Health Innovation Portal:
Archive of Innovative Practices

Theme: **Health Human Resources (Vol. 3)**

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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:**	**21 results out of 92**

1. Long and Brier Island Community Paramedicine Project

Implementation Year: Saturday, February 3, 2001 - 01:15	**Location: Nova Scotia**	**Practice Website: http://www.gov.ns.ca/health/ehs/documents/Community%20Paramedicine%20Article.pdf**

SNAPSHOT:

This innovative practice focuses on increasing access to health care professionals in remote places. Launched In 2001 in two rural communities in Nova Scotia, the three-year initiative implemented the health service delivery model that uses the more widely practiced model of community paramedicine and introduced a novel collaboration with registered nurse practitioners (NPs).

CONTACT INFORMATION:

Name: Connie Day Title: Nurse Practitioner Organization: Island Health Centre & EHS Paramedic Excess Line Capacity Telephone number: 902-839-2398 Email: info@swndha.nshealth.ca

2. Integrating Supported Post-secondary Education with Supported Employment Program for People with Mental Illness

Implementation Year: Tuesday, February 3, 2009 - 00:00	**Location: Ontario, International**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to facilitate successful college education and employment for students with mental health issues via supported education and supported employment. Launched as pilot studies in Israel and Canada, the program demonstrates that integrating supported education with supported employment may benefit people with mental illness to succeed in skilled occupations.

CONTACT INFORMATION:

Name: Dr. Abraham Rudnick Title: Associate Professor, Medical Director of the Mental Health and Addiction Services (MHAS) Organization: University of BC; Department of Psychiatry Email address: Abraham.rudnick@viha.ca Telephone number: 1-250-370-8396

3. Virtual Ward, South East Toronto Family Health Team

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

5. Rapid Access to Consultative Expertise (RACE)

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

6. National Surgical Quality Improvement Program (NSQIP) in British Columbia through the Surgical Quality Action Network (SQAN)

Implementation Year: Friday, February 3, 2012 - 00:15	**Location: British Columbia**	**Practice Website: http://bcpsqc.ca/clinical-improvement/sqan/**

SNAPSHOT:

This innovative practice addresses the need for health care providers to discuss best practices, share local innovations, and network to improve surgical care for patients in British Columbia. Launched in 2012 to facilitate the implementation of NSQIP in hospitals across British Columbia and leverage its use as a data measurement tool in the province, the BCPSQC established the Surgical Quality Action Network (SQAN) to help hospitals "act" on their report card through engagement and shared learning with other comparable hospitals.

CONTACT INFORMATION:

Name: Marlies van Dijk, RN, MSc Title: Director, Clinical Improvement, BC Patient Safety and Quality Council Organization: NSQIP Email address: mvandijk@bcpsqc.ca Telephone number: (604) 668-8228

7. Quality Academy of the British Columbia Patient Safety and Quality Council

Implementation Year: Wednesday, February 3, 2010 - 00:15	**Location: British Columbia**	**Practice Website: http://bcpsqc.ca/learning/quality-academy/**

SNAPSHOT:

This innovative practice is delivered to health care leaders across the system in British Columbia who lead quality improvement initiatives in their organizations. Launched in 2010, the aim of the Quality Academy is to provide participants with the capability to effectively lead quality and safety initiatives in their designated health field, including teaching and advising others in how to improve the quality of health care.

CONTACT INFORMATION:

Title: Director, Learning and Strategic Initiatives, BCPSQC Organization: BC Patient Safety and Quality Council (BCPSQC) Email address: awray@bcpsqc.ca Telephone number: 604-668-8215

8. Partners in Care Initiative

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

9. Electronic Medical Records in Northwest Territories

Implementation Year: Thursday, February 3, 2005 - 00:45	**Location: Northwest Territories**	**Practice Website: http://www.gov.nt.ca/**

SNAPSHOT:

This innovative practice addresses the necessity to coordinate information across multiple sites and care providers in the Northwest Territories. Many specialists are not available locally, and often patients must travel long distances to access certain types of care. In 2005, an EMR pilot project was initiated in Great Slave Medical House in Yellowknife, Northwest Territories. Based on the success of this pilot project, the Government of the Northwest Territories has begun a territory-wide EMR system to support an integrated service delivery model and address territorial care pathways.

CONTACT INFORMATION:

Name: Dr. Ewan Affleck Title: Medical Director Organization: Yellowknife Health and Social Services Authority Email address: Ewan_Affleck@gov.nt.ca

10. Divisions of Family Practice

Implementation Year: Sunday, February 3, 2008 - 00:45	**Location: British Columbia**	**Practice Website: https://www.divisionsbc.ca/provincial/home**

SNAPSHOT:

This innovative practice addresses the need for vertical and horizontal primary health care integration that require strong commitment from family physicians. Without this commitment, governments and regional health authorities achieve limited policy implementation success. In 2002, the British Columbia Ministry of Health Services and the British Columbia Medical Association (BCMA) partnered to form the General Practice Services Committee (GPSC). In 2008, the GPSC developed the Divisions of Family Practice initiative to improve patient care, to increase family physicians' influence on health care delivery and policy, and to enhance professional satisfaction for physicians.

CONTACT INFORMATION:

Name: Dr. Brian Evoy Title: Executive Lead, Divisions of Family Practice Organization: General Practices Service Committee, British Columbia Medical Association Email address: bevoy@bcma.bc.ca

11. St. John's Friendship Centre

Implementation Year: Tuesday, February 3, 2004 - 00:30	Location: Newfoundland & Labrador	Practice Website:

SNAPSHOT:

This innovative practice supports First Nations, Inuit, and Métis people who travel to St. John's for medical care. Launched in 2004, the Friendship Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

CONTACT INFORMATION:

Additional information on St. John's Friendship Centre is available at http://www.sjnfc.com.

12. Aboriginal Support Workers, Southern Regional Health Authority

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

SNAPSHOT:

This innovative practice has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve. Launched in Manitoba's Southern Regional Health Authority in 2012, Aboriginal Health Services have adapt their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people.

CONTACT INFORMATION:

For additional information on the Aboriginal Support Workers and Aboriginal Health Services at Southern Regional Health Authority, please feel free to connect with the office of Southern RHA's Regional Director of Aboriginal Health at (204) 239 2304 or dharris@rha-central.mb.ca.

13. Model of Care Initiative

Implementation Year: Saturday, February 2, 2008 - 00:15	Location: Nova Scotia	Practice Website: http://www.gov.ns.ca/health/mocins/

SNAPSHOT:

This innovative practice addresses specific problems in acture care and aims to provide more efficient high quality patient-centred care in hospitals. Launched across the province of Nova Scotia in 2008, the program is designed to orient providers towards working to their optimal scopes of practice, in a collaborative way as part of an interprofessional team.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Government of Nova Scotia Email address: N/A Phone number: 1-902-424-5818

14. Alberta's Caregiver Support

Implementation Year: Thursday, February 2, 2012 - 00:30	Location: Alberta	Practice Website: http://www.albertacaregivers.org/

SNAPSHOT:

This innovative practice aims to increase support for caregivers. Launched in Edmonton in 2012, the program strives to address caregiver burden through a

systematic approach by using validated assessment tools to pinpoint areas of need, and offering both publicly funded respite services and referrals to community support services to meet those needs.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Caregivers Association Email address: N/A Phone number: 1-877-453-5088 Last updated: 2012

15. Native Nurses Entry Program (NNEP) Lakehead University

Implementation Year: Friday, February 3, 2006 - 00:45	**Location: Ontario**	**Practice Website: http://nativenursing.lakeheadu.ca/index.php**

SNAPSHOT:

This innovative practice is a nine month transition program designed to provide the skills and academic preparation required for successful completion of the four-year nursing degree program. Students may choose field experiences in their own community or other Aboriginal health care settings.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Lakehead University Email address: www.lakeheadu.ca Phone number: (807) 343-8110

16. Northern Ontario School of Medicine (NOSM)

Implementation Year: Sunday, February 3, 2002 - 00:45	**Location: Ontario**	**Practice Website: www.nosm.ca/about_us/default.aspx?id=68**

SNAPSHOT:

This innovative practice addresses the complexity of being socially accountable to the cultural diversity of a region's health needs. The Northern Ontario School of Medicine (NOSM) is a pioneering faculty of medicine that educates skilled
physicians and undertaking health research suited to community needs, including Aboriginals, Francophones, remote communities, small rural towns, large rural communities, and urban centres.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Lakehead and Laurentian University Email address: admissions@nosm.ca Phone number: 705-675-4883

17. Undergraduate Medical Education - Indigenous Health Initiatives Program (IHIP), University of Alberta

Implementation Year: Monday, February 2, 1998 - 21:45	**Location: Alberta**	**Practice Website: www.med.ualberta.ca/education/ume/aboriginal/index.cfm**

SNAPSHOT:

This innovative practice addresses the under-representation of Aboriginal physicians in Canada by encouraging more Aboriginal students to consider careers in medicine and dentistry. The Indigenous Health Initiatives Program (IHIP) was founded by the University of Alberta's Faculty of Medicine and Dentistry in 1988.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Office of Undergraduate Medical Education Email address: ume@med.ualberta.ca Phone number: (780) 492-6350

18. Indigenous Cultural Competency Training (ICC)

Implementation Year: Tuesday, February 3, 2009 - 00:30	**Location: British Columbia**	**Practice Website: www.phsa.cawww.culturalcompetency.ca**

SNAPSHOT:

This innovative practice develops individual competencies and promote positive partnerships between health professionals and Aboriginal people. Indigenous Cultural Competency Training (ICC) is a unique, facilitated online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people.

CONTACT INFORMATION:

Name: Leslie Varley (Nisga'a) Title: Director Organization: Provincial Health Services Authority (PHSA) Aboriginal Health Program

19. Faculty of Medicine – University of Calgary Aboriginal Health Program

Implementation Year: Sunday, March 2, 2008 - 00:30	**Location: Alberta**	**Practice Website: http://www.ucalgary.ca/mdprogram/prospective/aboriginalhealthprogram**

SNAPSHOT:

This innovative practice aims to encourage awareness of First Nations, Métis, and Inuit health and healing issues; recruit quality Aboriginal students; provide effective student support; and offer professional development initiatives for those interested within the Faculty of medicine to work with Aboriginal individuals, families, and communities. In early 2008, the office of the Aboriginal Health Program opened at the University of Calgary, Faculty of Medicine.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: University of Calgary Email address: N/A Phone number: 403-210-3841 Last updated: 2012

20. Cultural Competence and Cultural Safety in Nursing Education

Implementation Year: Tuesday, February 3, 2009 - 00:45	**Location: National**	**Practice Website: www.anac.on.ca/competency.php**

SNAPSHOT:

This innovative practice is designed for nursing education programs and nurse educators that includes core competencies in post-colonial understanding, communication, inclusivity, respect, indigenous knowledge, and mentoring and supporting students for success. Cultural Competence and Cultural Safety in Nursing Education was developed by the Aboriginal Nurses Association of Canada, Canadian Nurses Association, and the Canadian Association of Schools of Nursing.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Aboriginal Nurses Association of Canada Email address: info@anac.org Telephone number: (613)-724-4677

21. Seventh Generation Midwives Toronto (SGMT)

Implementation Year: Tuesday, February 3, 2009 - 02:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice assists pregnant women and recent mothers with holistic care on culturally sensitive maternity care and midwifery services from conception to six weeks post-delivery. Seventh Generation Midwives Toronto (SGMT) is an urban collective of Aboriginal midwives serving women in Toronto.

CONTACT INFORMATION:

Long and Brier Island Community Paramedicine Project

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

SNAPSHOT: This innovative practice focuses on increasing access to health care professionals in remote places. Launched In 2001 in two rural communities in Nova Scotia, the three-year initiative implemented the health service delivery model that uses the more widely practiced model of community paramedicine and introduced a novel collaboration with registered nurse practitioners (NPs).

PRACTICE DESCRIPTION:

Long and Brier islands are two remote islands in Nova Scotia with a combined population of about 1,240 residents. Reaching these islands requires a one-hour commute by car and ferry from the nearest town, Digby. Access to primary care services on the islands has been minimal for many years because there are no resident physicians. Instead, paramedics and one registered nurse provided health services for these residents; if additional health services were required, a 50-minute trip was taken to Digby's General Hospital. In 2001 the Emergency Health Services (EHS) and the residents launched a three-year initiative focused on increasing access to health care professionals on the islands. The initiative consists of an innovative health service delivery model that uses the more widely practiced model of community paramedicine. In addition, it introduced a novel collaboration with registered nurse practitioners (NPs). The NP also acts as a liaison with an off-site physician in Digby. This model uses the islands' human health resources and demonstrates an innovative approach of tailoring delivery models to the community's needs.

The first phase of this model was established in an ambulatory base with increased access to paramedic care. Paramedics provided 24/7 ambulatory care to the residents in this phase. Paramedic services expanded in the second phase to include clinic roles and delivery of non-emergency services. The third phase marked the addition of the NP and, consequently, led to increased development of non-emergency services by the NP, of complex care by the paramedics, and of prevention and promotion programs by the health care team.

With the needs of the residents expanding, ongoing professional development has been provided to paramedics to help them better adapt to their community's needs and to become proficient in providing various medical services to the Long and Brier islands residents. Learning sessions have been a key resource in promoting these expansions.

This initiative not only models community-based care but also demonstrates the role of effective communication and collaboration among health care professionals, community residents, and provincial leaders in providing accessible and adequate care.

IMPACT:

The Long and Brier model has successfully achieved greater access to primary health care services for the residents of these two islands. Interviews with residents have highlighted personal success stories and satisfaction with the health services provided by the paramedics and NPs. They also noted that their health status has improved, and they expressed satisfaction with the shorter wait times and travel times to obtain access to care. These stories have been documented and shared with the public in recent news releases and program reports on Nova Scotia's government websites.

Furthermore, preliminary data collection has shown a 23% decrease in emergency department visits by islanders and an increase in the project's patient contacts by 250 to 300 during the 2002/2003 fiscal year. Average visits by islanders to Digby facilities decreased by 24% to 28% from 2001 to 2006. Data and figures have been documented in program reports.

APPLICABILITY/TRANSFERABILITY:

In late 2006, the Beausoleil First Nation on Lake Huron's Christian Island in Ontario started a program modelled after Nova

Scotia's Long and Brier Island Community Paramedicine Project. In its first year of implementation, from November to July, paramedics provided 1,000 home visits, lasting almost 495 hours to total, in addition to handling their usual volume of emergency calls (approximately 300 calls a year). Community paramedics do an average of six daily home visits, checking on the same three patients every day and sometimes visiting as many as nine. The daily check-ups and expanded practice of paramedics have reduced the number of transports and hospital admissions in this location. Similar programs in remote locations in countries such as Australia and Scotland have also consulted with Long and Brier administrators about their projects.

Those wishing to implement this innovative practice in a different context must be aware that this project dramatically altered the traditional scope of work for the paramedics involved. Accustomed to quickly responding to emergency calls within a specified period of time, paramedics are now called upon to spend more time with residents to conduct falls prevention assessments, participate to monthly first-responder training programs with fire departments on the islands, and generally establish closer relationships with local home-health services, including the Victorian Order of Nurses.

The success of the Long and Brier Island Community Paramedicine Project has spurred interest in expanding the initiative and the facilities in Digby County. In November 2012, Premier Dexter announced a two-year investment in a new health care facility for Digby County that will continue to provide care to Island residents via the expanded scope model. The facility will unite the clinic and EHS base in order to maximize collaboration and centralize services.

Finally, in February 2011, EHS launched a subsequent paramedic expanded scope initiative as part of the Better Care Sooner plan. Similar to the Long and Brier Island Community Paramedicine Project, the Collaborative Emergency Centres care model uses paramedics as health care professionals who can provide a larger repertoire of services to remote areas. The aim is to provide care to seniors in remote resident homes through collaboration among paramedics, NPs, EHS staff, and Capital Health. Further, the Ministry of Health in Saskatchewan is also adopting the community paramedicine concept.

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

- Government of Nova Scotia. (2013, January 18). P.E.I. exploring Nova Scotia's innovative emergency care model [News Release]. http://novascotia.ca/news/release/?id=20130118007
- Government of Nova Scotia. (2012, September 27). Province invests in new health-care facility for Digby County [News Release]. http://novascotia.ca/news/release/?id=20120927003
- Nova Scotia Health and Wellness. (n.d.). *Emergency health services: System report fiscal years 2009–10 and 2010–11*. http://www.gov.ns.ca/health/ehs/documents/EHS_System_Report_2011.pdf
- Lanktree, G. (2008, April). Paramedics ease rural MD's load. *National Review of Medicine, 5*(4). http://www.nationalreviewofmedicine.com/issue/2008/04/5_advances_medicine04_4.html
- Garza, M. (2008, July 26). *Beyond EMS: Community paramedics make house calls*. http://www.jems.com/article/cardiac-circulation/beyond-ems
- Dobson, T., & Buchholz, K. (n.d.). *Community paramedicine and the extended care paramedic* [Presentation Notes]. Halifax, NS: Nova Scotia Emergency Health Services System. http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/Ken_Buchholz.sflb.ashx
- Nova Scotia Emergency Health Services. (2005, April 1). *Community paramedicine: A part of an integrated health care system*. http://www.gov.ns.ca/health/ehs/documents/Community%20Paramedicine%20Article.pdf

CONTACT INFORMATION

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Title: Nurse Practitioner
Organization: Island Health Centre & EHS Paramedic Excess Line Capacity
Telephone number: 902-839-2398
Email: info@swndha.nshealth.ca

Information last updated on: March 6, 2013

External Source: http://www.gov.ns.ca/health/ehs/documents/Community%20Paramedicine%20Article.pdf

Integrating Supported Post-secondary Education with Supported Employment Program for People with Mental Illness

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

SNAPSHOT: This innovative practice aims to facilitate successful college education and employment for students with mental health issues via supported education and supported employment. Launched as pilot studies in Israel and Canada, the program demonstrates that integrating supported education with supported employment may benefit people with mental illness to succeed in skilled occupations.

PRACTICE DESCRIPTION:

This collaborative approach between colleges and employment services integrates supported post-secondary education with supported employment. The aim is to facilitate successful college education and employment for students with mental health issues via supported education and supported employment. This program consists of three main phases (phase 1 is optional):

1. Generic Skills Training (computer skills, social skills, etc.) – An interprofessional team provides this training to individuals and groups (of up to eight students) for six hours a day for five days a week. In addition, students are given a vocational assessment and experiential exposure to the various courses offered at the centre/college in order to confirm or revise course selection. Supportive group and individual counselling and liaison are offered weekly, and each student meets with the supported employment worker.

2. Supported Education in a skilled occupation (e.g., secretarial, computer programming, accounting, optician, electrical, high school courses) – Accommodations are provided to the trainees at the college. Further, generic skills training, counselling, and liaison (including with the course instructors) are offered, and the supported employment worker explores supported employment or other vocational options (including unpaid practicums) for each student.

3. Supported Employment in skilled occupation (e.g., job placement, on-the-job supports, liaison with necessary services) – After students complete a course or some coursework successfully, the supported employment worker helps them secure employment, and supports them on the job as needed. In addition, the social worker/psychologist/counsellor continues to provide supportive counselling and liaison. Thus, students could continue to attend counselling and generic skills training even after starting employment.

This innovative program targets college students with mental illnesses who find it challenging to obtain an education degree and a skilled occupation. It specifically targets community colleges because they focus on relatively short-term work-related education and market-ready training (more so than universities), and in Canada they are funded to provide supported education (unlike trade schools). The anticipated outcomes of this innovative approach are:

1. Vocational outcomes: a higher ratio of students employed in skilled work (skilled work consists of work matched with the student's college education and with other skilled work, which are counted separately as well as jointly).

2. Clinical outcomes: a greater reduction in symptom severity with respect to depression, anxiety, and total psychiatric symptomatology.

3. Moderation of negative predictive effects of students' personal factors on vocational outcome, since the program compensates for relevant personal challenges, particularly neurocognitive impairment and poor work history.

4. Satisfaction: specifically work-related satisfaction and general life satisfaction.

IMPACT:

Two pilot research studies (one in Israel and one in Canada) were conducted by Rudnick and colleagues to test the feasibility and effectiveness of such integration using a non-controlled qualitative and quantitative evaluation design. Pilot research was conducted, primarily consisting of co-location of supported employment staff at the college and of structured collaboration between supported employment and supported education staff, combined with aspects of supported employment, such as job development starting before graduation, from supported post-secondary education. One of the pilot studies has already been published in a peer-reviewed academic journal, (Rudnick & Gover, 2009) and the other (Rudnick et al.) is being prepared for publication. In addition to this, another non-controlled descriptive study was conducted in Toronto with similar promising results, (Nandlal et al, 2009), although it was limited to two skilled occupations.

Results from both pilot researches (Rudnick & Gover, 2009, and Rudnick et al., in preparation) were promising; they included a very low attrition rate (7%) and nearly 50% transitioning to skilled employment, suggesting a need for such integration. The findings in the first pilot study conducted in Ra'anana, Israel, (Rudnick & Gover, 2009) demonstrated that 40% of students successfully obtained skilled work within one year, and 55% of students completed generic skills training. Of these, 58% remained enrolled in their course and 28% completed their course within one year.

The second pilot study of such integration in Canada (conducted in London, Ontario) also yielded promising results: the recruitment rate was 100% and all students were very satisfied from the integration (Rudnick et al, in preparation). This pilot research demonstrated that of those who completed the program, 78.4% obtained skilled employment within one year, with 100% working in the industry that they were trained in. Sixty-five percent of employed students successfully remained in their job for at least one year and of these, 55.2% received an average wage of $10.89 per hour (range $8.75 to $18. 17 per hour).

The findings of this pilot research demonstrated that integrating supported education with supported employment may benefit people with mental illness to succeed in skilled occupations. Hence, a methodologically rigorous study of this integration is now in order.

APPLICABILITY/TRANSFERABILITY:

During the period from 2002 to 2010, this innovative practice was implemented at the vocational rehabilitation and training centre in Ra'anana, Israel, and at Fanshawe College in conjunction with LEADS Employment Services in London, Ontario. The vocational rehabilitation and training centre in Ra'anana provides certified courses in skilled occupations for individuals with various disabilities. Fanshawe College provides intensive education supports via Counselling and Accessibility Services and focuses on organizational skills, social skills, confidence, motivation, time management, and so on. It provides general and trades education. The latter program requires co-op placements or other related employment. LEADS Employment Services provides employment assistance for persons with barriers to employment due to physical or mental and developmental or learning disabilities. It also provides job preparation, job and skills development, transitional employment, job coaching, and job retention supports.

This practice was tested in two different settings in Israel and Canada. Despite the differences in the geographical locations and jurisdictions, this innovative practice was found to produce similar outcomes.

Content was adapted from the following sources and relevant websites:

Rudnick, A. & Gover, M. (2009). Combining supported education with supported employment. *Psychiatr. Serv., 60,* 1690.

Nandlal J, Bettazzoni M, Priolo T, McGurk S, Flora N & Perrier C. Augmented education: Effectiveness of a new employment training and support model for people with mental illness. Toronto: Canadian Council on Learning, 2009.

Rudnick et al. (2013). An integration of supported education and supported employment for people with mental illness: a pilot study. [Manuscript in writing]

Rudnick et al.(2013). Barriers, enablers and related strategies in relation to supported post?secondary education for people with mental health challenges: a organizational case study. [Manuscript in writing]

CONTACT INFORMATION:

Name: Dr. Abraham Rudnick
Title: Associate Professor, Medical Director of the Mental Health and Addiction Services (MHAS)
Organization: University of BC; Department of Psychiatry
Email address: Abraham.rudnick@viha.ca
Telephone number: 1-250-370-8396

Information last updated on: December 13, 2012

Virtual Ward, South East Toronto Family Health Team

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

Content was adapted from the following sources and relevant websites:

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

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

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Information last updated on: December 6, 2012

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

Canadian Medical Association's Referral and Consultation Process Toolbox

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

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

PRACTICE DESCRIPTION:

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

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

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

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

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

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

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

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

o Helping family physicians make more appropriate and informative referrals

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

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

o Facilitating more timely access to specialty care

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

Rapid Access to Consultative Expertise (RACE)

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

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

PRACTICE DESCRIPTION:

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

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

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

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

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

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

IMPACT:

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

Results include

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

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

Content developed from the following sources and relevant websites:

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

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

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External Source: www.RACEconnect.ca

National Surgical Quality Improvement Program (NSQIP) in British Columbia through the Surgical Quality Action Network (SQAN)

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

SNAPSHOT: This innovative practice addresses the need for health care providers to discuss best practices, share local innovations, and network to improve surgical care for patients in British Columbia. Launched in 2012 to facilitate the implementation of NSQIP in hospitals across British Columbia and leverage its use as a data measurement tool in the province, the BCPSQC established the Surgical Quality Action Network (SQAN) to help hospitals "act" on their report card through engagement and shared learning with other comparable hospitals.

PRACTICE DESCRIPTION:

The National Surgical Quality Improvement Program (NSQIP), which was originally developed by the US Department of Veterans Affairs, is offered through the American College of Surgeons across North America and internationally. NSQIP is the first validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care. The NSQIP initiative is currently being implemented in 24 hospitals in British Columbia as a measurement tool to improve the quality of surgical care in the province. The implementation is being coordinated by the British Columbia Patient Safety and Quality Council (BCPSQC), and the Regional Health Authorities in BC provide the funding for participating hospitals. To facilitate the implementation of NSQIP in hospitals across British Columbia and leverage its use as a data measurement tool in the province, the BCPSQC established the Surgical Quality Action Network (SQAN) to help hospitals "act" on their report card through engagement and shared learning with other comparable hospitals.

The SQAN is a forum for health care providers to discuss best practices, share local innovations, and network to improve surgical care for patients in BC. The SQAN is neither a committee nor a decision-making body; it is an open group of individuals sharing ideas and discussing ways to work together. Representatives from participating sites meet in person and via teleconference to share ideas and successes. Moving forward, a peri-operative efficiency initiative led by a coalition of stakeholders in BC will use the SQAN.

The Network brings together a number of surgical initiatives taking place across BC. The first is the American College of Surgeons' National Quality Improvement Program (NSQIP). The second is the Safety Attitude Questionnaire, which is used to measure teamwork and communication. The third is clinical care management (CCM), which includes implementing the surgical safety checklist and reducing surgical site infections. In addition, 14 hospitals across BC are examining culture at a unit level across the surgical pathway. The sites meet in person and via teleconference to share ideas and successes. The leaders at these sites recognize that culture plays a key part in implementing best practices, and they have created strategies to improve the culture. A second wave of hospitals is joining this group in 2013 to measure culture and enact changes based on these data.

Partnerships are central to the SQAN. The Network is coordinated by the BC Patient Safety & Quality Council (BCPSQC). The Provincial Surgical Advisory Council (PSAC) serves as the Clinical Expert Group for CCM, and the Health Services Purchasing Organization (HSPO) funds the NSQIP.

IMPACT:

The BCPSQC is doing innovative work in using the data collected under NSQIP to inform action and quality improvement for surgery pathways across BC. Through the SQAN, BCPSQC aims to help hospitals "act" on their outcomes report cards through engagement and shared learning with other comparable hospitals. The SQAN facilitates opportunities for all 24 enrolled hospitals to come together and share best practices and ways of implementing new guidelines in order to improve their surgical

outcomes. Additionally, the BCPSQC collates all results from NSQIP's semi-annual reports and can share these findings with the SQAN's members. This analysis gives members an overall sense of whether surgical outcomes have shifted to reflect better quality surgery in the province.

The SQAN provides surgeons and hospitals with improvement resources and education, as well as opportunities to engage with one another (via email, conferences, education opportunities, workshops, etc.) to discuss how to improve performance. At this time, the BCPSQC has received a great deal of positive feedback from surgeons and front-line support staff regarding its efforts to support the implementation of NSQIP and manage the SQAN network. However, no formal evaluation of this network and its impact on surgical care in the province has been conducted.

APPLICABILITY/TRANSFERABILITY:

Initially developed in 2006, the SQAN has grown in parallel with the adoption of NSQIP and other surgical quality improvement initiatives across British Columbia. For example, NSQIP began in 3 hospitals and has now expanded to 24 sites in BC, all of which are members of the SQAN. The Network now also acts as a central coordinator for multiple settings across Canada. The SQAN has welcomed membership from other NSQIP sites in the country, collaborating with stakeholders in Alberta, Newfoundland and Labrador, Ontario, and Quebec. Including non-BC sites, the network has grown to include over 555 members (of whom approximately 50 are surgeons).

Content was adapted from the following sources and relevant websites:

van Dijk, M., Director of NSQIP, BCPSQC (personal communication, January 23, 2013).

http://bcpsqc.ca/clinical-improvement/sqan/

http://bcpsqc.ca/clinical-improvement/nsqip/

http://www.fraserhealth.ca/?section_id=7184&section_copy_id=4914&tpid=110&

http://bcpsqc.ca/documents/2012/12/NSQIP-BCPSQC-Report-on-Surgical-Measurement-Systems.pdf

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Information last updated on: January 17, 2013

External Source: http://bcpsqc.ca/clinical-improvement/sqan/

Quality Academy of the British Columbia Patient Safety and Quality Council

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

SNAPSHOT: This innovative practice is delivered to health care leaders across the system in British Columbia who lead quality improvement initiatives in their organizations. Launched in 2010, the aim of the Quality Academy is to provide participants with the capability to effectively lead quality and safety initiatives in their designated health field, including teaching and advising others in how to improve the quality of health care.

PRACTICE DESCRIPTION:

The Quality Academy is a professional development program offered through the British Columbia Patient Safety and Quality Council (BCPSQC). The program is delivered to health care leaders across the system in British Columbia (BC) who lead quality improvement initiatives in their organizations. Participants attend five in-person residency sessions and work on a quality project for their affiliated organizations concurrently. The sessions take place over a six-month period, with quality projects potentially lasting many years. During the program, participants receive support through webinars and from an assigned faculty mentor.

The aim of the Quality Academy is to provide participants with the capability to effectively lead quality and safety initiatives in their designated health field, including teaching and advising others in how to improve the quality of health care. Participants build their knowledge, skills, and confidence around the core components of quality improvement, including:

- process and systems thinking;
- personal and organizational development;
- involving patients, users, caregivers, staff, and the public;
- making improvement a habit—initiating, sustaining, and spreading change;
- delivering on cost and quality;
- problem solving/internal consultancy skills; and
- innovation for improvement.

The program has approximately 120 graduates thus far. The fifth cohort completed the program in 2013, and the sixth cohort is already full. BCPSQC plans to continue to run the Quality Academy to meet the growing demand. In 2012, there is a charge of $1995.00 per participant, which is subsidized by the BCPSQC.

IMPACT:

The targeted outcomes of the Quality Academy program are for participants to develop and improve their skills and knowledge of various quality improvement tools and methods, and develop critical thinking skills to examine how to use opportunities and tools strategically to improve the quality of care. Participants have provided very positive self-reported feedback via interview, suggesting an improved competency level. An independent formal evaluation of the Quality Academy was completed with the first cohort of participants (18 months ago) and key informant interviews. It measured the outcomes of the program using self-rated pre- and post-skills development tests of participants, and internal evaluations of each cohort are ongoing which are indicating a positive impact. BCPSQC is currently planning for a longitudinal evaluation to determine whether there has been a lasting impact on the skills and competencies of participants who have been out of the program for 18 months. The BCPSQC would like to use the results from the evaluation to further refine the Quality Academy program.

APPLICABILITY/TRANSFERABILITY:

In developing the Quality Academy, the BCPSQC completed an international scan of capacity building programs for quality improvement in health care. At first, the goal was to find a program offered elsewhere that the BCPSQC could sponsor BC health leaders to attend. However, the council quickly realized that they needed something specific to the Canadian context, and that there was no ideal program that met the needs of health quality leaders in BC. Therefore, the BCPSQC decided to implement its own program. The Quality Academy is built heavily upon the learning and experience from the Intermountain Healthcare's Advanced Training Program (in the United States, US), the Institute for Healthcare Improvement's Improvement Advisor Program (in the US), and the National Health Service's Institute for Innovation and Improvement (in England). Intermountain Health (considered one of the world leaders for this type of program) generously provided the BCPSQC with their Advancing Training Program curriculum, which has seen positive feedback and improved skill development results since its launch in Utah in 1992. The BCPSQC then adapted the curriculum to meet the needs of BC, becoming the first province in Canada to offer this type of quality improvement capacity building program for health leaders

Content was adapted from the following sources and relevant websites:

http://bcpsqc.ca/learning/quality-academy/

http://bcpsqc.ca/documents/2012/12/Learning-Quality-Academy-Cohort-6-Brochure.pdf

Wray, A., Director, Learning and Strategic Initiatives, BCPSQC (personal communication, January 25, 2013).

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EXTERNAL LINK:

http://bcpsqc.ca/learning/quality-academy/

External Source: http://bcpsqc.ca/learning/quality-academy/

Partners in Care Initiative

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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Information last updated on:

December 20, 2012

Relevant websites:

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

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

Electronic Medical Records in Northwest Territories

LOCATION:	**Northwest Territories**	**HEALTH THEME:**	**E-Health**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice addresses the necessity to coordinate information across multiple sites and care providers in the Northwest Territories. Many specialists are not available locally, and often patients must travel long distances to access certain types of care. In 2005, an EMR pilot project was initiated in Great Slave Medical House in Yellowknife, Northwest Territories. Based on the success of this pilot project, the Government of the Northwest Territories has begun a territory-wide EMR system to support an integrated service delivery model and address territorial care pathways.

PRACTICE DESCRIPTION:

It is necessary to coordinate information across multiple sites and care providers in the Northwest Territories. Many specialists are not available locally, and often patients must travel long distances to access certain types of care. Communicating accurate and comprehensive patient information in a timely matter is vital, and use of electronic medical records (EMRs) enhances care delivery in this type of setting. In 2005, an EMR pilot project was initiated in Great Slave Medical House in Yellowknife, Northwest Territories. Based on the success of this pilot project, the Government of the Northwest Territories has begun a territory-wide EMR system to support an integrated service delivery model and address territorial care pathways. To date, EMRs have been implemented in two communities in the Northwest Territories. In some locations, patient charting is done; in others, the system is used as a viewing and messaging portal. The plan is to have the entire territory on a single charting system and to have as many divisions as possible within health care on that system to optimize quality care. This system provides residents with a health “informational home” (chart) within which their circle of health care providers can network. At present, 55% of patients in the Northwest Territories have EMR charts, including those served by primary health care providers, home care providers, and family counsellors, and in part by hospital-based services (emergency, hospitalist, obstetrics, psychiatry) and physician services in some remote communities. This allows, for example, for patients being discharged by the hospital to have their care coordinated by the discharging hospitalist, the home care provider, and the community-based family physician—all in the patient’s informational home. This system allows for integrated health care by distributed providers, i.e. “networked health.” Funding is provided by Canada Health Infoway and the Government of the Northwest Territories.

IMPACT

An evaluation to assess the impact of EMRs in the Northwest Territories has not taken place. However, there have been anecdotal reports indicating that EMR use has significantly improved workflow, efficiency, and staff morale at the Great Slave Medical House. Electronic transmission of test and laboratory reports enables physicians to receive results more quickly (six to ten hours versus one week)—a workflow change that has contributed to more accurate and up-to-date medical records, and that allows physicians to see more patients in the same allotted time as prior to the implementation of EMRs.

APPLICABILITY/TRANSFERABILITY

A mental health pilot program is currently being planned using video conferencing technology and EMR systems to facilitate remote psychiatry from Yellowknife and Dalhousie University in Halifax to communities across the Northwest Territories. The project is being piloted in two communities and will commence in spring 2013. It will allow patients to access expertise that may not be otherwise available, and will allow physicians to provide follow-up care when personal visits are not possible or practical. The EMR system will allow relevant caregivers to access a patient’s information, order lab tests, and write prescriptions from across the country.

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Information last updated on: November 23, 2012

Relevant websites:

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

External Source: http://www.gov.nt.ca/

Divisions of Family Practice

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

SNAPSHOT: This innovative practice addresses the need for vertical and horizontal primary health care integration that require strong commitment from family physicians. Without this commitment, governments and regional health authorities achieve limited policy implementation success. In 2002, the British Columbia Ministry of Health Services and the British Columbia Medical Association (BCMA) partnered to form the General Practice Services Committee (GPSC). In 2008, the GPSC developed the Divisions of Family Practice initiative to improve patient care, to increase family physicians' influence on health care delivery and policy, and to enhance professional satisfaction for physicians.

PRACTICE DESCRIPTION:

Attempts at vertical and horizontal primary health care integration require strong commitment from family physicians. Without this commitment, governments and regional health authorities achieve limited policy implementation success. In 2002, the British Columbia Ministry of Health Services and the British Columbia Medical Association (BCMA) partnered to form the General Practice Services Committee (GPSC). The GPSC first met in January 2003 as a provisional effort to improve patient care and physician satisfaction in British Columbia. Funding was provided by the British Columbia government through an allotment of $800 million over six years. The GPSC is made up of Ministry of Health officials, family physicians, the BCMA, and representatives from health authorities throughout the province. Its key role is to encourage and enhance full service family practice to benefit patients. In 2008, the GPSC developed the Divisions of Family Practice initiative to improve patient care, to increase family physicians' influence on health care delivery and policy, and to enhance professional satisfaction for physicians. Divisions of Family Practice are groups of family physicians organized at the local or regional level in communities where physicians wish to establish one. Doctors are compensated by the GPSC to participate in their local division. As of November 2012, there were 31 Divisions of Family Practice in British Columbia that encompassed 120 communities.

Each Division of Family Practice has a Collaborative Services Committee that includes local division physicians and representatives from the BCMA, Ministry of Health, and local health authority. When division physicians identify a patient care issue or problem in the community, they meet with the Collaborative Services Committee. The Committee discusses the issue and designs and implements solutions through a collaborative consensus building model. The solution may involve better coordination of services and resources, project management or change management support, or a new clinical service agreement. The Collaborative Services Committee may also invite community members to participate in discussions and planning. This is an opportunity for municipal leaders, community groups, and non-profit organizations to participate and make sure groups are not duplicating services or working at cross purposes from one another.

IMPACT:

Iterative processes for improvement have been used. More recently, an evaluation framework has been established and results are expected in spring 2013.

Networked local divisions have created the conditions for substantially more physician involvement in health system change processes. Health system administrators claim a greater ability to work with a community of doctors to garner general opinion and support for a policy rather than relying on a small number of doctors with personal opinions. Local physicians highlight a stronger belief that they are able to participate in health system change. All partners are committed to improving patient health outcomes via the Institute for Healthcare Improvement's Triple Aim framework. This strategy is a success because all partners are motivated, physician participation was voluntary, success has been built on strengthened relationships, funding has been protected through a Physician Master Agreement, and resources were provided for physician leadership training.

APPLICABILITY/TRANSFERABILITY

Similar models exist in New Zealand and Australia with positive results. Although British Columbia is the only province to adopt the Divisions model in Canada, it should translate well in other provinces and territories.

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Information last updated on: November 20, 2012

Relevant websites:

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

EXTERNAL LINKS:

https://www.divisionsbc.ca/provincial/home

http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

http://www.health.govt.nz/our-work/primary-health-care

http://www.apcc.org.au/about_the_APCC/

External Source: https://www.divisionsbc.ca/provincial/home

St. John's Friendship Centre

LOCATION:	**Newfoundland & Labrador**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice supports First Nations, Inuit, and Métis people who travel to St. John's for medical care. Launched in 2004, the Friendship Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

The Aboriginal Patient Navigators have opened the eyes of many practitioners. I've gotten support notes that say, "I never knew this. This is great! What did we ever do before these people were here?" It's been very well received by medical staff.

– David Penner

Executive Director, St. John's Native Friendship Centre, NL

The St. John's Friendship Centre in Newfoundland and Labrador has developed innovative ways to bring much needed supports for First Nations, Inuit, and Métis people who travel to St. John's for medical care. The Centre operates the Shanawdithit hostel and shelter, and administers an Aboriginal Patient Navigator program, provided in partnership with Eastern Health (EH). These supports are particularly valuable for people who have come to the city from remote and isolated communities.

The Aboriginal Patient Navigators (APNs) are employees of the Friendship Centre, but work out of EH's Health Science Centre. The two APNs serve as many as 500 First Nations, Inuit, and Métis clients and their families each year, and have taken broad responsibility for supporting clients' cultural safety throughout their experiences in the acute care system. The APNs are embedded in a multidisciplinary team, participating in medical rounds each morning and supporting the hospital's capacity to provide health care services to Aboriginal people in culturally specific and sensitive ways. The APNs help clients and their family members navigate the health care system, accompanying them to medical appointments, ensuring that they understand their medical conditions and needs, arranging on-site ceremonies, and attending to other culturally distinct needs. The APNs are skilful communicators, and are often fluent in one or more of the local Indigenous languages. They have helped medical staff learn how to incorporate respect for culture into their practice, and how to communicate and interact more effectively with Aboriginal clients.

The APNs try to minimize the length of time their clients must spend in care by making sure that appointments are scheduled as closely together as possible and assisting with the development and implementation of discharge plans. In a few instances, when the hospital has not been able to release a patient because the patient cannot find a way to purchase or access a specific piece of medical equipment they will need at home, the APNs have ordered and temporarily covered the cost for the equipment. This has allowed patients to return home without having to wait for the issue of which jurisdiction is financially responsible to be resolved. The APNs also ensure that clients' family members understand their medical conditions and needs.

Shanawdithit hostel and shelter, which began operating in 2004, offers temporary accommodations to Innu and Inuit residents of Labrador who are visiting St. John's to access medical services (a group that now constitutes approximately two-thirds of the facility's occupants), new Canadians, and people who are homeless. In its early years, Shanawdithit often struggled to fill its rooms. Today, demand for accommodations typically exceeds capacity. Shanawdithit is the only hostel/shelter in St. John's that has a cultural focus or that is equipped to take in families. To support residents' comfort and safety, management has implemented zero tolerance policies with respect to alcohol or drug use and aggressive behaviour. In addition to accommodations, Shanawdithit's health clients can access the shelter's transportation services to move between the airport, hostel, and health care sites, and they have on-site meals laundry and computer access. If needed, the hostel also arranges counselling for clients (a service used most often by women who have experienced violence) and assists them to find employment or more long-term housing.

Shanawdithit and the APN program work well together. The APNs often come to meet and visit with clients or family members in the culturally respectful environment provided by the shelter. For patients and clients, the combination of supports available through Shanawdithit and the APN program enables them to manage their time in St. John's productively and return to their home communities as quickly as possible. In the environment of Shanawdithit and with the support of the APNs, clients generally feel less socially and culturally isolated, and more comfortable and more confident through the care experience.

The APN program and Shanawdithit have succeeded, in large part, because they meet the real-life needs of the people and communities they serve. As David Penner, the Friendship Centre's executive director acknowledges, consultation is a "must-have" for success: "You need to get everyone's opinion, so that you can provide not what *you* want or even what the people might think they want, but what the people need." Research and documentation are also crucial components of success. Evaluations of the APN program have indicated that the services provided by the APN have minimized clients' stress and anxiety, enhanced coordination of after-hours care, and raised awareness of cultural differences, practices, and traditions within the health care system. Medical staff have confirmed that the combination of Western and traditional medical approaches and practices has improved outcomes for their patients, and that the APNs, by demonstrating and supporting culturally sensitive care, have helped them become more effective practitioners.

The APN program started in 2009 as a pilot project, initiated by the Ethics Department at Eastern Health and supported by the federal Aboriginal Health Transition Fund (AHTF). Eastern Health's leadership and its recognition of the need to work in partnership with an urban Aboriginal organization (which led to the Friendship Centre's participation in the project) have been invaluable. In the development phase of the project, the partners completed consultation activities in St. John's and Labrador, and established a steering committee and advisory committee to guide the project's development. These bodies evolved into standing committees that continue to monitor the program and ensure that activities are informed by and attend to community members' needs.

The most significant challenges for the APN program and Shanawdithit have related to the need for adequate sustainable funding. When the AHTF ended, Eastern Health and the Friendship Centre had to find alternate funding sources for the APN program; to date, it has not yet been able to secure sustainable funding. The Friendship Centre received some funding from the Homelessness Partnering Strategy (to cover Shanawdithit's capital expenditures and start-up) and other provincial and federal sources, but it relies primarily on per diem funding to support day-to-day operations. This has affected Shanawdithit's ability to recruit and retain staff because it cannot offer wages that compete with those provided by other local shelters, which receive block funding from the province. The centre has established tighter financial management for Shanawdithit, and now applies a social enterprise approach to this and all other programs at the centre. As David Penner has observed, "You need to do things that are going to sustain themselves, work towards the future, beyond your current activities, and bring a business approach to your work. Just because you are a not-for-profit doesn't mean you can't use a profit approach to your operations."

CONTACT INFORMATION:

Additional information on St. John's Friendship Centre is available at http://www.sjnfc.com.

Aboriginal Support Workers, Southern Regional Health Authority

LOCATION:	Manitoba	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve. Launched in Manitoba's Southern Regional Health Authority in 2012, Aboriginal Health Services have adapt their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people.

In Manitoba, the Southern Regional Health Authority's (Southern RHA's) Aboriginal Health Services has demonstrated that patient navigators can be central to the process of transforming relationships between health care practitioners, the health care system, and the First Nations, Métis, and Inuit people and communities they serve.

The Southern RHA was formed in 2012 through the merger of two existing health authorities, the Regional Health Authority—Central (RHA Central) and the South Eastman Health Authority. In the region Southern RHA serves, approximately one of every 10 residents is an Aboriginal person. In 2008, after community health assessments confirmed significant disparities between the health status of Aboriginal people and other residents of the region, RHA Central collaborated with local First Nations, Métis, and urban Aboriginal organizations on an initiative to adapt their system to make it more culturally appropriate for, navigable by, and capable of meeting the self-identified needs of Aboriginal people. Supported by the Aboriginal Health Transition Fund, the project enabled RHA Central to create two positions for Aboriginal Support Workers (ASW) within Aboriginal Health Services (AHS). The first ASWs began working out of the Portage District General Hospital (PDGH) in January 2009.

The ASWs are highly accessible and visible at PDGH and in the community, and available seven days a week. They circulate throughout the hospital, join the medical team for rounds, stop in at patients' rooms for a check-in, assist clients as they arrive at the Portage Hospital and guide them through the admissions and triage process in the emergency department, and visit with residents at personal care homes. Their presence has greatly enhanced Southern RHA's capacity to provide culturally appropriate health services. Clients can now request ceremonies or other traditional healing practices and, for example, within minutes of a request, the ASWs can arrange a smudge ceremony for a patient at PDGH. When the ASWs visit personal care homes, they are often joined by local Elders who facilitate monthly sharing circles and other cultural activities for residents. As Doretta Harris, Regional Director of AHS and a former ASW observed, "The residents yearn for their culture and traditions—and since they can't get back to their community, we try to bring the community to them."

The ASWs and AHS work closely with health practitioners and other staff in the RHA to ensure that Aboriginal clients can access the health care services they need. They have collected and developed culturally specific and culturally appropriate resources (available in local languages, including English, French, Ojibwe, and Dakota), offering information to support Aboriginal clients' ability to access existing services. For example, AHS is collaborating with Aboriginal partners and Southern RHA staff to provide translation for signage about the triage process that will be posted in emergency departments. Content in the patient handbook given to all clients who use hospital facilities has been translated into Aboriginal languages. This information will help dispel the frequent assumption that the order in which clients receive treatment in emergency departments is influenced by cultural identity or race.

The emergency department's triage process is only one of many sites within health systems where cultural conflicts can arise. The ASWs and AHS have played a major role in decreasing these conflicts. The ASWs often act as interpreters for clients and health practitioners, facilitating conversations between English, French, Ojibwe, or Dakota speakers. However, their communication skills extend well beyond language interpretation. They have also taken responsibility for interpreting meaning. One example of these valuable interventions involved surgical staff at PDGH who had contacted AHS because they were concerned about a client who had missed several appointments for a surgical procedure. The ASW participated in a meeting with the client and surgical staff, and as they talked, it became clear that the client did not understand what the procedure involved, but had imagined the worst. The client had been too afraid to show up for the surgical appointment, and delaying the

surgery was having a negative effect on his well-being and daily life. When the ASW was able to interpret and explain the procedure, the client's fears were alleviated. The next day, the client asked the ASW to accompany him to the appointment, and the surgery took place.

In this story, the client could not understand the surgical staff. The ASW was able to take the information the surgical staff had tried to share and communicate it in a way that made sense to the client. Physicians and other care providers have come to rely on the ASWs, because they recognize that the ASWs have the trust of Aboriginal clients. In turn, the ASWs demonstrate to clients through their interactions with staff that they, too, are trustworthy, and this can help patients and physicians develop more confident, trusting relationships.

The ASWs are connectors. They have built strong, reciprocal working relationships with practitioners that enable collaboration in service delivery, and are valuable to all parties. Emergency medical services workers are able to contact the ASWs directly to request that they meet an Aboriginal client being brought into emergency. The ASWs are able to participate in clients' planning meetings, and they connect with providers in clients' home communities to make sure that clients will be linked to whatever services they might need when they return. Medical personnel recognize and appreciate that through these relationships they have increased their own cultural knowledge and cultural competency. The ASWs appreciate the extra efforts that are made to support their clients, improving the quality and continuity of care for their clients. Together, these relationships support patient-centred, patient-driven care and help create a culturally safe health care experience for Aboriginal clients.

An external evaluation completed in 2010 affirmed the important contributions the ASWs have made to the cultural competency of staff and to the care experience and cultural safety of Aboriginalpatients. Communication, relationships, and collaboration have been key to the success of the ASWs and Aboriginal Health Services. The ASWs first appeared as part of a project undertaken in partnership with Aboriginal organizations, and the ASWs and AHS have maintained, strengthened, and built upon those relationships. They look to community leaders and community members for feedback, guidance, and direction, and find new ways to engage the participation of Aboriginal people. They recognize that the diverse perspectives that broad and deep engagement provides can only enhance and strengthen their own capacity.

The most significant challenges the program has faced have related to funding—in particular, whether funding can match the growth in demand for the ASWs' services. AHTF funding supported the ASW positions for their first three years; since then, the RHA has allocated permanent funding to support the positions. The RHA's commitment to support Aboriginal people, and the unwavering support (through initial planning and development stages to the program's implementation and delivery) from the organization's CEO, senior management, and board of directors have been "must haves" for success.

The commitment to a shared responsibility to improve health experiences and health outcomes for Aboriginal people has filtered throughout Southern RHA. As Doretta Harris acknowledged, "We all have a responsibility for the health of our patients. Patients share that responsibility too. We help them understand their own role in the healing journey, and discover their own ability to help themselves."

CONTACT INFORMATION

For additional information on the Aboriginal Support Workers and Aboriginal Health Services at Southern Regional Health Authority, please feel free to connect with the office of Southern RHA's Regional Director of Aboriginal Health at (204) 239 2304 or dharris@rha-central.mb.ca.

Model of Care Initiative

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

SNAPSHOT: This innovative practice addresses specific problems in acture care and aims to provide more efficient high quality patient-centred care in hospitals. Launched across the province of Nova Scotia in 2008, the program is designed to orient providers towards working to their optimal scopes of practice, in a collaborative way as part of an interprofessional team.

PRACTICE DESCRIPTION:

In 2008, due to an increasing demand for health services, staff shortages, and fiscal challenges, Nova Scotia reported on a study that concluded that a transformation of its health system, including acute care, was needed. Specific problems in acute care included health care professionals spending time on duties that didn't require their specific training, and a variety of processes that were inefficient or out of date. The Model of Care Initiative in Nova Scotia (MOCINS) was created to address these problems and others.

MOCINS was launched as a provincial partnership between the Nova Scotia Department of Health and Wellness, the District Health Authorities, and the IWK Health Centre in Halifax. The mandate was to design, implement, and evaluate a viable provincial model of care for acute care in-patient services that was to be patient-centred, high-quality, safe, and cost-effective. A provincial interprofessional team was tasked with designing a new model of care, referred to as the Collaborative Care Model.

The goal of the Collaborative Care Model is to provide more efficient high quality patient-centred care in hospitals. It is designed to orient providers towards working to their optimal scopes of practice, in a collaborative way as part of an interprofessional team. The model's implementation framework is focused on improving patient care and providing more support to health care providers by targeting four areas: people, processes, information, and technology. This is done through ongoing staff development and mentorship; strong and effective communications; committed and supportive leadership; and collaboration across the continuum of care.

An evaluation conducted by a research team from Dalhousie University/WHO Collaborating Centre on Health Workforce Planning and Research showed that the implementation of this new model has led to better patient care and increased job satisfaction for health care providers on the first 14 units. For example, on those units where the care was more coordinated and providers' respective roles were clear, there were better outcomes, such as shorter lengths of hospital stay, fewer repeated patient admissions to hospitals, and fewer shifts missed due to staff injury. In a related effort, work is being done to create province-wide standardized roles for a variety of health care professionals, to enable more consistent work at a full scope of practice.

Nova Scotia has designed and implemented a new model of care and, at the same time, conducted a research-based evaluation of its effects on patients, health care providers, and the health care system. As of January 2012, the District Health Authorities and the IWK were implementing the Collaborative Care Model in approximately 84 units representing the majority of medical, surgical, and maternal child units in Nova Scotia's hospitals. They are also in the planning stages of expanding the implementation of the model in peri-operative and emergency care settings across the province in late 2012. As well, Nova Scotia has been collaborating with two provinces, Prince Edward Island and British Columbia, which have similar work underway.

External Source: http://www.gov.ns.ca/health/mocins/

Alberta's Caregiver Support

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

SNAPSHOT: This innovative practice aims to increase support for caregivers. Launched in Edmonton in 2012, the program strives to address caregiver burden through a systematic approach by using validated assessment tools to pinpoint areas of need, and offering both publicly funded respite services and referrals to community support services to meet those needs.

PRACTICE DESCRIPTION:

Under Alberta's Continuing Care Strategy, Aging in the Right Place, a demonstration project aiming to increase support for caregivers was carried out in Edmonton. The demonstration project strived to address caregiver burden through a systematic approach by using validated assessment tools to pinpoint areas of need, and offering both publicly funded respite services and referrals to community support services to meet those needs. Participants in the program were caregivers who provided more than four hours of care a day and who indicated they needed additional support. The participants were interviewed and assessed using the CARE assessment tool (short version).

Prior to participating in the project, caregivers were receiving, on average, five hours per week of respite services. Under the program, ten additional hours were added for caregivers' respite based on assessed need. Preliminary results show that this enhanced service successfully reduces the feelings of caregiver burden typically associated with caregiving. Benefits to project caregivers include improvements to their emotional and physical health and to the quality of personal relationships, as well as an increased knowledge of formal and informal supports available to them. Project caregivers reported they used their additional respite time to participate in or complete activities that they had difficulty with before, such as going to the gym, buying groceries, and socializing. Interviews with caregivers indicated a need for additional support, such as emergency respite, extra days in a day program, easier access to facility respite, matching the age and language of respite providers with care recipients/caregivers, having a consistent care provider, and receiving more support in making health decisions.

External Source: http://www.albertacaregivers.org/

Native Nurses Entry Program (NNEP) Lakehead University

LOCATION:	Ontario	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Not Categorized

SNAPSHOT: This innovative practice is a nine month transition program designed to provide the skills and academic preparation required for successful completion of the four-year nursing degree program. Students may choose field experiences in their own community or other Aboriginal health care settings.

PRACTICE DESCRIPTION:

The Native Nurses Entry Program (NNEP) is a nine month transition program designed to provide the skills and academic preparation required for successful completion of the four-year nursing degree program (NNEP graduates with 70% overall) or the three-year compressed nursing degree program (NNEP graduates with 80% or higher).

The program is based on two semesters of 12 weeks each, as well as a two-week field experience. Students may choose field experiences in their own community or other Aboriginal health care settings. The program offers four academic preparatory courses: English, Chemistry, Mathematics, and Biology. In addition, three special purpose courses—Communications, Professional Orientation, and Study Skills/Logical Reasoning—are taken over the university academic year.

NNEP graduates are guaranteed a seat in the NNEP with successful completion of all courses and an overall average of 70% or greater. The program is funded in part by Health Canada through the Indian and Inuit Health Careers Program (IIHCP) and the Ministry of Training Colleges and Universities. Similar programs are provided in other provinces and in other health professions.

External Source: http://nativenursing.lakeheadu.ca/index.php

Northern Ontario School of Medicine (NOSM)

LOCATION:	**Ontario**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Not Categorized**

SNAPSHOT: This innovative practice addresses the complexity of being socially accountable to the cultural diversity of a region's health needs. The Northern Ontario School of Medicine (NOSM) is a pioneering faculty of medicine that educates skilled physicians and undertaking health research suited to community needs, including Aboriginals, Francophones, remote communities, small rural towns, large rural communities, and urban centres.

PRACTICE DESCRIPTION:

The Northern Ontario School of Medicine (NOSM) is a pioneering faculty of medicine. A medical school for the whole of Northern Ontario, the School is a joint initiative of Lakehead University and Laurentian University, with main campuses in Thunder Bay and Sudbury and multiple teaching and research sites distributed across Northern Ontario. By educating skilled physicians and undertaking health research suited to community needs, NOSM will become a cornerstone of community health care and contribute to improving the health of people in Northern Ontario.

A medical school like no other, Northern Ontario School of Medicine has a strong emphasis on the special features of Northern Ontario. These include a diversity of cultures and geographical locations; varying illness, injury, and health status patterns with specific clinical challenges; a wide range of health service delivery models which emphasize supporting local health care and interdisciplinary teamwork; and the personal and professional challenges, rewards, and satisfactions of medical practice in Northern and rural environments.

NOSM has a mandate to be socially accountable to the cultural diversity of the region it serves, including Aboriginals, Francophones, remote communities, small rural towns, large rural communities, and urban centres. Evidence of this mandate can be found in the School's curriculum, administrative structure, research program, student demographics, continuing professional education program, and more. In its student recruitment efforts, NOSM continues to follow its mandate of social accountability, and aims to have class profiles which reflect the cultural diversity of Northern Ontario.

External Source: www.nosm.ca/about_us/default.aspx?id=68

Undergraduate Medical Education - Indigenous Health Initiatives Program (IHIP), University of Alberta

LOCATION:	Alberta	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Not Categorized

SNAPSHOT: This innovative practice addresses the under-representation of Aboriginal physicians in Canada by encouraging more Aboriginal students to consider careers in medicine and dentistry. The Indigenous Health Initiatives Program (IHIP) was founded by the University of Alberta's Faculty of Medicine and Dentistry in 1988.

PRACTICE DESCRIPTION:

The Indigenous Health Initiatives Program (IHIP) was founded by the Faculty of Medicine and Dentistry in 1988 to encourage and assist more Aboriginal students to gain admission and graduate successfully from the Faculty of Medicine and Dentistry. The Faculty has now graduated 73 Aboriginal medical graduates, 23 doctors of dental surgery graduates, 20 dental hygiene graduates, and 14 medical laboratory technologists. The mandate of the IHI Program is to correct the under-representation of Aboriginal physicians in Canada by encouraging more Aboriginal students to consider careers in medicine and dentistry; to facilitate their admission into the MD Program and other programs in the Faculty; and to provide support services to enable students to graduate successfully. It is the Faculty's belief that Aboriginal students with a commitment to their culture and traditions will serve as role models for Aboriginal youth, become leaders in producing improvements in Aboriginal health standards, and enrich the life of the faculty as a whole. To fulfill this mandate, the faculty has instituted special admission to the MD, DDS, DH, and Medical Laboratory Sciences Degree programs for Aboriginal applicants as a national pro-active recruitment policy. The program is based in Edmonton.

External Source: www.med.ualberta.ca/education/ume/aboriginal/index.cfm

Indigenous Cultural Competency Training (ICC)

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Not Categorized**

SNAPSHOT: This innovative practice develops individual competencies and promote positive partnerships between health professionals and Aboriginal people. Indigenous Cultural Competency Training (ICC) is a unique, facilitated online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people.

PRACTICE DESCRIPTION:

Indigenous Cultural Competency Training (ICC) is a unique, facilitated online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people. The goal of ICC training is to further develop individual competencies and promote positive partnerships.

Skilled facilitators guide and support each participant through dynamic and interactive learning modules. Participants learn about terminology; diversity; aspects of colonial history such as Indian residential schools and Indian hospitals; timeline of historical events; and contexts for understanding social disparities and inequities. Through interactive activities, participants examine culture, stereotyping, and the consequences and legacies of colonization. Participants are also introduced to tools for developing more effective communication and skills to build relationships.

Core ICC Health Training builds on the foundation provided in Core ICC with a specific focus on health care issues for health care professionals working with Indigenous people in British Columbia. Core ICC Health is specific to those who work in the health care field, and the goal is to improve access to health services and health outcomes for Aboriginal people. The training is designed for non-Aboriginal health professionals working in PHSA, Regional Health Authorities, the Ministries of Healthy Living and Sport and Health, and their partner agencies.

The curriculum is intended as introductory training and is supplemented by nation- and region-specific training provided by regional health authorities or Indigenous groups. This training takes approximately eight hours (depending on prior knowledge and learning style) to complete over an eight week period. At the end of the training, participants receive a certificate.

External Source: www.phsa.cawww.culturalcompetency.ca

Faculty of Medicine – University of Calgary Aboriginal Health Program

LOCATION:	**Alberta**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Not Categorized**

SNAPSHOT: This innovative practice aims to encourage awareness of First Nations, Métis, and Inuit health and healing issues; recruit quality Aboriginal students; provide effective student support; and offer professional development initiatives for those interested within the Faculty of medicine to work with Aboriginal individuals, families, and communities. In early 2008, the office of the Aboriginal Health Program opened at the University of Calgary, Faculty of Medicine.

PRACTICE DESCRIPTION:

In early 2008, the office of the Aboriginal Health Program opened at the University of Calgary, Faculty of Medicine. The goal of the program is to encourage awareness of First Nations, Métis, and Inuit health and healing issues; recruit quality Aboriginal students; provide effective student support; and offer professional development initiatives for those interested within the Faculty of medicine to work with Aboriginal individuals, families, and communities. The Aboriginal Health Program also delivers Aboriginal Health curriculum to all medical students enrolled in the U of C Faculty of Medicine MD program as part of their core curriculum.

The Faculty of Medicine is committed to increasing the enrollment of qualified First Nations, Métis, and Inuit applicants. In order to accomplish this goal, the Faculty implemented a number of policies and programs:

- To ensure quality students are admitted, the Faculty of Medicine developed and enacted an Aboriginal Admissions Policy.
- To encourage, advocate, and enhance Aboriginal programming, specifically recruitment, retention, community involvement, as well as curricular activities, the Faculty of Medicine developed and implemented the Aboriginal Health Program (AHP).
- To ensure a culturally relevant and consistent policy is enacted, the AHP consults with Aboriginal health and education communities.

The University of Calgary, Faculty of Medicine does not have dedicated seats set aside for Aboriginal applicants.

External Source: http://www.ucalgary.ca/mdprogram/prospective/aboriginalhealthprogram

Cultural Competence and Cultural Safety in Nursing Education

LOCATION:	**National**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Not Categorized**

SNAPSHOT: This innovative practice is designed for nursing education programs and nurse educators that includes core competencies in post-colonial understanding, communication, inclusivity, respect, indigenous knowledge, and mentoring and supporting students for success. Cultural Competence and Cultural Safety in Nursing Education was developed by the Aboriginal Nurses Association of Canada, Canadian Nurses Association, and the Canadian Association of Schools of Nursing.

PRACTICE DESCRIPTION:

Cultural Competence and Cultural Safety in Nursing Education was developed by the Aboriginal Nurses Association of Canada, Canadian Nurses Association, and the Canadian Association of Schools of Nursing, with funding from AHHRI. The project is for nursing education programs and nurse educators, as well as for employers. It includes core competencies in post-colonial understanding, communication, inclusivity, respect, indigenous knowledge, and mentoring and supporting students for success. Implementation is voluntary in this multi-phase project.

External Source: www.anac.on.ca/competency.php

Seventh Generation Midwives Toronto (SGMT)

LOCATION:	Ontario	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Not Categorized

SNAPSHOT:This innovative practice assists pregnant women and recent mothers with holistic care on culturally sensitive maternity care and midwifery services from conception to six weeks post-delivery. Seventh Generation Midwives Toronto (SGMT) is an urban collective of Aboriginal midwives serving women in Toronto

PRACTICE DESCRIPTION:

Seventh Generation Midwives Toronto (SGMT) is an urban collective of Aboriginal midwives serving women in Toronto. Working directly with clients and appropriate service providers, they assist pregnant women and recent mothers with holistic care on culturally sensitive maternity care and midwifery services from conception to six weeks post-delivery. Services are provided in the clinic, hospital, and clients' homes (depending on circumstances). Multiple partnerships exist at the grassroots and structural level with Sunnybrook Hospital. The collective is involved in the cultural and Aboriginal health communities, as well as with academic and research communities.

Implementation:

Care is provided primarily at the central clinic in Toronto at Sunnybrook Hospital, and in clients' homes (occasionally). Workshops/education sessions for community members and organizations are held at the hospital or Aboriginal organizations.

Results:

Everyone involved benefits from the collaborative and integrative approaches to service delivery:

- clients and their families – Aboriginal and non-Aboriginal women who are pregnant, delivering, or 6 weeks post-delivery
- community (Aboriginal and health care) – a resource/information organization, public lectures, client referral, cultural sensitivity/awareness training for staff and partners
- medical students – placements for medical students from Universities of Toronto, Ryerson, McMaster and Laurentian, and medical clerks from Sunnybrook
- Sunnybrook staff – especially for cultural sensitivity/competence training about Indigenous philosophies and teachings
- staff members are highly trained and gain knowledge about Indigenous aspects in this field of work

Challenges/Obstacles:

- Providing support to more than the client directly – by supporting Aboriginal women, often entire families and extended families must be supported.
- Navigation/clear-language translation/advocacy support – SGMT assists clients in navigating and understanding the processes of Aboriginal maternal child health and the health care system.
- Transportation – SGMT holds fundraisers and receives donations to raise money for women in need of transportation.
- Referrals – SGMT advises clients of multiple services (culturally and individually appropriate) in their communities.
- Funding – Does not cover the "extra work" including home visits, support for women with travelling, educating/training clients, their families, and multitude of partners.