, lay leaders can be role models for participants, cost less than professionals, and may be better able to address the non-medical concerns of living with chronic conditions. But recruiting, training, supporting, and retaining lay leaders has proven to be challenging.

These operational concerns highlight the need for continued adaptation and study of this program in all its variations.⁴⁴ In addition, it's important to consider that a single model for self-management support is unlikely to reach all underserved groups; therefore, a range of programs will probably be needed within a single jurisdiction.

APPLICABILITY/TRANSFERABILITY

BC and other jurisdictions have aimed to improve participation by involving targeted communities in the design, implementation, and evaluation of the programs. For example, First Nations adaptations have incorporated community customs into the program, added culturally meaningful content such as the medicine wheel, and worked with the community to determine how and where to train program leaders and recruit participants. The University of Victoria worked with BC First Nations and Aboriginal communities between 1992 and 2009 on a series of six projects, testing modifications to the CDSMP based on local feedback. Using a similar approach, the CDSMP has been tailored for the Punjabi-speaking populations and is now being delivered throughout BC in that language.

Examples of the Stanford Chronic Disease Self- Management Program (CDSMP) across Canada:

British Columbia

- Chronic Disease Self -Management Program Generic
- Online Chronic Disease Self -Management Program Online
- Generic Arthritis/Fibromyalgia Self-Management Program
- Disease-specific Chronic Pain Self-Management Program
- Disease-specific Diabetes Self-Management Program Disease

Alberta

- Better Choices, Better Health Generic and disease-specific, including chronic pain and diabetes

Saskatchewan

- Live Well with Chronic Conditions Program Generic

Manitoba

- Get Better Together Generic
- Arthritis Self-Management Program Disease-specific

Ontario

- Living a Healthy Life with Chronic Conditions Generic
- Telehealth Chronic Disease Self-Management Program
- Arthritis Self-Management Program Disease-specific Diabetes
- Self-Management Program Disease-specific
- Chronic Pain Self-Management Program Disease-specific

Nova Scotia

- Your Way to Wellness Generic
- Chronic Pain Self-Management Program Disease-specific
- You're In Charge Youth, generic

New Brunswick

- My Choice-My Health Generic



Newfoundland and Labrador

- Improving Health My Way Generic
- Arthritis Self-Management Program Disease-specific

Prince Edward Island

- Living a Healthy Life Generic

Yukon

- Chronic Disease Self-Management Program Generic (no longer offered)

Northwest Territories

- Live Well with Chronic Conditions Program Generic (no longer offered)

Nunavut

- (Information not available)

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The 5As

LOCATION:	National	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the need for self management support for a range of chronic health issues from diabetes to depression. Assess, Advise, Agree, Assist, Arrange: these five steps make up a communication and action cycle known as “the 5As” that health care providers can use to help patients make challenging changes in their lives.

PRACTICE DESCRIPTION

Assess, Advise, Agree, Assist, Arrange: these five steps make up a communication and action cycle known as “the 5As” that health care providers can use to help patients make challenging changes in their lives. Originally developed as a smoking cessation strategy, this effective approach has been adapted, and widely adopted, in self-management support for a range of chronic health conditions from diabetes to depression. The 5As are endorsed by the Registered Nurses’ Association of Ontario (RNAO) as a clinical best practice for self-management support.

How it works

Nurse practitioner Cheryl Smith leads a primary health care clinic in a small community on the Bay of Fundy in Nova Scotia. In practice for 30 years, she learned the 5As just a few years ago. “I use it every day,” she told us in an interview. “It becomes second nature. It’s a good algorithm, a guideline to help you structure your visit.”

She described how she used the technique to help a young man who had phoned her unexpectedly at the clinic. He was in a serious mental health crisis—suicidal, in fact. The problem wasn’t new to him, but he was disillusioned with responses he had received in his previous attempts to get help. “You always start with assessing,” she said. “What kind of need did he have? What were his goals? And, if this is the first visit (as it was with this young man), you also start by establishing rapport.” This means ensuring the patient has a chance to express his or her feelings and fears, and that the provider gets a sense of the patient’s readiness to take action.

Moving into advising, Smith talked with him about what they each could do to help him reach his goals of getting through this crisis and avoiding a repeat in the future. Communication techniques such as “ask-tell-ask” and “closing the loop”—in which both the patient and provider repeat key points in their own words—ensure that patients feel heard and have actually received important advice or information.

The third step is to agree on a set of specific, short-term actions. “He wanted counselling, so we agreed that I would refer him into the mental health system and he would keep a diary until our next visit.” A diary helps patients monitor themselves and creates a tool for ongoing communication. In this case, the assist step was straightforward, since the young man was very motivated to get help. “Not everyone is committed to change when you first see them,” Smith said. For the “assist” step, the RNAO best practices guide recommends motivational interviewing, a counselling method designed to help people resolve their ambivalence about making changes in their lives. The last task is to arrange follow-up. “I was able to get him a mental health appointment in three days, and we arranged to meet again in four days’ time,” Smith explained. Regular, sustained, and integrated follow-up is essential to long-term success in self-management. “As a primary care provider, it’s key that we know what’s available in the community so that we can connect people with those resources,” she said.

Smith spent over an hour with the young man that first day. “Because nurse practitioners are not paid on a fee-for-service basis, we have more time to work with patients on self-management strategies than a busier primary care office might have. Sometimes doctors refer people to us for this kind of support,” she explained.

External Source: <http://www.ahrq.gov/clinic/tobacco/5steps.htm>



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Co-creating Health

LOCATION:	International	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses chronic disease management by drawing on an integrated approach. Co-creating Health began in 2007 with local primary health care and specialist services in eight communities.

PRACTICE DESCRIPTION

In the UK, a patient self-management course called the Expert Patients Programme (a version of the Stanford Chronic Disease Self-Management Program) had been widely delivered for some years. But the program was achieving only modest results. With chronic conditions consuming an estimated two-thirds of all health care spending in the UK, the Health Foundation—an independent non-profit organization dedicated to improving health care in Britain—began to examine how best to improve the lives of people living with chronic conditions while promoting the efficient use of National Health Service resources.

The reviewers concluded that “self-management courses alone are of limited effectiveness if they are isolated from mainstream health services. Self-management support requires a whole-system approach.” The foundation’s answer was Co-creating Health—an ambitious, large-scale demonstration program with more than £7.5 million invested to date. The initiative aims to embed self-management support within mainstream health services across the UK by transforming the patient-provider relationship.

Drawing on the integrated approach depicted in the Expanded Chronic Care Model, Co-creating Health began in 2007 with local primary health care and specialist services in eight communities. Each site focuses on one of four conditions—diabetes, depression, COPD, or musculoskeletal pain—and participates in all three streams of the program:

- Creating engaged, informed patients. Patients take a seven-week course that develops knowledge and skills for self-management, as other courses do, but this one puts added emphasis on helping patients work effectively with health care providers. Courses are co-led by a patient and a health care professional, which gives participants a model of a patient-provider partnership.
- Training clinicians in self-management support. Health care teams take a multi-faceted program of training, including workshops, web-based learning, coaching and support, and “action learning,” in which they practise and get feedback from patients on the clinicians’ self-management support skills. Here, too, patients are co-trainers along with local clinicians. The course focuses on three “enablers” that are common to many models of self-management support—agenda setting (visits start with a collaborative question like, “What do you want us to do today?”), goal setting (patients and clinicians agree on specific actions to address their concerns), and follow-up (someone from the clinic contacts the patient within 14 days to check progress on the patient’s goals).
- Promoting system improvements. Teams of patients and health care providers work together to identify and implement new approaches to service delivery—with the goal of removing any barriers to the effective partnership they are trying to create. One clinic decided to send the results of routine blood tests to diabetes patients ahead of their visits, so that patients come to the consultation informed and ready to discuss their priorities. Although each of the three streams of this strategy is being used in Canada, what is innovative about the UK Co-creating Health initiative is its systematic linkage through primary health care: clinicians refer patients to the community-based, self-management education course, patients are engaged in process redesign with their primary health care providers, and their providers receive advanced training in communication tools and techniques to support the self-management process.

Results from an independent evaluation of the first phase of Co-creating Health suggest that the initiative’s approach holds promise. The evaluation showed improvements to patient quality of life, activation, and some condition-specific outcomes. In addition, health care professionals improved their use of three specific self-management support tools: setting an agenda for change, establishing behavioural goals for change, and goal follow-up. However, the evidence for improved use of a wider



range of self-management support skills in clinician practice was weak. There were also benefits to joint facilitation of all training courses by clinicians and people with chronic conditions.

The evaluation also presents recommendations to support a more broad implementation and integration of self-management support programs. The evaluation, however, was constrained by the inability to evaluate the impact of the initiative's integrated approach. Phase 2 of the initiative has been designed to spread the Co-creating Health model to a wider population and to help the demonstration sites sustain their improvements through ongoing commitment from local authorities and providers. The phase 2 interventions reflect some of the lessons from the phase 1 evaluation, such as: creating a revised and updated clinician development program and producing a change package to support service redesign around self-management support.

For more information on Co-creating Health, see The Health Foundation website and their Self-Management Support Resource Centre for health care providers and policy-makers, www.health.org.uk.



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Patients as Partners

LOCATION:	British Columbia	HEALTH THEME:	Chronic Disease Management
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the need to help patients constructively share both positive and negative experiences as a voice for improvement to ensure patient experiences can inform system, program, and practice improvements. Patients as Partners is both a policy and philosophy of the British Columbia Ministry of Health. It offers an opportunity for patient engagement in redesign through the partners who deliver Integrated Primary and Community Care.

PRACTICE DESCRIPTION:

The Health Council of Canada’s symposium included presentations of a number of approaches to patient and public engagement that could be highlighted as promising practices. One that illustrates three aspects of patient engagement—policy influence, cultural change, and a methodology to improve practice—was the presentation on Patients as Partners.

Patients as Partners is both a policy and philosophy of the British Columbia Ministry of Health. The unofficial motto of Patients as Partners is “nothing about me without me.” It offers an opportunity for patient engagement in redesign through the partners who deliver Integrated Primary and Community Care: health authorities, non-governmental organizations (NGOs), and physician collaboration committees (partnerships with the BC Ministry of Health and the BC Medical Association). This includes the General Practice Services Committee, Shared Care Committee, and the Specialist Services Committee.

In 2002, the General Practice Service Committee (GPSC) was formed to enable the BC Government and primary care physicians to work together on strategies “focusing on what is best for patients, not best for physicians or best for government...”. Among other things, the GPSC “...is responsible for new initiatives, including clinical incentive payments, maternity care bonuses, training modules to enhance clinical and administrative skills, and the creation of Divisions of Family Practice to coordinate and support family doctors at the regional level.” This shift created an environment where physicians were supported to spend more time with their chronically ill and complex care patients. Over time, this has led to a change of culture where patients are more often seen as partners in the management of their care. In fact, according to Kelly McQuillen, Director of Patients as Partners, BC Ministry of Health, “Physicians now ask ‘how many patients are on this consultation call today or involved in our redesign approaches?’”

Patients as Partners collaborates with health authorities, NGOs, physician collaborative committees, and other key stakeholders to identify opportunities for patient and public engagement in program and service design, and system and community health care transformation. Patients are engaged through the Patient Voices Network, a mechanism to recruit, train, and support patients, families, and caregivers to participate in health care changes at the individual (patient to provider), program and service design, and community and system levels.

The network helps patients to constructively share both positive and negative experiences as a voice for improvement through support, training, and coaching. Patient voices for improvement are leveraged to ensure patient experiences can inform system, program, and practice improvements. More than 80% of patients report that they find participating in their engagement opportunity is a meaningful and valuable experience.

Patient experience measures are central to the overall Integrated Primary and Community Care evaluation, accountability, research, and quality improvement framework. Patients as Partners will know that patient and public voices in the change process have ‘stuck’ when they see an improvement in population health, an improved patient and provider experience of care, and lower per capita costs overall. And, patients will be engaged in the design of the provincial evaluation framework. Could patient engagement be the catalyst to move primary health care to the next level?

External Source: <http://www.impactbc.ca/patients-as-partners>