



Health Innovation Portal: Archive of Innovative Practices

Theme: Health Human Resources (Vol. 1)

January 2014



Health Council of Canada
Conseil canadien de la santé



Selected Search Output Table (January 23, 2014)

SEARCH TERMS:	N/A	LOCATION:	All
HEALTH THEME:	Health Human Resources	FRAMEWORK CATEGORY:	All
HEALTH SECTOR:	All	SEARCH RESULTS:	33 results out of 92

1. QuickCare Clinics

Implementation Year: Thursday, January 9, 2014 - 13:00	Location: Manitoba	Practice Website: http://www.gov.mb.ca/health/primarycare/quickcare.html
--	---------------------------	---

SNAPSHOT:

This innovative practice is designed to meet low-complexity, primary health care needs, thereby addressing unnecessary visits to the emergency room, duplicated diagnostics, testing, and imaging, and shortages around availability of family physicians. The first QuickCare Clinic opened in Winnipeg, Manitoba in 2012, followed by three more QuickCare Clinics in the same year. Collectively the four QuickCare clinics had over 45,000 patient visits by the fall of 2013.

CONTACT INFORMATION:

Name: Marta Crawford **Title:** Consultant **Organization:** Primary Care Network Implementation, Manitoba Health **Email address:** marta.crawford@gov.mb.ca **Telephone number:** 204-786-7342

2. Winnipeg Regional Health Authority Palliative Care Program (WRHA-PCP)

Implementation Year: Thursday, January 6, 2011 - 14:45	Location: Manitoba	Practice Website: http://www.wrha.mb.ca/prog/palliative/
--	---------------------------	--

SNAPSHOT:

This innovative practice aims to improve the quality of life for patients receiving palliative care through the development of interprofessional health care teams delivering services across the continuum of care. The WRHA-PCP was initiated in the Winnipeg region in 2011, receives ongoing support and funding from the Regional Health Authority, and continues to expand its health human resource capacities.

CONTACT INFORMATION:

Name: Lori Embleton **Title:** Program Director **Organization:** St. Boniface General Hospital, Winnipeg Regional Health Authority- Palliative Care **Email address:** lembleton@wrha.mb.ca **Telephone number:** 204-237-2371

3. The Taber Clinic

Implementation Year: Wednesday, January 6, 1999 - 14:45	Location: Alberta	Practice Website: http://www.chinookprimarycarenetwork.ab.ca/clinics/clinic.php?view=19
---	--------------------------	--

SNAPSHOT:

This innovative practice addresses the issue of accessibility and quality of care to primary care services in the context of an aging demographic. The practice has existed in Taber, Alberta since 1947, and in 2000, implemented the 'Taber Project', a demonstration project including new payment and service delivery system. The Clinic has operated within the Chinook Primary Care Network since 2005, and currently serves over 16,000 patients in the community. Functioning with a team-based model of care, this practice involves 12 physicians, 4 licensed practical nurses, 2 nurse practitioners as well as 6 registered nurses, a registered psychiatric nurse, behaviorist, Respiratory Therapist, dietitians, Diabetes Educator (RN), medical office assistants and health coaches.

CONTACT INFORMATION:



Name: Rob Wedel **Title:** Family Physician **Organization:** Taber, Alberta Chinook Primary Care Network **Email address:** robwedel@me.com
Information last updated on: January 3, 2013

4. Physician-Pharmacist Collaborative Care Management

Implementation Year: Saturday, January 6, 2007 - 14:45	Location: Quebec	Practice Website: http://www.opq.org/fr-CA/grand-public/nouvelles-activites-des-pharmaciens/
---	-------------------------	--

SNAPSHOT:

This innovative practice aims to address issues around access to primary health care services and improving the quality of drug-related chronic care management. Collaboration between pharmacists and physicians is becoming increasingly common across Canada. The practice highlighted here describes a high-impact study that has contributed to the broader provincial shift to expand scopes of practice of pharmacists in Quebec. This study was part of a larger study launched in Montreal from 2007 to 2010. It involved eight physician-pharmacists collaborative care management locations, twenty-seven physicians, twenty-eight pharmacists, and 108 patients. This study, among others, is linked to the most recent bill passed in Quebec in May, 2013 which allows pharmacists to extend prescriptions for one year, adjust medications, order and interpret laboratory tests that monitor drug use.

CONTACT INFORMATION:

Name: Lyne Lalonde **Title:** Professor **Organization:** Centre Hospitalier de l'Université de Montréal, Hôtel-Dieu **Email address:** lyne.lalonde@umontreal.ca **Telephone number:** 514-890-8000 ext 15491

5. Interprofessional Communications Skills Development Workshops

Implementation Year: Thursday, January 6, 2005 - 14:45	Location: Nova Scotia	Practice Website: http://www.cancercare.ns.ca/en/home/healthprofessionals/education/excellence/default.aspx
---	------------------------------	--

SNAPSHOT:

This innovative practice aims to improve community cancer care for patients and families by enhancing the communication skills of health care professionals across disciplines. The pilot series of interprofessional communications skills development workshops were initially implemented in 2005 and formally commenced in 2006 through Cancer Care Nova Scotia and Dalhousie University's Continuing Medical Education. Since the pilot year, these workshops have been informally integrated into the Health Professional Education workshops.

CONTACT INFORMATION:

Name: Meg McCallum **Title:** Provincial Manager, Education and Patient Navigation **Organization:** Cancer Care Nova Scotia **Email address:** meg.mccallum@ccns.nshealth.ca **Telephone number:** 902-473-3781

6. Hospital Home Team (Virtual Ward)

Implementation Year: Thursday, January 6, 2011 - 14:45	Location: Manitoba	Practice Website:
---	---------------------------	--------------------------

SNAPSHOT:

This innovative practice aims to reduce frequencies of emergency department visits, hospital admissions, re-admissions and duration of stay through the provision of accessible, comprehensive health care services. Established in 2011 out of Access River East, a Health and Social Services Centre in North East (NE) Winnipeg, this team managed an original caseload of ten select patients with complex health care needs and has since continued to expand patient intake.

CONTACT INFORMATION:

Name: Debra Vanance **Title:** Community Area Director, River East & Transcona **Organization:** Winnipeg Regional Health Authority and Government of Manitoba Family Services **Email address:** dvanance@wrha.mb.ca **Telephone number:** 204 938 5011

7. Communities of Practice

Implementation Year: Friday, January 6, 2006 - 14:45	Location: Alberta	Practice Website:
--	--------------------------	--------------------------



SNAPSHOT:

This innovative practice facilitates the implementation of interprofessional learning and care environments for students and providers. Through the support of Alberta Health Services, 'Communities of Practice' were initially piloted at seven practice sites across the province in 2006-2007. This model has continued to develop and now, there are over fifty Communities of Practice integrated within Alberta Health Services.

CONTACT INFORMATION:

Name: Esther Suter **Title:** Director, Workforce Research and Evaluation **Organization:** Alberta Health Services **Email address:** esther.suter@albertahealthservices.a **Telephone number:** 403-943-0183

8. Collaborative Practice & Learning Environments

Implementation Year: Wednesday, January 6, 2010 - 14:45	Location: Alberta	Practice Website:
---	--------------------------	--------------------------

SNAPSHOT:

This innovative practice aims to develop, implement and evaluate innovative interprofessional (IP) approaches to health care delivery across selected health care practice sites in Alberta, British Columbia, Manitoba and Saskatchewan. The multi-jurisdictional initiative began in 2010 and has been carried out by The Northern and Western Health Human Resource Forum in partnership with the Western Canadian Interprofessional Health Collaborative (WCIHC). The selected sites will constitute Collaborative Practice & Learning Environments (CP&LEs), providing a model for exemplary collaborative practice and hosting IP clinical student placements.

CONTACT INFORMATION:

Name: Esther Suter **Title:** Director, Workforce Research and Evaluation **Organization:** Alberta Health Services **Email address:** esther.suter@albertahealthservices.a **Telephone number:** 403-943-0183

9. Adopting Research to Improve Care Project (ARTIC)

Implementation Year: Wednesday, January 6, 2010 - 14:30	Location: Ontario	Practice Website: http://caho-hospitals.com/partnerships/adopting-research-to-improve-care-artic/
---	--------------------------	--

SNAPSHOT:

This innovative practice aims to integrate evidence-based research into the systematic improvement of health care service quality. The 'Adopting Research to Improve Care' Project (ARTIC) was launched through the network of the Council of Academic Hospitals of Ontario (CAHO) in 2010 and has initiated six evidence implementation projects to date.

CONTACT INFORMATION:

Name: Chris Paterson **Title:** Director, Stakeholder Relations **Organization:** Council of Academic Hospitals in Ontario **Email address:** cpaterson@caho-hospitals.com **Telephone number:** 416-402-4461

10. Longitudinal Elderly Person Shadowing Project

Implementation Year: Sunday, December 9, 2007 - 16:00	Location: Saskatchewan	Practice Website:
--	-------------------------------	--------------------------

SNAPSHOT:

This innovative practice aims to improve the quality of care provided to elderly patients through participatory educational programming. The Longitudinal Elderly Person Shadowing Project was first offered to health care professional students at the University of Saskatchewan in 2007. As of November 2013, a total of 410 students have completed this program and partnered with 127 seniors.

CONTACT INFORMATION:

Name: Jenny Basran **Title:** Regional Health Authority Geriatrics Program Director **Organization:** University of Saskatchewan, College of Medicine, Division of Geriatric Medicine **Email address:** jenny.basran@saskatoonhealthregion.ca **Telephone number:** 306 655 8925 **Information last updated on:** November 5, 2013



11. Learning Together with Cases

Implementation Year: Thursday, December 9, 2010 - 16:00	Location: Ontario	Practice Website: https://meds.queensu.ca/central/community/learningwithcases
---	--------------------------	---

SNAPSHOT:

This innovative practice facilitates the accessibility of interprofessional education for students and educators of health disciplines at pre-licensure levels. 'Learning Together with Cases' was initiated out of the Office of Interprofessional Education and Practice in the Faculty of Medicine at Queen's University in Kingston, Ontario. Beginning in 2010 as an eighteen-month pilot project, this program has informed the ongoing integration of interprofessional educational learning modules at the University. In the developmental stages of the program, participants included 100 first year medical students enrolled in an introductory musculoskeletal course, paired with 84 second year nursing students and 23 advanced practice nursing students studying geriatrics. Twenty-six second year occupational therapy master's students were involved as virtual consultants for student colleagues.

CONTACT INFORMATION:

Name: Lindsay Davidson **Title:** Associate Professor **Organization:** Queen's University, Department of Surgery, Division of Orthopaedics **Email address:** davidsonol@KGH.KARI.NET **Telephone number:** 613-544-9626 **Information last updated on:** November 6, 2013

12. Interfaculty Course Development for Interprofessional Collaboration

Implementation Year: Sunday, December 9, 2007 - 16:00	Location: Quebec	Practice Website: http://www.cihc.ca/regional/overview/atlanticlist/ficcp
--	-------------------------	---

SNAPSHOT:

This innovative practice improves the quality of health care services by providing an interprofessional program for health sciences students at pre-licensure levels. The program was introduced in Laval University in Quebec in 2007, and it continues to involve faculty and students from 10 health science disciplines.

CONTACT INFORMATION:

Name: Serge Dumont **Title:** Full Professor **Organization:** University of Laval, School of Social Work **Email address:** serge.dumont@svs.ulaval.ca **Telephone number:** 418-525-4444 ext. 20976 **Information last updated on:** October 17, 2013

13. Regional Departments of General Medicine (Départements régional de médecine générale; DRMGs)

Implementation Year: Monday, December 9, 1991 - 15:45	Location: Quebec	Practice Website:
---	-------------------------	--------------------------

SNAPSHOT:

This innovative practice coordinates the supply and planning of primary care services at the regional level. The practice was launched in each of Quebec's 18 health regions and involves all family physicians practicing in the region.

CONTACT INFORMATION:

Johanne Caseault **Conseillère en affaires intergouvernementales** **Direction des affaires intergouvernementales et de la coopération internationale** **Ministère de la Santé et des Services sociaux** 1005, chemin Ste-Foy, 1er étage Québec (Québec) G1S 4N4 **Téléphone:** (418) 266-5838 **Télécopieur:** (418) 266-8755 **Courriel:** johanne.caseault@msss.gouv.qc.ca

14. Primary Care Networks

Implementation Year: Friday, December 9, 2005 - 15:45	Location: Alberta	Practice Website:
--	--------------------------	--------------------------

SNAPSHOT:

This innovative practice involves the establishment of a new model of primary care that increases access to and the effectiveness of primary care. The practice was launched throughout Alberta and currently includes 41 primary care networks (PCNs) and involves more than 2,700 family physicians and about 900 other health professionals.



CONTACT INFORMATION:

Tricia Smith Director – Primary Care Networks Primary Health Care Branch Alberta Health Telephone: (780) 643-1435 Email: tricia.smith@gov.ab.ca

15. Physician Assistants in Manitoba

Implementation Year: Thursday, December 9, 1999 - 15:30	Location: Manitoba	Practice Website:
---	---------------------------	--------------------------

SNAPSHOT:

This innovative practice aims to “ensure more timely access to team-based care for Manitoba families” (Government of Manitoba, 2012) through the use of physician assistants. The integration of physician assistants (PAs) into practice was launched in a variety of acute and primary care settings and involves government funding of PA clinical positions in these settings.

CONTACT INFORMATION:

Dr. Sheldon Permack, MD FCFP Medical Director Family Medicine/Primary Care Winnipeg Regional Health Authority Telephone: 204-940-8734

16. Integration of Pharmacists in Family Health Teams

Implementation Year: Saturday, December 9, 2006 - 15:15	Location: Ontario	Practice Website:
---	--------------------------	--------------------------

SNAPSHOT:

This innovative practice improves the appropriateness and outcomes of medication management by including pharmacists in primary health care practices. The practice was launched in Ontario in family health teams (as well as community health centres and nurse practitioner–led clinics) and involves pharmacists and primary care clinicians.

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

18. Full Service Family Practice Incentive Program

Implementation Year: Tuesday, December 9, 2003 - 15:00	Location: British Columbia	Practice Website: http://www.primaryhealthcarebc.ca/gpsc_incentives.html
--	-----------------------------------	---

SNAPSHOT:



This innovative practice improves patient care by supporting and compensating the delivery of guideline-based care by general practitioners (GPs). The practice was launched province-wide in British Columbia and is available to all GPs.

CONTACT INFORMATION:

Kelly McQuillen Executive Director Primary Health Care and Specialist Services, Health Services and Quality Assurance Divisions Ministry of Health
3-2, 1515 Blanshard Street Victoria BC V8W 3C8 Phone: 250 952-1204 Email: Kelly.McQuillen@gov.bc.ca

19. Family Medicine Groups

Implementation Year: Tuesday, December 9, 2003 - 15:00	Location: Quebec	Practice Website: http://sante.gouv.qc.ca/systeme-sante-en-bref/groupe-de-medecine-de-famille-gmf/
--	-------------------------	--

SNAPSHOT:

This innovative practice provides access to a family doctor for all Quebec residents; increases accessibility of services, especially for vulnerable patients; improves quality of care; promotes continuity of care and coordination between primary care and other health care sectors; and enhances the role of family physicians. The practice was launched throughout Quebec and involves family physicians and other primary care clinicians, particularly nurses.

CONTACT INFORMATION:

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

20. Family Health Teams

Implementation Year: Friday, December 9, 2005 - 14:45	Location: Ontario	Practice Website: http://www.health.gov.on.ca/en/pro/programs/fht/
--	--------------------------	--

SNAPSHOT:

This innovative practice, which was launched in Ontario, improves access to and the quality of primary care. The 185 family health teams involve a broad range of primary health care providers and administrative support personnel.

CONTACT INFORMATION:

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

21. Community Health Centres in Ontario

Implementation Year: Sunday, December 9, 1979 - 14:45	Location: Ontario	Practice Website:
--	--------------------------	--------------------------

SNAPSHOT:

This innovative practice improves access to primary health care, particularly for populations that have traditionally faced access barriers. Ontario has 73 Community Health Centres (CHCs), which involve community governing boards and a broad array of primary health care providers.

CONTACT INFORMATION:

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

22. Sault Ste. Marie Group Health Centre

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



SNAPSHOT:

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

CONTACT INFORMATION:

Name: Garry Walsh **Title:** Vice President of Communications **Organization:** Group Health Centre **Email address:** walsh_gary@ghc.on.ca **Telephone number:** 705-759-5562 **Information last updated on:** November 13, 2013

23. Engaging Medical Assistants—A Patient- Centred Medical Home Chronic Care Model at the DFD Russell Medical Center

Implementation Year: Thursday, December 9, 1999 - 14:15	Location: International	Practice Website: http://www.dfdrussell.org/
---	--------------------------------	--

SNAPSHOT:

This innovative practice improves quality of care in the context of increased prevalence of chronic illnesses. There are currently three federally qualified community health centres operating under the interprofessional DFD Russell Medical Center in Maine, USA. This chronic care model capitalizes on health human resources by employing medical assistants as part of the health care team and participates in broader state-wide and national initiatives to promote the integration of patient-centred medical homes.

CONTACT INFORMATION:

Name: Catherine Dower **Title:** Associate Director **Organization:** Center for the Health Professions **Email address:** cdower@thecenter.ucsf.edu **Telephone number:** 1 (415) 476-1894 **Information last updated on:** September 20, 2013

24. The Caring Together Project

Implementation Year: Monday, December 9, 2013 - 14:00	Location: Ontario	Practice Website:
---	--------------------------	--------------------------

SNAPSHOT:

This innovative practice facilitates interprofessional practice for palliative care givers. The Caring Together Project was initiated in 2007 as an online learning resource and piloted in two not-for-profit long term care homes in Ontario involving a total of 55 staff members. Since the project continued from its pilot phase, the e-learning resource has been integrated into interprofessional course work for health science students at the University of Ottawa (2013).

CONTACT INFORMATION:

Name: Emma Stodel **Title:** Consultant **Organization:** Learning 4 Excellence **Email address:** estodel@learning4excellence.com **Telephone number:** 613-822-7060 **Information last updated on:** November 14, 2013

25. Bridging Relationships Across Interprofessional Domains (BRAID)

Implementation Year: Saturday, December 9, 2006 - 14:00	Location: New Brunswick	Practice Website: http://www.unb.ca/saintjohn/vp/tuckerpark/
---	--------------------------------	--

SNAPSHOT:

CONTACT INFORMATION:

Name: Roberta Clark **Title:** Assistant Dean for Health Research & Partnerships **Organization:** University of New Brunswick, Saint John **Email address:** Roberta.Clark@unb.ca **Telephone number:** (506) 648-5821 **Information last updated on:** Sep 13, 2013

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



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

SNAPSHOT:

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

CONTACT INFORMATION:

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

27. Express Chemotherapy Clinic

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

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

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

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 Lundon 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

29. Including patients and families on hospital Unit Action Councils to promote patient-centered Integrated Interprofessional Care

Implementation Year: Saturday, November 26, 2011 - 14:30	Location: Ontario	Practice Website:
---	--------------------------	--------------------------

SNAPSHOT:

This innovative practice portrays an interprofessional, patient-centred, collaborative practice model of care delivery through engaging patients and their families as members of Unit Action Councils (UACs). This project was launched in 2011 in Ontario across an alliance of four rural community hospitals.

CONTACT INFORMATION:



Name: Dianne Gaffney **Title:** Corporate Lead, Professional Practice Organization: Huron Perth Healthcare Alliance **Email address:** dianne.gaffney@hpha.ca **Telephone number:** 519-272-8210 ext. 2316 **Information last updated on:** July 31, 2013

30. Registered Nurse–Surgical First Assist

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

SNAPSHOT:

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

CONTACT INFORMATION:

Name: Colleen Lipskie **Title:** Team Lead/ Senior Policy Analyst **Organization:** Ministry of Health and Long-Term Care **Email address:** colleen.lipskie@ontario.ca **Telephone number:** 416-212-3846 **Information last updated on:** August 21, 2013

31. Primary Care Clinical Associate Initiative

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

32. Nurse and Dietitian Health Teams to Prevent Diabetic Complications

Implementation Year: Friday, November 26, 2004 - 14:00	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001687
---	--------------------------	--

SNAPSHOT:

This innovative practice improves the quality of diabetes management through the use of interprofessional health care teams delivering interventions to persons aged 17 years or older with diabetes and hypertension or albuminuria. The initial pilot round was launched in five communities in northern Alberta in 2004. The program has since been expanded to a total of eight communities (two urban and six rural), serving over 3,000 patients.

CONTACT INFORMATION:

Name: Carolyn Good **Title:** Office Coordinator **Organization:** Diabetic Nephropathy Prevention Clinics, Alberta Health Services **Email address:** carolyn.good@albertahealthservices.ca **Telephone number:** 780-407-1443 **Information last updated on:** July 26, 2013

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

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

SNAPSHOT:

This innovative practice addresses the need for improvement in FNIHB's programs and services in the Atlantic region, to better meet the needs of Elders and



improve their health and wellbeing. The Strategic Plan for Atlantic First Nations Elder Care was launched in January 2011. FNIHB Atlantic works collaboratively with the Mi'kmaq Maliseet Atlantic Board to implement the plan.

CONTACT INFORMATION:

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



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

QuickCare Clinics

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

SNAPSHOT: This innovative practice is designed to meet low-complexity, primary health care needs, thereby addressing unnecessary visits to the emergency room, duplicated diagnostics, testing, and imaging, and shortages around availability of family physicians. The first QuickCare Clinic opened in Winnipeg, Manitoba in 2012, followed by three more QuickCare Clinics in the same year. Collectively the four QuickCare clinics had over 45,000 patient visits by the fall of 2013.

PRACTICE DESCRIPTION:

QuickCare Clinics operate as 'nurse-led care models'. This means that registered nurses and nurse practitioners share the responsibility of seeing patients and make referrals outside of the clinic when necessary. Basic services offered at these centres are based on episodic primary care needs, and include treating infections, rashes, sprains, etc.; prescribing birth control; and administering immunizations. Patient intake is organized on the principles of the 'Advanced Access Model' and combines walk-in services with scheduled appointments to enable more immediate patient visits. In contrast to traditional payment systems where physicians bill per service provided, nurses are paid through block funding so that the flow of financial resources matches the input of the health human resources on-site.

By treating more basic health care needs within the scope of practice of the attending nurse, this model is designed to improve efficiency of health care services, theoretically diverging inappropriate demands away from urgent care centres and emergency departments. The clinics address issues of accessibility of primary care by providing extended hours and are open during weekends, evenings and holidays.

QuickCare Clinics are funded through the Regional Health Authorities, and are part of a broader provincial plan to ensure that every Manitoban who wants a family physician will have access to one by 2015. These clinics are therefore not considered a replacement to family practice clinics, but are integrated within the primary care network strategy to decrease the overall work burden on physicians, enabling them to accept more patients into their practice.

IMPACT:

This innovative practice has been implemented since February 2012 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

APPLICABILITY/TRANSFERABILITY:

The success of QuickCare Clinics has been facilitated by the broader provincial agenda to increase accessibility of family physicians, collaboration across regional health authorities, the staffing model, the convenient locations for the clinics, and having established an electronic medical record from the onset.

In terms of health human resource planning, challenges around nurse practitioner recruitment have been experienced province wide. For the case of the QuickCare Clinics, full nurse practitioner staffing was not achieved until the fall of 2013.

This particular nurse-led model is unique to Manitoba. The four Quick Care Clinics that are currently operational are: Steinbach, Selkirk, McGregor Avenue in Winnipeg, and St. Mary's Road in Winnipeg, which opened most recently in November 2012. Four more Quick Care Clinics are scheduled to open in the next few years.

CONTACT INFORMATION:

Name: Marta Crawford



Title: Consultant

Organization: Primary Care Network Implementation, Manitoba Health

Email address: marta.crawford@gov.mb.ca

Telephone number: 204-786-7342

Information last updated on: December 11, 2013

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

Personal Communications:

Marta Crawford; November 22, 2013 [telephone]

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



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Winnipeg Regional Health Authority Palliative Care Program (WRHA-PCP)

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

SNAPSHOT: This innovative practice aims to improve the quality of life for patients receiving palliative care through the development of interprofessional health care teams delivering services across the continuum of care. The WRHA-PCP was initiated in the Winnipeg region in 2011, receives ongoing support and funding from the Regional Health Authority, and continues to expand its health human resource capacities.

PRACTICE DESCRIPTION:

In 1999, administrative structures were regionalized across the province of Manitoba. During that process, new visions for the health care system emerged which included the creation of a palliative care model in order to better respond to patient needs, particularly with an aging demographic. In 2011, the WRHA received funding to put this model into action. An interprofessional palliative care team was developed, comprising of registered nurses, clinical nurse specialists, general practitioners, and social workers, with established referral systems to community programs such as mental health service provision. The entire program is organized through a centralized system to manage the coordination of care services across home, long-term or acute care settings. For example, with this centralized system, patients' needs can be prioritized to determine relative eligibility for unit beds (rather than leave determination of accessibility to site-specific availability). Moreover the centralized management enables coordinated communication so that patient information can be shared more easily across settings and providers. Providers are paid through block funding so that the supply and distribution of health human resources can be determined based on the community needs.

What makes this practice particularly innovative is its integration of the interprofessional health care team. Usual models of palliative care would be predominantly provided by nurses. In this model, the variety of health care team members enables the provision of more comprehensive care—this includes physicians visiting patients in their homes. Overall, this model aims to deliver the right care in the right place, mitigate unnecessary emergency room visits, and enable patients to stay in their homes, particularly during end-of-life care.

IMPACT:

This innovative practice has been implemented since 2011 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

APPLICABILITY/TRANSFERABILITY:

The organization behind the WRHA-PCP was developed internally, specific to the region's health care needs. The unified vision of the way in which this model was conceptualized and has been implemented to better meet patient has supported the successes of the program thus far. The greatest operational barrier over the last two years has been noted around the challenge of upgrading the technological infrastructure. With ongoing support for this program from the region, there are currently plans in place to expand health human resource capacities and the ability to provide more comprehensive services through the inclusion of psychosocial resources, clinical pharmacists, and health care aides into the palliative care team.

CONTACT INFORMATION:

Name: Lori Embleton

Title: Program Director

Organization: St. Boniface General Hospital, Winnipeg Regional Health Authority- Palliative Care



Email address: lembleton@wrha.mb.ca

Telephone number: 204-237-2371

Information last updated on: December 12, 2013

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

Personal Communications:

Lori Embleton; December 12, 2013 [telephone]

Alternative Profiles:

Community Model of Palliative Care: <http://www.manitoba.ca/health/mpan/pdf/palliative.pdf>

External Source: <http://www.wrha.mb.ca/prog/palliative/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

The Taber Clinic

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

SNAPSHOT:

This innovative practice addresses the issue of accessibility and quality of care to primary care services in the context of an aging demographic. The practice has existed in Taber, Alberta since 1947, and in 2000, implemented the ‘Taber Project’, a demonstration project including new payment and service delivery system. The Clinic has operated within the Chinook Primary Care Network since 2005, and currently serves over 16,000 patients in the community. Functioning with a team-based model of care, this practice involves 12 physicians, 4 licensed practical nurses, 2 nurse practitioners as well as 6 registered nurses, a registered psychiatric nurse, behaviorist, Respiratory Therapist, dietitians, Diabetes Educator (RN), medical office assistants and health coaches.

PRACTICE DESCRIPTION:

Of a population of 20,000 persons between the communities of Taber and Vauxhaull, Alberta, the Taber Clinic is able to link over 16,000 patients to a health care provider through improved patient intake processes and the efficient use of health human resources. This clinic is designed to meet the majority of patients’ primary care needs by bringing the expertise of dietitians, physicians, diabetes educators, asthma teams, RPNs, LPNs, RNs and nurse practitioners under one roof to create a centralized patient Medical Home. The medical office assistant plays a crucial role in this health care team, working directly with a physician and taking standard patient metrics. While every patient is attached to his or her own family physician and team, a patient can chose to see any one of the team during any given appointment, dependent upon the need presented at the time of visit.

Data is collected at each point of care. This data is then used to inform care pathways and determine appropriate provider allocation. There is a particular focus on preventative measures such that algorithms have been created for approximately 60 different types of screening and are automated to alert health personnel depending on patient profiles. On an aggregate level, this data collection also helps to inform the clinic’s progress relative to health care guidelines and population benchmarks. The integration of the electronic medical record system provides the infrastructure to enable both the data collection and communication among health care providers.

In the spring of 2000, the clinic moved away from fee-for-service payment structure and turned to ‘blended’ funding, based on Capitation funding for the designated population, plus fee-for-service for those patients attending from outside that population and procedure based services. Effective since September 2000, this ‘Alternative Relationship Plan’, now managed by Alberta Health has provided funding for patient care within the clinic. Effective with the inception of the Primary Care Network (PCN) in 2005, the clinic receives PCN funding to support the development and employment of the practice team. The Chinook PCN provides facilitation and evaluation support to assist with Quality Improvement within the clinics.

The “Taber Project” was initially launched on a three-year term and received funding from the Canadian Health Services Research Foundation, the Alberta Heritage Foundation for Medical Research, Chinook Health Region, and Alberta Health and Wellness. After 2003, the clinic was able to continue serving the communities through its standard Alberta Health funding sources. The clinic receives no additional sources of funding beyond that available to all Family Physicians in Alberta.

IMPACT:

There has been no system-based evaluation publically shared on this initiative. Various grey sources have referenced the positive impact of these primary care services on relative health services such as emergency department visits and acute care services. One paper noted that emergency asthma visits have been reduced from 340 in 2001 to 24 in 2011. Anecdotal evidence states that allied health professionals have been well accepted and integrated into the system by patients and other health professionals.

The Taber Clinic has been profiled nationally in 2011 in the Premier’s Report and highlighted by the Health Care Innovation Working Group as one of Canada’s leading innovative health care models in 2012.



APPLICABILITY/TRANSFERABILITY:

The clinic is currently in the process of changing facilities in order to capacitate a broader range of services included public health, homecare, mental health, addictions, family and community services.

In 1999 the Regional Health Authority hired project coordinator to share the work and knowledge gained during the development of this model of care and how it can be applied to different parts of the region however this position was discontinued in 2004.

The electronic medical record system is noted as an essential element to the functionality of a practice on this scale; however, the continuity of services, upgrading, and user knowledge around the electronic system remains as a constant challenge.

CONTACT INFORMATION:

Name: Rob Wedel

Title: Family Physician

Organization: Taber, Alberta Chinook Primary Care Network

Email address: robwedel@me.com

Information last updated on: January 3, 2013

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

Tholl, B., Grimes, K. (2012). Strengthening Primary Health Care in Alberta through Family Care Clinics: From concept to reality. Part One: Issue Brief <http://www.health.alberta.ca/documents/PHC-FCC-Concept-to-Reality-2012.pdf>

Alternative Profiles:

Wedel, R., Kischuk, R., Patterson, E. (2007) Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada. *Healthcare Policy*, 3(1): 80-95.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645121/pdf/policy-03-080.pdf>

Healthcare transformation in action- Alberta's Taber Clinic. A Commentary. Technologies for Doctors online. (2013). <http://www.canhealth.com/tfdnews0885.html>

Taber clinic recognized nationally. *The Taber Times.* (2012).

<http://internetgroup.ca/docs/cpcn/file/Taber%20Clinic/Taber%20Times%20-%20August%2022%202012.pdf>

Spotlight on Collaboration. (2006). <http://www.eicp.ca/en/spotlight/taber.asp>

Personal Communications:

Rob Wedel; January 3, 2013 [email]

External Source: <http://www.chinookprimarycarenetwork.ab.ca/clinics/clinic.php?view=19>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Physician-Pharmacist Collaborative Care Management

LOCATION:	Quebec	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to address issues around access to primary health care services and improving the quality of drug-related chronic care management. Collaboration between pharmacists and physicians is becoming increasingly common across Canada. The practice highlighted here describes a high-impact study that has contributed to the broader provincial shift to expand scopes of practice of pharmacists in Quebec. This study was part of a larger study launched in Montreal from 2007 to 2010. It involved eight physician-pharmacists collaborative care management locations, twenty-seven physicians, twenty-eight pharmacists, and 108 patients. This study, among others, is linked to the most recent bill passed in Quebec in May, 2013 which allows pharmacists to extend prescriptions for one year, adjust medications, order and interpret laboratory tests that monitor drug use.

PRACTICE DESCRIPTION:

Variations of the pharmacist-physician collaborative model have been explored for several years but still lack systematic integration across jurisdictions. The province of Quebec is advanced in their legislation around the expanded scope of pharmacists relative to the other provinces and territories. This study highlights a portion of the evidence behind innovative practices around pharmacist involvement and is associated with subsequent studies that are continuing to push this agenda forward.

The physician-pharmacist collaborative care management study was implemented as a clustered design and targeted patients with pre-existing lipid disorders in a Montreal hospital from 2007-2010. Responsibilities were clearly demarcated so that physicians were responsible for diagnosing and prescribing lifestyle changes and statin treatment and pharmacists were responsible for monitoring changes, tolerance, efficacy; adherence to pharmacotherapy, requesting lab analyses, and adjusting statin dosage. After each visit, communication protocols were established so that the pharmacist faxed the physician a report form summarizing the intervention. Pharmacists in the intervention group received a one-day protocol training workshop. The physician-pharmacist collaborative care model was then compared to a 'usual care' model in which physicians adjusted pharmacotherapy and the pharmacists provided basic counseling and dispensed medications. (Funding for this research was grant-based from the Canadian Institutes of Health Research, as well as AstraZeneca Canada Inc., Merck Frost Canada Inc., and Pfizer Canada Inc.).

Since this study, (and other similarly oriented studies conducted within Quebec), Bill 41 legislation was introduced in May 2013 to amend previous pharmacy laws and expand pharmacists' scope of practice. The six new front-line services proposed for pharmacists include:

- Renewing a doctor's prescription but not beyond one year
- Modifying or adjust a prescription's form, dosage and quantity
- Prescribing a medication when no diagnosis is required
- Substituting medications when there's a supply disruption
- Ordering and analyze laboratory tests to monitor medication use
- Administering injections as a demonstration for educational purposes

IMPACT:

The study described above was nested in a larger study entitled, Trial to Evaluate an Ambulatory primary care Management program (TEAM). The results from this nested study describe the impact of pharmacists adjusting statin treatments from the perspective of patients, pharmacists, and physicians. Patients and physicians reported appreciating the intervention as compared to usual models of care, whereas pharmacists experienced more difficulties around professional and organizational barriers.



Given how recently Bill 41 has been introduced into the system, there is no completed evaluation at this time but is suggested to be impacting on the proliferation of greater pharmacist involvement in the primary care setting.

APPLICABILITY/TRANSFERABILITY:

According to the Canadian Pharmacists Association's most recent summary of pharmacists' expanded scope of practice activities across Canada, Alberta, New Brunswick, and Nova Scotia at similar levels of legislation, regulation, and policies for pharmacists, compared to Quebec (<http://www.pharmacists.ca/cpha-ca/assets/File/ExpandedScopeChart.pdf>.)

In terms of other studies that evaluate models where pharmacists are responsible for adjusting medications to reach a therapeutic target, the literature is extensive. The articles listed below provide just a few examples of related interventions indicating promising outcomes around the management of oral anticoagulation, hypertension, and diabetes.

Stanschi, V., Chiolero, A., Paradis, G., Colosimo, A., Burnand, B. (2012). Pharmacist Interventions to Improve Cardiovascular Disease Risk Factors in Diabetes. *Diabetes Care*, 35(12): 2706-2717.

<http://care.diabetesjournals.org/content/35/12/2706.full.pdf+html>

Santaschi, V., Wuerzner, G., Chiolero, A., Burnand, B., Paradis, G., Burnier, M. (2012). [Team-based care involving pharmacists and nurses to improve the management of hypertension]. *Rev. Med Suisse*, 8(353): 1694-1996.

<http://www.ncbi.nlm.nih.gov/pubmed/23029981>

Stanschi, V., Chiolero, A., Burnand, B., Colosimo, A.L., Paradis, G. (2011). Impact of pharmacist care in the management of cardiovascular disease risk factors: a systematic review of meta-analysis of randomized trials. *Arch Intern Med*, 171(16): 1441-1453. <http://archinte.jamanetwork.com/article.aspx?articleid=1105914>

CONTACT INFORMATION:

Name: Lyne Lalonde

Title: Professor

Organization: Centre Hospitalier de l'Université de Montréal, Hôtel-Dieu

Email address: lyne.lalonde@umontreal.ca

Telephone number: 514-890-8000 ext 15491

Information last updated on: December 12, 2013

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

Publications

Lalonde, L., Hudon, E., Goudreau, J., Belanger, D., Villeneuve, J., Perreault, S., Blais, L., Lamarre, D. (2011) Physician-pharmacist collaborative care in dyslipidemia management: the perception of clinicians and patients. *Res Social Adm Pharm*, 7(3): 233-45.

<http://www.ncbi.nlm.nih.gov/pubmed/21272548>

Cote, L., Normandeau, M., Maheux, B., Authier, L., Lefore, L. (2013) Collaboration between family physicians and community pharmacists: Opinions of graduates in family medicine. *Canadian Family Physician*, 59: e413-e420.

<http://www.ncbi.nlm.nih.gov/pubmed/24029528>

Alternative Profiles:

Fidelman, C. (2013). Quebec to expand pharmacist's role to ease pressure on doctors, ERs. *Global News*. <http://globalnews.ca/news/409064/quebec-to-expand-pharmacists-role-to-ease-pressure-on-doctors-ers/>



Personal Communications:

Lyne Lalonde; September 26, 2013 [email]

External Source: <http://www.opq.org/fr-CA/grand-public/nouvelles-activites-des-pharmaciens/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Interprofessional Communications Skills Development Workshops

LOCATION:	Nova Scotia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to improve community cancer care for patients and families by enhancing the communication skills of health care professionals across disciplines. The pilot series of interprofessional communications skills development workshops were initially implemented in 2005 and formally commenced in 2006 through Cancer Care Nova Scotia and Dalhousie University’s Continuing Medical Education. Since the pilot year, these workshops have been informally integrated into the Health Professional Education workshops.

PRACTICE DESCRIPTION:

In 2004, a needs assessment was conducted with health care professionals working with oncology patients in community care settings across Nova Scotia. From this assessment, interprofessional communication emerged as one of the priority areas requiring improvement in order to strengthen both quality of services and effective use of health human resources. The initial development of the interprofessional communication skills development workshops involved an integrated evaluation to assess the process and impact of four 2-hour workshops. These workshops focused on the following areas:

- 1) Essential Communication Skills
- 2) Delivering Difficult News and Providing Support
- 3) When Patients and Families Are Angry
- 4) Managing Conflict in the Workplace

Targeted for trained health professionals, these workshops were structured to present the background evidence behind the interventions, enable opportunities to observe practice skills through role play scenarios by professional actors, and provide a platform to debrief different approaches. All of the workshops were facilitated by communication experts.

This innovative practice received funding from Health Canada’s Transition Fund and continues to collaborate with acting services provided by Irondale Ensemble Theatre, Halifax. Other stakeholders include The Alliance for Continuing Medical Education, the Society for Academic Continuing Medical Education, the Council on Continuing Medical Education, and the Association for Hospital Medical Education.

IMPACT:

Evaluations were conducted pre- and post- the initial implementation of the workshops, as well as three months after for follow-up. At the time of this assessment, 518 professionals representing over 20 health professions attended a total of 17 workshops. Of these health professionals, nurses comprised over 50% of participants, followed by care coordinators and social workers. Comparisons from before and after the workshops indicated that self-reported communication skills showed statistically significant improvement and 92% of respondents indicated intention to change their communication practices after the workshops. Of the 68 respondents that participated in the follow-up, 59 (87%) reported positive changes of reception among respective patients, including patients asking more questions. In terms of interprofessional impact, 98% (299/306) reported that interacting with other health professionals enhanced their learning and increased understanding around respective roles.

APPLICABILITY/TRANSFERABILITY:

As an approach for integrating some level of sustainability, the workshops included a “train the trainer” program for highly skilled facilitators and actors. Twenty-six health professionals completed 3-days of training and offered 6 workshops in teams of 3 to 5. Despite positive responses to extend the program beyond its initial workshops there have been significant challenges to



maintain the sustainability of the volunteer facilitator program. In order for the facilitator teams to continue to be integrated, volunteer facilitators identified that institutional and direct management support would be needed.

Lessons learned from the implementation of these workshops included: a) that interactive workshops can be used as effective tools to improve interprofessional communication skills and behavior; b) that interprofessional communication is a highly sought competency area for health professional participants; and c) that the interaction among different types of health professionals was considered to enhance learning. The main challenge was reported around gaining commitment from volunteers to continue as professional facilitators of the program.

Several continuing professional development initiatives focused on interprofessional competency development exist across the country. This particular series of workshops are unique to the province of Nova Scotia based on the level of coordination enabled through Cancer Care Nova Scotia, reaching as many affiliated health care professionals as possible.

CONTACT INFORMATION:

Name: Meg McCallum

Title: Provincial Manager, Education and Patient Navigation

Organization: Cancer Care Nova Scotia

Email address: meg.mccallum@ccns.nshealth.ca

Telephone number: 902-473-3781

Information last updated on: December 18, 2013

Content has been adapted from the following sources and relevant links

Personal Communications:

Brian Taylor, Project Officer, Cancer Care Nova Scotia [email]

Publications:

Sargeant, J., MacLeod, T., Murray, A. (2011) An interprofessional approach to teaching communication skills. *J Contin Educ Health Prof*, 31(4): 265-7. <http://www.ncbi.nlm.nih.gov/pubmed/22189990>

Sargeant, J., Hill, T. (2008) Partners for Interprofessional Cancer Education (PICE): Cultivating Communities of Practice for Collaborative care, Evaluation Report.

External Source: <http://www.cancercares.ns.ca/en/home/healthprofessionals/education/excellence/default.aspx>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Hospital Home Team (Virtual Ward)

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

SNAPSHOT: This innovative practice aims to reduce frequencies of emergency department visits, hospital admissions, re-admissions and duration of stay through the provision of accessible, comprehensive health care services. Established in 2011 out of Access River East, a Health and Social Services Centre in North East (NE) Winnipeg, this team managed an original caseload of ten select patients with complex health care needs and has since continued to expand patient intake.

PRACTICE DESCRIPTION:

A common consequence of poor access to primary care services is the overreliance on emergency departments to provide frontline care. Often times, patient needs would be more appropriately met in other settings; however, the structure of the system is not designed to provide such care, particularly after hours and on weekends. The Hospital Home Team was initiated on a pilot project basis from 2011-2012 to improve access, continuity of care and quality of life by enabling patients to safely and happily stay at home. This pilot was funded by Manitoba Health through the Manitoba Patient Access Network.

This pilot used a predictive risk model to identify individuals most likely to benefit from the program. The identified individuals included in the first cohort were all existing clients of Home and Primary Care at Access River East and due to their health care complexity were frequent visitors to hospital emergency units. The initial interprofessional health care team included a physician, a home care case coordinator (social worker) and a registered nurse. The current expanded team has other community and hospital staff that includes other existing medical, allied health, nursing and support staff. As the model continues to expand, there is intention to include mental health professionals and pharmacists. The team does weekly rounds. Patient documentation occurs via the Electronic Medical Record and the Resident Assessment Instrument (RAI), Home Care, Minimum Data Set (MDS). Patients are contacted by telephone to arrange appropriate timing of home visits. The team is notified when patients attend emergency and emergency staff have access to MDS. An evolving characteristic of this model is the availability of the on call primary care team during evenings and weekends.

IMPACT:

An assessment was conducted pre- and post-implementation of the pilot virtual ward model. The initial ten patients had sought care in the emergency department a total of 27 times over the 12-month period in 2011 which was compared to 64 times in the 12 months previous in 2010. Length of hospital stay for these patients was also compared at 138 in 2011 to 319 in 2010. Qualitative feedback from the families identified that they felt supported in caring for their loved one in the community and appreciated the timely response of the team. For patients living on their own, they reported greater confidence living independently with complex needs. From the palliative care coordinator, they reported patients and families expressing satisfaction with the care received and from the palliative care physician, they considered the team approach to be vital to keeping patients in their home communities. The original pilot used existing staff and potential cost reduction for inpatient bed days alone were approximately \$140,000 based on a bed cost of \$800/day. These savings are not extractable but represent an ability to care for more patients within the same budget allocation.

APPLICABILITY/TRANSFERABILITY:

The concept of the virtual ward is linked to development in the United Kingdom in the early 2000's. A Canadian-led research team has since developed the 'LACE' index (L—length of stay; A—acuity of admission; C—Charlson Comorbidity Index; E—number of emergency room visits in the last six months) to predict otherwise unplanned readmission within 30 days post hospital discharge and provides a transferrable algorithm for calculated appropriate case management for this type of care model.

The successes of the Hospital Home Team in Winnipeg are related to the well-established relationships between the NE Winnipeg staff and leadership across community and acute care and the health and social services programs of the Winnipeg Regional Health Authority and Government of Manitoba, Family Services.



The Hospital Home Team expansion will increase patient capacities to 100 over the next few years and include Access Transcona, a second Health and Social Services site in NE Winnipeg. In addition a second team has been established in West Winnipeg with another planned for South Winnipeg. Additionally, there are three other virtual wards at various stages of development in Canada.

- Toronto Central Community Care Access Centre (and in some hospitals associated with the University of Toronto).

http://www.ncmn.ca/Resources/Documents/LKS_15_-_NCMN-VirtualWard-Oct2012_-_Effie_Galanis.pdf

- South East Toronto Family Health Team (for patients being discharged from Toronto East General Hospital)

http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/Kavita_Mehta.sflb.ashx;

http://www.uwo.ca/fammed/csfm/siiren/documentation/AHRQ_Virtual_Ward_Pre...

- St Mary's Hospital in Quebec (which focuses on patients with mental illness)

CONTACT INFORMATION:

Name: Debra Vanance

Title: Community Area Director, River East & Transcona

Organization: Winnipeg Regional Health Authority and Government of Manitoba Family Services

Email address: dvanance@wrha.mb.ca

Telephone number: 204 938 5011

Information last updated on: January 2014

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

The Use of Virtual Wards to Reduce Hospital Readmissions in Canada. Canadian Agency for Drugs and Technologies in Health. (2011). http://www.cadth.ca/media/pdf/ES-27_virtual_wards_e.pdf

Personal Communications:

Debra Vanance; January 2, 2013 [email]

Other:

Virtual ward, real results: Doctor, nurse, home-care coordinator team up in a year-long project keeping elderly, chronic patients in their homes instead of hospital beds. (2012)

<http://www.winnipegfreepress.com/breakingnews/virtual-ward-real-results-148364425.html>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Communities of Practice

LOCATION:	Alberta	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice facilitates the implementation of interprofessional learning and care environments for students and providers. Through the support of Alberta Health Services, ‘Communities of Practice’ were initially piloted at seven practice sites across the province in 2006-2007. This model has continued to develop and now, there are over fifty Communities of Practice integrated within Alberta Health Services.

PRACTICE DESCRIPTION:

Communities of Practice involve health care providers from various disciplines who work together to develop solutions around ways to better meet patient needs. Practice changes generated focus on the expanded capacities health human resources through interprofessional collaboration. Examples of practice changes introduced include improving communication processes through regular staff meetings across all health care personnel located at different health care centres and streamlining admission and discharge processes through the consolidation of multiple patient intake forms. Communities of Practice also promote interprofessional mentoring programs for students to benefit from learning about the roles and capacities of other health care providers they will be working with in the practice setting. These mentoring experiences are offered in addition to formal preceptorship or clinical supervision.

The pilot phase of this project was funded by Health Canada’s initiative, Interprofessional Education for Collaborative Patient-Centred Practice. The project team had members from two former regional health authorities (Calgary Health Region and Capital Health in Edmonton), two universities (University of Calgary, University of Alberta) and three colleges (Mount Royal College [now Mount Royal University], Bow Valley College, SAIT Polytechnic).

IMPACT:

No formal evaluation has been conducted. Anecdotally, improved relations and a greater sense of cohesion have been reported among participating health care providers where Communities of Practice is active and changes have been introduced. Communities of Practice have been viewed as a way to increase awareness around the importance and efficacies of integrating interprofessionalism into education and practice. Furthermore, it has enabled a space to assess existing structures and processes and to explore new ways of doing things.

Successes were found in improvements to communication processes, internally or externally, allowing providers to exchange patient care information more effectively. Changing admission or discharge information processes eliminated unnecessary or duplicate documentation, increased opportunities to jointly examine patient issues and engage in shared decisions.

For participating students, interprofessional mentoring was reported to improve students’ clinical practicum experiences and the classroom activities enhanced students’ interprofessional competencies. Areas most affected were knowledge of roles (e.g., understand and appreciate the roles and responsibilities of other professions, demonstrate awareness of how the roles of providers relate to each other), communication skills (e.g., use language that is appropriate to the target audience, model interpersonal skills in building consensus and problem solving) and collaboration skills (e.g., engage in shared goal settings and decision making, partner with other organizations to coordinate patient care).

APPLICABILITY/TRANSFERABILITY:

After the completion of the pilot phase in 2007, one of the Communities of Practice facilitators took on a permanent position with the Knowledge Management Team in Alberta Health Services. This facilitator has been integral for the development and implementation of the Communities of Practice training programs and educational resources that have been used across health care settings in the province. The facilitator has provided consultations and mentoring to persons interested in developing Communities of Practice in their own locations. More recently the facilitator has been supported by a team of 6 to 8 co-consultants dedicated to integrating Communities of Practice across Alberta. The program is now in the fifth cohort of facilitator training, with 20 people having completed in each cohort. The spread of 7 to 50 Communities of Practice over the last



seven years is indicative of the scalability of this mode of quality improvement. They have also covered a variety of health care areas such as accreditation, community mental health, patient engagement, quality metrics, emergency medical services, senior's health, demonstrating the programs' broader applicability.

CONTACT INFORMATION:

Name: Esther Suter
Title: Director, Workforce Research and Evaluation
Organization: Alberta Health Services
Email address: esther.suter@albertahealthservices.ca
Telephone number: 403-943-0183

Information last updated on: November 15, 2013

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

Personal Communications:

Esther Suter; November 15, 2013 [email]

Publications:

Suter, E., Taylor, L., Arthur, N., Clinton, M. (2008) Creating an interprofessional learning environment through communities of practice: An alternative to traditional preceptorship - Final report

<http://www.albertahealthservices.ca/Researchers/if-res-hswru-iecpcp-report-2008.pdf>

Suter E, Arndt J, Lait J, Jackson K, Kipp J, Taylor L, Arthur N. How can front line managers demonstrate leadership in enabling interprofessional practice? Healthcare Management FORUM, 2008, 20(4):38-42.

White D, Suter E, Parboosingh J, Taylor E. Communities of practice: creating opportunities to enhance quality of care and safe practices. Quarterly Healthcare Quarterly, 2008, 11(Sp):80-84.

Suter E, Arndt J, Arthur N, Parboosingh J, Taylor L, Deutschlander S. Role understanding and effective communication as core competencies for collaborative practice. Journal of Interprofessional Care 2009, 23(1):41-51.

Suter E, Arndt J, Arthur N, Parboosingh J, Taylor L, Deutschlander S. Role understanding and effective communication as core competencies for collaborative practice. Journal of Interprofessional Care 2009, 23(1):41-51.

Trojan L, Suter E, Arthur N, Taylor E. Evaluation framework for a multi-site interprofessional practice and education intervention. Journal of Interprofessional Care, 2009, 23 (4): 380-389.



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Collaborative Practice & Learning Environments

LOCATION:	Alberta	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	

SNAPSHOT: This innovative practice aims to develop, implement and evaluate innovative interprofessional (IP) approaches to health care delivery across selected health care practice sites in Alberta, British Columbia, Manitoba and Saskatchewan. The multi-jurisdictional initiative began in 2010 and has been carried out by The Northern and Western Health Human Resource Forum in partnership with the Western Canadian Interprofessional Health Collaborative (WCIHC). The selected sites will constitute Collaborative Practice & Learning Environments (CP&LEs), providing a model for exemplary collaborative practice and hosting IP clinical student placements.

PRACTICE DESCRIPTION:

In Alberta, two community mental health outpatient clinics were recruited for this project. Staff at both clinics demonstrated a collaborative, client-centred care philosophy with following objectives: 1. Increase IP competencies of providers; 2. Develop structures and processes to facilitate collaborative practice; 3. Develop staff competencies to act as IP mentors for students; and 4. Increase capacity for IP student placements. At both sites, students from different disciplines started their practicum and were also interested in learning more about collaborative practice. External facilitators guided the staff and student discussions every two weeks for about one hour to focus on areas for change and to assist with the design of the strategies. Most team members also attended three workshops for in-depth discussions on current concerns.

Tools and approaches from Human Systems Dynamics were used to structure the conversations and arrive at meaningful strategies at the practice and systems levels (<http://www.hsdinstitute.org/>). Staff used the *Legacy Sustainability Framework* as developed by Royce Holladay to plan a sustainable interprofessional mentoring strategy by considering relevant factors (e.g., coherence, commitment, connections, constructs, communication, capacity building and continuous assessment). The Canadian Interprofessional Health Collaborative (CIHC) Interprofessional Practice Competency Framework laid the foundation for the competency discussions (www.CIHC.ca).

Funding was provided by Alberta Health through the Health Workforce Action Plan and Health Canada.

IMPACT:

Following the initial research and development stages of the project in 2010, an evaluation was conducted to assess the outcomes, process, and context (staff and manager interviews). The evaluation was designed specifically to monitor changes in knowledge, attitudes, skills, and behaviours among program participants. Two validated tools were used to quantitatively measure these changes, in relation to interprofessional practice and changes in communication and relationships. Overall, staff reported having developed a greater awareness for the need to collaborate, identify issues within each team, and implement collaborative practice changes. Team members concurred that the overall level of collaboration at the clinics had increased. The majority of students stated that they gained greater awareness about how other practitioners work at the clinics and that collaborative practice is an important part of client care. At the time of the evaluation, client processes that had associated improvements included triage, discharge, treatment of clients with concurrent mental health and addictions issues.

APPLICABILITY/TRANSFERABILITY:

This approach to creating Collaborative Practice & Learning Environments is highly transferrable to other practice settings for both students and staff. While the initial project was limited to one year, this model of education and effort to improve IP care has since been formally integrated into the Health Professions Practice & Strategy Portfolio at Alberta Health Services.

One of the greatest benefits to this practice has been the ability to increase capacity for interprofessional mentoring of students (e.g., evaluating interprofessional skills, recognizing interprofessional opportunities). Staff indicated that external facilitators and internal champions endorsing the project were crucial to the successful development and completion of the project. The Interprofessional Mentoring Guide enabled supervisors to systematically develop and evaluate the learning modules across disciplinary backgrounds.



CONTACT INFORMATION:

Name: Esther Suter
Title: Director, Workforce Research and Evaluation
Organization: Alberta Health Services
Email address: esther.suter@albertahealthservices.ca
Telephone number: 403-943-0183

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

Deutschlander, S, Suter, E. 2011. Interprofessional Mentoring Guide. Available at:

<http://www.albertahealthservices.ca/Researchers/if-res-wre-ip-mentoring-guide.pdf>.

Suter, E., Deutschlander, S. 2011. Creating Collaborative Practice & learning Environments (CP&LE Project)- Final Report. Available at: <http://www.albertahealthservices.ca/Researchers/if-res-wre-ccple-report.pdf>.

Personal Communications:

Esther Suter; November 14, 2013 [email]

Publications:

Suter, E., Taylor, L., Arthur, N., Clinton, M. (2008) Creating an interprofessional learning environment through communities of practice: An alternative to traditional preceptorship - Final report

<http://www.albertahealthservices.ca/Researchers/if-res-hswru-iecpcp-report-2008.pdf>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Adopting Research to Improve Care Project (ARTIC)

LOCATION:	Ontario	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to integrate evidence-based research into the systematic improvement of health care service quality. The ‘Adopting Research to Improve Care’ Project (ARTIC) was launched through the network of the Council of Academic Hospitals of Ontario (CAHO) in 2010 and has initiated six evidence implementation projects to date.

PRACTICE DESCRIPTION:

The Council of Academic Hospitals of Ontario is a non-profit association involving 24 academic hospitals across Ontario. Each member hospital is directly affiliated with a university medical or health sciences faculty and focuses on the bridging of research and teaching to provide innovative and specialized patient care. Based on the Council’s Strategic Plan for 2010-2015, the internal governance is structured to facilitate collaboration among experts and prioritize multidisciplinary leadership.

The projects below represent the six projects that have been implemented to date. Each project was selected after undergoing a rigorous research application process. In 2010, the ARTIC Projects were funded by the Council of Academic Hospitals in Ontario with each participating hospital providing in kind support and human resources. After recognizing the impact of these programs on systematic implementation of new evidence, CAHO received another \$6.3 million over three years, aligning with the Excellent Care for All Strategy (<http://www.health.gov.on.ca/en/public/programs/ecfa/>).

2010-2011:

- 1) ‘Handy Audit’—an innovative auditing tool that measures hand hygiene compliance in health care settings.
- 2) ‘Canadian C-Spine Rule’—a clinical decision tool for emergency department nurses; designed to reduce wait times and approve appropriateness of care by identifying patients who do not require immobilization.

2011-2012:

- 3) ‘Move-On’—an interprofessional approach to focus on mobilization of elderly patients staying in hospital.
- 4) ‘Antimicrobial Stewardship Program’—optimization of antimicrobial use in intensive care units.

2012-2013:

- 5) ‘Transitional Discharge Model’—support of successful transition from hospital to the community for people diagnosed with mental illness.
- 6) ‘Implementing an Enhanced Recovery after Surgery’—a guideline to implement a range of interventions for patients undergoing colorectal surgery.

Affiliated hospitals and research institutes include: Baycrest Centre for Geriatric Care, Baycrest Centre for Addiction and Mental Health, Bruyère Continuing Care, Children’s Hospital of Eastern Ontario, Hamilton Health Sciences, Health Science North, Hôpital Montfort, Hotel Dieu Hospital Kingston, Kingston General Hospital, Lawson Health Research Institute, London Health Sciences Centre, Mount Sinai Hospital, North York General Hospital, Ontario Shores Centre for Mental Health Sciences, Providence Care, Royal Ottawa Health Care Group, St. Joseph’s Healthcare Hamilton, St. Joseph’s Health Care London, St Michael’s Hospital, Sudbury Regional Hospital, Sunnybrook Health Sciences Centre, The Hospital for Sick Children, The Ottawa Hospital, Toronto Rehabilitation Institute, Thunder Bay Regional Health Sciences Centre, University Health Network, and Women’s College Hospital.



IMPACT:

As part of CAHO's mandate, each initiative under ARTIC has involved an integrated evaluation. To briefly summarize reports on the successes of the respective initiatives:

- 1) The 'Handy Audit' was completed as of December 2011 and 15 of the 16 participating hospitals have renewed their contracts with the Handy Metrics distribution company.
- 2) The 'Canadian C-Spine Rule' has passed testing for accuracy, reliability, and safety among triage nurses and has been widely adopted by emergency department physicians across member hospitals.
- 3) The impact of 'Move On' has not yet been publically shared but it is working collaboratively with 14 member hospitals and is expected to improve rates of regular mobilization in hospitalized elderly patients (currently estimated at less than 30%).
- 4) The anticipated effect of the 'Antimicrobial Stewardship Program' will reduce antimicrobial use in intensive care units by 12-25% and reduce antimicrobial costs to the units by 23-41%; the program is currently participating with 12 collaborating health centres/hospitals.
- 5) In a study involving 4 psychiatric facilities, length of stay was reduced by an average of 116 days per client after the introduction of the 'Transitional Discharge Model'. This resulted in \$12 million worth of freed bed space from the 200 intervention group compared to the control group and \$4,400 of reduced consumption of hospital and emergency room services per person in year post discharge.
- 6) The 'Implementing an Enhanced Recovery After Surgery' project demonstrated a 50% decrease in postoperative complications and reducing average length of stay postoperative care by 2 or more days.

APPLICABILITY/TRANSFERABILITY:

ARTIC is one of two broad-reaching partnerships working under the support of the Council of Academic Hospitals for Ontario. The other innovative partnership developed is the Physician Quality Improvement Initiative. This physician-led collaborative program involves all 24 of its member hospitals and provides an opportunity for physicians to share best practices, gain feedback performance, access tools for continuing professional development (<http://caho-hospitals.com/partnerships/physician-quality-improvement-initiative-pqii/>).

ARTIC is currently developing its Knowledge Translation tools in order to advance adoption of research evidence into practice to broader settings.

CONTACT INFORMATION:

Name: Chris Paterson

Title: Director, Stakeholder Relations

Organization: Council of Academic Hospitals in Ontario

Email address: cpaterson@caho-hospitals.com

Telephone number: 416-402-4461

Information last updated on: October 31, 2013

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

Council of Academic Hospitals in Ontario. (2013). Ontario Research Hospitals : Building a Healthier, Wealthier and Smarter Ontario. 2012-13 Annual Report

http://caho-hospitals.com/wp-content/uploads/2013/09/CAH-103-AR2013_Web.pdf

External Source: <http://caho-hospitals.com/partnerships/adopting-research-to-improve-care-artic/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Longitudinal Elderly Person Shadowing Project

LOCATION:	Saskatchewan	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to improve the quality of care provided to elderly patients through participatory educational programming. The Longitudinal Elderly Person Shadowing Project was first offered to health care professional students at the University of Saskatchewan in 2007. As of November 2013, a total of 410 students have completed this program and partnered with 127 seniors.

PRACTICE DESCRIPTION:

The shifting demographic of aging populations and associated prevalence of chronic illness has changed the nature of demand in the health care system. As a strategy to prepare the incoming health workforce to be responsive to these changing needs, the University of Saskatchewan introduced an interprofessional, student-senior mentorship program to increase awareness among pre-licensure, health professional students about the experiences and complexity of issues facing elderly patients managing multiple illnesses. Small teams of three to four students from various health disciplines, including medicine, pharmacy, nutrition, nursing, social work, and physical therapy are partnered with seniors from a nearby housing complex, LutherCare Communities (<http://luthercare.com/>).

The program consists of the following five main components that take place over the three-month course:

1. Students collect general life history of senior partner
2. Students asks seniors about their living situations and perspectives on our changing world
3. Students review knowledge about seniors' medications, nutrition, physical activities
4. Students and program leaders meet for Interprofessional small group discussions
5. Participation in unstructured social event with students, seniors and program leaders

This program is voluntary for most participating health science students but mandatory for physical therapy students. Initial funding for this initiative was awarded through Health Canada's Patient Centred Interprofessional Team Experiences Program. Ongoing funding is now provided by each participating faculty at the University of Saskatchewan Health Sciences College or School.

IMPACT:

Surveys were administered to students to gauge the level of knowledge and satisfaction associated with having participated in the program. From an evaluation completed in February 2011, 184 students (teamed with fifty-four seniors) completed surveys upon admission to the program as well as one year after to provide pre- and post-comparisons. For students from 2008 and 2010, there was an 88.7% response rate. Overall, between 83% and 96% of students responded that they were very satisfied with the Longitudinal Elderly Shadowing Program. Specific areas of knowledge improvement were noted across general geriatrics, interprofessional teamwork competencies, the roles and responsibilities of other providers, community resources available, and effective communication with seniors. This program was also noted to have had an impact on reducing negative stereotypes among students towards elderly persons in general.

This program was awarded the Provost's Prize for Innovative Practice in 2012 which provided further funding for its continuation.

APPLICABILITY/TRANSFERABILITY:

This program is theoretically transferrable however no other similar designs are known in Canada. This program remains to be formally integrated into the health sciences curricula. Difficulties were noted around scheduling between faculties but these issues are being addressed as the University strengthens its interprofessional education programming. The strong relationship with the LutherCare Communities and mutual benefits from participating seniors and students are noted as the most supporting



factors contributing to this program's success and continuation.

CONTACT INFORMATION:

Name: Jenny Basran

Title: Regional Health Authority Geriatrics Program Director

Organization: University of Saskatchewan, College of Medicine, Division of Geriatric Medicine

Email address: jenny.basran@saskatoonhealthregion.ca

Telephone number: 306 655 8925

Information last updated on: November 5, 2013

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

Publications:

Basran, J.F.S., Dal Bello-Haas, V., Walker, D., MacLeod, P., Allen, B., D'Eon, M., et al. (2012) The Longitudinal Elderly Person Shadowing Program: Outcomes From an Interprofessional Senior Partner Mentoring Program. *Gerontology and Geriatrics Education*, 33(3): 302-23. <http://www.tandfonline.com/doi/abs/10.1080/02701960.2012.679369#.UjyvNj-wU8w>

Personal Communications:

Doreen Walker, Interprofessional Education Coordinator at the University of Saskatchewan and Jenny Basran; November 5, 2013 [email].

Alternative Profiles:

<http://usaskmedalumni.com/2012/09/24/alumni-pride-leps-or-longitudinal-elderly-person-shadowing/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Learning Together with Cases

LOCATION:	Ontario	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice facilitates the accessibility of interprofessional education for students and educators of health disciplines at pre-licensure levels. ‘Learning Together with Cases’ was initiated out of the Office of Interprofessional Education and Practice in the Faculty of Medicine at Queen’s University in Kingston, Ontario. Beginning in 2010 as an eighteen-month pilot project, this program has informed the ongoing integration of interprofessional educational learning modules at the University. In the developmental stages of the program, participants included 100 first year medical students enrolled in an introductory musculoskeletal course, paired with 84 second year nursing students and 23 advanced practice nursing students studying geriatrics. Twenty-six second year occupational therapy master’s students were involved as virtual consultants for student colleagues.

PRACTICE DESCRIPTION:

The goal for the Learning Together with Cases program is to provide resources for teachers wishing to include interprofessional education in existing courses for pre-licensure health professionals. The areas of focus are guided by the Canadian Interprofessional Health Collaborative’s National Framework for Interprofessional Competencies, prioritizing: 1) Role Clarification, 2) Team Functioning, 3) Patient/Client/Family/Community-Centred Care, 4) Collaborative Leadership, 5) Interprofessional Communication, and 6) Interprofessional Conflict Resolution. Initial funding was received from HealthForce Ontario.

The Learning Together with Cases program is facilitated through an open-source, online software, providing a library of interprofessional cases that highlights competencies and requisite knowledge, skills, attitudes, and values. The ‘interprofessional toolbox’ provides resources for targeted skills development, mechanisms for ensuring patient safety, and involvement of patient perspectives. This space also allows a platform for teachers to discuss challenges and successes, faculty development guidelines, and knowledge translation strategies.

Since the completion of the pilot project phase, the Learning Together with Cases Program is currently being used as a learning tool to inform and provide resources for educators incorporating interprofessional tools into respective health sciences programming, however, no students are currently enrolled in the program.

IMPACT:

At the end of the interprofessional education sessions of the pilot phase (2011), students from each discipline were asked to participate in a focus group. Reports around respectful and engaging interaction were consistent across disciplines. The most beneficial aspects to the program were around increased understanding of respective scopes of practice and how cumulative knowledge bases effectively improved the provision of integrated care for patients.

Faculty members have presented the work of Learning Together with Cases at conferences such as: Interprofessional Education Ontario (2011), the International Conference on Residency Education with the Royal College of Physicians and Surgeons (2010), and the Canadian Conference on Medical Education (2010).

APPLICABILITY/TRANSFERABILITY:

The development of this program was informed by previous efforts from within the Faculty of Health Sciences at Queen’s University, which had offered an interprofessional patient safety course through the School of Medicine, School of Nursing and School of Rehabilitation Therapy in 2007 and 2008. The program involved a blended instructional design constructed around a series of virtual patient scenarios, allowing for both individual online learning and collaborative face-to-face interprofessional team-based learning sessions. This program was funded by the Canadian Patient Safety Institute (<http://www.patientsafetyinstitute.ca/English/Pages/default.aspx>) supported by the Queen’s University Office of Health Sciences Education and Practice. It was active for two years, with 200 students involved each year, and survey results indicated that the program was effective in raising student awareness of core patient safety principles and improving understanding of the roles of



other health care providers. Despite positive evaluations, the program was discontinued due to obstacles around incongruent curricula between faculties and through this, the Learning Together with Cases platform.

At this time, the degree to which Learning Together with Cases will continue at Queen's remains unclear. In terms of transferability, questions remain around whether or not these programs should be mandatory and implemented more broadly, and whether interprofessional educational programs should be offered at the earlier stages of health students' educational careers or later, once students have had the opportunity to develop discipline-specific skills and professional identities.

CONTACT INFORMATION:

Name: Lindsay Davidson

Title: Associate Professor

Organization: Queen's University, Department of Surgery, Division of Orthopaedics

Email address: davidsonl@KGH.KARI.NET

Telephone number: 613-544-9626

Information last updated on: November 6, 2013

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

Publications:

Davidson, L., Walz, L. (2013) Virtual Patient Stories as a Facilitator of IPE: A Pilot Study. *The Journal of the International Association of Medical Science Educators*, 23(3S): 419-420. http://www.iamse.org/ijamse/volume23-3s/23-3s_419-420.pdf

Davidson, L., Aiken, A., Donnelly, C. (2008) Learning about Patient Safety through an Interprofessional Lens. Canadian Patient Safety Institute. <http://www.patientsafetyinstitute.ca/english/research/cpsiresearchcompetitions/2006/documents/davidson/reports/davidson%20full%20report.pdf>

Personal Communications:

Dr. Lindsay Davidson, Associate Professor, Queens University, School of Medicine, Department of Surgery; October 17, 2013 [email].

External Source: <https://meds.queensu.ca/central/community/learningwithcases>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Interfaculty Course Development for Interprofessional Collaboration

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

SNAPSHOT: This innovative practice improves the quality of health care services by providing an interprofessional program for health sciences students at pre-licensure levels. The program was introduced in Laval University in Quebec in 2007, and it continues to involve faculty and students from 10 health science disciplines.

PRACTICE DESCRIPTION:

As a strategy to better prepare the incoming health workforce to meet population health needs, Laval University developed an interfaculty program to involve students from medicine, pharmacy, kinesiology, nutrition, community health, nursing, psychology, physiotherapy, and more recently, occupational therapy. The program consists of three courses in Interprofessional Collaboration (levels I, II, and III) that focus on patient- and family-centred care. Each course is 15 hours and is conducted during weekends to increase accessibility for students with full course loads.

Despite motions from the university steering committee on interdisciplinary programming in 1998, this program did not come to fruition until nearly 10 years later. This was accomplished via funding from Health Canada and its initiative on Interprofessional Education for Collaborative Patient-Centred Practice. The design of the program was guided by the National Interprofessional Competency Framework, which promotes health care professionals learning “with, from, and about one another” to improve family- and patient-centred primary care. The program focuses on developing skills and competencies related to involving patients, collaboration, communication, and understanding respective roles and responsibilities. Baseline research was conducted on perceptions of necessary skills for acquisition, prospective practice environments, and attitudes towards the program in order to inform further program development.

This program has also focused on intensive training for associated educators—including four half-day sessions to develop collaborative skills, one half-day to present educational activities and materials, and four 90-minute workshops held during a six-week period. To facilitate the continuation of interprofessional education into the practice setting, training was also incorporated into the family medicine residency program at each family medicine unit.

IMPACT:

A pre-and-post study was conducted from both the students’ perspective and the educators’ perspective. The former evaluation was conducted in 2010, and involved 342 students, 215 of whom completed questionnaires. Comparing attitudes from baseline to program completion, average satisfaction rate regarding quality of courses, teaching approaches, and perceptions of knowledge and skill acquisition was reported at 4.05 out of 5.00. Overall, respondents felt that this program contributed to the preparation of the incoming health workforce to better meet contemporary practice requirements and patient needs.

For the evaluation of educators’ training and process implementation, both quantitative and qualitative methods were used. Professionals from six family medicine units participated in the training and evaluation. They reported an average of 4.26 out of 5.00 regarding the appropriateness of content and general positive reflections on pedagogic strategies and opportunities to work as a team to understand respective roles.

APPLICABILITY/TRANSFERABILITY:

A common challenge of these types of innovative programs is transferring the developed interprofessional competencies into the practice setting. This was addressed through

- the ongoing preparation of family medicine unit professionals;



- training preceptors;
- training residents and trainees; and
- the designated training leader providing support to educators.

For active student participation, the mandatory nature of the program was reported positively and reaffirming around the importance of this style of learning.

Several other interprofessional education programs exist across Canada. However the commitment, requirements, and accreditation of these programs remain sporadic.

CONTACT INFORMATION:

Name: Serge Dumont

Title: Full Professor

Organization: University of Laval, School of Social Work

Email address: serge.dumont@svs.ulaval.ca

Telephone number: 418-525-4444 ext. 20976

Information last updated on: October 17, 2013

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

Publications:

Dumont, S., Briere, N., Morin, D., Houle, N., Iloko-Fundi, M. (2010). Implementing an interfaculty series of courses on interprofessional collaboration in prelicensure health science curriculums. *Education for Health*, 23(1), 395. Retrieved from http://old.educationforhealth.net/publishedarticles/article_print_395.pdf

Paré, L., Maziade, J., Pelletier, F., Houle, N., & Iloko-Fundi, M. (2012). Training in interprofessional collaboration: Pedagogic innovation in family medicine units. *Canadian Family Physician*, 58(4), e203–e209. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3325472/>

Other:

Université Laval. (n.d.). *Le patient au coeur de nos actions: Mieux se former*

pour mieux collaborer. [Poster]. Retrieved from <http://www.cihc.ca/files/projects/atlantic/FIPCCP%20Poster.pdf>

Personal Communications:

Dumont, S. (October 17, 2013).

External Source: <http://www.cihc.ca/regional/overview/atlanticlist/ficcp>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Regional Departments of General Medicine (Départements régional de médecine générale; DRMGs)

LOCATION:	Quebec	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	

Snapshot: This innovative practice coordinates the supply and planning of primary care services at the regional level. The practice was launched in each of Quebec's 18 health regions and involves all family physicians practicing in the region.

Practice Description:

Départements régional de médecine générale (DRMGs) operate under the aegis of regional health authorities, and they make recommendations to and report to the health authority CEO. DRMGs are composed of all general practitioners practicing in the region. The head of the DRMG is elected by the membership. DRMGs inform human resources planning by generating a region-specific list of "particular medical activities" (Activités médicales particulières; AMP) that general practitioners are expected to perform, and by proposing and implementing a regional medical staffing plan (Plan régional d'effectifs médicaux) aligned with those activity requirements. The staffing plan may include emergency department coverage, care in nursing homes and rehabilitation centres, home care, acute hospital care, obstetrics, and management of vulnerable patients. In their first 20 years of practice, general practitioners are required to perform a specified number of hours of AMP. The requirement is higher for physicians in their first 15 years of practice. The specific activities a physician performs are negotiated between the physician and the DRMG.

Impact:

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

This innovative practice has been implemented since 1991 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

Applicability/Transferability

The DRMG model has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings.

Contact Information:

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



Téléphone: (418) 266-5838

Télécopieur: (418) 266-8755

Courriel: johanne.caseault@msss.gouv.qc.ca

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.

Agence de la Santé et des Services Sociaux de Montréal. (2012). *Looking backward to move forward: A synthesis of primary care reform evaluations in Canadian provinces*. Agence de la Santé et des Services Sociaux de Montréal and Canadian Foundation for Healthcare Improvement. Retrieved from http://www.inspq.qc.ca/pdf/publications/1439_RegarderArriereMieuxAvancer_SynthEvalReforSoins1Ligne_VA.pdf

DRMG de Montréal – 2012. Retrieved from http://www.drmgmontreal.com/index_en.html

Fédération des médecins omnipraticiens du Québec. (2013). *Quoi de neuf?* Retrieved from <http://www.fmoq.org/fr/organization>

Hutchison, B., Levesque, J.-F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *The Milbank Quarterly*, 89(2), 256–288. Abstract retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00628.x/abstract>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Primary Care Networks

LOCATION:	Alberta	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

Snapshot: This innovative practice involves the establishment of a new model of primary care that increases access to and the effectiveness of primary care. The practice was launched throughout Alberta and currently includes 41 primary care networks (PCNs) and involves more than 2,700 family physicians and about 900 other health professionals.

Practice Description:

PCNs are supported and administered by Alberta Health. They were established in 2003 by Alberta Health and Wellness (now Alberta Health), the Alberta Medical Association, and Alberta’s regional health authorities (now Alberta Health Services) to improve access to and effectiveness of primary care services. The PCNs were created as a vehicle for achieving the following objectives:

- increase the proportion of residents with ready access to primary care;
- provide coordinated 24-hour, 7-days-per-week management of access to appropriate primary care services;
- increase the emphasis on health promotion, disease and injury prevention, care of medically complex patients, and care of patients with chronic diseases;
- improve coordination and integration with other health care services, including secondary, tertiary, and long-term care through specialty care linkages to primary care; and
- facilitate the greater use of interprofessional teams to provide comprehensive primary care.

Over 80% of Alberta’s family physicians participate in PCNs, providing a defined set of 16 core primary care services to about three million Albertans (72% of the population). PCNs work in partnership with Alberta Health Services to address population health care needs. Physician participation in PCNs is voluntary. PCNs vary in size from four to 346 physicians (median 34.5 physicians). Non-physician health care providers in PCNs can include registered nurses, nurse practitioners, social workers, pharmacists, mental health workers, kinesiologists, exercise specialists, medical office assistants, and dietitians. PCNs may be located in a single or, more commonly, in multiple sites. They operate under an agreement between the PCN physicians (organized as a not-for-profit corporation) and Alberta Health Services. Depending on the specific governance model, PCN staff other than physicians may be employed exclusively by the corporation or by either the corporation or Alberta Health Services (Scott and Lagendyk, 2012). Apart from the payment (usually fee for service) that physicians receive for the primary care services they provide, the PCN receives an annual payment of \$62 per patient per year to support network operations (including the salaries of non-physician personnel and payment to physicians for administrative or additional clinical work they do on behalf of the PCN).

For purposes of the per-patient funding, patients are assigned to specific physicians based on their use of primary care services over the previous 36 months.

The PCN model allows for wide local variation in the organization and delivery of services. This facilitates innovation and tailoring of programs and services to the needs of the local community and the PCN’s patient population. However, the model can also lead to uneven performance across PCNs. In a qualitative, longitudinal comparative case study of eight PCNs over a three-year period, it was found that five sites were “surging ahead”; two sites were “cautious planners” and had not made substantial changes even after frequent team meetings; and one site was “mired in antagonism” because professionals showed little interest in trying new practices (Reay, Goodrick, Casebeer and Hinings, 2013).

The PCNs that were most successful were able to obtain buy-in from professionals, entice people to try new practices, encourage structured disagreement, and focus on overall goals of change.



The 2012 Alberta Auditor General's report noted variation of PCN development in the province and stated there were "significant weaknesses in the design and implementation of the accountability systems for the PCN program" (Auditor General Alberta, 2012). To improve accountability, the Auditor recommended that the Department of Health establish clear expectations and targets for PCN program objectives; implement systems to evaluate performance and support PCNs and Alberta Health Services to achieve objectives; proactively inform Albertans about which PCN they are informally assigned to; and improve its systems for oversight of PCNs to assess compliance with financial and operating policies.

The provincial government is currently focusing on enhancing the role of PCNs. Alberta Health has tasked the Primary Care Alliance (PCA) of the Alberta Medical Association to lead the development of a blueprint and action plan for an enhanced PCN program in Alberta. The PCA will review policy, review operational and performance issues related to the current program, and identify the key principles for a revised program.

In early 2012, the Alberta Government announced the creation and implementation of family care clinics (FCC) as a complementary model to PCNs. FCCs differ from PCNs in that:

- providers will be required to provide certain hours of service;
- the governance model will be community led;
- the range of services delivered to patients will be more comprehensive (e.g., emphasis on wellness, self-management, patient education, addiction and mental health treatment, chronic disease prevention and management, and injury prevention);
- services will be provided to underserved and high-needs patients;
- linkages and partnerships will be formed with the community;
- patients will be attached to the team; and
- FCCs will be required to report on their objectives through measurement of clearly defined indicators (Alberta Government, 2012).

FCCs are expected to have a minimum of five members on their board of directors: two types of health care providers, one client representative, and two external community leader(s)/representatives (Alberta Government, 2012).

Impact:

R.A. Malatest & Associates Ltd. was commissioned to complete an evaluation of the PCN for the period from December 1, 2008, to March 31, 2011. The evaluation examined 29 operational PCNs by collecting information from baseline and follow-up survey data with PCN staff, interviews with key stakeholders, and site visits. To compare the outcomes of patients receiving care in PCNs in comparison to those receiving care in non-PCNs, the evaluation examined administrative databases and administered surveys to patients, physicians, and other providers. In addition, focus groups were held to gain additional feedback from patients receiving care from PCNs. A comparison of PCNs and non-PCNs showed the following:

- More PCN patients were attached to a regular family physician and reported access to appointments after hours.
- More PCN physicians reported having the capacity to book same-day appointments for urgent patients, provide care to non-urgent patients within three days, and provide after-hours care.
- Emergency department use was lower among PCN patients than among non-PCN patients.
- PCN physicians were considerably more likely to offer screening tools for health promotion and disease prevention (e.g., smoking cessation, tetanus/diphtheria immunization, clinical breast exam, mammography, and bone density). PCN patients were more likely than non-PCN patients to obtain information about healthy living.
- PCN physicians reported greater use of evidence-based drug therapies for chronic conditions.
- PCN patients were more satisfied with their involvement in treatment plans, and those with chronic obstructive pulmonary disease and diabetes had better outcomes than non-PCN patients.

The Interdisciplinary Chronic Disease Collaboration (ICDC) studied diabetes care and outcomes in patients managed in PCN and non-PCN practices using a controlled before-after research design. Their results "suggest that patients with diabetes who are managed in PCNs may have lower rates of hospitalization and emergency room visits for diabetes specific ACSCs [ambulatory care sensitive conditions], although this was only noted in patients with prevalent disease [as opposed to those with newly diagnosed (incident) diabetes]. Care in a PCN also appears to be associated with better glycemic control in patients with incident and prevalent diabetes, and improved use of metformin in patients with incident diabetes" (ICDC, 2011).



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

Applicability/Transferability

Although PCNs have not been directly adapted from another jurisdiction, interprofessional primary care teams and/or networks of varying size and composition are in place in many countries and have been implemented widely in Ontario and Quebec.

The success of this specific program is dependent on investment of resources, obtaining the formal buy-in of stakeholders, strong evidence to support interprofessional teams, support of the initiative by patients, human resource capacity, alignment of incentives to support interprofessional teams, and appropriate public marketing of the initiative.

Contact Information:

Tricia Smith

Director – Primary Care Networks

Primary Health Care Branch

Alberta Health

Telephone: (780) 643-1435

Email: tricia.smith@gov.ab.ca

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.

Publications:

Alberta Government. (2012). *Draft primary health care transformation: Family Care Clinic—Application kit wave 1*. Retrieved from

<http://www.acfp.ca/Portals/0/docs/Draft%20Family%20Care%20Clinic%20Application%20Kit-Dec20-12.pdf>

Auditor General Alberta. (July 2012). *Report of the Auditor General of Alberta*. Retrieved from

<http://www.oag.ab.ca/files/oag/OAGJuly2012report.pdf>

Interdisciplinary Chronic Disease Collaboration. (February 2011). *The impact of primary care networks on the care and outcomes of patients with diabetes: Report to Alberta Health and Wellness and Alberta Health Services*. Retrieved from

http://www.albertapci.ca/Resources/ReportsDocuments/Documents/ICDC%20PCNs%20Diabetes%20Study%20-%20Final%20Report%20AHW%20%20AHS_February%2028%202011.pdf

R.A. Malatest and Associates Ltd. (May 2011). *Primary care initiative evaluation: Summary report*. Edmonton, AB: Alberta Medical Association. Retrieved from <http://www.health.alberta.ca/documents/PHC-PrimaryCareInitiative-Evaluation2011.pdf>

Reay, T., Goodrick, E., Casebeer, A., & Hinings, C.R. (2013). Legitimizing new practices in primary health care. *Health Care Management Review*, 38(1), 9–19. Abstract retrieved from

http://journals.lww.com/hcmrjournal/Abstract/2013/01000/Legitimizing_new_practices_in_primary_health_care.2.aspx

Scott, C., & Lagendyk, L. (April 2012). *Contexts and models in primary healthcare and their impact on interprofessional relationships*. Prepared for Canadian Health Services Research Foundation. Retrieved from

http://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/ScottLagendyk-April2012-E.sflb.ashx



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Physician Assistants in Manitoba

LOCATION:	Manitoba	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

Snapshot: This innovative practice aims to “ensure more timely access to team-based care for Manitoba families” (Government of Manitoba, 2012) through the use of physician assistants. The integration of physician assistants (PAs) into practice was launched in a variety of acute and primary care settings and involves government funding of PA clinical positions in these settings.

Practice Description:

In 2008, the University of Manitoba introduced a two-year Master of Physician Assistant Studies program, the only graduate-level PA program in Canada, with the capacity to admit 12 students per year. In 2009, the provincial government amended the Medical Act to allow the province’s College of Physicians and Surgeons to regulate and register PAs. PAs are registered on the Physician Assistant Register (Canadian Association of Physician Assistants, 2012). As of August 2013, there were 52 PAs on the College registry, including both acute and primary care PAs.

PAs practice medicine under the supervision and direction of a physician, acting as physician extenders. Their scope of practice includes obtaining medical histories, performing physical examinations, ordering and interpreting laboratory and diagnostic tests, providing therapeutic procedures, prescribing medications, and educating and counselling patients. The base salary for PAs in Manitoba is \$75,000 to \$110,000 per year.

The Government of Manitoba has funded positions in the province for graduates of the PA educational program. Regional health authorities have partnered with government to provide placements for the PAs in their own sites and to facilitate their incorporation into rural and urban fee-for-service family practices.

In 2012, the Manitoba Department of Health committed to a major initiative to implement and evaluate the impact of PAs on primary care system development. In particular, the evaluation examined the potential of PAs to increase the number of patients attached to a primary care provider, to support continuity of care, and to improve access for all patients. To this end, an initiative was launched in three primary care settings with an associated evaluation. In 2013/14, additional PAs will be introduced into primary care settings and family medicine practices.

Impact:

A study of the addition of three PAs to a four-surgeon arthroplasty program in a Winnipeg hospital “saved” an estimated 200 hours of orthopedic surgeons’ time per surgeon per year. It also increased surgical volumes and reduced surgical wait times for primary hip and knee replacements compared to the previous year (Bohm, Dunbar, Pitman, Rhule, and Araneta, 2010).

Although international research indicates a number of benefits to the PA role in primary care related to access, attachment, and cost-effectiveness, the potential roles and impact of PAs in primary care in Canada has not yet been assessed.

Early findings suggest that PAs could have a significant impact on:

- the ability of primary care practices to accept new patients;
- patient access (i.e. timeliness of care);
- improved continuity of care for patients across the continuum (e.g., hospital, community, personal care home);
- improved patient/family communication in community and hospital settings; and
- reducing patient volumes in high-intensity care settings.



The Introducing Physician Assistants in Primary Care Steering Committee (IPAPCSC) is currently exploring research funding alternatives to systematically explore impacts and determine the roles and settings in which PAs may be more effective in primary care in Canada.

Applicability/Transferability:

Manitoba has an established history of using PAs, but to date PAs have been mainly employed in acute care sites, where benefits have been demonstrated (Bohm et al., 2010). Whereas PAs have long been an integral part of primary care provision in many parts of the world, including the US, this role is relatively new in Canada. Manitoba's physician assistant initiative has been adapted from the Canadian Forces Physician Assistant Program and from PA programs in the United States. PAs have recently been introduced with provincial government support in Ontario, New Brunswick, and Alberta.

Evaluation activities and the research literature have identified a number of factors associated with successful implementation of this specific practice. These include: support and leadership from provincial stakeholders; physician engagement, support, and education; appropriate "match" between supervising physician and PA; ensuring appropriate resources for implementation; appropriate community education; and mechanisms for early troubleshooting. The current evaluation is focusing on identifying (and incorporating into implementation guidelines) principles to guide planning in other Canadian jurisdictions.

Contact Information:

Dr. Sheldon Permack, MD FCFP

Medical Director Family Medicine/Primary Care

Winnipeg Regional Health Authority

Telephone: 204-940-8734

Contact # 2

Ingrid Botting, Ph.D.

Director, Health Services Integration

Winnipeg Regional Health Authority

526-496 Hargrave St.

Winnipeg, MB, R3A 0X7

Telephone: 204-940-8572

Email: ibotting@wrha.mb.ca

Contact # 3

Chris Rhule

Director, WRHA Physician & Clinical Assistants

Winnipeg Regional Health Authority

St. Boniface Hospital

I.H. Asper Clinical Research Institute

CR1060, 369 Taché Avenue

Winnipeg, MBR2H 2A6

Telephone: 204/226.0835



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.

Brohm, E.R., Dunbar, M., Pitman, D., Rhule, C., & Araneta, J. (2010). Experience with physician assistants in a Canadian arthroplasty program. *Canadian Journal of Surgery*, 53(2), 103–108. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845948/>

Canadian Association of Physician Assistants. (2012). *Legislation*. Retrieved from <http://capa-acam.ca/pa-employers/legislation/>

College of Physicians and Surgeons of Manitoba. (2012). *Physician assistants register*. Retrieved from <http://cpsm.mb.ca/registration/categories-of-registration/physician-assistants>

Government of Manitoba. (2009, August 13). Physician assistant students to become associate medical college members under legislation proclaimed today: Oswald. [News Release]. Retrieved from <http://news.gov.mb.ca/news/index.html?item=6437>

Government of Manitoba. (2012, November 9). More doctors, physician assistants providing more care for Manitoba families: Oswald. [News Release]. Retrieved from <http://news.gov.mb.ca/news/index.html?item=15540>

Jones, I. & Hooker, R. (2011). Physician assistants in Canada: Update on health policy initiatives. *Canadian Family Physician* 57(3), e83–e88. Retrieved from <http://www.cfp.ca/content/57/3/e83.short>

University of Manitoba, Faculty of Medicine. (2013). *Master of physician assistant studies*. Retrieved from <http://umanitoba.ca/faculties/medicine/education/paep>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Integration of Pharmacists in Family Health Teams

LOCATION:	Ontario	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

Snapshot: This innovative practice improves the appropriateness and outcomes of medication management by including pharmacists in primary health care practices. The practice was launched in Ontario in family health teams (as well as community health centres and nurse practitioner-led clinics) and involves pharmacists and primary care clinicians.

Practice Description:

Pharmacist positions have been incorporated into family health teams (FHTs) on a part- or full-time basis with funding from the Ontario Ministry of Health and Long-Term Care. Ninety-five full-time equivalent (FTE) pharmacists currently work in 110 (60.5%) of Ontario's FHTs. An additional 21.5 FHTs (11.6%) have approved funding for pharmacist services but do not yet have a pharmacist in place. The number of FTE pharmacists per FHT varies from 0.1 (in eight FHTs with physician complements varying from one to 10 physicians) to nine (in a networked FHT of 147 physicians). Pharmacists work as a member of the interprofessional team, providing on-site care to FHT patients and contributing to a common medical record. Pharmacists in FHTs frequently participate in quality improvement initiatives directed towards improved use of medications.

Impact:

This innovative practice has been implemented since 2006. While the practice has not been fully evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

Dolovich et al. (2008) conducted a two-year multi-faceted study of pharmacist integration into family practice teams in Ontario from 2004 to 2006. Seven non-dispensing pharmacists were incorporated into seven physician-led group family practices, varying in size from seven to 14 family physicians. Three of the seven practices had recently incorporated nurse practitioners into the practice, but none had well-developed interprofessional teams or previous experience working with pharmacists in their practice setting. The pharmacists, who worked approximately half-time in the family practices, provided medication assessments and follow-up for referred patients, drug information and education for clinicians, and office-system enhancements to optimize drug therapy. Sixty (94%) of the physicians referred at least one patient to the pharmacist during the two years of the study. The referred patients had an average of 4.8 medical conditions and were taking an average of 7.0 prescription medications and 3.4 over-the-counter medications. The pharmacists identified at least one drug-related problem in 94% of the referred patients. The most common problem was a required therapy that the patient was not receiving. One year after the pharmacists began working in the practice, physicians reported several benefits, including having a colleague who provided reliable drug information, getting fresh perspectives, having increased security in prescribing, and liaising with community pharmacies.

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

Applicability/Transferability

The practice informant did not identify other practices that the pharmacist integration in family health teams had adapted and was unaware if it was used as a model elsewhere. However, research indicates that a variety of approaches to pharmacist integration in primary care are being applied in other Canadian and international jurisdictions.

The success of this specific program is dependent on supporting the establishment of effective governance structures, administration, and organizational development (e.g., interprofessional team functioning) and optimizing roles within the team.

Contact Information:

Phil Graham



Manager, Family Health Teams and Related Programs

Primary Care Branch

Negotiations and Accountability Management Division

Ontario Ministry of Health and Long-Term Care

Telephone: 416-212-0832

Email: Phil.Graham@ontario.ca

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.

Personal Communications

Graham, P. (September 16, 2013).

Publications

Dolovich, L. (2012). Ontario pharmacists practicing in family health teams and the patient-centered medical home. *Annals of Pharmacotherapy*, 46(4), S33–S39. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/22499739>

Dolovich, L., Pottie, K., Kaczorowski, J., Farrell, B., Austin, Z., Rodriguez, C., Gaebel, K., & Sellors, C. (2008). Integrating family medicine and pharmacy to advance primary care therapeutics. *Clinical Pharmacology & Therapeutics*, 83(6), 913–917. Abstract retrieved from <http://www.nature.com/clpt/journal/v83/n6/abs/clpt200829a.html>

Pottie, K., Farrell, B., Haydt, S., Dolovich, L., Sellors, C., Kennie, N., Hogg, W. & Martin, C. (2008). Integrating pharmacists into family practice teams: Physicians' perspectives on collaborative care. *Canadian Family Physician*, 54(12), 1714–1717.e5. Retrieved from <http://www.cfp.ca/content/54/12/1714.short>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Integration of Primary Health Care Nurse Practitioners (PHC NPs)

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

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

Practice Description:

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

Education

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

Regulation

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

NP Practice

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

Impact:

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

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



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

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

Applicability/Transferability

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

The success of this specific program is dependent on:

- educating patients, providers, and insurance companies about the role and responsibilities of nurse practitioners and NPLCs;
- establishing effective governance structures, administration, and organizational development (e.g., interprofessional team functioning, information technology);
- engaging nursing stakeholders;
- providing appropriate NP compensation;
- optimizing roles within the team; and
- aligning financial incentives to ensure specialists are not disadvantaged by referrals from NPs.

Contact Information:

Ministry of Health and Long-Term Care

Email: nursingsecretariat.moh@ontario.ca

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.

Personal Communication

Skelly, J. (August 19, 2013). [Assistant Dean, Nursing Graduate Program, School of Nursing, McMaster University].

Publications

Canadian Nurses Association. (2008). *Position statement: The nurse practitioner*. Retrieved from http://www2.cna-aici.ca/CNA/documents/pdf/publications/PS_Nurse_Practiti...

College of Nurses of Ontario. (2013). *Membership totals at a glance*. Retrieved from <http://www.cno.org/what-is-cno/nursing-demographics/membership-totals-at-a-glance/>

Conference Board of Canada. (2012). *Improving primary health care through collaboration: Briefing 1—Current knowledge about interprofessional teams in Canada*. Retrieved from <http://www.wrha.mb.ca/professionals/collaborativecare/files/CBCBriefing12012.pdf>

DiCenso, A., Bourgeault, I., Abelson, J., Martin-Misener, R., Kaasalainen, S., Carter, N., ... Kilpatrick, K. (2010). Utilization of nurse practitioners to increase patient access to primary healthcare in Canada—Thinking outside the box. *Canadian Journal of Nursing Leadership, 23* (Special Issue), 239–259. Retrieved from <https://www.longwoods.com/content/22281/print>

Ducharme, J., Alder, R.J., Pelletier, C., Murray, D., & Tepper, J. (2009). The impact on patient flow after the integration of nurse practitioners and physician assistants in 6 Ontario emergency departments. *Canadian Journal of Emergency Medicine, 11*(5), 455–461. Retrieved from http://www.aimhealthgroup.com/pressreleases/companynews_jd.pdf

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care



can provide equivalent care to doctors. *British Medical Journal*, 324, 819–823. Retrieved from <http://www.bmj.com/content/324/7341/819>

Mian, O., Lacarte, S., & Koren, I. (2012). *2012 nurse practitioner workforce tracking study*. Centre for Rural and Northern Health Research. Retrieved from

http://www.cranhr.ca/pdf/CRaNHR_2012_NP_TS_survey_report_November_2012.pdf

Newhouse, R.P., Stanik-Hutt, J., White, K.M., Johantgen, M., Bass, E.B., Zangaro, G., ... Weiner, J.P. (2011). Advanced practice nurse outcomes 1990–2008: A systematic review. *Nursing Economics*, 29(5), 230–250. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/22372080>

Ontario Primary Health Care Nurse Practitioner Program. (2013). *About the PHCNP Program*. Retrieved from http://np-education.ca/?page_id=23823

Russell, G.M., Dahrouge, S., Hogg, W., Geneau, R., Muldoon, L., & Tuna, M. (2009). Managing chronic disease in Ontario primary care: The impact of organizational factors. *Annals of Family Medicine*, 7(4): 309–318. Retrieved from <http://www.annfammed.org/content/7/4/309.short>

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, R.S., Gent, M., Kergin, D.J., ... Wright, K. (1974). The Burlington randomized trial of the nurse practitioner. *New England Journal of Medicine*, 290(5), 251–256. Abstract retrieved from <http://www.nejm.org/doi/full/10.1056/NEJM197401312900506>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Full Service Family Practice Incentive Program

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

Snapshot:

This innovative practice improves patient care by supporting and compensating the delivery of guideline-based care by general practitioners (GPs). The practice was launched province-wide in British Columbia and is available to all GPs.

Practice Description:

In 2003, the General Practice Services Committee (GPSC), a joint committee of the Ministry of Health and the British Columbia Medical Association, developed the Full Service Family Practice Incentive Program (FSFPIP), which provides fee-for-service incentive payments to family physicians for enhanced primary care. Physicians receive incentive payments for:

- providing care to patients with diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, and hypertension, according to clinical guidelines;
- delivering babies (low-volume obstetrics);
- training for maternity care skills;
- developing clinical action plans and discharge plans for frail elderly, palliative care patients, patients with mental illness, or patients with co-morbidities;
- developing plans for high-risk patients with two or more chronic illnesses;
- conducting health risk assessments of patients in targeted populations;
- providing ongoing management services to mental health patients; and
- promoting shared care with specialists and interprofessional health care providers.

Impact:

This innovative practice has been implemented since September 2003. The practice has been externally evaluated, and personal testimonials, observations, and evaluation results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

In 2007, the provincial government commissioned an evaluation of FSFPIP. The evaluation found there was a high uptake of financial incentives in 2007/08 by regular GPs for patients to whom the physician provided a majority of the patient's primary care services (referred to as "majority source of care" (MSOC) patients). Ninety-two percent of physicians were billing for at least one incentive. Uptake was highest for diabetes (85.9%) and complex care (87.5%) and lowest for congestive heart failure (47.4%). After controlling for age and gender, costs were found to be consistently lower for patients who received incentive-based care compared to those patients who did not (Hollander, 2009).

Between 2006 and 2010, an increased number of patients were seen for congestive heart failure, diabetes, hypertension, complex care, and mental health issues (BCMA, 2012).

In 2009, an evaluation found that GPs who actively used incentive payments increased the proportion of attached (i.e. MSOC) patients (Hollander, 2009; Hollander & Tessaro, 2009). Attachment to a primary care practice is inversely related to the cost of care for high-needs patients with diabetes and congestive heart failure. The average annual cost (fiscal year 2007/08) for high-needs diabetic patients who had less attachment to a practice (used fewer services) was \$16,988, whereas the cost was



\$5,909 for those who were more attached to a practice (Hollander et al., 2009). Thus, attachment of high resource users to a primary care practice and increased continuity of providers reduced overall costs to the health care system due to the lower cost of hospital services (Hollander et al., 2009).

A physician survey (reported by GPSC, 2010) indicated that complex care incentives encouraged GPs to be more proactive, pay attention to the frequency of patient visits and ordering of tests, examine laboratory tests more closely, and identify patients who met the billing criteria. Chronic disease management incentives resulted in adoption of more complex patients and providing more proactive care. Maternity health incentives encouraged physicians to stay in obstetrics. Mental health incentives resulted in the adoption of more mental health patients and more time spent on planning care by some physicians. On the other hand, results of a patient survey revealed there was no perceived difference in the quality of care with the introduction of financial incentives (Hollander, 2009).

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

Applicability/Transferability

The practice informant did not identify other practices that the Full Service Family Practice Incentive Program adapted and was unaware of whether the practice was used as a model elsewhere. However, financial incentives for priority services have been implemented in other jurisdictions, both internationally and in Canada.

The success of this specific practice is dependent on:

- establishing formal structures (committees) that allow for collaboration among all partners (ministry, medical association, and regional health authorities);
- consulting with primary care physicians on their support needs;
- building a program that is based on evidence;
- creating an environment that allows for changing incentives over time as needed;
- access to data that allows for analysis of gaps in service and continuous evaluation of incentives;
- innovative approaches that allow for the inclusion of comprehensive incentives within a fee-for-service payment structure; and
- willingness of primary care providers to participate in the initiative.

Contact Information:

Kelly McQuillen

Executive Director

Primary Health Care and Specialist Services, Health Services and Quality Assurance Divisions

Ministry of Health

3-2, 1515 Blanshard Street

Victoria BC V8W 3C8

Phone: 250 952-1204

Email: Kelly.McQuillen@gov.bc.ca

Contact # 2:

Dr. Shelley Ross

Co-Chair GP Services Committee

115-1665 West Broadway



Vancouver, BC V6J 5A4

Phone: 604 736-5551

Email: Shelley.Ross@usa.net

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.

Publications

British Columbia Medical Association. (January 2012). *Charting the course: Designing British Columbia's health care system for the next 25 years*. (BCMA Submission to the Select Standing Committee on Health). Retrieved from https://www.bcma.org/files/Charting_the_Course_FINAL.pdf

Cavers, W., Tregillus, V., Micco, A., & Hollander, M. (2010). Transforming family practice in British Columbia: The General Practice Services Committee. *Canadian Family Physician*, 56(12), 1318–1321. Retrieved from <http://www.cfp.ca/content/56/12/1318.short>

General Practice Service Committee. (2010). *Annual report 2009/10*. Retrieved from <http://www.health.gov.bc.ca/library/publications/year/2010/gpsc-ar-2010.pdf>

General Practice Services Committee. (2011). *Annual Report 2011/2012*. Retrieved from http://www.gpsc.bc.ca/system/files/GPSC_AR2012_FINAL.pdf

Hollander, M. (June 2009). *Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program: Final synthesis report*. (Report for the British Columbia Ministry of Health Service and General Practice Services Committee). Retrieved from http://www.gpsc.bc.ca/system/files/GPSC_Synthesis_Report_2009-06-28.pdf

Hollander, M., & Tessaro, A. (2009). *Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program: Final report of the relationship between billing for incentive payments and majority source of care patients per GP*. (Report for the BC Ministry of Health Service and General Practice Services Committee). Retrieved from http://www.hollanderanalytical.com/Hollander/Home_files/Incentives%20and%20MSOC%202009-06-29_.pdf

Mazowita, G., & Cavers, W. (August 2011). Reviving full-service family practice in British Columbia. *Issues in International Health Policy* 1538, vol 19. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/IssueBrief/2011/Aug/1538_Mazowita_restoring_fullservice_family_practice_BC_intl_brief_v3_CORRECTED_20110906.pdf

External Source: http://www.primaryhealthcarebc.ca/gpsc_incentives.html



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Family Medicine Groups

LOCATION:	Quebec	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

Snapshot:

This innovative practice provides access to a family doctor for all Quebec residents; increases accessibility of services, especially for vulnerable patients; improves quality of care; promotes continuity of care and coordination between primary care and other health care sectors; and enhances the role of family physicians. The practice was launched throughout Quebec and involves family physicians and other primary care clinicians, particularly nurses.

Practice Description:

In response to the recommendations of the Clair Commission in 2000, the provincial government established family medicine groups (FMGs). FMGs are accredited organizations that have contractual agreements with Quebec's regional health authorities. FMGs can be private entities or be part of Centres locaux de services communautaires (CLSCs; Local Community Service Centres). They often consist of six to 10 physicians, two nurses, and two administrative staff, who serve approximately 15,000 people (1,300 per physician). An on-call telephone service is available to enrolled patients 24 hours a day, seven days a week, and limited walk-in services are available to patients during holidays and weekends.

The compensation model for FMGs is based on fee-for-service and is supplemented with per capita payments and incentive payments for registering vulnerable patients. Additional funding is provided for operating costs (e.g., rental costs for space for additional staff, salaries of administrative staff), enrolment of patients, administrative activities by the clinical lead, 24/7 phone access, the inclusion of nurses and administrative support staff, and computer resources. These payments are also available to physicians in non-FHG practices, weakening the incentive for physicians to practice in FMGs but allowing private practices to function in a similar way to FMGs. As of April 2011, there were 223 accredited FMGs. The Ministry of Health and Social Services plans to increase this to 300 FMGs, with the aim of having 75% of the population registered with an FMG.

FMGs vary significantly in their organizational structures, in the physicians' conception of the role of nurses, and in the degree of collaboration among providers.

Impact:

A variety of studies have examined the impact of the FMGs and found that this model improved:

- accessibility outside of regular working hours (Beaulieu et al., 2006);
- accessibility during regular working hours (Ministère de la santé et des services sociaux, 2009; Beaulieu et al., 2006);
- knowledge of patients (Beaulieu et al., 2006);
- physician-nurse collaboration (Beaulieu et al., 2006; Aubin et al., 2007);
- provider and patient satisfaction (Aubin et al., 2007);
- patient communication with the FMG physicians (Ministère de la santé et des services sociaux, 2009);
- quality of relationships with physicians (Ministère de la santé et des services sociaux, 2009); and
- access to a regular source of care (Ministère de la santé et des services sociaux, 2009; Tourigny et al., 2010).

The model has also encouraged family physicians to participate in and influence the structuring of services in their region (Aubin et al., 2007). A comparison of FMGs and non-FMG practices indicated a lack of impact on the use of emergency departments



and on avoidable hospitalizations (Ministère de la santé et des services sociaux, 2009).

A study examining the perception of patients before and after the implementation of five FMGs found that patients' perceptions of continuity (relational and informational) increased, but there was no change to organizational and first-contact accessibility and service responsiveness (Tourigny et al., 2010). The proportion of participants reporting visits with nurses and use of FMGs' emergency services increased. However, physician-nurse coordination remained unchanged, and primary care physician to specialist coordination was perceived to have declined.

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

Applicability/Transferability

The practice informant did not identify other practices that FMGs have adapted and was unaware if FMGs were used as a model elsewhere. However, research indicates that team-based primary care models are being developed and implemented in many Canadian and international jurisdictions.

Contact Information:

Johanne Caseault

Conseillère en affaires intergouvernementales

Direction des affaires intergouvernementales et de

la coopération internationale

Ministère de la Santé et des Services sociaux

1005, chemin Ste-Foy, 1er étage

Québec (Québec) G1S 4N4

Téléphone: (418) 266-5838

Télécopieur: (418) 266-8755

Courriel: johanne.caseault@msss.gouv.qc.ca

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.

Publications

Agence de la santé et des services sociaux de Montréal. (2012). *Looking backward to move forward: A synthesis of primary care reform evaluations in Canadian provinces*. Agence de la santé et des services sociaux de Montréal and Canadian Foundation for Healthcare Improvement. Retrieved from http://www.inspq.qc.ca/pdf/publications/1439_RegarderArriereMieuxAvancer_SynthEvalReforSoins1Ligne_VA.pdf

Aubin, M., Bonin, L., Haggerty, J., Leduc, Y., Morin, D., Reinharz, D., ... Tourigny, A. (2007). Reorganization of primary care services as a tool for changing practices. Retrieved from http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/OGC/Aubin_E.pdf

Beaulieu, M.D., Denis, J.L., D'Amour, D., Goudreau, J., Haggerty, E., Hudon, E., ... Lebeau, R. (2006). *L'implantation des groupes de médecine de famille: Le défi de la reorganisation de la pratique et de la collaboration interprofessionnelle*. Montreal, QC: Chaire Docteur Sadok Besroor en médecine familiale. Retrieved from <http://www.gmfrn.com/docs/etudes/UdeMRapportImplantationGMFCompleet.pdf>

Breton, M., Lévesque, J.F., Pineault, R., & Hogg, W. (2011). Primary care reform: Can Quebec's family medicine group model benefit from the experience of Ontario's family health teams? *Healthcare Policy*, 7(2), e122-e135. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3287954/>



Haggerty, J.L., Pineault, R., Beaulieu, M.-D., Brunelle Y., Gauthier, J., Goulet, F., & Rodrigue, J. (2008). Practice features associated with patient-reported accessibility, continuity, and coordination of primary health care. *Annals of Family Medicine*, 6(2), 116–123. Retrieved from <http://annfammed.webliv.us/content/6/2/116.short>

Hutchison, B., Levesque, J.F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *Milbank Quarterly*, 89(2), 256–288. Abstract retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00628.x/abstract>

Ministère de la santé et des services sociaux. (2009). *Groupe de médecine de famille. Qu'est-ce qu'un groupe de médecine de famille (GMF)?* Ministère de la santé et des services sociaux 2009

Pomey, M.P., Martin, E., & Forest, P.G. (2009). Quebec's family medicine groups: Innovation and compromise in the reform of front-line care. *Canadian Political Science Review*, 3(4), 31–46. Abstract retrieved from <http://ojs.unbc.ca/index.php/cpsr/article/viewArticle/193>

Strumpf, E., Levesque, J.F., Coyle, N., Hutchison, B., Barnes, M., & Wedel, R.J. (2012). Innovative and diverse strategies toward primary health care reform: Lessons learned from the Canadian experience. *Journal of the American Board of Family Medicine*, 25(S1), S27–S33. Abstract retrieved from http://www.jabfm.com/content/25/Suppl_1/S27.short

Tourigny, A., Aubin, M., Haggerty, J., Bonin, L., Morin, D., Reinharz, D., ... Carmichael, P.-H. (2010). Patients' perceptions of the quality of care after primary care reform: Family medicine groups in Quebec. *Canadian Family Physician*, 56(7), e273–e282. Retrieved from <http://171.66.125.180/content/56/7/e273.short>

External Source: <http://sante.gouv.qc.ca/systeme-sante-en-bref/groupe-de-medecine-de-famille-gmf/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Family Health Teams

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

Snapshot:

This innovative practice, which was launched in Ontario, improves access to and the quality of primary care. The 185 family health teams involve a broad range of primary health care providers and administrative support personnel.

Practice Description:

The impetus for creating the Family Health Team (FHT) model in Ontario was a “crisis in access” due to the lack of primary care capacity (i.e. shortage of family physicians, orphan patients, and medical graduates having low interest in family medicine). The key objectives of the provincial government’s FHT initiative are improved access to primary health care, quality and comprehensiveness of care (with an emphasis on chronic disease management, health promotion, and disease prevention), interprofessional teamwork, patient engagement, and integration and coordination of care (system navigation).

Two hundred FHTs were created in Ontario between 2006 and 2011. They have since been amalgamated into 185 organizations .

FHTs are interprofessional primary care organizations that vary in family physician complement from one to 147. Only six FHTs include more than 50 family physicians and the two largest are networks of smaller physician groups. As of September 2013, these teams included 2,716 family physicians, 2,022 other primary health care professionals (most commonly nurses (739), social workers (355), nurse practitioners (496), dietitians (161), pharmacists (95), and registered practical nurses (95)), and 936 administrative support staff. A majority of FHTs (71%) receive funding for sessional payments to specialists, but fewer than half that have approved funding have been successful in engaging specialists to provide on-site services. There are three defined FHT governance models: physician (54%), community (12%), and mixed (34%). One in five FHTs serves a community of less than 10,000 population. Almost three million Ontarians (22% of the province’s population) are currently enrolled with an FHT physician.

The Ministry of Health and Long-Term Care funds FHTs through an annually approved global budget. However, this funding is not for physician services or for the minority of clinical and support staff who are employed by FHT physicians rather than by the FHT directly. FHT physicians are remunerated through a blended capitation or blended salary model, and they must meet the requirements of the payment model to which they belong.

Impact:

This innovative practice has been implemented since 2006 and does not have a completed evaluation at this time. A multi-year evaluation of the Family Health Team initiative, commissioned by the Ontario Ministry of Health and Long-Term Care, will be completed in 2014. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

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

Applicability/Transferability

The practice informant did not indicate other practices that FHTs had adapted or whether FHTs themselves were being used as a model. However, interprofessional primary care models are becoming increasingly common internationally and in Canada. Primary care networks and family medicine groups have been widely implemented in Alberta and Quebec, respectively. Alberta is launching family care clinics, which resemble FHTs.

The success of this specific practice is dependent on:



- being committed to funding for wide-scale implementation;
- establishing one legal entity with accountability mechanisms for the organization and all its providers;
- supporting the establishment of effective governance structures, administration, and organizational development (such as the functioning of interprofessional teams); and
- conducting comprehensive evaluations based on analysis of qualitative and quantitative

Contact Information:

Phil Graham

Manager, Family Health Teams and Related Programs

Primary Care Branch, Negotiations and Accountability Management Division

Ontario Ministry of Health and Long-Term Care

Email: Phil.Graham@ontario.ca

Telephone: 416-212-0832

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.

Personal Communications

Graham, P. (August 20, 2013).

Graham, P. (September 6, 2012).

External Source: <http://www.health.gov.on.ca/en/pro/programs/fht/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Community Health Centres in Ontario

LOCATION:	Ontario	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Leading

Snapshot: This innovative practice improves access to primary health care, particularly for populations that have traditionally faced access barriers. Ontario has 73 Community Health Centres (CHCs), which involve community governing boards and a broad array of primary health care providers.

Practice Description:

Ontario's Community Health Centres (CHCs) are interprofessional primary health care organizations that combine clinical, health promotion, and community development services and focus on the social determinants of health. Services are tailored to the needs of the diverse populations CHCs serve, including people with low incomes, disabilities, mental health issues, and addiction issues; Francophones; Aboriginal Ontarians; and immigrants. Between 2008/09 and 2009/10, more than a third of CHC clients were in the lowest income quintile (Glazier, Zagorski, & Rayner 2012). The Standardized ACG Morbidity Index for the population served by CHCs was 1.84, indicating an illness burden 84% higher than the provincial population average.

CHCs are non-profit organizations governed by community-elected boards comprised of clients, community members, health providers, and community leaders. CHCs are globally funded by the Ontario Ministry of Health and Long-Term Care. These organizations are the only primary care model that is mandated to provide services to individuals without health cards (i.e., uninsured patients).

The first CHCs were established in Ontario in 1979. The province's CHC program experienced rapid growth during the late 1980s. New funding for CHCs was halted in 1995/96 but resumed in 2002 following a strategic review of the CHC program in 2001. The program has undergone major expansion since 2005, growing from 54 to 73 centres. Many centres have satellite operations to extend their geographic reach. Between 2007 and 2011, funding and accountability for all CHCs was devolved to the local health integration networks (LHINs). The 73 CHC corporations have a Multi-Sector Accountability Agreement (MSAAs) with its LHIN which outlines the approved funding allocation to each CHC to cover primary care, administrative staffing, and general operating costs. The salary of CHC physicians is negotiated through the Physician Services Agreement between the ministry and the Ontario Medical Association (OMA).

CHCs serve 500,000 Ontarians (3.7% of the population) in more than 110 communities, providing primary care services to 250,000 of these clients. In 2012 CHCs employed 394 primary care physicians, 322 nurse practitioners, and large numbers of other clinical, health promotion, community development, administrative, and management personnel.

Impact:

In a study of four Ontario primary care organizational and physician payment models in 2005/06, CHCs performed better than fee-for-service practices and two capitation-based models in chronic disease management, health promotion, and community orientation (Russell et al., 2009; Hogg et al., 2009; Muldoon et al., 2010). However, CHCs were the least efficient model (Milliken et al., 2011). A full assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

CHCs have been implemented in many jurisdictions internationally and in Canada. In most cases they serve a small proportion of the population and target socially disadvantaged populations.

The success of this specific program is dependent on:

- significant investment of resources;
- consistent oversight of CHCs;



- similar compensation being provided to all physicians;
- basing evaluations on comprehensive data; and
- targeting programs and services to the needs of the community.

Contact Information:

Nadia Surani

Program Manager, Specialized Models Programs

Primary Health Care Branch

Negotiations and Accountability Management Division

Ontario Ministry of Health and Long-Term Care

1075 Bay Street, 9th Floor

Toronto ON M5S 2B1

Email: Nadia.Surani@ontario.ca

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.

Personal communications:

Rayner, J. (August 15, 2012).

Publications:

Glazier, R.H., Zagorski, B.M., & Rayner, J. (2012). *Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10*. Toronto, ON: Institute for Clinical Evaluative Sciences. Retrieved from http://www.ices.on.ca/file/ICES_Primary%20Care%20Models%20English.pdf

Hogg, W., Dahrouge, S., Russell, G., Tuna, M., Geneau, R., Muldoon, L., ... Johnston, S. (2009). Health promotion activity in primary care: Performance of models and associated factors. *Open Medicine*, 3(3), e165–e173. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3090121/>

Milliken, O., Devlin, R.A., Barham, V., Hogg, W., Dahrouge, S., & Russell, G. (2011). Comparative efficiency assessment of primary care service delivery models using data envelopment analysis. *Canadian Public Policy*, 37(1), 85–109. Retrieved from <http://utpjournals.metapress.com/content/a888218vt7122416/>

Muldoon, L., Dahrouge, S., Hogg, W., Geneau, R., Russell, G., & Shortt, M. (2010). Community orientation in primary care practices: Results from the comparison of models of primary health care in Ontario study. *Canadian Family Physician*, 56(7), 676–683. Abstract retrieved from <http://171.66.125.180/content/56/7/676.abstract>

Ontario's Community Health Centres, <http://www.ontariochc.org>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Sault Ste. Marie Group Health Centre

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

CONTACT INFORMATION:



Name: Garry Walsh

Title: Vice President of Communications

Organization: Group Health Centre

Email address: walsh_gary@ghc.on.ca

Telephone number: 705-759-5562

Information last updated on: November 13, 2013

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

Publications:

Sault Ste. Marie Group Health Centre: Big Success in a Small Community. Government of Ontario.

<http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/ssmarie.pdf>

Shaw, N., Ward, A. (2011) Case Study: A look into the Group Health Centre's Electronic Medical Record Procurement Process

http://www.nosm.ca/uploadedFiles/Research/Northern_Health_Research_Conference/Ward.%20Amanda_Case%20Study-Group%20Health%20Centre%20Record%20Procurement.pdf

Personal Communications:

Garry Walsh; November 13, 2013 [telephone]

External Source: <http://www.ghc.on.ca/index.php>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Engaging Medical Assistants—A Patient- Centred Medical Home Chronic Care Model at the DFD Russell Medical Center

LOCATION:	International	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	

SNAPSHOT: This innovative practice improves quality of care in the context of increased prevalence of chronic illnesses. There are currently three federally qualified community health centres operating under the interprofessional DFD Russell Medical Center in Maine, USA. This chronic care model capitalizes on health human resources by employing medical assistants as part of the health care team and participates in broader state-wide and national initiatives to promote the integration of patient-centred medical homes.

PRACTICE DESCRIPTION:

DFD Russell Medical Center was originally established in Leeds, Maine, in 1975. It established new locations in Turner and Monmouth, Maine, in 2001. Since its inception, the Russell Medical Center has operated under an “alternative care model.” Its current mandate involves patient self-management, evidence-based decision-making, regular systems monitoring, and creating linkages with other community resources. A distinctive feature of this centre is its integration and promotion of medical assistants to improve accessibility and quality of services for patients. Since 1999, the medical assistants have been responsible for scheduling appointments, conducting follow-up calls with lab results, expediting prescription refills, and answering patient questions through the Telebank call centre. No previous formal health education is required for the medical assistant positions; new assistants undergo a six-to-eight-week training period, they are closely supervised, and their performance is evaluated annually.

In more recent years, the medical centre has changed its practice to move away from traditional 15-minute office visits with physicians and adapt to the changing nature of demand. The health care team, comprised of a medical assistant working with another health care provider (physician, nurse practitioner, or physician assistant), see 22 patients per day on average. Overall health care team management and workflow is coordinated by the health care team leader, responsibilities and communications are clarified during daily team meetings, and protocols for delegation of tasks to non-provider staff are standardized.

The interprofessional composition is financially enabled through a private-public partnership model. Stakeholder support exists under Health Resources and Services Administration’s (HRSA) Health Disparities Collaboratives, Centre for Health Professions, and external evaluative research is conducted by the Hitachi Foundation.

IMPACT:

Based on external accreditation reported in December 2010, DFD Russell Medical Center continues to meet all National Care Quality Assessment goals for diabetes, heart and stroke measures for patients with cardiovascular disease. Increases in productivity were noted with the upgrade to the teleservices infrastructure in 2009. Overall, patients reported increased satisfaction with the additional time medical assistants were able to provide them (compared to traditional physician-exclusive visits).

APPLICABILITY/TRANSFERABILITY:

The DFD Russell Medical Center has become a part of a state-wide collaborative model titled The Maine Patient-Centered Medical Home Pilot project (2009–2014). This pilot project is in alignment with national movements for primary care improvement through the development of patient-centred medical homes (2007), which link pilot projects across New Hampshire, Vermont, and Rhode Island. *Patient-centered medical home* refers broadly to a model of care—rather than a building or place—in which health care professionals work together to manage patient needs better. Similarly structured community care teams (although not necessarily using the medical assistant engagement model) include Androscoggin Home Health, Coastal



Care Team, Eastern Maine HomeCare, Kennebec Valley, Maine Medical Centre, Community Health Partners, and Penobscot Community Health Care.

Factors associated with the success of the medical assistant engagement/patient-centred medical home model at DFD Russell have been attributed to the ability to track health outcomes, strong leadership, and regular accreditation processes. Challenges experienced include general physician resistance to working so closely with a medical assistant, and competitive remuneration models that have pulled professionals to more urban settings.

CONTACT INFORMATION:

Name: Catherine Dower

Title: Associate Director

Organization: Center for the Health Professions

Email address: cdower@thecenter.ucsf.edu

Telephone number: 1 (415) 476-1894

Information last updated on: September 20, 2013

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

Publications:

Blash, L., Chapman, S., Dower, C. (2011). *DFD Russell medical centers—Engaging medical assistants in quality improvement efforts*. Retrieved from

http://www.futurehealth.ucsf.edu/Content/11660/2011_06_DFD_Russell_Medical_Centers--Engaging_Medical_Assistants_in_Quality_Improvement_Efforts.pdf

Maine Patient Centered Medical Home Pilot Halfway Report. (2012). Retrieved from

http://illinoisap.org/wp-content/uploads/ME-PCMH-Pilot_Halfway-Report-WEB-version_March-2012.pdf

External Source: <http://www.dfdrussell.org/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

The Caring Together Project

LOCATION:	Ontario	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice facilitates interprofessional practice for palliative care givers. The Caring Together Project was initiated in 2007 as an online learning resource and piloted in two not-for-profit long term care homes in Ontario involving a total of 55 staff members. Since the project continued from its pilot phase, the e-learning resource has been integrated into interprofessional course work for health science students at the University of Ottawa (2013).

PRACTICE DESCRIPTION:

Elderly individuals receiving care at the end of their lives require care from a variety of caregivers. Recognizing gaps in interprofessional education particularly for the delivery of palliative care services, the Caring Together Project was designed to increase patient-centred care skills within a collaborative care model. Using case-based learning activities to allow participants to apply clinical theory in the practice setting, the project targets frontline caregivers including physicians, pharmacists, and nurses. The electronic format enables the interactive modality of drawing upon the knowledge and experience of health care professionals, educators, academics, and industry while integrating the patient perspective. This project was originally funded in part by an Inukshuk Wireless Grant. After the initial pilot phase, the core components of the Caring Together Project have been integrated into health sciences interprofessional programming at the University of Ottawa, most recently as an elective for third year Health Sciences students (2013).

IMPACT:

The latest data available regarding the impact of the Caring Together Project are derived from the evaluation conducted alongside the pilot implementation (2008-2009). The assessment examined the effectiveness of using the online learning resource to increase palliative care and interprofessional care skills as well as the stimulation of respective knowledge translation in the workplace. An experimental group (128 residents and 189 staff) was compared to a controlled replication group (100 residents and 88 staff) drawn from two long-term care homes in Ontario. From these two settings, a total of 55 caregivers from 19 disciplines volunteered to participate in the project, of which 94% completed the learning resource and evaluation.

Overall, the online learning resource met the learners' needs for accessing relevant education materials that could be applied to their practice settings to effectively care for residents at the end of life. Participants reported that these resources enabled them to learn with, from, and about one another in an engaging and convenient way. Perceptions of knowledge transfer and effectiveness of the resources were positive, however, associated evidence was weak. There was no distinctive change in attitudes toward interprofessional care, however, this was attributed to relatively high baseline attitudes.

While the Caring Together resources are still being used intermittently for interprofessional health sciences education at the University of Ottawa, current data are not publically available as the projects are intended for registered staff and students.

APPLICABILITY/TRANSFERABILITY:

The development of the Caring Together Project has been informed by previous work conducted by related innovators with similar intentions to improve quality of collaborative care through e-learning initiatives. A variation of Caring Together that focused on dementia care was initiated as a pilot project from 2003 to 2004. Later, 'the Working Together Project' was piloted in the spring of 2006 through collaboration of experts from: the Elisabeth Bruyere Research Institute; Bruyere Continuing Care; and the University of Ottawa's Faculty of Education, Centre for e-Learning, Department of Family Medicine, and the Primary Health Care Nurse Practitioner Program in the School of Nursing (funded by the Ministry of Health and Long Term Care). 'E-Physician Health' was then launched in October 2009, branded as 'the world's first comprehensive online physician health and wellness resource' (<http://ephysicianhealth.com/>). It has been used by over 27,000 individuals from over 130 countries. The most recent related initiative is the 'Caring for Persons with Spinal Cord Injury' project (<http://eprimarycare.onf.org/>), which went live in March 2013 and has yet to be evaluated.



Together, these initiatives are indicative of an educational shift towards more flexible and accessible resources for continuing education for health care professionals. Significant barriers have been experienced as a result of the general 'pilot nature' of the projects and difficulty ensuring continuity of funding, communication, and technical support.

CONTACT INFORMATION:

Name: Emma Stodel

Title: Consultant

Organization: Learning 4 Excellence

Email address: estodel@learning4excellence.com

Telephone number: 613-822-7060

Information last updated on: November 14, 2013

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

Publications:

MacDonald, C., Stodel, E., Hall, P., Weaver, L. (2009) The Impact of an Online Learning Resource Designed to Enhance Interprofessional Collaborative Practice in Palliative Care: Findings from the Caring Together Pilot Project. *Journal of Research in Interprofessional Practice and Education*, 1(1): 42-66. <http://www.jripe.org/index.php/journal/article/view/6/17>

Macdonald, C. J., Archibald, D., Stodel, E. J., Chambers, L.W., Hall, P. (2008) Knowledge translation of interprofessional collaborative patient-centred practice: The Working Together Project experience. *McGill Journal of Education*, 43(3): 26.

Halabisky, B.L., Humbert, J., **Stodel, E.J.**, MacDonald, C.J., Chambers, L.W., Doucette, S., Dalziel, W.B., & Conklin, J. (2010). Elearning, knowledge brokering, and nursing: Strengthening collaborative practice in long-term care. *Computers, Informatics, Nursing*, 28(5), 264-273.

MacDonald, C.J., Archibald, D., Kellam, H., Sun, R., **Stodel, E.J.**, & Puddester, D. (2011) Evaluation of online health and wellness resources for healthcare professionals. *International Journal of Advanced Corporate Learning*, 2(4), 18-23.

Personal Communications:

Emma Stodel; November 13, 2013 [telephone]



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Bridging Relationships Across Interprofessional Domains (BRAID)

LOCATION:	New Brunswick	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the issue of siloed health professional education, training, and practice. In the pilot phase from 2006–2008, BRAID was launched in collaboration with four partners: University of New Brunswick Saint John, Dalhousie University Faculty of Medicine, New Brunswick Community College Saint John, and Atlantic Health Sciences Corporation. The four partners are now co-located on the Tucker Park Campus and host approximately 690 health sciences students.

PRACTICE DESCRIPTION:

The BRAID project was designed to develop a model of health care education that would equip students and health professionals to work collaboratively in interprofessional teams towards patient-centred care. To initiate the project, funding was provided by Health Canada as part of the Interprofessional Education for Collaborative Patient-Centred Care Initiative. In September 2006, steering committees and project teams were established; they outlined the following focal points for the initiative:

- 1) to facilitate and increase the capacity for health educators to deliver the interprofessional education for collaborative patient-centred practice model;
- 2) to increase the competencies of learners and health professionals across disciplines to effectively participate in collaborative health care teams;
- 3) to increase opportunities for learners and health professionals across disciplines to apply interprofessional education competencies to interprofessional teamwork; and
- 4) to identify and share better practices for the delivery of interprofessional education initiatives.

Subsequent stages in the development of this project involved integrating a competency framework; formulating areas of inquiry; delivering interprofessional education and practice awareness workshops; delivering competency-building workshops; implementing working group activities; developing sustainability plans; developing data collection, coding, and analysis activities; and preparing the final project report (2008).

By the completion of the pilot phase, 31 interprofessional education and interprofessional practice workshops and 19 competency-building workshops had been carried out. With the transition from the pilot phase to mainstream functioning, BRAID was foundational to the evolving interprofessional collaboration among the four partner organizations that is overseen by the Tucker Park Collaborative. This collaborative involves a steering committee, a program/operational sub-committee, a research sub-committee, and a designated communications group, as well as cross representation on committees. These committees contribute to the project's sustainability from one academic year to another.

While several interprofessional education programs have been developed across Canada, the BRAID program is unique in two respects: it started without any history of similar efforts in the community prior to its implementation, and its four-partner structure includes a community college.

IMPACT:

Data were collected throughout the course of the pilot project to document the baseline readiness for interprofessional integration; conceptualization and implementation of the initiative; potential outcomes related to the interprofessional education and practice capacity; and competencies of stakeholders including educators, students, and post-licensure practitioners. Overall, 90% of students who participated in the interprofessional workshops reported enhanced understandings of the



importance of and modes for quality improvement through interprofessional practice. Students who participated in the interprofessional health communications course reported acquiring more effective communication, team decision-making, and conflict management competencies, and educators reported experiencing greater inter-institutional collaboration and increased recognition of the need to work together.

APPLICABILITY/TRANSFERABILITY:

Several spin-off projects have been developed out of BRAID and the Tucker Park Collaborative, including the establishment of (1) collaborative committees such as the Health Educator's Learning Partnership Group and the Health and Life Sciences Steering Committee; (2) regular student-focused events such as the Health Mentor's Program (ongoing for the last three years and to be assessed soon) and Interprofessional Health Research Day (ongoing for the last five years); (3) a new program to bridge licensed practical nurses into the baccalaureate-accredited program, which received additional funds from the provincial government and will start accepting students in January 2014; and (4) interprofessional integration through clinical placements, co-teaching of a communications course, development of a Master of Adult Education for Health Educators, and extended research collaborations. The interprofessional education strategies have been presented at regional, national, and international conferences, including several Collaborating Across Borders Conferences. The Tucker Parker Steering Committee serves as the overall monitoring body.

Key areas identified as contributing to the success of BRAID include the establishment of the non-hierarchical structure among interdisciplinary faculty and program organizers, the standardization and consistent application of the BRAID Interprofessional Competencies Framework across all BRAID education initiatives, and the engagement of students in the program design via the New Brunswick Health Sciences Student Association (e.g., students participated in the creation of two IP educational videos). Given that this project was primarily federally funded, transferability of this project is dependent on local capacities and political will.

CONTACT INFORMATION:

Name: Roberta Clark

Title: Assistant Dean for Health Research & Partnerships

Organization: University of New Brunswick, Saint John

Email address: Roberta.Clark@unb.ca

Telephone number: (506) 648-5821

Information last updated on: Sep 13, 2013

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

Publications:

Bridging Relationships Across Interprofessional Domains (BRAID). (2008). *Final BRAID project report*. Saint John, NB: BRAID. Retrieved from

http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&lin...=6536&cf_id=68&lang=en

Personal Communications:

Clark, R. (October 21, 2013).

Alternative Profiles:

BRAID. (n.d.). *A logic model in action: Interprofessional education for collaborative patient-centred chronic disease care*. Retrieved from http://www.cihc.ca/files/projects/atlantic/BRAID_LogicModel_07.jpg

Canadian Interprofessional Health Collaborative. (2007). *BRAID: Bridging relationships across professional domains*. Retrieved from http://www.cihc.ca/files/projects/atlantic/CIHC_IPE-BRAID.pdf

External Source: <http://www.unb.ca/saintjohn/vp/tuckerpark/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Oncology Patient-Navigator Nurse (infirmière pivot en oncologie)

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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



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

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

CONTACT INFORMATION:

Name: Lise Fillion

Title: Registered Nurse

Organization: Faculty of Nurses, Laval University

Email address: lise.fillion@fsi.ulaval.ca

Telephone number: (418) 525-4444 ext. 15754

Information last updated on: August 20, 2013

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

Publications

Fillion, L., de Serres, M., Lapointe-Goupil, R., Bairati, I., Gagnon, P., Deschamps, M., ... Demers, G. (2006). Implementing the role of patient-navigator nurse at a university hospital centre. *Canadian Oncology Nursing Journal*, 16(1), 11–7, 5–10. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17078346>

Santé et Services Sociaux du Québec–Comité consultatif des infirmières en oncologie. (2008). *Rôle de l'infirmière pivot en oncologie ; Direction de la lutte contre le cancer*. Retrieved from <http://collections.banq.qc.ca/ark:/52327/bs2034490>

Santé et Services Sociaux du Québec. (2009). *Le Rapport d'activité 2008–2009 de la Direction de la lutte contre le cancer*. Retrieved from <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2009/09-902-02.pdf>

Direction québécoise du cancer. (2012). *Le Bilan des réalisations : Orientations prioritaires 2007–2012 du Programme québécois de lutte contre le cancer*. Retrieved from <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2011/11-902-16.pdf>

Ministère de la Santé et des Services sociaux, Direction québécoise du cancer. (2013). *Plan d'action en cancérologies 2013–2015: Ensemble en réseau pour vaincre le cancer*. Retrieved from <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2013/13-902-03W.pdf>

Personal Communications:

Lise Fillion, L. (August 20, 2013). [Laval University].

External Source: http://www.msss.gouv.qc.ca/sujets/prob_sante/cancer/index.php?accueil



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Express Chemotherapy Clinic

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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



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

CONTACT INFORMATION:

Name: Eleanor Hendershot

Title: Clinical Nurse Specialist-Nurse Practitioner; Lecturer

Organization: The Hospital for Sick Children; University of Toronto

Email address: eleanor.hendershot@sickkids.ca

Telephone number: 416-813-7515

Information last updated on: July 15, 2013

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

Publications:

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

Personal Communications:

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

External Source:

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



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

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:

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.landon@cogeco.ca

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/>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Including patients and families on hospital Unit Action Councils to promote patient-centered Integrated Interprofessional Care

LOCATION:	Ontario	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice portrays an interprofessional, patient-centred, collaborative practice model of care delivery through engaging patients and their families as members of Unit Action Councils (UACs). This project was launched in 2011 in Ontario across an alliance of four rural community hospitals.

PRACTICE DESCRIPTION:

There is growing recognition of the need for health care professionals across all sectors to work in interprofessional teams in order to improve the quality, safety, continuity, and cost-effectiveness of health care delivery. To ensure success, patients and their families need to be meaningfully engaged on interprofessional teams as full partners in the design, delivery, and evaluation of health care services.

The Huron Perth Healthcare Alliance (HPHA) of four rural community hospitals began implementing an interprofessional practice model in 2010. The creation of Unit Action Councils (UACs) on patient care units is one of the key initiatives to advance interprofessional care (IPC) and enhance patient and family-centred care (PFCC); however, traditionally these councils have only included health care professionals. In partnership with the Canadian Foundation for Healthcare Improvement (CFHI), the University of Western Ontario, and Fanshawe College, the HPHA launched a patient engagement project that would see the inclusion of patients and family members on the UACs, to create a unique model of interprofessional, patient-centred, collaborative practice.

The two-year project launched in 2011 and began with a collection of narratives written by patients and families that were validated through open community forums. These narratives shared both positive and negative experiences and established the core values of care recipients. These data were then used by UACs to guide project work that would enhance IPC, PFCC, and the quality of care delivered.

The pilot consists of 15 UACs, eight of which include a patient and a family member on the council (intervention). The remaining seven UACs include only health care professionals (control). All leaders and care providers at each hospital attended an educational workshop on IPC and PFCC prior to the formation of the UACs. The patient and family members recruited also participated in an educational workshop prior to the first meetings of their UACs.

All 15 UACs have now developed patient-centred models to revise care delivery based on the values determined through narratives and forums. As council members, patients and family members are involved in setting up new processes and structures to reflect the PFCC model, collecting data to monitor output, and evaluating the intervention's effect on outcomes. Following the two-year study, the UACs will remain as part of the hospitals' organizational structure.

IMPACT:

Qualitative data to guide the projects were obtained from the patient narratives, community forums, and focus groups that were held with the intervention and control units. Common themes emerged, including timeliness, communication, caring, respect, and continuity of care.

An evaluation plan is in place. The effectiveness and impact of the UACs will be evaluated through a variety of measures. UAC members will be assessed using validated tools that measure collaboration, quality of life, and empowerment. Patients and families will be surveyed using validated tools that measure quality and safety of care and self-care management. Additionally, clinical data related to quality of care and safety outcomes will be collected. Summative and formative evaluations will be



completed at five points during the study. These evaluations will compare intervention and control outcomes to determine the impact of including patients and families as UAC members. A final report is expected in November 2013.

The project was funded in part by the CFHI's patient engagement initiative (2011). Each of seven projects received support, mentoring, and an investment of \$700,000 that was matched through co-sponsorship support. After November 2013, costs will be covered by operating budgets in each hospital.

APPLICABILITY/TRANSFERABILITY:

The UAC patient engagement project has not been adapted from another jurisdiction or implemented elsewhere; it is the first to engage patients and families on UACs. However, this initiative is theoretically transferable to other settings. Already, this model of patient engagement is being used to enhance the involvement of patients and families in other patient care committees throughout the HPHA organizations. Results from this pilot are theoretically applicable in other health care organizations.

Lessons learned for applicability/transferability:

- Educational sessions for staff, leadership, and patient and family members were critical in enabling and sustaining the culture shift to a new model of care.
- Patients and family members contribute more than simply perspectives on care; they bring diverse skills that complement those of staff. However, recruitment may take longer than expected.
- Mentoring is useful for the staff who fulfill the facilitator role for the UACs.
- Alignment with organizational strategies and priorities, as well as support from the Senior Leadership Team, Clinical Program Directors, and Board is essential.
- Meaningful engagement of physicians early in the process is necessary.

CONTACT INFORMATION:

Name: Dianne Gaffney

Title: Corporate Lead, Professional Practice

Organization: Huron Perth Healthcare Alliance

Email address: dianne.gaffney@hpha.ca

Telephone number: 519-272-8210 ext. 2316

Information last updated on: July 31, 2013

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

Personal Communications:

Gaffney, D. (review, July 2013). [Huron Perth Healthcare Alliance].

Other:

Gaffney, D. Abstract submission to the Health Council of Canada's National Symposium of Integrated Care (2012).

Canadian Foundation for Healthcare Improvement. (n.d.). *Patient engagement projects funded in 2011*. Retrieved from <http://www.cfhi-fcass.ca/WhatWeDo/Collaborations/PatientEngagement/Projects2011.aspx>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Registered Nurse–Surgical First Assist

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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



CONTACT INFORMATION:

Name: Colleen Lipskie

Title: Team Lead/ Senior Policy Analyst

Organization: Ministry of Health and Long-Term Care

Email address: colleen.lipskie@ontario.ca

Telephone number: 416-212-3846

Information last updated on: August 21, 2013

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

Health Force Ontario. (2009). *Registered nurse: Surgical first assist (RN-SFA) pilot project update*. Retrieved from

http://www.health.gov.on.ca/english/providers/program/nursing_sec/docs/surgical_first_assist.pdf

Personal Communications:

Lipskie, C. (interview, August 21, 2013).



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Primary Care Clinical Associate Initiative

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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



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

CONTACT INFORMATION:

Name: Grace Moe

Title: Executive Director, Strategic Planning

Organization: WestView Primary Care Network

Email address: grace.moe@westviewpcn.ca

Telephone number: 780-948-2435

Information last updated on: August 7, 2013

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

Publications:

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

Personal Communications:

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

External Source: www.westviewpcn.ca



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

Nurse and Dietitian Health Teams to Prevent Diabetic Complications

LOCATION:	Alberta	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice improves the quality of diabetes management through the use of interprofessional health care teams delivering interventions to persons aged 17 years or older with diabetes and hypertension or albuminuria. The initial pilot round was launched in five communities in northern Alberta in 2004. The program has since been expanded to a total of eight communities (two urban and six rural), serving over 3,000 patients.

PRACTICE DESCRIPTION:

To address the generally increasing burden of diabetes and chronic kidney disease, interprofessional teams were established to include a registered nurse and a registered dietitian in clinics staffed by an endocrinologist, nephrologist, advanced practitioner/project manager, pharmacist, and clerk. The roles of the nurse and dietitian involved promoting the development and use of evidence-based protocols and guidelines, helping to control risk factors through lifestyle coaching, conducting regular follow-ups, and adjusting multifactorial interventions based on individual development.

The clinics were advertised to health care providers to initiate the referral process. New patient intakes involved a standardized assessment conducted by the nurse and dietitian (two hours in duration), subsequent visits lasted one hour, and reports from each visit were sent to the referring physician. The education program for nurses and dietitians associated with introduction of this care model involved an initial five-day residential training program, followed by monthly one-day training sessions, bi-weekly telehealth sessions, and ongoing, on-site mentoring by the program's advanced nurse practitioner.

Initially, the pilot project was funded by the provincial government, with a start-up budget of \$800,000 per annum. Funding now falls under the Northern Alberta Renal Program, with the local health authority as the acting employer.

IMPACT:

During the initial data collection period between 2004 and 2005, there were 570 referrals received, 99% of which were eligible and came predominantly from family physicians (as compared to specialists). A longer assessment period continued into 2007, in which 235 patients were followed up for one year of receiving services. Clinically significant improvements were reported for patients across indicators for blood pressure, glycemia, lipid levels, and albuminuria. However, patients who did not adhere to lifestyle changes such as smoking cessation had consistently worse clinical outcomes. Successes were attributed to the role of the interprofessional team and the follow-up visits to reinforce advice from physicians to operationalize lifestyle changes. Follow-up visits were calculated to cost \$130 each, but no formal cost-effectiveness evaluation was done.

APPLICABILITY/TRANSFERABILITY:

This innovative practice is considered to be transferrable as demonstrated by its expansion to other northern Alberta communities following the initial pilot period. Although one of the initial clinics in Red Deer closed, there are now eight communities hosting these interprofessional clinics, which are monitoring over 1,800 patients in total. Active clinics include:

- Edmonton, Northeast Community Health Centre (est. January 2004);
- Vermilion (est. January 2004);
- Hinton (est. January 2004);
- Wetaskiwin (est. January 2004);
- Edmonton, Grey Nuns Hospital (est. October 2005);



- Edson (est. January 2007);
- Grande Prairie (est. February 2007); and
- Fort McMurray (est. June 2008).

Challenges in the background context that were noted included persistent underuse of proven therapies, undersupply of physicians in rural settings, and fee-for-service payment schemes that are not aligned with ongoing, chronic disease management. Specific to the introductions of new programs, careful communication was required to establish trust around the transcendence of traditional roles practised by the registered nurses and manage perceptions of overlapping services with pre-existing programs. Key factors contributing to this program's success were the partnership with local health authorities and the positive reception from participating communities.

CONTACT INFORMATION:

Name: Carolyn Good

Title: Office Coordinator

Organization: Diabetic Nephropathy Prevention Clinics, Alberta Health Services

Email address: carolyn.good@albertahealthservices.ca

Telephone number: 780-407-1443

Information last updated on: July 26, 2013

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

Publications:

Senior, P.A., MacNair, L., & Jindal, K. (2008). Delivery of multifactorial interventions by nurse and dietitian teams in a community setting to prevent diabetic complications: A quality improvement report. *American Journal of Kidney Diseases*, 51(3), 425–434. Retrieved from <http://www.ajkd.org/article/S0272-6386%2807%2901586-7/abstract>

Gamble, J.M., Hoang, H., Eurich, D.T., Jindal, K.K., & Senior, P.A. (2012). Patient level evaluation of community-based, multifactorial intervention to prevent diabetic nephropathy in northern Alberta, Canada. *Journal of Primary Care & Community Health*, 3, 111–119. Retrieved from <http://jpc.sagepub.com/content/3/2/111.full.pdf+html>

Personal Communications:

Senior, P.A. (July 25, 2013). [Associate Professor/Principal Investigator, University of Alberta].

McKenzie, J. (July 25, 2013). [Project Manager, Alberta Health Services].

External Source: <http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001687>



Share to: [Facebook](#) [Twitter](#) [LinkedIn](#)

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

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

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

PRACTICE DESCRIPTION:

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

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

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

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

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



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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

CONTACT INFORMATION:

Name: Louise Cholock

Title: Director, NIHB

Organization: Health Canada, First Nations and Inuit Health Branch, Atlantic Region

Email address: Louise.Cholock@hc-sc.gc.ca

Telephone number: (902) 426-2519

Information last updated on: October 7, 2013

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

Personal Communications:

Boychuk, R. and Cholock, L. (interview and feedback, July 2013). [First Nations Inuit Health Branch-Atlantic Region].