Health Innovation Portal:
Archive of Innovative Practices

Theme: **Health Human Resources (Vol. 2)**

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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:	34 results out of 92

1. 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

2. The C.A.R.E. Tool—Support for integrated care of caregivers and care receivers

Implementation Year: Monday, November 5, 2001 - 14:15	**Location: Quebec**	**Practice Website: www.msvu.ca/nsca/caregiverassessment**

SNAPSHOT:

This innovative practice supports the integrated care of both care receivers and care givers by offering a framework for engaging caregivers in a discussion about their concerns and expectations. This multidimensional psycho-social instrument was initially piloted in 2001 with practitioners in Quebec and Nova Scotia working in publicly funded agencies responsible for coordinating home care services.

CONTACT INFORMATION:

Name: Nancy Guberman Title: Retired Professor of Social Work Organization: University of Quebec in Montreal Email address: Guberman.nancy@uqam.ca ; caretool@msvu.ca Telephone number: 514-276-6236 Information last updated on: July 16, 2013

3. Nova Scotia's Cancer Patient Navigation Program

Implementation Year: Sunday, October 7, 2001 - 14:00	**Location: Nova Scotia**	**Practice Website: http://www.cancercare.ns.ca/en/home/nscancerservices/cancerpatientnavigation/default.aspx**

SNAPSHOT:

This innovative practice addresses the issue of improving the coordination and continuity of care for cancer patients. The program is a proactive intentional process of collaboration between the patient/family and interprofessional care team to provide clinical interventions, education, emotional support, and logistical assistance as patients and families cope with complex treatments, services, and potential barriers throughout the continuum of care. The community-based practice employs specialized oncology nurses as cancer patient navigators and was launched in Nova Scotia in 2001 at the district health authority level.

CONTACT INFORMATION:

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

4. The Mental Health Engagement Network: Providing Patients Access to Personalized Health Records via

Smartphone Technology

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

5. Glenrose Rehabilitation Hospital's Interprofessional Student Service Initiative

Implementation Year: Sunday, October 7, 2012 - 13:15	**Location: Alberta**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the issue of increasing student access to interprofessional clinical educational experiences while also increasing access to rehabilitation services for adults and seniors. It was initiated at the Glenrose Rehabilitation Hospital in 2012 through collaboration with the University of Alberta's Faculty of Rehabilitation Medicine.

CONTACT INFORMATION:

Name: Isabel Henderson, Vice President Organization: Alberta Health Services, Glenrose Rehabilitation Email address: Isabel.henderson@albertahealthservices.ca Telephone number: 780-735-7984

6. Resources in Clinics (RICs): Interprofessional Teamwork in Primary Care

Implementation Year: Thursday, October 7, 2010 - 13:00	**Location: Alberta**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the issue of encouraging teamwork in an interprofessional primary care setting by pairing (forming dyads) of family physicians and support staff. The practice was launched in June 2010 in Alberta in one primary care network (Edmonton North) and involved individual family physicians and their staff.

CONTACT INFORMATION:

Name: Paul Regehr Title: Clinical Manager Organization: Edmonton North Primary Care Network Email address: pregehr@enpcn.com Telephone number: 780-377-4084

7. Antimicrobial Stewardship Program to Decrease Hospital Infections

Implementation Year: Wednesday, February 3, 2010 - 11:00	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the issue of optimizing antimicrobial use as a means to control hospital-acquired infections and enhance patient safety. In April 2010, Toronto East General Hospital implemented an antimicrobial stewardship program (ASP) as part of the Ontario Antimicrobial Stewardship Project.

CONTACT INFORMATION:

Name: Dr. Jeff Powis, Director, Antimicrobial Stewardship Program Organization: Toronto East General Hospital Email address: jpowi@tegh.on.ca Telephone number: 416-4698-6252

8. Safer Care for Older Persons (in residential) Environments (SCOPE)

Implementation Year: Thursday, September 2, 2010 - 00:45	**Location: Alberta, British Columbia**	**Practice Website: N/a**

SNAPSHOT:

This innovative practice addresses improving the safety and quality of care of frail elderly residents living in nursing homes, as well as improving the quality of work life for front-line caregivers in nursing homes. The practice was launched in Alberta and British Columbia in two large nursing homes (Alberta) and five smaller ones (Okanagan, BC). The initiative involved 10 units over the seven homes, each consisting of a senior sponsor (manager), two or three health care aides, and one or two registered professionals such as a registered nurse or registered physiotherapist.

CONTACT INFORMATION:

Name: Lisa A Cranley Title: Associate Professor Organization: Faculty of Nursing, University of Alberta Email address: lisa.cranley@nurs.ualberta.ca Telephone number: N/A Information last updated on: July 8, 2013

9. North York Family Health Team Colorectal Cancer Survivorship Program

Implementation Year: Friday, February 3, 2012 - 09:00	**Location: Ontario**	**Practice Website: http://www.nyfht.com/displayProgram.php?prog=Colorectal%20Cancer%20Surviorship%20Program**

SNAPSHOT:

This innovative practice addresses providing care for patients who have received treatment for colorectal cancer (stage 1, 2, or 3) for the recommended five-year follow-up period. The practice was launched in Ontario in one hospital and involved nurse practitioners, a case worker, and a receptionist.

CONTACT INFORMATION:

Name: Dr. Kimberly Wintemute Title: Medical Director Organization: North York Family Health Team Email address: N/A Telephone number: (416) 223-0555 Program number: (416) 494-3003 ext. 131 Information last updated on: (put in the date that you found the information)

10. The Reitman Centre CARERS Program: Equipping carers with practical skills and emotional support to provide better care for individuals with dementia

Implementation Year: Sunday, February 3, 2008 - 00:00	**Location: Ontario**	**Practice Website: http://www.mountsinai.on.ca/care/reitman**

SNAPSHOT:

This innovative practice addresses the need to equip professional and community carers with practical and emotional coping skills to enable them to effectively provide care to individuals with dementia. The program launched in an academic teaching hospital training centre in Ontario in 2008 with a focus on community-based carers, but is now expanding to provide workplace-based training to carers engaged in the workforce (working carers).

CONTACT INFORMATION:

Name: Dr. Joel Sadavoy Title: Head of Geriatric Psychiatry, the Reitman Centre for Alzheimer's Support and Training; Head of Community Psychiatry Services Organization: Mount Sinai Hospital Email address: Jsadavoy@mtsinai.on.ca Telephone number: 416-586-5262 Information last updated on: August 8, 2013

11. Kingston General Hospital Interprofessional Collaborative Practice Model

Implementation Year: Tuesday, February 3, 2009 - 00:15	**Location: Ontario**	**Practice Website: N/a**

SNAPSHOT:

This innovative practice addresses the design and implement of a safe, cost-effective, patient- and n family-centred interprofessional collaborative in-hospital practice model (ICPM). The ICPM was implemented in Ontario beginning in November 2009 in multiple patient care units in a large hospital.

CONTACT INFORMATION:

Name: Cynthia Phillips Title: Manager, Interprofessional Collaborative Practice & Education Organization: Kingston General Hospital Email address: phillipc@kgh.kari.net Telephone number: 613-549-6666 x.4867 Information last updated on: May 29, 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

13. Performance Huddles: Bringing Interprofessional Teams Together to Improve Quality and Safety

Implementation Year: Thursday, February 3, 2011 - 00:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses how interprofessional teams communicate, collaborate, and monitor their progress on quality improvement at the point of care. This interactive practice was launched in Ontario in November 2011, taking place in numerous patient care units at three sites of a multi-site hospital system.

CONTACT INFORMATION:

Name: Kiki Ferrari Title: Executive Director, Clinical Services Organization: William Osler Health System Email address: kiki.ferrari@williamoslerhs.ca Telephone number: 905 494 2120 ext. 50167 Information last updated on: May 6, 2013

14. Heart Failure Outreach Support Team (HOST)

Implementation Year: Thursday, February 10, 2011 - 09:00	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice facilitates reduction in 30-day hospital readmissions for patients with heart failure by changing the role of registered nurses in the discharge process. The practice was launched in British Columbia in one health authority and involved registered nurses, cardiovascular services, cardiovascular department administration, and interprofessional hospital teams.

CONTACT INFORMATION:

Name: Carol Galte Title: Heart Failure Outreach Support Team Leader Organization: Cardiac Services for Surrey Memorial Hospital, Fraser Health Authority Email address: Carol.Galte@fraserhealth.ca Telephone number: 604-805-1142 Information last updated on: May 19, 2013

15. Assessment of Implementing Disease-State Education Modules on Specific Pharmacist Interventions: "AIMS" Study

Implementation Year:	**Location: British Columbia**	**Practice Website:**

Thursday, February 10, 2011 - 00:00		

SNAPSHOT:

This innovative practice aims to determine if disease-state education models result in improved patient care. The practice was launched in British Columbia in one health region (Interior Health) and involved pharmacists and pharmacy leaders with a background in pedagogy and training.

CONTACT INFORMATION:

Name: Sean K. Gorman Title: Regional Coordinator Organization: Clinical Quality and Research Pharmacotherapeutic Specialist –Critical Care, Interior Health Email address: N/A Telephone number: N/A Information last updated on: May 31, 2013

16. Interprofessional Student-Led Clinic for Physiotherapy and Occupational Therapy

Implementation Year: Monday, February 2, 2009 - 00:30	**Location: British Columbia**	**Practice Website: http://physicaltherapy.med.ubc.ca/clinical-education/clin-ed-current-students/placement-opportunities/**

SNAPSHOT:

This innovative practice aims to increase clinical placement capacity and leadership among physiotherapy and occupational therapy students, and to promote an integrated interprofessional care model. The practice was launched in British Columbia in June 2009 as an outpatient clinic in a large acute care hospital setting.

CONTACT INFORMATION:

Name: Scott Brolin Title: Program Director, Rehabilitation / Allied Health Organization: Fraser Health Email address: scott.brolin@fraserhealth.ca Telephone number: 604-897-4252

17. Primary Musculoskeletal Provider

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

18. Occupational Therapy Examination and Practice Preparation (OTepp) Program

Implementation Year: Sunday, February 3, 2008 - 00:15	**Location: Ontario**	**Practice Website: http://www.otepp.ca/**

SNAPSHOT:

This innovative practice demonstrates how to support and enable the transition of internationally educated occupational therapists (IEOTs) into Canadian practice.

CONTACT INFORMATION:

Name: Sue Baptiste Title: Professor Organization: McMaster University, School of Rehabilitation Science Email address: baptiste@mcmaster.ca Telephone number: 905 525 9140 ext. 27804

19. The Ottawa Hospital Inter-professional Model of Patient Care (TOH IPMPC©)

Implementation Year: Saturday, February 3, 2007 - 00:30	**Location: Ontario**	**Practice Website: http://www.ottawahospital.on.ca/wps/portal/Base/TheHospital/OurModelofCare/ProfessionalModels/InterProfessionalModelofPatientCare**

SNAPSHOT:

This innovative practice is a guide to organizing the delivery of patient care among health professionals from different disciplines, taking into account their competencies, collaborative patient-centred practice, and their hospital's strategic directions.

CONTACT INFORMATION:

Name: Ginette Rodger Title: Senior VP Professional Practice and Chief Nursing Executive Organization: The Ottawa Hospital Email address: grodger@ottawahospital.on.ca Telephone number: 613-737-8749 Information last updated on: April 5 2013

20. A Continuum of Care from Hospital to Home for Clients Requiring Long-Term Ventilation

Implementation Year: Sunday, February 3, 2008 - 00:30	**Location: Ontario**	**Practice Website: http://www.crto.on.ca/hfo.aspx**

SNAPSHOT:

This innovative practice aims to demonstrate that the addition of Respiratory Therapists (RT) to the community healthcare team would allow many of Long Term Ventilation (LTV) clients to safely transition into, and remain in their own homes.

CONTACT INFORMATION:

Name: Carole Hamp Title: Manager of Quality Assurance & Member Relations Organization: College of Respiratory Therapists of Ontario Email address: hamp@crto.on.ca Telephone number: 416-591-7800 x33

21. Nurse Practitioner–Led Clinics: Reforming Health Care with Interprofessional Teams

Implementation Year: Saturday, February 3, 2007 - 00:45	**Location: Ontario**	**Practice Website: http://npao.org/nurse-practitioners/clinics/**

SNAPSHOT:

This innovative practice addresses the lack of community health care services through a nurse practitioner led clinic.

CONTACT INFORMATION:

Name: Beth Cowper-Fung Title: Clinic Director, Georgina NPLC and President of NPAO Organization: Nurse Practitioners' Association of Ontario Email address: beth.cowperfung@gnplc.ca Telephone number: 905-722-3251 Information last updated on: April 17, 2013

22. The Nursing Graduate Guarantee (NGG): An Innovative Employment Policy in Ontario

Implementation Year: Saturday, February 3, 2007 - 00:45	**Location: Ontario**	**Practice Website: http://www.healthforceontario.ca/en/Home/Nurses/Training_%7C_Practising_In_Ontario/Nursing_Strategy/Nursing_Graduate_Guarantee**

SNAPSHOT:

The aim of this innovative program is to increase full-time employment and integration of new graduate nurses into the workforce across diverse healthcare sectors.

CONTACT INFORMATION:

Name: Andrea Baumann, RN, PhD Title: Scientific Director Organization: Nursing Health Services Research Unit, McMaster University Email address: baumanna@mcmaster.ca Telephone number: 905-525-9140 x22581 Information last updated on: April 22 , 2013

23. Bereavement Information and Support Program, Multimedia Resource Manual

Implementation Year: Friday, February 3, 2012 - 01:15	**Location: Newfoundland & Labrador**	**Practice Website: http://www.easterhealth.ca**

SNAPSHOT:

This innovative practice equips individuals and groups with knowledge and tools to establish bereavement support programs in their own communities.

CONTACT INFORMATION:

Name: Rick Singleton Title: Regional Director of Pastoral Care and Ethics Organization: Eastern Health Telephone: (709) 777-8940 Email: rick.singleton@easternhealth.ca

24. Advanced Training Program, Intermountain Healthcare

Implementation Year: Friday, February 1, 1991 - 00:45	**Location: International**	**Practice Website: http://intermountainhealthcare.org/qualityandresearch/institute/courses/atp/Pages/home.aspx**

SNAPSHOT:

This innovative practice is designed to train senior leaders, middle managers, and front-line health professionals in the theory and application of cost control, quality control, and the health services academic infrastructure. Launched in the US in 1991, the training program has expanded and is offered across Canada.

CONTACT INFORMATION:

Name: Jean-Ann Wurtz Title: Advanced Training Program Coordinator Organization: Institute for Health Care Delivery Research, Intermountain Healthcare Email address: jean-ann.wurtz@imail.org Telephone number: (801) 442-3718

25. BC Health Leadership Development Collaborative – Transforming Linx

Implementation Year: Monday, January 2, 2012 - 00:30	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the need for senior health system levels to lead innovative and change. This 10-month, project-based leadership development experience was launched in British Columbia in 2012.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

26. BC Health Leadership Development Collaborative - Collaboration Practice

Implementation Year: Friday, February 3, 2012 - 00:30	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice is a province-wide collaboration between all Health Authorities in British Columbia to support, develop, engage and advocate for leaders with the ultimate goal of delivering exceptional patient outcomes.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

27. BC Health Leadership Development Collaborative – Mentoring Linx

Implementation Year: Friday,	**Location: British Columbia**	**Practice Website:**

February 3, 2012 - 00:30		

SNAPSHOT:

This innovative practice provides flexible, individualized mentoring opportunities, including long-term mentoring relationships and short-term engagements to discuss specific topics or situations and is available to "people who lead people". Using state-of-the-art software health system leaders create their own mentoring match based on skills, goals, interests and personality and can be matched with leaders across British Columbia.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

28. BC Health Leadership Development Collaborative – Core Linx

Implementation Year: Friday, February 3, 2012 - 00:30	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice is a comprehensive leadership and management development program designed for managers in the first 18 months of their first formal management role in a British Columbia Health Authority.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

29. BC Health Leadership Development Collaborative – Coaching Linx

Implementation Year: Friday, February 3, 2012 - 00:30	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice is designed to help senior leaders (directors and above) within each Health Authority in British Columbia enhance their leadership capacity by focusing on topics such as managing challenging workplace issues, learning from feedback or implementing a new initiative.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

30. InspireNet: Innovative Nursing Services & Practice Informed by Research & Evaluation Network

Implementation Year: Thursday, February 3, 2011 - 09:30	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to create a web based network of individuals and organizations working collaboratively to advance and use research and knowledge to improve nursing health services in British Columbia.

CONTACT INFORMATION:

Name: Pat Atherton Title: Manager Organization: Inspirenet Email address: patherton@inspirenet.ca

31. Physician Integrated Network (PIN) Initiative

Implementation Year: Friday,	**Location: Manitoba**	**Practice Website:**

February 3, 2006 - 00:45		**http://www.gov.mb.ca/health/primarycare/pin/index.html**

SNAPSHOT:

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

CONTACT INFORMATION:

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

32. ColonCancerCheck

Implementation Year: Sunday, February 3, 2008 - 00:45	**Location: Ontario**	**Practice Website: http://www.health.gov.on.ca/en/public/programs/coloncancercheck/**

SNAPSHOT:

This innovative practice is a population based colorectal screening program. Launched in Ontario in spring 2008, it aims to increase capacity of primary care providers (PCPs) to facilitate the screening tests.

CONTACT INFORMATION:

Name: Jill Tinmouth Title: Scientific Lead Organization: ColonCancerCheck Program, Cancer Care Ontario Email address: jill.tinmouth@sunnybrook.ca Telephone number: 416-480-6100, ext. 5910

33. Manitoba Lean Six Sigma Strategy Training: Green and Black Belt Networks

Implementation Year: Wednesday, February 3, 2010 - 00:30	**Location: Manitoba**	**Practice Website: http://www.gov.mb.ca/health/mpan/pdf/demone.pdf**

SNAPSHOT:

This innovative practice addresses the need to support health care stakeholders in applying Lean Management throughout the Manitoba health system. Established in 2010, this program fosters a community of particpants that provide up to a year of mentorship for staff undergoing Lean training and a way for staff to come together to learn about and support each other's diverse improvement projects.

CONTACT INFORMATION:

Name: Dawn Ridd Title: Manager Provincial Lean Strategy, Manitoba Health; Rapid Improvement Lead, Cancer Patient Journey Organization: Manitoba Health Email address: dawn.ridd@gov.mb.ca Telephone number: 204-788-6667

34. Strategic Clinical Networks in Alberta

Implementation Year: Thursday, February 3, 2011 - 00:30	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/6047.asp**

SNAPSHOT:

This innovative practice has been developed as part of a provincial quality improvement effort to enhance the patient journey, improve health outcomes, and standardize care delivery. Established throughout Alberta in 2011, the purpose of the Strategic Clinical Networks is to engage clinicians and patients in decision-making about clinical services planning and to support clinical practice improvement by implementing clinical practice guidelines (CPG), developing care 'pathways', improving the patient experience and more.

CONTACT INFORMATION:

Name: Dr. Tom Noseworthy Title: Associate Chief Medical Officer, SCNs and Clinical Care Pathways Organization: Alberta Health Service Email address: Tom.Noseworthy@albertahealthservices.ca Telephone number: (780) 342-2014

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/

The C.A.R.E. Tool—Support for integrated care of caregivers and care receivers

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

SNAPSHOT:

This innovative practice supports the integrated care of both care receivers and care givers by offering a framework for engaging caregivers in a discussion about their concerns and expectations. This multidimensional psycho-social instrument was initially piloted in 2001 with practitioners in Quebec and Nova Scotia working in publicly funded agencies responsible for coordinating home care services.

PRACTICE DESCRIPTION:

The well-being of family caregivers is a growing public health issue, and yet they have little formal status and access to the health and social service system in their own right. While practitioners are aware of the challenges caregivers face, they are challenged to provide integrated care to both the patient and the caregiver.

In response to this, the Caregivers' Aspirations, Realities and Expectations (C.A.R.E.) Tool was developed in 2001 for practitioners as part of an initiative focused on developing appropriate, evidence-informed instruments for assessing and evaluating the specific needs of family caregivers. The C.A.R.E. Tool provides a framework for a conversation between practitioners and caregivers about the caregivers' potential concerns and expectations, while providing insight into the caregiving situation and ways to integrate the support of the caregiver with that of the care recipient.

The original tool was developed in 1999/2000 and assessed to ensure relevance and reliability. It was developed with input from family caregivers and after examining close to 100 other instruments. None of the other instruments addressed a range of caregiver issues, which was the aim of the C.A.R.E. Tool. The Tool is available in both English and French, and training for practitioners to use the tool is required.

Overall, the C.A.R.E. Tool enhances the assessment skills of practitioners and their understanding of the needs of caregivers, while improving their capacity to support caregivers and care recipients. It is hoped that these discussions will lead to a more integrated approach to supporting care receivers and caregivers, as well as greater recognition of the role played by caregivers in the health system.

IMPACT:

The C.A.R.E. Tool has been used in a number of research studies and evaluation initiatives since its development in an effort to understand its utility in practice and its impact with different caregiver populations. The draft instrument was piloted with over 150 caregivers through home care practitioners from seven agencies in Quebec and Nova Scotia. Results from the pilot were used to refine the tool, which was further condensed in 2007 through a contract with Health Canada. In several studies, caregivers have reported benefits such as having the opportunity to share their experience with a professional, feeling comfortable identifying their own needs and concerns, having their experiences validated, and becoming increasingly aware of information about support services.

In a study involving nursing students, using the tool increased their awareness of the realities of older spouse caregivers, provided information on available resources, and helped them understand the role they have as a health care professional in supporting caregivers. The body of evidence suggests the C.A.R.E. Tool as a stand-alone intervention has positive implications for the caregiver and practitioner, increasing practitioners' appreciation of caregivers' situations, enhancing caregiver-practitioner relationships, and providing evidence to support referrals to services and supports for caregivers.

There is no fee to access the C.A.R.E. Tool, although implementation may carry costs involved with one-time training (in person or online). For a project with Alberta Health Services (AHS), $213 was the estimated cost of completing a caregiver assessment

based on the salary rates of coordinators (RNs), travel allowance, and the average length of time required.

APPLICABILITY/TRANSFERABILITY:

The C.A.R.E. Tool is currently in use in several agencies in Quebec, as well as by practitioners in Nova Scotia, Ontario, and Alberta. It has also been culturally adapted for use in France and New Jersey.

The tool was used in 2011/12 as part of a Caregiver Support and Enhanced Respite Pilot Project led by AHS. Its use in this context showed findings similar to those of previous studies. Caregiver assessment had positive outcomes for caregivers—they became more aware of their role, began to consider their own needs, gained a better understanding of their situation and how caregiving was affecting them, and became more accepting of support and information. Likewise, the Home Care Coordinators reported a greater appreciation of the caregiver situation and used the results of the caregiver assessment as a decision support tool to provide rationale for referrals to respite services and other community services.

While originally conceived for use by home care programs, the C.A.R.E. Tool has been used in hospitals and by community organizations (including the Alzheimer's Society and community care giver groups), and with a wide variety of caregivers, including those caring for the elderly or for adults with disabilities or mental health issues. The tool was recently used as part of an initiative to understand the experience of spouses caring for persons with dementia.

A major challenge for implementing this tool is that caregivers are not always formally recognized in the system. This can make it difficult for practitioners to engage them in the assessment, or even to recognize the need for their involvement. As well, concerns about time to conduct a comprehensive assessment and the inability to meet expectations that may arise have also been identified as challenges.

To facilitate future implementation of the C.A.R.E. tool, it is believed that caregivers must become an agency priority, the purpose and use of the Tool should be clearly defined, the Tool should be integrated with existing tools, staff should be brought on board from the outset, and training must be assured.

CONTACT INFORMATION:

Name: Nancy Guberman

Title: Retired Professor of Social Work

Organization: University of Quebec in Montreal

Email address: Guberman.nancy@uqam.ca ; caretool@msvu.ca

Telephone number: 514-276-6236

Information last updated on: July 16, 2013

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

Personal Communications:

Guberman, N., & Fancey, P. (review and feedback, July 2013).

Publications:

Keefe, J., Guberman, N., Fancey, P., Barylak, L., &Nahmiash, D. (2008). Caregivers' Aspirations, Realities, and Expectations: The C.A.R.E. Tool. *Journal of Applied Gerontology, 27*(3), 286–308.

Guberman, N., Keefe, J., Barylak, L., & Fancey, P. (2007). "Not another form!": Lessons for implementing caregiver assessment in health and social service agencies. *Health and Social Care in the Community, 15*(6), 577–587.

External Source: www.msvu.ca/nsca/caregiverassessment

Nova Scotia's Cancer Patient Navigation Program

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

SNAPSHOT: This innovative practice addresses the issue of improving the coordination and continuity of care for cancer patients. The program is a proactive intentional process of collaboration between the patient/family and interprofessional care team to provide clinical interventions, education, emotional support, and logistical assistance as patients and families cope with complex treatments, services, and potential barriers throughout the continuum of care. The community-based practice employs specialized oncology nurses as cancer patient navigators and was launched in Nova Scotia in 2001 at the district health authority level.

PRACTICE DESCRIPTION:

A new cancer diagnosis can be overwhelming. It involves an intensive diagnostic workup and complex treatment regimens that can result in patients and their families feeling anxious and overwhelmed. Today, most cancer care and treatments are delivered in ambulatory settings, requiring patients to travel great distances for short visits at tertiary treatment centres. As a result, patients have to deal with the daily adjustments to cancer and its side effects in their own homes and communities, away from the specialist team. Many have difficulty obtaining the information and support they need to cope and understand their treatment choices.

To help cancer patients navigate the cancer system and deal with the challenges of a cancer diagnosis, Cancer Care Nova Scotia (CCNS), a program of Nova Scotia's Department of Health and Wellness, launched the Cancer Patient Navigation program in 2001. This program is a community-based partnership between CCNS and eight district health authorities. While the cancer patient navigators (CPNs) are employed by district health authorities and work in those communities, they are part of a network of navigators that is coordinated by CCNS. CCNS links them with the tertiary cancer program's interprofessional teams and provides them with continuing education, support, educational resources, and continuous quality improvement by monitoring the program. This type of patient navigation model is an early intervention model, resulting in better coordination of care and enhanced community capacity to support cancer patients and their caregivers. Access to the CPN is available through self-referral or from any health professional. The program has a toll-free number that routes the caller to the nearest navigator in that telephone exchange.

CPNs are oncology nurses who connect cancer patients with the right services, ensure continuity of care, and ensure access to care and resources. CPNs also work with family physicians, community-based specialists, oncologists, and other cancer health professionals to coordinate services for the patient. CPNs help patients and families as an advocate, educator, and support person throughout the cancer experience, helping to enhance patients' well-being, coping skills, and quality of life while living with cancer.

The program design was determined as a result of needs identified through extensive consultation with cancer patients, family members, health professionals, community organizations, and volunteers in Nova Scotia. The program was implemented through CCNS in collaboration with district health authorities. CCNS works closely with health districts to coordinate and recruit patient navigators; prepare marketing materials (posters, brochures, and other educational materials about cancer and the program); and identify and implement support systems, referral processes, outreach strategies, and a database to enable data collection for evaluation and quality improvement.

IMPACT:

The program was evaluated in 2004 using both qualitative and quantitative research methods. Data for the evaluation were collected through 16 focus groups, 57 one-on-one interviews, 162 patient surveys, and a review of 808 records in the patient navigation database. The results found that navigation has improved the quality and consistency of community cancer care. Health providers reported that navigation has resulted in fostering collaboration and communication among health care providers and reduced the duplication of services. Cancer survivors consistently reported that navigators should be a top priority in the cancer care system.

Although the program was considered highly valuable, limitations have been identified, including excessive case load, not available across the province, and extensive geographical areas. Another area requiring attention was the communication regarding the program and getting health professionals to refer their patients. To address this issue, education of health care professionals was strengthened. Since the evaluation in 2004, eight out of nine district health authorities have CPNs, including four located in rural and remote areas. The remaining district has nurses in navigation roles for head and neck cancer patients and for patients with brain tumours.

Over the last five years, CCNS's CPN program has been part of a pan-Canadian research project funded by CIHR and the Canadian Partnership against Cancer. The purpose of the research was to elaborate, refine, and validate the professional navigation framework in a Canadian context. CCNS's model of navigation was one of two models studied. The framework clarified the role and functions of professional navigators and suggested relevant outcomes for program evaluations. Further research identified the core areas of practice and associated competencies for nurses working as professional cancer navigators. Cancer patient navigation is now recognized by many provinces as a key component of an integrated system of cancer care.

APPLICABILITY/TRANSFERABILITY:

Since the evaluation report was completed, the program has spread to all but one of the health districts in Nova Scotia and the number of navigators has increased as well.

Nova Scotia initiated its navigation model in 2001 after consulting with patients/ families and health professionals. It was not based on any other model, since navigation was not well defined at the time. Patient navigators now exist at some level almost all over the country; however, Nova Scotia's program is leading the way with respect to structure, organization, and its ability to engage relevant stakeholders. Although health services may vary slightly across provinces, the program model can be easily adopted in a Canadian setting to improve management of chronic diseases. For example, the Canadian Partnership against Cancer recognizes the Nova Scotia program as a best practice model and has produced a guide to facilitate implementation of the Patient Navigator program.

Other jurisdictions have reached out to CCNS to learn about its model of professional navigation and many have adapted the model throughout Canada, Australia, and Europe.

Key factors in the success of program implementation included hiring a dedicated Project Manager; creating and following a detailed change management approach grounded in quality improvement; and engaging patients/families, health professionals, and administrators in the development of the program. Challenges included establishing and maintaining awareness of the program by both health professionals and patients, and securing funding for the navigator position in the district.

PRACTICE WEBSITE: http://www.cancercare.ns.ca/en/home/nscancerservices/cancerpatientnaviga...

CONTACT INFORMATION:

Name: Meg McCallum

Title: Provincial Manager Education & Patient Navigation

Organization: Cancer Care Nova Scotia

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

Telephone number: (902) 473-3781

Information last updated on: May 6, 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communications:

Loshaj, S. (feedback and review, May 1, 2013). [Carleton University, School of Public Policy and Public Administration].

Smith, C. (feedback and review, May 3, 2013). [Cancer Care Nova Scotia].

Cook, S. (feedback and review, May 3, 2013). [Cancer Care Nova Scotia].

Other:

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

External Source: http://www.cancercare.ns.ca/en/home/nscancerservices/cancerpatientnavigation/default.aspx

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

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

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

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

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

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

CONTACT INFORMATION:

Name: Cheryl Forchuk

Title: Lead Investigator

Organization: University of Western Ontario/Lawson Health Research Institute

Email address: cforchuk@uwo.ca

Telephone number: (519) 685-8500 ext. 77034

Information last updated on: June, 2013

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

Personal Communications:

McKillop, M. (review and feedback, July 9, 2013). [Research Coordinator, MHEN].

Other:

London Health Sciences Centre. (2012, October 15). *Announcing the Mental Health Engagement Network*. Retrieved from http://www.lhsc.on.ca/About_Us/LHSC/Publications/Features/MHEN.htm

Mental Health Engagement Network. (2013). *From Idea to transformation—Enabled by collaboration*. [Content developed from submission for National Health Leadership Conference].

Mental Health Engagement Network (2013). http://publish.uwo.ca/~cforchuk/MHEN/side.html

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

Glenrose Rehabilitation Hospital's Interprofessional Student Service Initiative

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

SNAPSHOT: This innovative practice addresses the issue of increasing student access to interprofessional clinical educational experiences while also increasing access to rehabilitation services for adults and seniors. It was initiated at the Glenrose Rehabilitation Hospital in 2012 through collaboration with the University of Alberta's Faculty of Rehabilitation Medicine.

PRACTICE DESCRIPTION:

Glenrose Rehabilitation Hospital and the Faculty of Rehabilitation Medicine, University of Alberta, established a joint team to address declining clinical placements in the face of a 25% increase in 2012 student enrolment concurrent with limited staff involvement in student training. The majority of occupational therapy, physical therapy, and speech-language pathology students in Canada are supervised under a model of one supervisor to one student with both the supervisor and the student being from the same discipline. The Student Service Initiative (SSI) is innovative because it emphasizes rehabilitation mentorship through one clinical supervisor for every two to six medical students, regardless of professional designation. The initiative was developed with input from clinical and academic staff, physicians, students, and patients.

The purpose of the SSI is to:

- promote increased access to occupational therapy, physical therapy, and speech-language pathology clinical placements;
- foster enriched educational experiences including interprofessional collaboration opportunities;
- support interprofessional practice and enhance interactions between disciplines through the integration of education activities into existing Glenrose services; and
- facilitate increased access to Glenrose services by current patient populations of adults and seniors with needs for access to complex, specialized rehabilitation within the context of the GRH Service Redesign framework and the Specialized Rehabilitation Outpatient Program (SROP) redesign. For more information on SROP, please see the Glenrose Specialized Rehabilitation Outpatient Program innovative practice overview.

IMPACT:

The SSI reported results within a year of initiation. The number of students involved in interprofessional clinical placements has increased from 3 to 31 across all three disciplines, contributing to an overall increase in all Glenrose Rehabilitation Hospital's allied health clinical placements by 34% in 2012. ISS students contributed to the care of 31% of patients referred to SROP, representing over 350 newly disabled patients being able to receive rehabilitation services. The ISS is said to have contributed to ensuring a sustainable workforce and quality patient care in rehabilitative services.

APPLICABILITY/TRANSFERABILITY:

The SSI at Glenrose has not been adapted from another jurisdiction or yet implemented elsewhere in Canada. However, this initiative is theoretically applicable and transferable to other settings. Successful implementation of this practice requires establishing a collaborative model of student education through partnerships with hospitals and academic teaching facilities. Participating physicians must be able to successfully mentor multiple students at once without increased burden, which can be accomplished through appropriate training and regular feedback from the academic institution.

EXTERNAL LINKS:

http://www.physicaltherapy.ualberta.ca/en/ClinicalEducation/Students/PlacementInformation/ChoosingaPlacement/ClinicalPlacementProfiles/GlenroseOPInterprofStudentService.aspx

CONTACT INFORMATION:

Name: Isabel Henderson, Vice President

Organization: Alberta Health Services, Glenrose Rehabilitation

Email address: Isabel.henderson@albertahealthservices.ca

Telephone number: 780-735-7984

Information last updated on: July 11, 2013

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

Other:

Awards:

3M Health Care Quality Team Award: http://www.cchl-ccls.ca/assets/awardsprogram/15,877-3M%20Health%20Awards...

Resources in Clinics (RICs): Interprofessional Teamwork in Primary Care

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

SNAPSHOT: This innovative practice addresses the issue of encouraging teamwork in an interprofessional primary care setting by pairing (forming dyads) of family physicians and support staff. The practice was launched in June 2010 in Alberta in one primary care network (Edmonton North) and involved individual family physicians and their staff.

PRACTICE DESCRIPTION:

Edmonton North Primary Care Network (PCN), with over 130 member family physicians, is one of the largest PCNs established in Alberta under the Primary Care Initiative program that has been running since 2003. One objective of this program is to increase the use of interprofessional primary care teams to contribute to the improved health of Albertans. The Edmonton North PCN developed a Resources in Clinics (RICs) Pilot Project to inform changes to clinical practice, in this case through the development of high-functioning, formalized “dyads”.

The RIC program started in 2010, with dyads created between a family doctor and either a hired medical office assistant (MOA) or licensed practical nurse (LPN), depending on the needs of the doctor. Individual RICs (either MOA or LPN) were recruited, hired, and trained by the PCN. The objectives for the RIC program included increasing efficiencies in the use of physician time; increasing physician, staff, and patient satisfaction; increasing unattached/orphan patient access; and decreasing patient wait times.

The individual RICs’ core responsibilities included assisting with administrative tasks; patient triage; providing clinical supports and patient education; and patient follow-up. Patients had access to a coordinated, collaborative primary care team supporting them from previsit through to follow-up. Daily interaction between the two people who formed the dyad ensured continuous and ongoing consultation, to the patients’ benefit.

A pilot of this project ran from 2010 to 2012. Since April 2012, the RIC has become the direct employee of the physician/clinic, and the PCN continues to be reimbursed for the RIC costs by Alberta Health Services. As of April 1, 2013, the RIC initiative has become a permanent program of the PCN; however, reimbursed costs will now be based on how many physicians are participating and the budget available.

IMPACT:

The impact of the pilot RIC project was evaluated as follows:

- Baseline data were gathered from log charts that tracked number of patients and time spent with each. Interim data were gathered between June 2010 and March 2012.
- Quantitative data included PCN administrative data, four surveys, and log chart data. Qualitative data involved key informant interviews with physicians and RICs.
- A summative report was completed in spring 2012 that included log charts; separate satisfaction surveys from the doctors, RICs, other clinic staff and patients; and results from key informant interviews.

A consistent pattern of positive findings was discovered. There was a high level of satisfaction with the RIC project among all stakeholders: physicians (98%), RICs (93%), and patients (93%). Other key findings included:

- increased capacity to accept new and “unattached” patients;
- a fourfold increase in new patients being seen (increased efficiency in the use of physician time and improvements in patient access);

- increased productivity of physicians providing direct patient care, with RICs also contributing to patient engagement;
- decreased patient wait times and high patient satisfaction with the teams' awareness of their health condition; and
- physicians indicated they had improved work/life balance, and RICs reported that the professional relationship was rewarding and meaningful.

Further data collection with new parameters is ongoing, as is a cost analysis for the program.

APPLICABILITY/TRANSFERABILITY:

The RICs project has not been adapted from another jurisdiction or implemented elsewhere at this time. However, this initiative is theoretically applicable and transferable to other settings, and to any family/general practitioner willing to work in a dyad model.

Challenges faced when implementing this practice included:

- initial integration of the RIC into the clinical workplace;
- the physicians and RICs were unsure of how to implement the teamwork framework concepts of the practice; and
- need for recruitment and funding through the PCN of increased human resources.

PRACTICE WEBSITE: n/a

CONTACT INFORMATION:

Name: Paul Regehr

Title: Clinical Manager

Organization: Edmonton North Primary Care Network

Email address: pregehr@enpcn.com

Telephone number: 780-377-4084

Information last updated on: April 29 2013

Personal Communications

Lien-Willcott, D. (feedback and review, April 29, 2013). [Edmonton North Primary Care Network]

Publications:

Alternative Profile:

Other:

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

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Antimicrobial Stewardship Program to Decrease Hospital Infections

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

SNAPSHOT: This innovative practice addresses the issue of optimizing antimicrobial use as a means to control hospital-acquired infections and enhance patient safety. In April 2010, Toronto East General Hospital implemented an antimicrobial stewardship program (ASP) as part of the Ontario Antimicrobial Stewardship Project.

PRACTICE DESCRIPTION:

Antimicrobial resistance is a known public health issue. Antimicrobial stewardship, the appropriate prescribing of antibiotics, is critical to stemming the continued emergence of antimicrobial-resistant organisms. Antimicrobial overuse in acute care hospitals promotes the emergence of resistant strains such as methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*). Literature has shown that appropriate use of antimicrobials can reduce occurrences of antibiotic-resistant organisms that lead to hospital acquired infections.

The ASP pilot offered at Toronto East General Hospital in 2010 consisted of an interprofessional team led by a pharmacist who met daily with attending physicians in the intensive care unit (ICU) and an infectious disease specialist to consult on the appropriate prescription of antibiotics for patients. The ASP pharmacist then disseminated suggestions for antimicrobial optimization, customizing end-user communication to each attending physician according to their preferences. After the success of the pilot, the ASP practice has extended to include all adult, acute care in-patient areas in the Toronto East General Hospital.

IMPACT:

An infectious diseases team, consisting of a physician and a pharmacist, conducted a prospective audit and provided feedback during the ASP pilot study (April to June 2010). The team met daily with the ICU team to discuss optimization of antimicrobial use. The cost and usage of antimicrobial drugs, as well as rates of *C. difficile* infection during the pilot period were compared to those in the same period during the previous year (April to June 2009). For three months after the pilot phase (i.e. July to September 2010), the strategy was continued three days per week.

After introduction of the ASP, there was significant reduction in the cost of antimicrobial drugs: $27,917 less than during the same period in the previous year, equivalent to a reduction of $15.45 (36.2%) per patient-day ($42.63 versus $27.18). Utilization of broad-spectrum antipseudomonal antimicrobial agents was also significantly lower, declining from 63.16 to 38.59 defined daily doses (DDDs) per 100 patient-days (a reduction of 38.9%). After the pilot period, the rate declined further, to 28.47 DDDs per 100 patient-days. During the pilot period, there were no cases of *C. difficile* infection, and in the post-pilot period, there was one case (overall rate of 0.42 cases per 1,000 patient-days). This rate was lower than (but not significantly different from) the rate for April to September 2009 (1.87 cases per 1,000 patient-days). There were no differences in mortality rate or severity of illness.

Physicians and patients advocate that the ASP team has become integral in changing antimicrobial prescribing patterns and developing a positive culture at Toronto East General Hospital. Results from the program's evaluation are published in the US National Library of Medicine.

APPLICABILITY/TRANSFERABILITY:

ASPs exist across Canada, with a specific concentration in Ontario hospitals as part of the Ontario Antimicrobial Stewardship Strategy, an antimicrobial stewardship project led by ISMP Canada for Ontario as a knowledge translation project comprised of multiple phases. In the first phase, a comprehensive survey was conducted to examine the current state of hospital-based antimicrobial stewardship practices in Ontario. In the second phase, the ISMP ASP project team convened and prioritized interventions that were considered to be appropriate and effective. The following six interventions were identified:

- implement an antimicrobial stewardship program at the hospital level;
- antimicrobial stewardship self-assessment tool;
- prospective audit with intervention and feedback at the individual patient and prescriber levels;
- education/training to build antimicrobial stewardship capacity;
- data collection and feedback at an institutional or program level; and
- tailoring antimicrobial therapy including de-escalation, streamlining, and IV-to-PO switches.

The third phase tested these interventions in a representative sample of pilot hospitals. With initial successes seen in the intensive care unit (ICU) through the pilot study in 2010, Toronto East General Hospital is one of the first ASPs in Canada to expand to include all adult, acute care in-patient areas in the hospital. Knowledge exchange, peer-to-peer communication, and decision support, which were key factors in this success, were applied in implementing the antimicrobial stewardship program throughout the hospital. A hospital-wide ASP is theoretically applicable and transferable to other settings in Canada.

EXTERNAL LINKS: n/a

CONTACT INFORMATION:

Name: Dr. Jeff Powis, Director, Antimicrobial Stewardship Program

Organization: Toronto East General Hospital

Email address: jpowi@tegh.on.ca

Telephone number: 416-4698-6252

Information last updated on: July 11, 2013

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Other:

Institute for Safe Medicine Practices (ISMP) Canada. (n.d.). *Ontario antimicrobial stewardship project: Preserving antibiotics for future generations*. Retrieved from http://www.ismp-canada.org/abx/

Awards:

2013 3M Health Care Quality Team Award: http://www.cchl-ccls.ca/assets/awardsprogram/15.877-3M%20Health%20Awards...

Safer Care for Older Persons (in residential) Environments (SCOPE)

LOCATION:	**Alberta, British Columbia**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice addresses improving the safety and quality of care of frail elderly residents living in nursing homes, as well as improving the quality of work life for front-line caregivers in nursing homes. The practice was launched in Alberta and British Columbia in two large nursing homes (Alberta) and five smaller ones (Okanagan, BC). The initiative involved 10 units over the seven homes, each consisting of a senior sponsor (manager), two or three health care aides, and one or two registered professionals such as a registered nurse or registered physiotherapist.

PRACTICE DESCRIPTION:
The current profile of residents living in Canadian nursing homes includes elder persons with complex physical and social needs. High resident acuity can result in increased staff workload and decreased quality of work life.

Funded by Health Canada, Safer Care for Older Persons [in residential] Environments is a two-year (2010 to 2012) proof-of-principle pilot study conducted in seven nursing homes in Alberta and British Columbia. The purpose of the study is to evaluate the feasibility of engaging front-line staff to use quality improvement methods to integrate best practices into resident care. The goals of the study are to improve the quality of work life for staff, in particular health care aides, and to improve residents' quality of life. The study has parallel research and quality improvement intervention arms. It includes an education and support intervention for direct caregivers to improve the safety and quality of their care delivery.

Local improvement teams in each nursing home (one or two per facility) are led by health care aides (non-regulated caregivers) and focus on the management of specific areas of resident care. This initiative has gathered expert gerontologists, stakeholders, and the quality improvement teams to decide on three focal areas from the RAI-MDA 2.0 quality indicators: skin care/pressure ulcer prevention, pain management, and dementia-related behaviour management. Following the development of resources and tools, these three themes have been tested out in the nursing homes using three plan-do-stop-assess cycles (PDSA) that are part of the Model for Improvement. These cycles facilitate the gathering of local measurements and implementation of pilot sample quality improvement techniques for each theme. Nursing homes with a skin care focus monitored turning schedules for at-risk residents, whereas pain management was addressed specifically in the context of education on screening tools. Lastly, behaviour management included isolating residents with behavioural issues at meals.

The implementation of these best practices was supported by weekly teleconference, and face-to-face learning sessions related to change management, quality improvement methods, and clinical expertise.

IMPACT:
Progress on the PDSA cycles has been gathered in two surveys and frequent feedback reports that are produced as run charts and consist of data from RAI-MDS 2.0 and process data collected by teams. Teams were able to use the feedback to track their performance and progress towards their improvement goals. The methodology has been published in a peer-reviewed journal, and the findings were presented at the 2012 BC Quality Forum.

The satisfaction surveys showed positive reception of the intervention and indicated qualitative results on team dynamics. Teams placed greater value on manager support than administrator support and successful teams had strong leadership engagement and support. Team success was also greater with more frequent team huddles and regular participation in telephone calls.

Quantitative results on each quality improvement technique have not all been published.

APPLICABILITY/TRANSFERABILITY:
The study is modelled on the Safer Healthcare Now! (SHN!) national initiative, which successfully enabled front-line teams—primarily in acute care—to use QI methods to implement new knowledge and best practices into direct patient care. SCOPE facilitates implementation of SHN! strategies in the long term care sector. SCOPE has not been adapted by other

jurisdictions but can theoretically be applied in other settings with proper managerial support, collaboration among specialists and front-line health care providers, and proper tracking of PDSA implementation results.

CONTACT INFORMATION:

Name: Lisa A Cranley
Title: Associate Professor
Organization: Faculty of Nursing, University of Alberta
Email address: lisa.cranley@nurs.ualberta.ca
Telephone number: N/A
Information last updated on: July 8, 2013

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

University of Alberta Faculty of Nursing. (n.d.). *Safer Care for Older Persons (in residential) Environments (SCOPE)*. Retrieved from http://www.kusp.ualberta.ca/en/Research/ActiveProjects/SCOPE.aspx

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External Source: N/a

North York Family Health Team Colorectal Cancer Survivorship Program

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

SNAPSHOT: This innovative practice addresses providing care for patients who have received treatment for colorectal cancer (stage 1, 2, or 3) for the recommended five-year follow-up period. The practice was launched in Ontario in one hospital and involved nurse practitioners, a case worker, and a receptionist.

PRACTICE DESCRIPTION:

The North York Family Health Team Colorectal Cancer Survivorship Program (CCSP) is a collaborative partnership with North York General Hospital (NYGH) that was launched on May 8, 2012. It provides nurse practitioner–led (NP) patient-centred care for patients who have completed active treatment for colorectal cancer and require five-year surveillance for cancer recurrence or metastases. The team maintains close ties to each patient's oncologist and surgeon, who refer patients to the program.

The CCSP is a new model of cancer survivorship care that transfers the monitoring of patients who have finished active treatment from oncologists and surgeons to primary care. This innovative program centralizes follow-up care for patients and will alleviate wait times for newly diagnosed patients needing to see a cancer specialist.

The survivorship program follows the latest best practices and includes three important components: NP provision of care when needed, and connection to community resources when needed. The Colorectal Cancer Association of Canada runs a local support group, and NYGH psychiatrists who support the hospital's cancer care program continue to support patients during their survivorship period.

Located in the community, the CCSP provides care from North York Family Health Team's central clinic. The presence of both allied health providers and electronic medical record systems have made it possible to create a robust program that translates evidence-based care into clinical best practices. Together, North York Family Health Team and NYGH are improving access to cancer care in Ontario. They are also striving to have all clinicians work to full scope in roles that are engaging, challenging, and satisfying. The program is overseen by the medical directors of the Family Health Team and the Cancer Care Program at NYGH.

IMPACT:

The CCSP innovative practice has reduced duplication of care provided by multiple specialists, resulted in fewer specialist appointments billed to OHIP, reduced costly duplication of tests, and streamlined care into one location provided by one health care professional. The program has shifted the roles in survivorship care from a physician-driven hospital model to a community-based, NP-led environment. In 2012, the CCSP received an Innovation Award Honourable Mention from Cancer Quality Ontario.

APPLICABILITY/TRANSFERABILITY:

The Colorectal Cancer Survivorship Program is the first of its kind in Ontario and has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings.

CONTACT INFORMATION:

Name: Dr. Kimberly Wintemute
Title: Medical Director
Organization: North York Family Health Team
Email address: N/A
Telephone number: (416) 223-0555

Program number: (416) 494-3003 ext. 131
Information last updated on: (put in the date that you found the information)

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

Other:

Association of Family Health Teams of Ontario. (2012, August 20). *Colorectal Cancer Survivorship Program: North York FHT*. Retrieved from http://www.afhto.ca/uncategorized/colorectal-cancer-survivorship-program-north-york-fht/

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External Source: http://www.nyfht.com/displayProgram.php?prog=Colorectal%20Cancer%20Surviorship%20Program

The Reitman Centre CARERS Program: Equipping carers with practical skills and emotional support to provide better care for individuals with dementia

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

SNAPSHOT: This innovative practice addresses the need to equip professional and community carers with practical and emotional coping skills to enable them to effectively provide care to individuals with dementia. The program launched in an academic teaching hospital training centre in Ontario in 2008 with a focus on community-based carers, but is now expanding to provide workplace-based training to carers engaged in the workforce (working carers).

PRACTICE DESCRIPTION:

Alzheimer's disease and related dementias pose significant challenges to the well-being of patients, but also to the health of family carers as they struggle with the emotional and physical stress of providing ongoing care. The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer's Support and Training at Mount Sinai Hospital (MSH) delivers therapeutic skills training that address the needs of family carers providing care to individuals with dementia. The centre offers individual and family training, access to an outpatient geriatric mental health clinic, and training programs for both professionals and community carers dealing with dementia.

The Reitman Centre CARERS Program (Coaching, Advocacy, Respite, Education, Relationship, and Simulation) gives carers practical skills and emotional support to deal with the complexities of caregiving. The centre is staffed by social workers, psychiatrists, a psychologist, occupational therapists, group leaders, an educator, researchers, and administrators.

After an assessment phase, CARERS involves a 10-week small-group program that includes education, problem-solving therapy, and skills training using simulation, followed by a maintenance group (one hour per month) for one year after the intervention. The simulation phase includes live encounters with a standardized patient, a professional simulator trained to simulate real-life situations the carer is currently encountering. Carers are guided by expert clinical coaches and can learn to deal with their specific challenging situations. The goals of the program are for carers to enhance practical skills, improve coping and problem-solving, improve management of difficult emotions and communication with the care recipient, reduce anxiety and depression, optimize their health and social interactions, and access professional support if necessary.

The CARERS program has been funded in part by the Government of Canada's Social Development Partnerships Program (SDPP). The services are offered to carers enrolled in the program at no additional cost.

IMPACT:

The effectiveness of the CARERS approach has been demonstrated through a formal outcome evaluation completed by participating carers (*n*=61). Eight scales were administered pre- and post-intervention to assess whether the program was meeting its key goals: improved coping/problem-solving, emotional regulation, and self-efficacy, and reduced caregiver burden. Pre- and post-scores were significantly improved for measures of emotion-oriented stress coping and caregiving competence. Carers with more compromised baseline scores also experienced statistically significant improvements in measures of depression, task-oriented coping, mastery, and caregiver burden.

Satisfaction surveys revealed almost all participants believed the groups were important and effective, and reported that skills training had changed their behaviour, attitudes, and feelings. The professional support and camaraderie were highly valued, and the practice and repetition allowed in simulation exercises was deemed the most helpful component of the intervention.

The program leaders estimate the cost to run a 10-week CARERS group is approximately $1800 (or $360 per carer, or equivalently $12.00 an hour per carer). This is based on an estimate that assumes an hourly rate of $30/hour for both the community-based mental health clinician leading a CARERS group and a paid standardized patient over 10 weeks (3 hour sessions/week). From the original four staff the program has grown to a staff of 14 and space has been doubled.

APPLICABILITY/TRANSFERABILITY:

The Reitman Centre was founded through a private grant from the Cyril and Dorothy, Joel and Jill Reitman family. The goal was to create a centre dedicated to the care of carers, not as adjuncts to the management of the person with dementia but as a primary target of intervention. MSH strongly supported the concept of a community-focused program for carers, providing space and technical help. A purpose-built facility was constructed. A small interprofessional team from the department of psychiatry at MSH determined the key factors that contribute to caregiver burden and breakdown, based on the best available research data. To address these factors, evidence-based treatment interventions were created or adapted. Each burden factor was operationally defined prior to starting the program, and then evaluated in every carer using specific validated research instruments.

Much attention was paid to promoting this program and to making it accessible to carers living in the community. A barrier-free referral process was initiated to ensure ease of access for all.

To date, the Reitman Centre has run 30 CARERS groups (300 small-group sessions). The model has been modified and streamlined to make it financially viable for use in the community, including non-medical community services and programs. In Toronto satellite groups are underway at the Yee Hong Geriatric Care Centre, MSH Wellness Centre, St Christopher House Toronto, and Holy Blossom Temple.

The core MSH CARERS program was crafted to be scalable, and Human Resources and Skills Development Canada (HRSDC) has provided support for further development of the model and its dissemination more broadly elsewhere in Canada. To facilitate dissemination, MSH offers courses for professionals and has produced educational tools, such as manuals and e-learning modules. The CARERS program has been adopted in Calgary, Alberta, with the Calgary Chinese Elder Citizens' Association and the Alzheimer Society of Calgary each starting Reitman Centre CARERS groups.

In June 2013, MSH was awarded a five-year, $2.84 million grant from the Government of Canada's SDPP to develop the first comprehensive program in Canada devoted to supporting working carers (carers currently engaged in the workforce). The Working CARERS Program will be offered through a partnership of the federal government, MSH, and private-sector partners. Launching in fall 2013, it will be delivered to employees by employee assistance professionals from Ceridian Human Capital Management (HCM), an employee assistance service at BMO Financial Group.

CONTACT INFORMATION:

Name: Dr. Joel Sadavoy
Title: Head of Geriatric Psychiatry, the Reitman Centre for Alzheimer's Support and Training; Head of Community Psychiatry Services
Organization: Mount Sinai Hospital
Email address: Jsadavoy@mtsinai.on.ca
Telephone number: 416-586-5262
Information last updated on: August 8, 2013

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

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Sadavoy, J. (Review and feedback, July 2013). [Mount Sinai Hospital].

Publications:

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Other:
Reitman Centre CARERS Program. (n.d.). *CARERS: Coaching, advocacy, respite, education, relationship, simulation*. Retrieved from http://www.mountsinai.on.ca/static/carers/

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External Source: http://www.mountsinai.on.ca/care/reitman

Kingston General Hospital Interprofessional Collaborative Practice Model

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

SNAPSHOT: This innovative practice addresses the design and implement of a safe, cost-effective, patient- and n family-centred interprofessional collaborative in-hospital practice model (ICPM). The ICPM was implemented in Ontario beginning in November 2009 in multiple patient care units in a large hospital.

PRACTICE DESCRIPTION:

The goal of this quality improvement initiative was to design, implement, and evaluate a safe, cost-effective, patient- and family-centred interprofessional collaborative practice model (ICPM) at Kingston General Hospital (KGH). One of KGH's 2015 strategies is to bring to life new models of interprofessional care and education. The implementation of ICPM was one of the foundations of this transformational change. Areas identified for improvement included communication, discharge planning, and purposeful engagement of patients and families in the care process.

The ICPM was launched in 2009 as part of a fiscal recovery strategy. From March to October 2009, 54 representatives from various disciplines gathered to design a new approach to care delivery. The design team began by focusing on the issues and challenges affecting care delivery and then defined a future vision, resulting in the ICPM.

Eight implementation teams supported the redesign of roles and processes. The resulting model was patient- and family-centred and conceptualized as an integrated system of people, technologies, information, and processes, enabled by collaboration, coordination, communication, education, and leadership.

Between November 2009 and April 2012, the model was implemented in 18 in-patient units and 33 ambulatory care areas. The initial focus was on adult in-patient medical/surgical units, then on specialty care units, and finally on outpatient and ambulatory care areas. The implementation of the model was overseen by a steering committee with teams reporting on progress in documentation, technology, process design, education, and human resources.

All staff attended mandatory education sessions on ICPM—to date, over 2,200 people have attended these sessions, which are facilitated by staff and patient experience advisors.

Soon after implementation began, the team realized that patients and families had to be consulted and given the opportunity to contribute to the process as it developed. To achieve this, a Patient & Family Advisory Council was formed in February 2010 and continues to influence the ongoing transformation of the organization.

IMPACT:

Using a pre/post mixed-methods design, an evaluation framework focusing on patient, provider, and system outcomes was designed to determine ICPM's impact. Six in-patient units and eight ambulatory care areas were evaluated at specific time intervals. The review team also conducted four-week chart reviews on patients admitted to ICPM units to identify delays in delivery of patient care services and the reasons for them, quality issues, and delays in discharge, and to evaluate the effect of ICPM on system outcomes.

Thirty-month post-implementation results show improvements in quality of patient care and quality of work life. On patient and provider surveys, respondents are satisfied with outcomes. To date, 624 patients and 398 providers have completed ICPM surveys. Patients reported they are more aware of the plans relating to their health care, their care is well coordinated, and they feel safe and secure. In general, the patient surveys reveal a stable trend with regards to satisfaction with care, although there is some variation between units. The staff and physician survey results demonstrate improvements in collaborative practice and job satisfaction, although the results also vary by units.

APPLICABILITY/TRANSFERABILITY:

The model was designed for the in-patient setting and later adapted for the ambulatory care areas. Through seven waves, the ICPM was implemented on 18 in-patient units and then adapted for the 33 ambulatory and outpatient units in five waves.

During the design phase of ICPM, the project team visited Toronto East General Hospital in March 2009 to learn about a new model of patient care that was designed and implemented on three in-patient units in that organization. The team also had a teleconference with leads from the Model of Care Initiative in Nova Scotia. The ICPM was not based on either of these models, but the project team learned about successes and challenges of implementing a new model of care delivery from both organizations. In turn, KGH has now had many site visits and inquiries from other organizations looking to implement similar models.

Challenges during implementation included engagement of staff, resistance to change, long-held practices, and competing demands. Lessons learned include careful attention to branding, ensuring clear communication throughout the process, engagement of all stakeholders early and often, and remembering that changing practice takes time.

CONTACT INFORMATION:

Name: Cynthia Phillips
Title: Manager, Interprofessional Collaborative Practice & Education
Organization: Kingston General Hospital
Email address: phillipc@kgh.kari.net
Telephone number: 613-549-6666 x.4867
Information last updated on: May 29, 2013

CONTENT HAS BEEN ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communications:
Phillips, C. (Review and feedback, May 29, 2013). [Kingston GeneralHospital].

Publications:

Alternative Profiles:

Other:
Phillips, C. Abstract submission to the Health Council of Canada's National Symposium on Integrated Care (2012).

External Source: N/a

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

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

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

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

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

CONTACT INFORMATION:

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

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

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Performance Huddles: Bringing Interprofessional Teams Together to Improve Quality and Safety

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

SNAPSHOT:

This innovative practice addresses how interprofessional teams communicate, collaborate, and monitor their progress on quality improvement at the point of care. This interactive practice was launched in Ontario in November 2011, taking place in numerous patient care units at three sites of a multi-site hospital system.

PRACTICE DESCRIPTION:

Creating a culture of participation and collaboration across any organization can be a challenge. To harness the ingenuity of interprofessional teams at the front line, William Osler Health System has implemented performance huddles, which enable corporate priorities to be lived, evaluated, and improved continuously at the point of care. Born out of an organization-wide access and flow initiative, performance huddles are short (five to 10 minutes), focused daily staff meetings dedicated to quality improvement. Huddles provide an opportunity for health care providers and support staff to discuss the previous day's performance based on real-time data, and to collaboratively identify barriers, develop solutions, and celebrate joint successes.

Led by each unit's Patient Care Manager (PCM), huddles involve everyone on the unit—physicians, nurses, allied health professionals, and administrative and support staff—and occasionally even patients and visitors. Huddles use visual management techniques to help interprofessional teams communicate in the same language, through a standardized display called the Vital Signs board. Every day, the PCM obtains the previous day's data from an online performance data portal and posts them on their board. These daily data are linked to the corporate scorecard. Data also include direct feedback from patients collected through the Osler call centre. Nurses at the call centre phone the majority of in-patients within 48 hours of discharge to learn about their experiences. Through huddles, staff bring forward improvement ideas and are empowered with resources and support to implement solutions. This creates accountability at an individual level and allows each person to play a role in the organization's success.

The performance huddle boards are located in public areas on the units for patients, families, and visitors to see and ask questions about. Patients and families have also been involved in the huddle.

The initiative was introduced in November 2011 at all three sites of the William Osler Health System and then quickly spread to all the other patient care units and some non-clinical service areas. In order to roll out performance huddles, a senior leadership champion was established, as dedicated leadership is required to implement the initiative and to monitor its progress. It is also important to have "standardized work"—clear, written, standardized steps on how to perform a huddle and a standardized approach across the organization.

IMPACT:

Performance huddles are evaluated in three key ways. First, unit participation is assessed through monthly audits of Vital Signs boards across the organization, and followed up with coaching for units with less consistent participation. Second, huddle effectiveness is gauged through progress against corporate performance metrics, which are assessed monthly at executive, clinical, and program leadership levels. If targets are not met, program and unit leaders work with front-line staff to develop plans for improvement. Third, leadership support is provided in the form of peer-to-peer mentorship for huddle leaders. Patient care leaders also attend huddles on a weekly basis and provide coaching to huddle leaders.

While the practice of performance huddles has not been formally evaluated at this time, personal testimonials, observations, and early results suggest that this practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

Huddles have been instrumental in building interprofessional teams, enhancing communication, and creating a culture of open communication, trust, and belonging. Examples of success through huddles include an improvement in "time to in-patient bed," which has decreased by over 50%, and reductions in rates of falls and urinary tract infections. In non-clinical service areas, such as Health Information Management, huddles have enabled reductions in records distribution processing time and chart preparation turnaround time. Key success factors include a multidisciplinary approach with physician involvement, weekly attendance by program directors to provide coaching and guidance, and regular attendance by the Senior Leadership Team. Members from the Board of Directors have also attended the huddles, which has helped increase their awareness of the direct impact of huddles on quality and safety initiatives.

APPLICABILITY/TRANSFERABILITY:

This practice was implemented through the Ontario emergency room (ER) and alternative level of care (ALC) Performance Improvement Process (PIP) strategy. Adapted for use at William Osler Health System, the concept of a performance huddle is not new, but has been enhanced by the inclusion of real-time patient satisfaction data.

Due to its effectiveness in integrating interprofessional teams, the practice of performance huddles has quickly spread from pilot clinical units to all clinical areas and most non-clinical and administrative areas across two hospital sites and the administrative site. Key to the broader adoption of the practice have been champions at the senior leadership level who provide guidance and monitor progress, decision support services related to the collection and reporting of metrics, a standardized guide for huddle leaders, and change management and project management resources to help teams to implement solutions.

CONTACT INFORMATION:

Name: Kiki Ferrari
Title: Executive Director, Clinical Services
Organization: William Osler Health System
Email address: kiki.ferrari@williamoslerhs.ca
Telephone number: 905 494 2120 ext. 50167
Information last updated on: May 6, 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communication:
Ferrari, K. (feedback and review, May 6, 2013). [William Osler Health System].

Publications:

Alternate Profiles:

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

Heart Failure Outreach Support Team (HOST)

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice facilitates reduction in 30-day hospital readmissions for patients with heart failure by changing the role of registered nurses in the discharge process. The practice was launched in British Columbia in one health authority and involved registered nurses, cardiovascular services, cardiovascular department administration, and interprofessional hospital teams.

PRACTICE DESCRIPTION:

Heart failure (HF) is a complex condition characterized by high personal burden, negative hospitalization experience, a 20% readmission rate within 30 days, poor discharge quality, and a highly risky transition from acute to community care. Data from Fraser Health Authority reveal that almost half of the follow-up physician visits were not scheduled prior to discharge and less than a quarter of discharge plans were clearly documented.

Consequently, a new initiative at Fraser Health Authority launched a Heart Failure Outreach Support Team (HOST) with the principal aim of reducing 30-day all-cause readmissions by 15% from baseline. To accomplish this, the team used the discharge transition model for quality improvement of the Institute of Health Improvement (IHI). This model includes an innovative role for registered nurses to support a quality discharge. Registered nurses in cardiovascular care are case managers who identify heart failure patients for the intervention through focused chart assessments and support the implementation by working with the interprofessional team and by providing direct care.

The HOST based their approach on four objectives:

1) enhanced admission assessment for post-discharge needs;
2) enhanced teaching and learning;
3) patient- and family-centred communication; and
4) adequate post–acute care follow-up within 72 hours of discharge.

IMPACT:

The HOST team captured data from the implementation of the intervention and published their findings in government presentations and publications such as the *Canadian Journal of Cardiology Journal*. They observed that within one month of implementation, the 30-day readmission rate decreased from 39.1% to 14.6%. Patient surveys also revealed that the HOST intervention increased emotional support and educational awareness of HF and the Advanced Care Plan. Patients appreciated the post-discharge follow-up phone calls as well.

Further data will be documented and reported on through the established HOST Registry. This registry tracks important information about the assessment and follow-up for HF patients, which will be used for subsequent program evaluations.

Currently, the project is being expanded to train registered nurses who have a background in medicine, surgery, and home care, but not cardiovascular services. This training study will determine how well prepared nurses are to engage HF patients in self-management initiatives, including HOST.

APPLICABILITY/TRANSFERABILITY:

Aside from making use of the IHI discharge transition model, the HOST initiative has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. Successfully implementing HOST requires some quality improvement work, including addressing language barriers, non-adherence, transportation barriers to the clinics, and clients involved in multiple specialties. Success is dependent on communication

between registered nurses, interprofessional teams, and community agencies.

CONTACT INFORMATION:

Name: Carol Galte
Title: Heart Failure Outreach Support Team Leader
Organization: Cardiac Services for Surrey Memorial Hospital, Fraser Health Authority
Email address: Carol.Galte@fraserhealth.ca
Telephone number: 604-805-1142
Information last updated on: May 19, 2013

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

Personal Communications:

Publications:

M. Cournoyer, M., Thomas, L., Galte, C., Greenberg, K., & Meloche, M. (2012) N018 Heart failure outreach support team—Cardiovascular nurses navigate the transition from hospital to home. *Canadian Journal of Cardiology, 28*(5), S425. Abstract available at http://download.journals.elsevierhealth.com/pdfs/journals/0828-282X/PIIS0828282X12011208.pdf

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Assessment of Implementing Disease-State Education Modules on Specific Pharmacist Interventions: "AIMS" Study

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice aims to determine if disease-state education models result in improved patient care. The practice was launched in British Columbia in one health region (Interior Health) and involved pharmacists and pharmacy leaders with a background in pedagogy and training.

PRACTICE DESCRIPTION:

Priority disease states such as heart failure account for a significant number of emergency department visits, hospital admissions, and longer stays, which result in increased cost. Randomized clinical trials using self-reported surveys have shown that hospital pharmacists resolving drug-related problems (DRP) for patients with priority disease states can reduce all of these indicators. However, the benefits of training pharmacists to resolve DRPs have not been quantified, analyzed or reported.

To determine whether continuing professional development can help pharmacists better respond to DRPs for patients with priority disease states, Interior Health developed four-week disease-state education modules (DSEMs). The first week featured discussions around tertiary resources, followed by a week of training on clinical practice guidelines that have been appraised by the Appraisal of Guidelines for Research and Evaluation Instrument. The third week focused on the application of the learning into interactive clinical cases, while the last week wrapped up the module with group discussions and debrief sessions.

Upon completion of the DSEMs, pharmacists were encouraged to resolve DRPs in their daily practice. Hence, in efforts to determine correlation between DSEMs and improvements in patient care, outcomes for all visits (regular DRPs and those identified in the DSEMs) were recorded. The eight DSEM DRPs are pneumonia, heart failure, chronic obstructive cystic fibrosis, ischemic heart disease, diabetes mellitus, urinary tract infections, gastroesophageal reflux disease, peptic ulcer disease, and atrial fibrillation.This observational study tracked visits and outcomes using the DRP Tracker (an iPod Touch program).

The analysis compared the DRP data prior to the intervention to those that followed the intervention and determined what proportion of all DRPs could statistically be attributed to the DSEMs. Secondary analyses also focused on the clinical outcome based on both DSEM and by hospital site in order to delineate the effects of DSEMs and individual hospital performance on patient success.

IMPACT:

The results of the analysis were discussed and presented via statistical media (graphs, charts, etc.) in the British Columbia Patient Safety & Quality Council's Quality Forum presentation sessions. Data from the DSEMs themselves reveal that 61% of pharmacists completed all the modules and 44% responded to the post-module survey. The survey results indicate that 95% of respondents either "strongly agreed" or "agreed" that DSEMs provided them with sufficient training to be confident in resolving DRPs.

Longitudinal data show that with a steady increase in total DRPs over time, there was also a steady increase in DSEM-based DRPs. DSEM-based DRPs increased by 8.3% from October 1, 2011, to March 31, 2012, with the greatest increase occurring in the early part of that period. All the DSEMs resulted in improvements in patient status except for heart failure, pneumonia, urinary tract infections, and atrial fibrillation.

APPLICABILITY/TRANSFERABILITY:

The AIMS study has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. Although the results of this study appear significant and reflect a positive benefit of implementing DSEMs, it is clear that the majority of DRPs were not resolved using DSEMs. This indicates room for improvement, particularly in changing prescribing practice.

To benefit clinically from the DSEMs, local leaders must be engaged, and educational meetings and outreach visits with printed materials and reminders for upcoming sessions are required. Lastly, there need to be audits and feedback to ensure proper DSEM implementation and improvement. A subsequent study is currently underway to develop, implement, and analyze the effect of knowledge translation strategies on the clinical impact of DSEMs around patient care.

CONTACT INFORMATION:

Name: Sean K. Gorman
Title: Regional Coordinator
Organization: Clinical Quality and Research Pharmacotherapeutic Specialist –Critical Care, Interior Health
Email address: N/A
Telephone number: N/A
Information last updated on: May 31, 2013

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

Personal Communications:

Publications:

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Other:

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Interprofessional Student-Led Clinic for Physiotherapy and Occupational Therapy

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT:

This innovative practice aims to increase clinical placement capacity and leadership among physiotherapy and occupational therapy students, and to promote an integrated interprofessional care model. The practice was launched in British Columbia in June 2009 as an outpatient clinic in a large acute care hospital setting.

PRACTICE DESCRIPTION:

Health professional students need clinical experiences with patients who have unresolved chronic health issues and chronic impairments. They also need new opportunities for interprofessional learning experiences. The interprofessional student-led clinic offers both, as well as providing enhanced clinical health services for stroke survivors, frail elderly, diabetics, and others with chronic diseases.

This practice opened as a physiotherapy student-run clinical service in June 2009 as a collaborative initiative between Fraser Health and the University of British Columbia. The program was delivered in an under-utilized former outpatient facility at the Royal Columbian Hospital, a large acute care centre. The original clinic was staffed with six physical therapy students under the direction of a single physiotherapy clinician. Within a year, the physical therapy student-led clinic was expanded to include other student health care providers. In 2010, occupational therapy and medicine programs introduced students to the clinic so that a truly interprofessional learning experience could be tested.

Currently, the student-led clinic employs one clinical educator in physical therapy and one in occupational therapy. Up to six students are supervised at any one time by each educator.

The objectives of the clinic included

1) to significantly enhance student teaching and learning by providing an innovative interprofessional clinical placement site;
2) to combine teaching and learning within and between health professions that are naturally aligned in clinical practice; and
3) to evaluate the feasibility of sustaining a clinic that is truly interprofessional and that could provide a model for the incorporation of other health professions.

The program is innovative in that physiotherapy and occupational therapy students take responsibility for all aspects of clinic functioning, including patient assessment, treatment, client booking, and referral to other services as needed. As well, the clinic provides an interprofessional setting where collaborative learning and practice is encouraged.

Drivers for the clinic included increased enrollment of physical therapy (PT) and occupational therapy (OT) students at UBC with the concurrent need to increase clinical placement capacity, the need to improve access to PT and OT services for patients with complex rehabilitation needs, and the desire to promote an integrated and interprofessional care model.

Fraser Health has been supportive of the initiative since its inception, due to its perceived impact on patient care, ability to fill a service gap, potential for recruiting new graduates to the health region, potential for decreasing lengths of stay, and ability to act as a model and catalyst for change in interprofessional practice. The clinic was initially supported by a grant from UBC; Fraser Health now provides sustainability funding for ongoing operating costs.

IMPACT:

Evaluation has been carried out using satisfaction surveys, evaluation of student interprofessional competencies, informal analysis of student feedback, and statistical analysis of clinical outcomes. Data collection consisted of Likert scale surveys and open-ended questions, including pre- and post- student self-assessment, observer assessment, and student/observer

post-placement evaluations.

The student-led clinic has had a positive effect on student placement capacity, allowing up to six students to be placed with each clinical educator instead of the usual one or two. Student evaluation of the clinic has indicated a high level of satisfaction with the placement experience, particularly in the areas of peer learning and preparation for transition into practice as a new graduate. The clinic has been effective in providing a valuable interprofessional clinical learning experience, which has also been accessed by medical students.

Patient outcomes from the clinic have been favourable, demonstrating the same or better outcomes for specific client groups as outpatients than corresponding groups experience as in-patients. Clients have indicated high levels of satisfaction with the service, and the clinic has provided increased access to service for specific client groups. Over the course of three years, over 900 patients have been treated who would otherwise have had difficulty accessing service. In addition, clients receive an interprofessional service from both OT and PT in the same treatment session, which provides a high standard of integrated care.

This interprofessional student-led rehabilitation model has directly influenced the development of a coordinated interprofessional outpatient rehabilitation program. This program, which has now been expanded to six communities in Fraser Health, has staff in PT, OT, and speech and language pathology, as well as rehabilitation assistants. Detailed analysis of system impact has revealed an average reduction of 10 days in in-patient length of stay for patients referred to coordinated interprofessional rehabilitation.

APPLICABILITY/TRANSFERABILITY:

Increasing evidence points to the importance of collaborative practice models in health service delivery for improving quality of care and health outcomes. All health professional academic programs are examining ways to develop interprofessional clinical learning opportunities as a way of training future collaborative practitioners. Lessons learned can be applied to a variety of clinical settings, where there is an opportunity to incorporate interprofessional activities and reflection.

Since its initial launch, the clinic has expanded from only physiotherapy students to include occupational therapy and medicine students. Due to the success of this student-led model, a similar clinic has been successfully initiated in at least one rehabilitation centre, with further clinics in the planning stages for geriatric clients and for clients in rural/remote areas. This model has also enabled the development of an interprofessional outpatient rehabilitation program, which has expanded to six communities in Fraser Health.

As well, the student-led clinic experience suggests that there is potential for the growth of this model as a key interprofessional education strategy. This model also has potential for adaptation as a “student-led program” concept, where specific student-led programs are offered several times a year while students are on placement.

Some challenges and “lessons learned” for implementation include

- The challenge of keeping the clinic operational when UBC students were not on clinical placement was solved by accepting students from programs across Canada and international students.
- While the current clinic was implemented in an under-utilized outpatient space, current replication of the student-led clinic at another hospital is presenting additional space challenges, since student activities will be integrated in a fully staffed, busy outpatient department. The strategy will be exploring alternate scheduling options to enable optimal workflow, in order to minimize the impact of space challenges on the learning experience. Fraser Health is also considering expansion of the student clinic to more rural areas of the health region; however, student availability to access rural settings will have to be examined to ensure sustainability.
- As with many interprofessional education initiatives, scheduling students from different health professional programs to be in the clinic at the same time remains challenging due to differing curricular models and schedules. Nevertheless, the incorporation of students from multiple programs helps to optimise the mix of interprofessional students in the clinic at any one time.

CONTACT INFORMATION:

Name: Scott Brolin
Title: Program Director, Rehabilitation / Allied Health
Organization: Fraser Health
Email address: scott.brolin@fraserhealth.ca

Telephone number: 604-897-4252

Name: Sue Murphy
Title: Associate Head, Clinical Education, Department of Physical Therapy
Organization: University of British Columbia
Email address: sue.murphy@ubc.ca
Telephone number: 604-822-7413

Information last updated on: May 6, 2013

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

Personal Communications:
Brolin, S. (review and feedback, May 6, 2013). [Fraser Health]
Murphy, S. (review and feedback, May 6, 2013). [University of British Columbia].

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Gee, H., & Stock, C. (2011). *Evaluation of an innovative interprofessional student run clinic*. [Presentation Notes]. Retrieved from http://www.fraserhealth.ca/media/ResearchWeek2011-DAY1-2_GeeanStock.pdf

External Source: http://physicaltherapy.med.ubc.ca/clinical-education/clin-ed-current-students/placement-opportunities/

Primary Musculoskeletal Provider

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

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

Participation in the program also increased physicians'

- confidence in assessing and managing LBP patients;

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

CONTACT INFORMATION:

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

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Publications:

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

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Other:

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

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

Occupational Therapy Examination and Practice Preparation (OTepp) Program

LOCATION:	Ontario	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice demonstrates how to support and enable the transition of internationally educated occupational therapists (IEOTs) into Canadian practice.

PRACTICE DESCRIPTION:

The Occupational Therapy Examination and Practice Preparation (OTepp) Project was developed to support the transition of internationally educated occupational therapists (IEOTs) to Canadian practice. OTepp was created

• in recognition of the need for increased diversity within the occupational therapy (OT) profession;
• to meet projected workforce shortages; and
• to reduce barriers to labour market integration and inclusion of IEOTs.

The OTepp project at the School of Rehabilitation Science (SRS), McMaster University, received funding from the Government of Ontario from 2008 to 2013. OTepp partnered with the Canadian Association of Occupational Therapists (CAOT) and received additional funding from the Government of Canada to enable participation of IEOTs across the country and off-shore.

The project, based on problem-based learning (PBL) pedagogy and adult learning principles, has become a formal program offered by the SRS. Originally the project consisted of:

• four modules offered at McMaster University's SRS. These modules covered exam preparation, mentorship, work readiness, and transition counselling. They were developed based on participant feedback and input from research team members on needs that were not being met. While the transition counselling module had limited uptake, the other modules have been or are being offered by the CAOT as part of OTepp's sustainability plans. This ensures access for IEOTs as well as members of the broader occupational therapy community who may benefit from the learning and resources.
• a 23-week core curriculum model approved by the University Senate. This module entailed five academic courses and an eight-week supervised practicum. Based on annual course evaluations and reviews, the program has been extended to 29 weeks consisting of four academic courses and the eight-week supervised practicum. The academic courses are of equal length and depth, followed by a break that allows marking to be completed prior to students beginning their practicum. This module has been renamed the OTepp Certificate Program to reflect its status at the university.

McMaster University continues to offer this program to IEOTs face-to- face or online, which makes it accessible to IEOTs across the country and overseas. Project advisory committees include representatives from employers, regulatory bodies, and professional associations in order to ensure relevance to workforce and workplace needs.

IMPACT:

Findings from exit interviews and course evaluations show a high correlation between successful completion of the Certificate Program and passing the national certification exam. Most importantly, there are examples of IEOTs being hired by their practicum site upon completion of the practicum course. In addition, other data reveal a growing number of project graduates gaining licensure and employment following course completion.

Employers have offered placements nationally, resulting in shared learning about cultural differences and inclusion. The project has been fortunate to build partnerships with many large hospitals and community agencies. An important lesson learned is that partnerships are necessary, particularly with provincial regulatory bodies, to ensure the curriculum meets regulatory requirements. Future challenges include ensuring the long-term sustainability of the certificate program, given that many new

Canadians have difficulty obtaining practicum experiences independently and are often unable to afford expensive tuition costs.

APPLICABILITY/TRANSFERABILITY:

The project model has relevance for other professions interested in supporting the transition of internationally educated professionals within their workforces. The modules may also be relevant for re-entry professionals or for practitioners who require remediation to obtain continued credentialing for practice.

CONTACT INFORMATION:

Primary Contact
Name: Sue Baptiste
Title: Professor
Organization: McMaster University, School of Rehabilitation Science
Email address: baptiste@mcmaster.ca
Telephone number: 905 525 9140 ext. 27804

Secondary Contact:
Name: Leah Dix
Title: Assistant Clinical Professor; Project Manager for the OTepp Program
Organization: McMaster University, School of Rehabilitation Science
Email address: dixlm@mcmaster.ca
Telephone number: 905 525 9140 ext. 26896
Information last updated on: April 3, 2013

Content was adapted from the following sources and relevant websites:
Other:
Baptiste, S. (2012). Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care.

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

The Ottawa Hospital Inter-professional Model of Patient Care (TOH IPMPC©)

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

SNAPSHOT:

This innovative practice is a guide to organizing the delivery of patient care among health professionals from different disciplines, taking into account their competencies, collaborative patient-centred practice, and their hospital's strategic directions.

PRACTICE DESCRIPTION:

The Ottawa Hospital Inter-professional Model of Patient Care (TOH IPMPC©)is a guide to organizing the delivery of patient care among health professionals from different disciplines, taking into account their competencies, collaborative patient-centred practice, and The Ottawa Hospital's (TOH's) strategic directions. TOH IPMPC© is the next building block in the TOH system redesign and appears to be the first of its kind. TOH IPMPC© is a set of 22 guiding principles by which teams coordinate clinical care. These principles are centred on the concepts of collaboration, accountability, interprofessional communication, and patient involvement in decision-making.

To support the implementation of TOH IPMPC©, an interprofessional education (IPE) program was created to reinforce the principles of interprofessional care (IPC) with health care professionals, students, and patients. The education program is multidimensional and has reached a large number of health professionals. Financial support for the first three years of implementation of this interprofessional care initiative (2007–2010) was provided by Ontario's Ministry of Health and Long-Term Care (MoHLTC). Funding has since been assumed by TOH.

TOH IPMPC© was created by patients and health care providers and is guided by a steering group whose membership is interprofessional and representative of the health professions. Because it has been created by patients and their health care providers, it is unique in its flexibility to be implemented hospital-wide across diverse teams. It has been implemented with 96 teams across a large academic health science centre. Each team reflects on the guiding principles and decides how to put these principles into practice within the team. The team then develops an Action Plan around the changes to be implemented to meet the guiding principles.

IMPACT:

A research team is using qualitative and quantitative research methodologies to evaluate the model at baseline (T0), six months (T1), and 12 months (T2) post-implementation. T0 and T1 data collection is complete and T2 is underway. The expected outcomes are enhanced quality of patient care through improved interprofessional collaboration, staff well-being, and organizational climate.

Current anecdotal evidence shows that engagement of team members has increased, and that the innovative strategies that have been implemented have enhanced their collaboration and the care being provided to patients and families. Some of these changes were simple ones, such as initiating regular social events to improve team spirit or updating a unit-specific pamphlet. Others were slightly more complicated, such as improving the discharge and transfer process for patients out of and into a unit, implementing a policy of zero tolerance for bullying and disrespectful behaviours, initiating an interprofessional council, and a team commitment to improving interprofessional communication and using interprofessional documentation tools. One such strategy, the Cardiac Arrest with Roles Defined (CARD) study, aims to enhance patient safety in the operating rooms. It was profiled on CJOH, CTV's affiliate in Ottawa, in September 2011.

Over 5,000 nurses and other health professionals are participating in the implementation. Enhancements in empowerment, job satisfaction, and recruitment and retention are anticipated. The findings will affect clinical practice, research, education, and administration.

A preliminary report of the findings will be ready at the end of April, 2013. Full data analysis will commence once T2 data collection is concluded at the end of April.

APPLICABILITY/TRANSFERABILITY:

TOH IPMPC© was fully developed and implemented at TOH, and it appears to be the first program of its kind. However, the guiding principles of this program and the implementation and evaluation processes are flexible enough to be used in a variety of health care settings, for a variety patient populations, and by various kinds of interprofessional teams. Already the TOH IPMPC© model has been implemented across 96 diverse teams in the Ottawa Hospital.

The educational program is available to over 5,000 nurses and other health professionals in the organization, and it has already been adapted for and delivered in five academic health sciences centres in the Champlain LHIN. Additionally, external partners who are currently implementing The Ottawa Hospital Model of Nursing Clinical Practice have indicated interest in also implementing TOH IPMPC©.

CONTACT INFORMATION:

Name: Ginette Rodger
Title: Senior VP Professional Practice and Chief Nursing Executive
Organization: The Ottawa Hospital
Email address: grodger@ottawahospital.on.ca
Telephone number: 613-737-8749
Information last updated on: April 5 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

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

External Source:
http://www.ottawahospital.on.ca/wps/portal/Base/TheHospital/OurModelofCare/ProfessionalModels/InterProfessionalModelofPatientCare

A Continuum of Care from Hospital to Home for Clients Requiring Long-Term Ventilation

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

SNAPSHOT:

This innovative practice aims to demonstrate that the addition of Respiratory Therapists (RT) to the community healthcare team would allow many of Long Term Ventilation (LTV) clients to safely transition into, and remain in their own homes.

PRACTICE DESCRIPTION:

Clients who require LTV but are otherwise medically stable often remain in an intensive care unit (ICU) due to inadequate support in the community. With an aim to address this identified care gap, the College of Respiratory Therapists of Ontario (CRTO) applied for and received a grant from HealthForceOntario's *Optimizing Use of Health Providers' Competencies Fund*. The project ran from October 2008 until March 2010.

This key objective was to be accomplished within a framework of best clinical practice, interprofessional collaboration and client-centred care. A criterion was established for determining which clients requiring LTV could potentially be safely transitioned into the community. This formed the basis of the tools that were developed to assist ICU RTs in the timely identification of those who had both the ability and the desire to return to their own home. These hospital-based RTs then facilitated the education and discharge process in collaboration with the client, his/her family and the rest of the healthcare team. RTs already employed in the community assisted in the coordination of this transition to enable seamless continuity of care. Once the client was returned to his/her place of residence, the homecare RTs were given with the necessary resources to provide on-going training and direct, 24/7 support for these individuals and all other care providers.

IMPACT:

A detailed final report that outlined the activities and outcomes of the project was submitted to HealthForceOntario (http://www.crto.on.ca/pdf/ProfPractice/HFO_Final_Report.pdf). The Final Report Executive Summary (http://www.crto.on.ca/pdf/ProfPractice/HFO_Executive_Summary.pdf) contains details regarding the key findings from the project, which were:

1. Improved client Quality of Life (QoL)
2. Increased job satisfaction (for healthcare providers)
3. Estimated cost savings (to the healthcare system)

The most significant project achievement was the transition of 30 clients who require LTV directly from the ICU setting into the community (ages ranged from 1 to 77). These individuals reside in Central and South-Western Ontario and have a variety of clinical diagnoses and prognoses. Since the completion of the project in March 2010, all have been able to remain in their homes with the continued support of the community-based RTs.

Providing this care option quantifiably enhanced their quality of life, in part by decreasing the incidence of unnecessary hospital readmissions. In addition, this initiative demonstrated a significant financial saving (approximately $500,000 per patient per year) to the healthcare system by optimizing infrastructure costs.

Another outcome of this project was the creation of an extensive resource manual, *A Training Manual for Paediatrics & Adults (Healthcare Professionals and Caregivers*), available to healthcare professions and caregivers who provide support for both adult and paediatric clients who require LTV in a community setting. Available at http://www.crto.on.ca/pdf/ProfPractice/HFO_Training_Manual.pdf, the manual contains tools to facilitate ICU discharge planning and to support safe and effective client care in the home environment.

There has been a positive response to the training manual, and CRTO has received requests to share it from a wide variety of healthcare professionals in both the hospital and community setting.

APPLICABILITY/TRANSFERABILITY:

Recent changes to the *Provision of Community Services* regulation (O.Reg 386/99) made under the *Home Care and Community Service Act* permits Community Care Access Centres in Ontario to contract RT services in the community for individuals who require LTV. The project outcomes will assist in defining the optimal model for the delivery of community respiratory services for this population by providing substantiated information that identifies best practice, as well as risk management and safety strategies. Subsequent to the completion of this project, a Community Care Access Centre (CCAC) Services Schedule was developed for Respiratory Therapy, which outlines the range of services that Respiratory Therapists can provide in the community.

While, there are several models of care for this specialized patient population that are active in other Canadian jurisdictions, the CRTO model is somewhat unique in that it utilizes Respiratory Therapists who are already working in the community. By enabling these practitioners to work to their full scope of practice, services for individuals with complex respiratory care needs can be provided in the community in a safe, efficient and cost effective manner.

This model of care delivery may be applicable to other jurisdictions interested in transitioning LTV services for eligible patients into the community. This model of care can be readily adapted and replicated under a variety of different funding models and staffing designs.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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

http://www.crto.on.ca/pdf/ProfPractice/HFO_Final_Report.pdf).

http://www.crto.on.ca/pdf/ProfPractice/HFO_Executive_Summary.pdf

CONTACT INFORMATION:

Name: Carole Hamp
Title: Manager of Quality Assurance & Member Relations
Organization: College of Respiratory Therapists of Ontario
Email address: hamp@crto.on.ca
Telephone number: 416-591-7800 x33

External Source: http://www.crto.on.ca/hfo.aspx

Nurse Practitioner–Led Clinics: Reforming Health Care with Interprofessional Teams

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

SNAPSHOT: This innovative practice addresses the lack of community health care services through a nurse practitioner led clinic.

PRACTICE DESCRIPTION:

The concept of the Nurse Practitioner–Led Clinic (NPLC) began with a group of nurse practitioners working in Sudbury, Ontario. They could see a lack of health care service to their community and an opportunity to start a new and innovative interprofessional model of primary health care. With strong lobbying and the support of the Registered Nurses' Association of Ontario and the Nurse Practitioners' Association of Ontario, they opened their doors in 2007.

The Ontario Ministry of Health and Long-Term Care announced the addition of 25 more clinics based on the success of the Sudbury clinic and the continuing lack of primary health care services for underserved people of Ontario. NPLCs are part of the government's family health care strategy and were implemented to increase access to primary health care for patients without a regular primary care provider. These clinics are founded on a nursing model with the patient as partner in the care process, and there is an emphasis on health promotion and disease prevention. This model has also increased awareness of the nurse practitioner role with the public, stakeholders, and the media.

The NPLC is a new primary health care delivery model in which nurse practitioners are the lead providers of primary health care. This collaborative practice approach includes nurse practitioners, registered nurses, registered practical nurses, social workers, registered dieticians, pharmacists, collaborating family physicians, and administrative support staff. With this innovative model of care, nurse practitioners provide comprehensive, accessible, and coordinated family health care services to populations across Ontario who do not have access to a primary health care provider (i.e. unattached patients). NPLCs improve the quality of care through enhanced health promotion, disease prevention, and chronic disease management. They also improve care coordination and navigation of the health care system at the local level.

A non-profit governing board has overall responsibility and accountability for the clinic, to the Ministry of Health and Long-Term Care, and to the community. The board of directors is comprised of a mix of nurse practitioners, other health care professionals, and community members. Funding for the clinics is provided by the Ministry of Health and Long-Term Care. Nurse Practitioners working in these clinics are paid a salary; they do not work on a fee for service basis.

IMPACT:

The Ministry of Health and Long-Term Care is finalizing the criteria to be used to formally evaluate the NPLCs. In the interim, many clinics have begun to collect data at the clinic level. Areas of measurement include (but are not limited to) patient satisfaction, level of chronic disease in the population served , number of cancer screening evaluations performed, number of immunizations provided, and number of clients served by one or more team members.

An example of the outcomes achieved can be taken from the Georgina NPLC, which has been in operation since July 2011 and has received an outstandingly positive response from registered clients. A patient satisfaction survey showed that 97% of clients were satisfied with the care provided at the clinic. In addition, there has been a steady increase of clients enrolling in the clinic, reaching 78% of the initial target of client registration. A second satisfaction survey is now underway to provide comparative measures.

At this time, the ministry has not provided any plans for a formal evaluation beyond collecting baseline numbers of patients cared for and number of visits. However, a provincial working group is developing a global measurement tool for primary health care and the NPLCs intend to use this tool when it is available.

APPLICABILITY/TRANSFERABILITY:

The Government of Ontario is committed to implementing a total of 26 nurse practitioner–led clinics by the spring of 2012. The first NPLC opened in Sudbury in 2007. The government then announced three additional clinics for Belle River, Sault Ste. Marie, and Thunder Bay. Eight more clinics were announced in the fall of 2009 and another 14 clinics in August 2010. All clinics were targeted to be fully operational by the end of 2012, with current NPLCs in various stages of development across 24 communities in Ontario.

Primary health care nurse practitioners across the country are educated and trained to provide comprehensive, full-scope, safe and effective care. With this innovative interprofessional team approach, other provinces can learn from Ontario's successes and expand their provision of care for otherwise underserved populations. For example, Alberta has put out an RFP for non-physician–led family care centres and has contacted the Nurse Practitioners' Association for input on their clinics based on the NPLC model.

CONTACT INFORMATION:

Name: Beth Cowper-Fung
Title: Clinic Director, Georgina NPLC and President of NPAO
Organization: Nurse Practitioners' Association of Ontario
Email address: beth.cowperfung@gnplc.ca
Telephone number: 905-722-3251
Information last updated on: April 17, 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

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

Ministry of Health and Long-Term Care. (n.d.). *Public information: Nurse practitioner–led clinics*. http://www.health.gov.on.ca/transformation/np_clinics/np_mn.html

External Source: http://npao.org/nurse-practitioners/clinics/

The Nursing Graduate Guarantee (NGG): An Innovative Employment Policy in Ontario

LOCATION:	Ontario	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

The aim of this innovative program is to increase full-time employment and integration of new graduate nurses into the workforce across diverse healthcare sectors.

PRACTICE DESCRIPTION:

The Nursing Graduate Guarantee (NGG), launched in 2007, is a component of the Ontario Nursing Strategy. It is an initiative of the Ontario Ministry of Health and Long-Term Care aimed at ensuring full-time employment for new graduate nurses including registered nurses (RNs) and registered practical nurses (RPNs). Each year, the government invests $90 million dollars in new graduate nurses through the NGG.

Recognizing nurses as the main care providers at the point of care, the government of Ontario created funding to stimulate employment to build capacity in the healthcare system. The intent of the NGG is to provide full-time employment and mentorship for new graduates as they transition to practice. The key objectives of the program are to:

1) increase full-time employment for new graduate nurses across all healthcare sectors;
2) improve integration of new graduate nurses into the workforce; and
3) promote recruitment and retention of new graduate nurses in Ontario.

The NGG uses an online employment portal, the HealthForceOntario Nurses' Career Start Gateway, to link new graduates with employers. When employers hire a new graduate through the portal, the position is subsidized by the government for a minimum of three months and up to six months. According to the policy, the new graduate nurse is directly supervised by a mentor and is not counted as base staff.

IMPACT:

Each year, the NGG is evaluated to assess its effectiveness in integrating new graduate nurses into the nursing workforce. A mixed methods approach to data collection is used. Quantitative methods include on-line surveys of employers and new graduate nurses. Qualitative methods include focus groups with employers and individual interviews with new graduates and frontline staff nurse mentors.

Results from the evaluation of the NGG indicate that the program has been successful in meeting the key objectives as outlined by the government. From the years 2007/08 to 2011/12, over 200 healthcare employers and 12,146 new graduate nurses participated in the NGG (Baumann et al., 2012). Of the NGG positions, 85% were in the hospital sector, 9% were in long-term care and 6% were in the community sector. Longitudinal trend data from the College of Nurses of Ontario (CNO) indicate that full-time employment of new members (RNs and RPNs) has increased since the introduction of the NGG. From 2006 (pre-policy) to 2012, there has been a 14% increase in full-time employment for new member RNs (47% to 61%) and RPNs (21% to 35%) (Baumann et al., 2012).

Stakeholders viewed the extended orientation and mentorship component of the NGG as instrumental in transitioning new graduate nurses into the workforce. The extended orientation and mentorship provided the time and support that was needed to develop comfort and confidence in the workplace. It increased clinical decision-making and time management skills helping new graduates to meet clinical practice demands and become integrated into the organization. The program provided vital support and helped new graduate nurses move from students to practicing nurses.

APPLICABILITY/TRANSFERABILITY:

The NGG is an innovative solution designed to improve quality of care provided by nurses across the continuum of services. Provincial and territorial governments across Canada can theoretically implement a similar initiative to ease new graduate nurses into practice to be well-positioned to promote the delivery of integrated care.

If interested in adapting this practice, it should be noted that sector differences in the way employers provided mentorship posed some challenges for employers. Community and public health organizations have had some difficulty providing a one-to-one model of mentoring for their new graduates due to the independent nature of the work.

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http://www.healthforceontario.ca/en/Home/Nurses/Training_%7C_Practising_In_Ontario/Nursing_Strategy/Nursing_Graduate_Guarantee/Program_Overview

CONTACT INFORMATION:

Name: Andrea Baumann, RN, PhD
Title: Scientific Director
Organization: Nursing Health Services Research Unit, McMaster University
Email address: baumanna@mcmaster.ca
Telephone number: 905-525-9140 x22581
Information last updated on: April 22 , 2013

External Source:
http://www.healthforceontario.ca/en/Home/Nurses/Training_%7C_Practising_In_Ontario/Nursing_Strategy/Nursing_Graduate_Guarantee

Bereavement Information and Support Program, Multimedia Resource Manual

LOCATION:	**Newfoundland & Labrador**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice equips individuals and groups with knowledge and tools to establish bereavement support programs in their own communities.

PRACTICE DESCRIPTION:

The Bereavement Information and Support program provides information and support to adults who are grieving the death of a loved one. The program offers multimedia resources to build grief and bereavement support program capacity in communities, including the following:

1. A 190-page manual provides information, tools, and resources to help community organizations such as health care agencies, community groups, and faith groups plan and organize a Bereavement Information and Support Group. Included is information on selecting facilitators, using an appropriate space, advertising, and screening participants, as well as tips for facilitators.

2. Notes are provided for eight sessions focused on topics that inform participants about grief and help them process their grief. These notes include a timetable, preparation checklist, and all the materials to move through the session, including discussion starters, handouts for discussions, skills training, and activity sheets. A 30-minute video by an expert on the topic accompanies each session. These videos are provided free on DVD.

3. For potential facilitators, six facilitator training sessions are available on DVD.

4. Evaluation material to help facilitators and sponsors determine the effectiveness of the group is also included.

IMPACT:

Feedback on the program has been very positive.

- Facilitators appreciate the detail and clarity of instructions for establishing and maintaining groups.
- Participants' evaluations, using the "pre and post" survey indicate positive outcomes.
- Professionals appreciate having bereavement resources available and a mechanism to separate those needing individual counselling for complicated grief from those needing supports for acute grief.
- Facilitators and organizations that have offered the program several times are discovering increased interest from clients and those endeavouring to support grieving and bereaved people.

At this time, no formal evaluation of the program has been completed.

APPLICABILITY/TRANSFERABILITY:

This program was designed for use in urban and rural settings in Eastern Health Region, NL. It has now been offered in all four regional health authorities in Newfoundland and Labrador.

The design and piloting was multi-site, with similar feedback and outcomes from all sites. It is theoretically applicable and transferable to other settings.

CONTACT INFORMATION:

Name: Rick Singleton
Title: Regional Director of Pastoral Care and Ethics
Organization: Eastern Health
Telephone: (709) 777-8940
Email: rick.singleton@easternhealth.ca

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

- Bereavement Information and Support Program. (2013). *External submission to the Health Innovation Portal.*

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

Advanced Training Program, Intermountain Healthcare

LOCATION:	International	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice is designed to train senior leaders, middle managers, and front-line health professionals in the theory and application of cost control, quality control, and the health services academic infrastructure. Launched in the US in 1991, the training program has expanded and is offered across Canada.

PRACTICE DESCRIPTION:

Health care professionals, leaders, and managers around the world are continuously striving to improve the performance and quality of health care systems through the advancement of their knowledge and skills. In the United States, the Advanced Training Program (ATP) offers a practical, in-depth course for health care professionals who need to teach, implement, and investigate quality improvement, outcome measurement, and management of both clinical and non-clinical processes.

The ATP was originally implemented in Utah at the beginning of 1991. The program is designed to train senior leaders, middle managers, and front-line health professionals in the theory and application of cost control, quality control, and the health services academic infrastructure. The program is funded through course fees ($10,500 per participant) and external funds from collaborators of the Institute for Health Care Delivery Research at Intermountain Healthcare.

The purpose of the program is to give participants the knowledge and tools necessary to conduct state-of-the-art clinical practice improvement projects, use quality improvement methods to manage and integrate non-clinical processes, implement quality improvement programs, and conduct internal quality improvement training. The ATP also gives participants the opportunity to join a national/international network that provides ongoing support and information sharing for future collaborations.

As part of the course, each ATP participant must select, complete, and report on an improvement project. The ATP faculty and analysts provide consultation and support for participants' projects. The Institute offers a nine-day mini-ATP course that is largely geared to clinicians, and a full 20-day ATP course that is divided into four sessions. The Institute builds on the experience of Intermountain Healthcare and brings national experts together to teach the theory and techniques of quality improvement, outcome measurement, health care policy and economics, leadership, and other subject areas.

The ATP is a seminal practice that has been recognized around the world for bringing front-line clinicians, health care leaders, and internal change agents to a common understanding of quality and how to make this a core component of organizational strategies in health. The program does not endorse any one specific approach to improvement (such as Plan-Do-Study-Act, Model for Improvement, Lean, or Six Sigma). Instead, it teaches a core set of improvement principles and introduces tools from a variety of approaches. Further, the action-based nature of the program allows for interdisciplinary collaboration and a culture change aimed at continuously improving quality in health care.

IMPACT:

The ATP is part of Intermountain Healthcare Continuing Medical Education, which is evaluated and accredited annually by the Accreditation Council of Continuing Medical Education based on consistent positive outcomes from extensive evaluations. To date, over 3,500 national and international participants have graduated from the program, generating more than 1,000 quality improvement projects, some of which have received recognition themselves. Participants' backgrounds are varied: 40% physician executives, 20% nurse/other clinician executives, 15% administrative staff, 10% senior executives, and 10% academic researchers. The ATP has a proven track record with respect to patient outcomes and value for money. Brent C. James, Intermountain Healthcare's vice-president of medical research and continuing medical education and the executive director of the Institute for Health Care Delivery Research, estimates that the ATP has yielded a four-to-one return on investment for the Intermountain Healthcare system since its implementation in the early 1990's. Currently, only 20% of graduates are from within Intermountain Healthcare.

Intermountain Healthcare has received several awards as a result of its quality improvement initiative, including the ATP. These include the Quality Health Care Award presented in 1996 by the National Committee for Quality Health Care and the Healthcare Forum/Witt Award: Commitment to Quality presented in 1991 by The Healthcare Forum and Witt Associates.

APPLICABILITY/TRANSFERABILITY:

The ATP has been adapted by over 50 jurisdictions and/ or health systems, such as Veterans Affairs in the United States and the National Health System in the United Kingdom. Other countries, including Australia and Germany, have also expressed interest in adapting this practice. In Canada, the ATP has been adapted in British Columbia since 2006 as the Quality Academy, and will begin in Ontario in the fall of 2013 as Improving & Driving Excellence Across Sectors (IDEAS).

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

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- Intermountain Healthcare. (2013). *20-day course for executives & QI leaders: Advanced Training Program (ATP)*.http://intermountainhealthcare.org/qualityandresearch/institute/courses/atp/Pages/home.aspx

CONTACT INFORMATION:

Name: Jean-Ann Wurtz
Title: Advanced Training Program Coordinator
Organization: Institute for Health Care Delivery Research, Intermountain Healthcare
Email address: jean-ann.wurtz@imail.org
Telephone number: (801) 442-3718

Information last updated on: March 7, 2013

External Source: http://intermountainhealthcare.org/qualityandresearch/institute/courses/atp/Pages/home.aspx

BC Health Leadership Development Collaborative – Transforming Linx

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice addresses the need for senior health system levels to lead innovative and change. This 10-month, project-based leadership development experience was launched in British Columbia in 2012.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities (HAs) driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created "Leadership LINX, a Provincial Pathway of Leadership Development" with key areas of: coaching, mentoring, core and transforming.

The Transforming LINX is a comprehensive 10-month, project-based leadership development experience designed specifically for healthcare leaders at the senior level. The program theme is 'complexity in healthcare', which requires new and higher levels of skill, leadership behaviour, innovation, systems awareness and collaborative practice for success in the most senior BC healthcare leadership roles. Transforming LINX aims to accelerate the pipeline of senior leaders prepared to lead innovation and change in the increasing complexity of BC Healthcare and create a community of senior leaders who are connected, committed to change, and who collaborate for the transformation of healthcare system. These leaders are learning together and engaging in learning designed to help them think differently and form networks and partnerships across traditional boundaries. The program consists of 3 Residencies; Online Community; Multi-disciplinary/Cross-Health Authority Action Learning Project Teams; Executive Coaching; 360 Assessments. The program was funded by a grant by the BC Health Education Foundation and each health authority.

IMPACT:

Personal accounts by particpants from Residency #1 and the Guiding Coalition already indicate some changes in thinking desired by the program and the formation of cross-health authority networks. Evaluation of the program will continue throughout and a full report will be available January, 2014. It is too early to determine the impact of the program given the first residency just concluded (February, 2013), but evaluation data from the first residency indicated changes in thinking, which is the first step in healthcare transformation

APPLICABILITY/TRANSFERABILITY:

All Health Authorities are participating so the only replication anticipated is when the next cohort beings in 18-24 months.

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

External submission from the BCHLDC.

CONTACT INFORMATION:

Name: Rachael Roberts
Title: Lead
Organization: BC Health Leadership Development Collaborative (BCHLDC)
Email address: rachael.roberts@phsa.ca
Telephone number: 604-875-7234

Information last updated on: April 2013

BC Health Leadership Development Collaborative - Collaboration Practice

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice is a province-wide collaboration between all Health Authorities in British Columbia to support, develop, engage and advocate for leaders with the ultimate goal of delivering exceptional patient outcomes.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes.

BCHLDC aims to attract and retain the best leadership in response to an acute shortage in healthcare leadership and the changing demands of the leadership role. As a solution to these problems, 7 BC health authorities formed a collaborative to focus on leadership development. The vision, in part, is to advocate for leaders and leadership practice, improve access to leadership development opportunities, attract and retain the best leaders. The collaboration was funded through Sep, 2013 with a grant from the BCHEF, the CNOs and through Mar 2015 with contribution by all health authorities.

The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created Leadership LINX, a Provincial Pathway of Leadership Development, with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

IMPACT:

Ministry of Health reprentatives remarked one time that the BCHLDC was the most successful collaborative in BC and that most fall by the wayside very early on in their process. Personal accounts by all involved indicate evidence of success, not to mention the physical evidence of the programs' existence. The BCHLDC is contemplating a formal evaluation if its objectives in the next few months.

The program has an impact on system performance because the system's capacity to develop its leaders has grown dramatically because of this collaboration. Since 2010 the following has occurred: a mentoring program previously in one HA is now in 5 and will be in 7 by Spring; an experience leader program in 2 HAs is now in all 7; a coach approach program previously only in 2 HAs is now in 7; the new manager training available across the province has been pulled into 1 comprehensive program thereby improving all programs; a senior leadership program is in delivery. Discounted prices have been negotiated, shared memberships create additional cost savings, and no one has to reinvent the wheel.

APPLICABILITY/TRANSFERABILITY:

The collaborative model of the BCHLDC Steering Committee has been replicated in the working groups its formed, using the same principles, to create the individual program streams. Nationally, a LEADS Collaborative is forming in a similar structure as BCHLDC. They have sought BCHLDC's leadership and coaching as they get started. It's early days to determine if true collaboration will be cultivated.

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

External submission from the BCHLDC.

CONTACT INFORMATION:

Name: Rachael Roberts
Title: Lead
Organization: BC Health Leadership Development Collaborative (BCHLDC)
Email address: rachael.roberts@phsa.ca
Telephone number: 604-875-7234

Information last updated on: April 2013

BC Health Leadership Development Collaborative – Mentoring Linx

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice provides flexible, individualized mentoring opportunities, including long-term mentoring relationships and short-term engagements to discuss specific topics or situations and is available to “people who lead people". Using state-of-the-art software health system leaders create their own mentoring match based on skills, goals, interests and personality and can be matched with leaders across British Columbia.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities (HAs) driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created “Leadership LINX, a Provincial Pathway of Leadership Development” with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

The Mentoring LINX provides flexible, individualized mentoring opportunities, including long-term mentoring relationships and short-term engagements to discuss specific topics or situations and is available to “people who lead people. Using state-of-the-art software leaders create their own mentoring match based on skills, goals, interests and personality and can be matched with leaders across the province. Mentoring LINX is free to eligible participants and there is no work or commitments outside of the contract designed by the mentor or mentee.

According to the vendor used to support the program, Mentoring LINX is the only cross-organization mentoring program in existence in North America. By Fall of 2013, all health authorities will be involved in the program. The program was funded through March, 2013 with a grant from the BC Health Education Foundation and will be supported by HAs starting this fiscal year

IMPACT:

The Mentoring LINX program has been evaluated twice - once while in the pilot stage and once after a Phase I roll-out. The evaluation consisted of an online survey of participants on both occasions. The revised second evaluation linked the questions and subsequent data analysis to the short-term outcomes from the logic model prepared for the overarching project (BC Health Leadership Development Collaborative). Data is available upon request. The data provides both qualitative (program testimonials) and quantitative measures.

Results in both evaluations demonstrated positive impact on health care system performance. Specific results from the second evaluation, for those matched with a mentor/mentee are noted below:

(1) The program is valuable & essential to personal & organizational success & needs to be continued

(2) 68% attributed specific results, mostly learning specific knowledge or skill, directly to their participation in the program.

(3) 74% indicated they would stay with organizations that had this type of development program

One notable qualitative result: "I was going to leave my health authority, but found a mentor who guided me and I stayed" potentially saving thousands of dollars in turnover costs.

APPLICABILITY/TRANSFERABILITY:

This program was originally implemented by Interior Health Authority and now has been adopted by Northern Health Authority, Fraser Health Authority, Vancouver Island Health Authority, and Provincial Health Services Authority. By Fall, 2013, Vancouver Coastal Health and Providence Health Care will have adopted the program meaning 100% of the health authorities will be both contributing and benefiting from Mentoring LINX.

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

External submission from the BCHLDC.

CONTACT INFORMATION:

Name: Rachael Roberts
Title: Lead
Organization: BC Health Leadership Development Collaborative (BCHLDC)
Email address: rachael.roberts@phsa.ca
Telephone number: 604-875-7234

Information last updated on: April 2013

BC Health Leadership Development Collaborative – Core Linx

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice is a comprehensive leadership and management development program designed for managers in the first 18 months of their first formal management role in a British Columbia Health Authority.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities (Has) driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created "Leadership LINX, a Provincial Pathway of Leadership Development" with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

The Core LINX is a comprehensive leadership and management development program designed for managers in the first 18 months of their first formal management role. Due to the large amount of retirements projected in the system, it is necessary to ensure new leaders are preparing in a comprehensive manner and accelerate and deepen their growth. The program serves any new manager regardless of occupation. As a participant of Core LINX, leaders learn essential leadership skills to increase confidence and build a strong foundation for their future as a healthcare leader. Core LINX uses a variety of active learning methodologies and includes courses in leadership and management development, as well as coaching, electives, Hot Topic sessions and manager check-ins.

The Core LINX program just completed a pilot and is expected to be implemented in all HAs by the end of FY2013/2014. The development is funded through Sep, 2013 with a grant from the BCHEF and CNOs. Ongoing delivery will be funded by the HAs.

IMPACT:

Evaluation of the Core Linx pilot program included the following: 1) tracking 4 participants through the program to analyze behavior change using interviews with an external interviewer, 2) end of module evaluation, 3) mid-program manager assessment, and 4) in-module content audits. Also planned are 3 & 6 month follow up assessments with participants and managers.

Mid-program manager assessments indicated new managers had more of a systems lens; less micromanaging, interactions with staff increased; greater clarity; clearer strategies. Participants indicate increased self-responsibility; increased confidence; improved relationships, enhanced team effectiveness; and decrease in stress. Additionally, because all health authorities shared their leading practice content openly, none of the health authorities bore a development cost to increase or improve their leadership development offerings to this important management audience.

APPLICABILITY/TRANSFERABILITY:

This program has been piloted in one health authority and all other HAs have plans to implement the program in FY2013/2014. Results are theoretically replicable across health authorities.

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

External submission from the BCHLDC.

CONTACT INFORMATION:

Name: Rachael Roberts
Title: Lead
Organization: BC Health Leadership Development Collaborative (BCHLDC)
Email address: rachael.roberts@phsa.ca
Telephone number: 604-875-7234

Information last updated on: April 2013

BC Health Leadership Development Collaborative – Coaching Linx

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice is designed to help senior leaders (directors and above) within each Health Authority in British Columbia enhance their leadership capacity by focusing on topics such as managing challenging workplace issues, learning from feedback or implementing a new initiative.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created "Leadership LINX, a Provincial Pathway of Leadership Development" with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

The 1:1 Coaching Service LINX is designed to help senior leaders (directors and above) within each Health Authority enhance their leadership capacity by focusing on topics such as managing challenging workplace issues, learning from feedback or implementing a new initiative. 1:1 Coaching is client-centered and designed to support a client over time. The 1:1 Coaching service has a centrally-coordinated provincial list of highly quality coaches who are available to senior leaders in BC health organizations. Each coaching contract is customized to the coachee's needs and outlines specific goals, time committed to coaching sessions and timelines. BCHLDC created this program using sophisticated collaboration.

IMPACT:

Personal accounts by those managing coaching services indicate the benefits of the provincial list, the common price, and the assurance of high quality coaches. An evaluation of the program is expected to be undertaken in 2013.

The program has an impact on system performance because of the efficiencies created in the coach only signing one contract, rather than each HA managing its own contract. Additionally, for those who have been using 1:1 external coaching services, there is an expectation that some of the costs will decrease because of the common price. Lastly, it's more efficient for leaders to find an external coach because of the list's existence.

APPLICABILITY/TRANSFERABILITY:

This service has been replicated in all BC health authorities and Providence Health Care.

The same self-reported positive results are being experienced in all health authorities.

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

External submission from the BCHLDC.

CONTACT INFORMATION:

Name: Rachael Roberts
Title: Lead
Organization: BC Health Leadership Development Collaborative (BCHLDC)
Email address: rachael.roberts@phsa.ca

Telephone number: 604-875-7234

Information last updated on: April 2013

InspireNet: Innovative Nursing Services & Practice Informed by Research & Evaluation Network

LOCATION:	British Columbia	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	

SNAPSHOT: This innovative practice aims to create a web based network of individuals and organizations working collaboratively to advance and use research and knowledge to improve nursing health services in British Columbia.

PRACTICE DESCRIPTION:

InspireNet is a vibrant and interactive network of individuals and organizations working collaboratively to advance and use research and knowledge to improve nursing health services in British Columbia. Primarily InspireNet connects people across geography, institutions and disciplines leveraging Web 2.0, web conferencing and emerging social media.

Through province-wide networking, directed supportive activities, linkages between health services/academic institutions, InspireNet aims for:

- Increased capacity for nursing health services research
- Coordinated approach to nursing health services research planning/priority setting
- Strategic nursing/interprofessional health services research partnerships/collaborations within BC and beyond
- Care delivery/education innovations based on health services research findings
- Sustainability Plan

IMPACT:

As of January 2013, InspireNet has over 2,500 members. About 65% of InspireNet's members work in BC's health authorities; about 25% work in academic settings. InspireNet brings these populations together. It is too early to well understand the impact these connections are having on health care system performance but anecdotally we are hearing encouraging stories. There is a formal evaluation planned for this initiative.

APPLICABILITY/TRANSFERABILITY:

InspireNet builds on the experiences of the 8 BC-based health of population research networks funded by the Michael Smith Foundation for Health Research during the period 2005-2010: (http://www.msfhr.org/resources/public/Funding/HoPN_Background.pdf) and using lessons from the health research networks funded by the FRQS (Fonds de recherche du Québec - Santé): http://www.frsq.gouv.qc.ca/en/centregroupereseau/reseaux/reseaux_liste.shtml.

At this point the program is spreading through BC with good results reported.

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

- Evaluation plan: http://www.inspirenet.ca/Evaluation.
- Reports from ongoing evaluation activities are available under Performance Reporting: http://www.inspirenet.ca/publications
- www.msfhr.org
- http://ehealth.med.ubc.ca/projects/inspirenet/

- http://solr.bccampus.ca:8001/bcc/items/7d8e2dc3-19c7-5e03-887c-4388481e0...
- http://health-evidence.ca/additional_resources_links
- http://www.cano-acio.ca/links/
- http://www.bcahc.ca/index.php?option=com_docman&task=doc_details&gid=203...
- http://www.kusp.ualberta.ca/en/KUSPNews/2011/12/DrCaroleEstabrooksdelive...
- http://www.crpnbc.ca/wp-content/uploads/2011/02/CRPN_Communicator_SPRING...
- http://www.ipanel.ca/
- http://www.arnbc.ca/

CONTACT INFORMATION:

Name: Pat Atherton
Title: Manager
Organization: Inspirenet
Email address: patherton@inspirenet.ca

Information last updated on: April 8, 2013

Physician Integrated Network (PIN) Initiative

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

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

PRACTICE DESCRIPTION:

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

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

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

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

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

IMPACT

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

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

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

APPLICABILITY/TRANSFERABILITY

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

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

Content adapted from the following sources and relevant websites:

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- Wranik, D., & Durier-Copp, M. (no date). Quality based incentive payments: International experiences, lessons for Canada. Halifax, NS: Program Evaluation and Economic Konsulting.
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- Australian Government Department of Human Services. (2012). Practice Incentives Program (PIP). Retrieved on December 20, 2012 from http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp
- Manitoba Health. (no date). Primary Care Networks. Retrieved on December 10, 2012 from http://www.gov.mb.ca/health/primarycare/pcn/index.html

- Manitoba Health. (no date). Chronic Disease. Chronic Disease Management (CDM) tariffs. Retrieved from http://www.gov.mb.ca/health/primarycare/chronicdisease/cdmtariffs.html

CONTACT INFORMATION:

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

Information last updated on: December 20, 2012

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

ColonCancerCheck

LOCATION:	Ontario	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice is a population based colorectal screening program. Launched in Ontario in spring 2008, it aims to increase capacity of primary care providers (PCPs) to facilitate the screening tests.

PRACTICE DESCRIPTION:

Colorectal cancer is the third most common cancer in Canada, and is diagnosed in 423 Canadians every week. In Ontario, it is even more prevalent, ranking as the second leading cause of cancer. In efforts to improve screening rates with a population-based screening approach, the Ministry of Health and Long-Term Care (MOHLTC) of Ontario, together with Cancer Care Ontario (CCO), committed a $193.5 million investment to colorectal screening in 2007. This led to the launch of an innovative, province-wide program called ColonCancerCheck (CCC) in the spring of 2008. The aims of the CCC are to

- screen every Ontario citizen between the ages of 50 and 74 at an average risk for colorectal cancer with the guaiac fecal occult blood test (gFOBT), and with a colonoscopy for people with abnormal gFOBT results or who have a family history of colorectal cancer; and
- increase capacity of primary care providers (PCPs) to facilitate the screening tests.

This is the first population-based colorectal screening program in Canada. Practices are founded on evidence collected from published literature, and all gFOBTs and colonoscopies delivered are regulated to meet Cancer Care Ontario's standards of practice. The over-arching goal is to reduce mortality from colorectal cancer through a comprehensive and pre-emptive strategy.

IMPACT:

CCO publishes ColonCancerCheck program reports with updates on progress made to date. During the 2010/2011 fiscal year, the percentage of endoscopists in Ontario reaching CCO's volume standard (200 colonoscopies annually) increased to 79%. Based on 2010 statistics, participation has risen to 53% of the population aged 50 to 74 being up-to-date with their colorectal tests. Detection outcomes were positive, showing that

- for every 1,000 people aged 50 to 74 screened using gFOBT in 2010, 1.5 cancers were detected;
- for every 1,000 people aged 20 to 74 with a family history of CCC screened in 2010, 4.3 cancers were detected; and
- for every 1,000 people aged 50 to 74 who were negative for colorectal cancer in the 2008 screening but were re-screened in 2010, 1.7 cancers were detected.

CCO captures progress and data on efficiency through a rigorous framework that enables Ontarians to be tracked, updated on their results, and re-screened for data acquisition. Screening and information gathering protocols are in line with the standards of the International Agency for Research on Cancer, and the quality determinants of the Canadian Partnership Against Cancer are being used for reporting purposes. Currently, up to 85% of hospital colonoscopies are being captured in the data, with new efforts being made to capture colonoscopies performed in non-hospital facilities.

Communication with patients is a well-established component of the program, with data management tools in place to ensure information sharing is bilateral and continuous. Correspondence has improved since 2008 via update letters to patients with abnormal gFOBT results, recall letters for repeat screening, and invitation letters for new participants.

APPLICABILITY/TRANSFERABILITY:

Similar programs have existed since 2006 in England and Australia. However, Ontario is the only jurisdiction to begin screening at age 50 using a strongly evidence-based approach to the screening process. Colorectal cancer screening programs have now been adopted to varying degrees of implementation in British Columbia, Alberta, Saskatchewan, Manitoba, and Nova Scotia,

which demonstrates that the CCC program is easily transferable to the remaining provinces and territories. Various organizations such as the Ontario Hockey League and The Giant Colon have teamed up with Cancer Care Ontario to continue promoting CCC throughout Ontario.

Content was adapted from the following sources and relevant websites:

http://www.mybettermedicare.ca/provincial-primary-care-and-cancer-engagement-strategy.html

https://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=226298

CONTACT INFORMATION:

Name: Jill Tinmouth
Title: Scientific Lead
Organization: ColonCancerCheck Program, Cancer Care Ontario
Email address: jill.tinmouth@sunnybrook.ca
Telephone number: 416-480-6100, ext. 5910

Information last updated on: March 4, 2013

External Source: http://www.health.gov.on.ca/en/public/programs/coloncancercheck/

Manitoba Lean Six Sigma Strategy Training: Green and Black Belt Networks

LOCATION:	Manitoba	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the need to support health care stakeholders in applying Lean Management throughout the Manitoba health system. Established in 2010, this program fosters a community of particpants that provide up to a year of mentorship for staff undergoing Lean training and a way for staff to come together to learn about and support each other's diverse improvement projects.

PRACTICE DESCRIPTION:

Since 2010/11, Manitoba Health has been committed to integrating Lean Management into ongoing health system improvement. Lean Management is a quality improvement methodology that has been implemented in various Canadian provinces to improve health care efficiency. The Manitoba-specific Lean Strategy is a province-wide five-year training and mentoring strategy. The aim of this strategy is to deliver training in system efficiency and quality improvement to Manitoba Regional Health Authorities (RHAs) and health system stakeholder agencies. The initial goal for the five-year strategy was to train over 1600 health care staff and implement a minimum of 225 improvement projects resulting in anticipated minimum savings of $4.1 million.

In Year 2, Manitoba Health provided the funding and coordination to establish a Green Belt network to foster a community of practice to support Lean. In Year 3, a Black Belt network was also created to bring together health providers trained at the Black Belt level. The Green Belt and Black Belt networks are unique to Manitoba Health, and are an innovation in implementing Lean Management in health systems.

The Green and Black Belt networks provide up to a year of mentorship for staff undergoing Lean training and a way for staff to come together to learn about and support each other's diverse improvement projects. Furthermore, as the staff involved in the networks develop expertise in diverse areas of improvement, their knowledge and experience can be shared among others looking to address similar issues. The Green and Black Belt networks have also allowed members to leverage additional training sessions, inviting participants from different regions to observe or participate in training taking place across the province.

The networks connect monthly through teleconference meetings (with over 50 participants per call) supported by screen-sharing software that gives all participants access to the same presentation materials. The meetings focus on providing mentorship and assistance to current trainees, but they are also open to past graduates. Additionally, all health staff trained in Lean implementation can access a password-protected website that hosts Lean-related improvement tools and resources for all of the Pursuing Excellence initiatives. Annually, a face-to-face graduation event called "Congress" is organized to celebrate the new trainees and showcase their improvement projects. The incoming cohort of trainees, executive sponsors, and executive leadership involved with the projects are invited to attend.

The Green Belt and Black Belt networks will continue to grow in Years 4 and 5 of the initiative, accommodating all new trainees and Lean staff who have been certified externally into the Lean Community of Practice.

IMPACT (of Green/Black Belt Networks):

The positive impact of the Green Belt and Black Belt networks in supporting the training initiatives mentioned below has not yet been formally evaluated. However, Manitoba Health intends to conduct another evaluation of their training strategy as it continues to roll out over Years 4 and 5. Anecdotal evidence among network participants suggests the networks have been instrumental in bringing trainees together and providing opportunities for effective learning, mentorship, engagement, and collaboration. The teleconferences provide a direct, organized way to ensure participants are progressing towards goals and targets, as well as a safe venue to discuss and address obstacles to improvement and lessons learned. A future evaluation may help determine what resources are required for the continued coordination and long-term sustainability of the Green Belt and Black Belt networks.

Positive impact from Lean Six Sigma initiatives has been formally evaluated, which provides context for the potential role of the Green and Black Belt Networks. In Year 1, approximately 45 small Lean Six Sigma initiatives were implemented as a result of training throughout the province. An evaluation of the first year of the Lean program was completed using the Kirkpatrick Evaluation methodology to examine whether the rollout of the training could be improved. Based on the results of this evaluation, the Green Belt and Black Belt networks were established to increase collaboration and staff-to-staff time. Other modifications were made in Year 2 to increase participation from executive sponsors and to build more capacity within RHAs for long-term sustainability of Lean.

As part of the training initiative, all improvement projects are required to complete an Improvement Report detailing the work undertaken and the amount and types (i.e. space, inventory, staff time, etc.) of savings achieved. Preliminary results for improvement savings for 12 of 23 Rapid Improvement projects resulted in the following:

- staff time available to reinvest = 10,261 hours;
- reduction in the number of pt bed days = 13,683;
- increase in patient throughput (number of patients that can enter the system) = 1,129 patients;
- supplies savings = $8,394;
- 5S space savings = $5,952; and
- financial resources redeployable = $6,398,729

APPLICABILITY/TRANSFERABILITY:

The idea to establish the Green Belt and Black Belt networks in Manitoba to support Lean training originated from prior positive experiences with developing networks or community of practice models that support trainees as they develop their skills and begin work on novel projects. Prior networks coordinated by Manitoba Health that have had a positive impact include the Baby Friendly Breastfeeding network and an Injury Prevention network.

An original goal in establishing the Green Belt and Black Belt networks was to ensure that a comprehensive, provincial-level approach was undertaken, bringing together all of the health regions as well as health care organizations. A benefit of this province-wide approach is that it has accelerated the spread and uptake of improvement projects across regional and institutional boundaries. For example, the Green Belt and Black Belt networks have provided a mechanism through which improvement projects working at one site in the province can be shared and spread to other sites. Successful projects are presented at the Green Belt meetings and may be adapted by others looking to address the same problem, thereby helping to spread the innovation and improvement throughout the province. For example, one site's successful experience with organizing a kanban ordering system has now spread to four additional sites in the province.

The model provided by the Green Belt and Black Belt networks may be readily adopted by other initiatives aiming to develop a Community of Practice to engage and support participants.

Content adapted from the following sources and relevant websites

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CONTACT INFORMATION:

Name: Dawn Ridd
Title: Manager Provincial Lean Strategy, Manitoba Health; Rapid Improvement Lead, Cancer Patient Journey
Organization: Manitoba Health
Email address: dawn.ridd@gov.mb.ca
Telephone number: 204-788-6667

Information last updated on: February 10, 2013

External Source: http://www.gov.mb.ca/health/mpan/pdf/demone.pdf

Strategic Clinical Networks in Alberta

LOCATION:	**Alberta**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice has been developed as part of a provincial quality improvement effort to enhance the patient journey, improve health outcomes, and standardize care delivery. Established throughout Alberta in 2011, the purpose of the Strategic Clinical Networks is to engage clinicians and patients in decision-making about clinical services planning and to support clinical practice improvement by implementing clinical practice guidelines (CPG), developing care 'pathways', improving the patient experience and more.

PRACTICE DESCRIPTION:

Strategic Clinical Networks (SCNs) have been developed in Alberta as part of the province's quality improvement effort to enhance the patient journey, improve health outcomes, and standardize care delivery. Essentially, SCNs are province-wide teams comprised of health care professionals, researchers, community leaders, patients and policy makers, organized around a specific clinical focus. The purpose of each network is to engage clinicians and patients in decision-making about clinical services planning and to support clinical practice improvement by implementing clinical practice guidelines (CPG), developing care 'pathways', improving the patient experience and more.

SCNs were established throughout the province in 2011. Alberta began with six focused networks:

- Addiction and Mental Health
- Bone and Joint Health
- Cancer Care
- Cardiovascular Health and Stroke
- Obesity, Diabetes and Nutrition
- Seniors' Health

One senior leader in Alberta has described a SCN as "… almost like a program-based model of delivery where you get a group of health care professionals, largely physicians - but not exclusively physicians - together to talk about how they can systematically standardize the care for important populations of patients." Another leader stressed that "the networks get diverse groups to start working together on common targets, standardizing care pathways, and then showing that it actually [makes] a difference to the patient's experience and the patient's outcomes."

Each SCN has been asked to align their work with Alberta Health Services' priorities, as well as provincial priorities and take on a major "reassessment" project, with the goal of identifying and potentially eliminating harmful, outdated, ineffective and/or inappropriate processes, procedures, technologies, drugs or care programs. Each SCN has been asked to develop a focussed research and innovation program, in collaboration with academic partners. Since a large part of the work of SCNs is implementing clinical practice guidelines, there is also collaboration with, and learning from, groups doing similar work in other provinces. Finally, the aims of Alberta's SCN initiative align with the Institute for Healthcare Improvement's (IHI) "Triple Aim framework" which is predicated on: improving the health of the population; enhancing the patient experience of care (quality, access and reliability); and reducing/controlling the cost of care, or adding "value for money."

IMPACT:

Scientific literature has shown clinical networks to be a proven model in reducing variation and improving care, by promoting the use/uptake of clinical experience, knowledge and research. As well, clinical networks have been proven to be effective mechanisms to ensure collaboration, joint decision-making and shared learning.

The Strategic Clinical Network's approach—involving a collaborative structure, integrated decision making and physician and patient engagement—is a recent development and has yet to be formally evaluated. Within Alberta Health Services, there are plans for each clinical network to undergo an assessment according to a maturation framework developed from existing

corporate instruments and approaches. The purpose is to make an assessment of a network's 'baseline maturity' and establish appropriate characteristics by which to measure a network's trajectory of maturation. Periodic evaluations will help to ensure that the SCNs are maturing and developing in such a way as to achieve their goals. Additionally, a Collaborative Research in Outcomes (CRIO) grant from Alberta Innovates – Health Solutions will facilitate a future comparative study comparing Alberta's new strategic clinical networks with similar networks in the province of New Brunswick. The research study will evaluate outcomes in four networks (two from each province) in a comparative case study design. Earlier pilot work verified the feasibility of such a study and informed the design of the evaluation plan.

APPLICABILITY/TRANSFERABILITY:

Many high performing health care systems have adopted a system-wide approach to establishing, promoting, and implementing evidence based clinical best practices. In its development, Alberta's Strategic Clinical Network approach reviewed the experiences of clinical networks implemented in other jurisdictions, including Scotland, England and Australia. These models also informed the design of the Operational Clinical Networks (OCNs; ie. Critical care, emergency, and surgery), that have been established in Alberta. "Lessons learned" for effective network design and success factors were also taken from the experience of the Canadian Institutes of Health Research (CIHR) and its 13 partner institutes throughout the country.

Within the province of Alberta, there are plans for the SCN model to be further expanded to other clinical domains. Six more SCNs will be phased into operation over the course of 2013, including:

- Complex Medicine (which will include the current Respiratory Clinical Network)
- Maternal Health
- Neurological Disease, ENT (ear, nose, throat) and Vision
- Newborn, Child and Youth Health
- Population Health and Health Promotion
- Primary Care and Chronic Disease Management

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Alberta Health Services: Strategic Clinical Networks A Primer & Working Document (August 7, 2012 – V5)
http://www.albertahealthservices.ca/hp/if-hp-ce-scn-primer.pdf

Alberta Strategic Clinical Networks Terms of Reference: http://www.albertahealthservices.ca/hp/if-hp-clin-network-tor.pdf

Health Council of Canada Interviews with senior leaders in Alberta, 2012.

Health Council of Canada Interview with Alberta Health Services staff, 2013.

Noseworthy, T. (2012). Innovation, Quality & Accountability in Alberta Health Services, Presentation to the National Health Leadership Conference, Halifax, Nova Scotia: June 4, 2012. http://www.nhlc-cnls.ca/assets/Noseworthy_Final.pdf

Determinants of successful clinical networks: the conceptual framework and study protocol. Haines et al, Implementation Science, 7:16, 2012

A qualitative study of stakeholders' views of the preconditions for and outcomes of successful networks. McInnes et al, BMC Health Serv Res, 2011.

Bringing networks to life- An RCPCH guide to implementing clinical networks. Royal College of Pediatrics & Child Health, UK, 2012.

CONTACT INFORMATION:

Name: Dr. Tom Noseworthy
Title: Associate Chief Medical Officer, SCNs and Clinical Care Pathways
Organization: Alberta Health Service
Email address: Tom.Noseworthy@albertahealthservices.ca
Telephone number: (780) 342-2014

Information last updated on: February 20, 2013

External Source: http://www.albertahealthservices.ca/6047.asp