Health Innovation Portal:
Archive of Innovative Practices

Theme: **Health Policies and Governance**

January 2014

Health Council of Canada
Conseil canadien de la santé

Selected Search Output Table (December 16, 2013)

SEARCH TERMS:	**N/A**	**LOCATION:**	**All**
HEALTH THEME:	**Health Policies and Governance**	**FRAMEWORK CATEGORY:**	**All**
HEALTH SECTOR:	**All**	**SEARCH RESULTS:**	**36 results out of 61**

1. Regional Departments of General Medicine (Départements régional de medicine générale; DRMGs)

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

2. Primary Health Care Charter

Implementation Year: Sunday, December 9, 2007 - 15:45	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice establishes strategic directions for primary care in British Columbia and involves the provincial government and a broad range of stakeholders.

CONTACT INFORMATION:

Sylvia Robinson Ministry of Health 1515 Blanshard Street Victoria BC V8W 3C8 Telephone: 250-589-0877 Email: Sylvia.Robinson@gov.bc.ca

3. Physician Assistants in Manitoba

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

4. Patients as Partners—Patient Voices Network

Implementation Year: Wednesday, December 9, 2009 - 15:30	Location:	Practice Website:

SNAPSHOT:

This innovative practice improves health care through patient, family, and caregiver engagement in voice, choice, and representation in health reform and quality improvement. The practice was launched province-wide in British Columbia and involves patients, families, and caregivers working in partnership with health system decision-makers. The Institute for Healthcare Improvement's Triple Aim is a guiding principle of the Patient Voices Network.

CONTACT INFORMATION:

Caryl Harper Ministry of Health Patients as Partners: Patient Voices Network 3-2, 1515 Blanshard St. Victoria, BC V8W 3C8 Telephone: 604-742-1772 Email: connect@patientvoices.ca

5. Midwifery in Ontario

Implementation Year: Friday, December 9, 1994 - 15:15	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice expands the accessibility and choice of maternal and newborn care through the use of midwives. The practice was launched across Ontario and involves provincial government funding of midwifery education and payment for the provision of midwifery services.

CONTACT INFORMATION:

Richard Yampolsky Program Manager, Specialized Models Programs Primary Health Care Branch Negotiations and Accountability Management Division Ontario Ministry of Health and Long-Term Care 1075 Bay Street, 9th Floor Toronto ON M5S 2B1 Telephone: 416-325-1957 Email: Richard.Yampolsky@ontario.ca

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

7. Full Service Family Practice Incentive Program

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

8. Centres de la santé et des services sociaux (CSSSs)

Implementation Year: Monday, December 9, 2002 - 14:45	Location: Quebec	Practice Website: http://sante.gouv.qc.ca/systeme_sante_rn_bref/csss

SNAPSHOT:

This innovative practice improves the accessibility, coordination, and integration of health and social services in Quebec. The practice was launched in 95 local areas covering the entire province, and it involves a broad range of health and social service organizations and providers

CONTACT INFORMATION:

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

9. Blended Payment Arrangements for Primary Care Physicians in Ontario

Implementation Year: Monday, December 9, 2002 - 14:45	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice aligns physician remuneration methods with the health system goals of improving access, appropriateness, and quality of care. The practice was launched in Ontario and has gradually expanded to include 70% of family physicians in the province.

CONTACT INFORMATION:

Jeff Morgenstern Manager, Blended Models Primary Health Care Branch, Kingston Negotiations & Accountability Management Division Ontario Ministry of Health and Long-Term Care 80 Queen St., 3rd FloorKingston, ON K7K 5W7 Email: Jeff.Morgenstern@ontario.ca Phone: (613) 536-3207

10. Quality Improvement Policy Framework for First Nations

Implementation Year: Wednesday, November 7, 2012 - 11:30	Location: National	Practice Website:

SNAPSHOT:

This innovative practice provides policy tools to help guide continuous quality improvement in government health care policy and program development. The practice was launched by Health Canada's First Nations and Inuit Health Branch (FNIHB) in 2012 to establish a national system of culturally relevant accreditation for on-reserve First Nations and Inuit health and treatment services in Canada and is being implemented by a small group of staff and an external training consultant.

CONTACT INFORMATION:

Name: Jennifer Greene Title: Manager, Quality Improvement and Accreditation Program Organization: First Nations and Inuit Health Branch, Health Canada, Government of Canada Email address: jennifer.greene@hc-sc.gc.ca Telephone number: (613) 954-2295

11. Patient Navigation Program for Low-Income Women with Breast Cancer: Seminal Innovation at Harlem Hospital, New York City

Implementation Year: Sunday, October 7, 1990 - 14:15	Location: International	Practice Website: http://www.hpfreemanpni.org/

SNAPSHOT:

This innovative practice addresses barriers low-income women experience when seeking screening, diagnosis, and treatment of breast cancer. The practice was launched in New York City at the Harlem Hospital Center and involved members of the community trained in patient navigation.

CONTACT INFORMATION:

Name: Amber Paquette Title: Development Strategist Organization: Harold P. Freeman Patient Navigation Institute Email address: apaquette@hpfreemanpni.org Telephone number: 1-646-380-4060

12. Piloting the Use of Equity-focused Health Impact Assessment (EfHIA) as a Planning Tool in Manitoba

Implementation Year: Friday, October 7, 2011 - 13:30	Location: Manitoba	Practice Website: http://www.gov.mb.ca/healthychild/pdre/pop_based.htm

SNAPSHOT:

This innovative practice addresses the need to plan for population health and health equity impacts of policies, programs, and services outside of the health sector. An equity-focused health impact assessment Manitoba pilot in 2011 while planning for the implementation of a proposed parenting program—the Teen Positive Parenting Program (Triple P).

CONTACT INFORMATION:

Name: Benita Cohen, PhD Title: Associate Professor Organization: University of Manitoba, Faculty of Nursing Email address: Benita.Cohen@umanitoba.ca Telephone number: (204) 474-9936

13. Healthy Development Index: Evaluating Municipal Planning from a health-Impact Perspective

Implementation Year: Wednesday, October 7, 2009 - 13:30	Location: Ontario	Practice Website: www.peelregion.ca/health/resources/healthbydesign/our-initiatives.htm

SNAPSHOT:

This innovative practice addresses the need for planning tools to support the development of a healthy built environment. The Healthy Development Index was developed in Ontario in 2009 and involved a research team, municipal government stakeholders, and input from private developers.

CONTACT INFORMATION:

Name: Gayle Bursey Title: Director of Chronic Disease and Injury Prevention Organization: Region of Peel Email address: Gayle.Bursey@peelregion.ca Telephone number: 905-791-7800, x2617

14. Geriatric Day Hospital: Improving Health Outcomes of Seniors Living in the Community

Implementation Year: Saturday, February 3, 1990 - 00:30	Location: Ontario	Practice Website: http://www.nygh.on.ca/Default.aspx?cid=1199&lang=1

SNAPSHOT:

This innovative practice addresses the issue of improving the health outcomes of senior patients living in the community through an interprofessional, patient-centred approach within a specialized geriatric day hospital setting. This program was launched about 25 years ago in Ontario within the Seniors' Health program at a large hospital.

CONTACT INFORMATION:

Name: Timmy Olanubi Title: Registered Nurse Organization: Senior's Health Centre – North York General Hospital Email address: timmy.olanubi@nygh.on.ca Telephone number: (416) 756 6050 ext. 8053 Information last updated on: July 7 2013

15. National Standard for Psychological Health and Safety in the Workplace

Implementation Year: Saturday, March 2, 2013 - 00:45	Location: National	Practice Website: www.csa.ca/z1003/

SNAPSHOT:

This innovative practice helps to prevent psychological harm from conditions in the workplace and promote psychological health in the workplace through support. The practice was launched nationally in Canada on January 16 2013, and is being adopted by organizations across Canada.

CONTACT INFORMATION:

Name: Sapna Mahajan, MPH, PMP Title: Director, Prevention and Promotion Initiatives Organization: Mental Health Commission of Canada Email address: smahajan@mentalhealthcommission.ca Telephone number: 403.385.4054 Information last updated on: June 14, 2013

16. Registry of Methods and Tools for Knowledge Translation in Public Health

Implementation Year: Saturday, February 3, 2007 - 00:15	**Location: National**	**Practice Website: http://www.nccmt.ca/registry/index-eng.html**

SNAPSHOT:

This innovative practice reveals effective resources for knowledge translation, making them easier to find and use for public health purposes.

CONTACT INFORMATION:

Name: Pamela Forsyth Title: Managing Director Organization: National Collaborating Centre for Methods and Tools Email address: forsyp@mcmaster.ca Telephone number: 905-525-9140, ext. 20450 Information last updated on: March 22, 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

18. Community and Rural Health Planning Framework: Health Service Planning through the Community Assessment Service Response (CASR) Model

Implementation Year: Thursday, February 11, 2010 - 00:15	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/community&ruralplanning.asp**

SNAPSHOT:

This innovative practice provides a standardized approach to planning community and rural health services across Alberta.

CONTACT INFORMATION:

Name: Maz Rahman Title: Senior Planner - Priorities & Performance Organization: Alberta Health Services Email address: Maz.Rahman@albertahealthservices.ca Telephone number: (780) 735-1414

19. Policy Readiness Tool

Implementation Year: Thursday, February 3, 2011 - 01:15	**Location: Alberta**	**Practice Website: http://policyreadinesstool.com/**

SNAPSHOT:

This innovative practice aims to assess a municipality's readiness to implement health public policies.

CONTACT INFORMATION:

Name: Dr. Candace Nykiforuk, PhD Title: Co-Principal Investigator Organization: Alberta Policy Coalition for Chronic Disease Prevention Email address: candace.nykiforuk@ualberta.ca Telephone number: 780-492-4109

20. First Nations Health Authority

Implementation Year: Friday, February 3, 2012 - 00:00	**Location: British Columbia**	**Practice Website: http://www.fnhc.ca**

SNAPSHOT:

This innovative practice transfers all service delivery to improve the health and well-being of First Nations peoples, to eliminate gaps in health between First Nations people and other British Columbians, and to provide a role for meaningful involvement of First Nations in decision-making regarding the health of their peoples. Launched in 2012, the First Nations Health Authority will design and deliver all federally funded health programs and services for British Columbia.

CONTACT INFORMATION:

Name: Davis McKenzie Title: Director, Communications and Public Relations Organization: First Nations Health Authority Email address: dmckenzie@fnhc.ca Telephone number: 604-913-2080 ext: 243

21. Thrive! A Plan for a Healthier Nova Scotia

Implementation Year: Wednesday, February 3, 2010 - 00:00	**Location: Nova Scotia**	**Practice Website: https://thrive.novascotia.ca/about-thrive**

SNAPSHOT:

This innovative practice focuses on creating supportive environments and policies that promote physical activity and healthy eating. Launched in Nova Scotia in 2010, this strategic program plan uses a whole-government and multi-sector approach to address the issue.

CONTACT INFORMATION:

Name: Caroline Whitby Title: Thrive! Implementation Coordinator Organization: Nova Scotia Department of Health and Wellness Email address: Caroline.whitby@gov.ns.ca Telephone number: 902-424-1686

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

23. Health Quality Council of Alberta—Systematic Systems Analysis: A Practical Approach to Patient Safety Reviews (SSA: PSR)

Implementation Year:	**Location: Alberta**	**Practice Website: http://www.hqca.ca/assets/files/HQCA%20Revie**

Tuesday, February 3, 2004 - 00:30		**w%20FINAL%202011-2012%20(no%20signature).pdf**

SNAPSHOT:

This innovative practice addresses the issue of conducting appropriate reviews of health service quality and patient safety issues. Launched by the Health Quality Council of Alberta in 2004, this methodology is use to conduct retrospective reviews of care where one or more patients suffered harm; or where one or more patients were nearly harmed in a close call.

CONTACT INFORMATION:

Name: Lisa Brake Title: Communications Lead Organization: Health Quality Council of Alberta (HQCA) Email address: lisa.brake@hqca.ca Telephone number: 403-297-4091

24. Transformation by Design in Ontario

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

25. Edmonton Oliver Primary Care Network—Pharmaceutical Strategy

Implementation Year: Thursday, February 2, 2006 - 00:45	**Location: Alberta**	**Practice Website: http://www.edmontonoliverpcn.com/**

SNAPSHOT:

This innovative practice addresses post-discharge issues that are related to medications. In 2009 the pharmacists, with support of the other health professionals in the Edmonton Oliver Primary Care Network developed a primary care strategy to improve medication management after hospital discharge and reduce medication-related errors. The physicians felt that integration of a clinical pharmacist into practices would assist in identifying and implementing processes to support patients during these transitions of care.

CONTACT INFORMATION:

Name: Kara May Organization: Edmonton Oliver Primary Care Network Email address: kmay@edmontonoliverpcn.com

26. British Columbia's Clinical Care Management (CCM)

Implementation Year: Wednesday, February 3, 2010 - 00:15	**Location: British Columbia**	**Practice Website: http://www.clinicalcaremanagement.ca**

SNAPSHOT:

This innovative practice is designed to harness the collective energy and commitment of healthcare providers across a province to promote guideline-driven care and clinical best practice. Launched in 2010, this program takes a system-wide approach, with participation from BC's Ministry of Health, regional health authorities and the BC Patient Safety and Quality Council (BCPSQC) to to improve the quality, safety and consistency of key clinical services and improve patient experiences of care.

CONTACT INFORMATION:

Name: James Watson Title: Director, Clinical Improvement and Risk Management Organization: BC Ministry of Health; Patient Safety and Care Quality Branch Email address: james.watson@gov.bc.ca Telephone number: (250) 952-2336

27. National Surgical Quality Improvement Program (NSQIP)

Implementation Year: Wednesday, February 3, 1999 - 00:15	Location: National, International	Practice Website: http://site.acsnsqip.org/program-specifics/nsqip-history/

SNAPSHOT:

This innovative practice addresses the need for outcomes-based measures of surgical care. Launched by the US Department of Veterans Affairs in 1999, this program can be used by participating institutions to evaluate their own patient outcomes and quality indicators, make valid, informative comparisons to other sites, and set targets for improvement.

CONTACT INFORMATION:

Name: Gina M. Pope Title: RN, CNOR Organization: ACS NSQIP Email address: gpope@facs.org Telephone number: 312.202.5607

28. Toronto Virtual Ward

Implementation Year: Wednesday, February 3, 2010 - 00:15	Location: Ontario	Practice Website: http://www.gim.utoronto.ca/Research/vward.htm

SNAPSHOT:

This innovative practice addresses the period after discharge from hospital which can be very difficult for patients, and adverse events are common. Unplanned readmission to hospital is a frequent, expensive, and potentially avoidable adverse event. In March 2010, the Toronto Virtual Ward was implemented in central Toronto through a multi-institutional partnership among St. Michael's Hospital, Women's College Hospital, the University Health Network, Sunnybrook Health Sciences Centre, and the Toronto Central Community Care Access Centre (CCAC). Virtual wards use the daily routines and staffing of a hospital ward to deliver care at home to patients at high risk of unplanned hospital readmission.

CONTACT INFORMATION:

Name: Dr. Irfan A. Dhalla Title: Department of Medicine Organization: St. Michael's Hospital Email address: DhallaI@smh.ca

29. Inter-Organizational Partnership for Medical Complexity: The Integrated Complex Care Model

Implementation Year: Tuesday, February 3, 2009 - 00:45	Location: Ontario	Practice Website: http://www.sickkids.ca/PaediatricMedicine/What-we-do/Complex-Care-Clinic/Index.html#ComplexCareProgram

SNAPSHOT:

This innovative practice addresses the fact that children with medical complexity (CMC) are a growing population characterized by serious chronic conditions, functional limitations, multiple family-identified needs, and high resource utilization, requiring services from a variety of providers across numerous settings. Recognizing the need for integrated care for this population, The Hospital for Sick Children (SickKids) has engaged in a series of voluntary partnerships since 2009 that surround the child and family that supports the delivery of community-based holistic care that is accessible, continuous, comprehensive, compassionate, coordinated, patient- and family-centred, and culturally effective.

CONTACT INFORMATION:

Name: Dr. Eyal Cohen Organization: The Hospital for Sick Children Email address: eyal.cohen@sickkids.ca Telephone number: 416-813-7654

30. 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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

32. WRHA Framework for Action: Cultural Proficiency & Diversity

Implementation Year: Tuesday, February 1, 2011 - 00:15	Location: Manitoba	Practice Website:

SNAPSHOT:

This innovative practice emphasizes the need to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. Developed in the Winnipeg Regional Health Authority in 2011, The Framework for Action is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the
interests and experiences of a diverse population and authentically engaging and collaborating with community.

CONTACT INFORMATION:

Additional information on WRHA's Aboriginal Health Programs is available at http://wrha.mb.ca/aboriginalhealth/index.php. WRHA's Framework for Action: Cultural Proficiency & Diversity can be found at http://www.wrha.mb.ca/community/commdev/files/WRHA_cpd_framework_final.pdf.

33. Provincial Health Services Authority's (PHSA) Aboriginal Health Program

Implementation Year: Friday, February 3, 2006 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice delivers a facilitated online training program that acts as an educational bridge to transform attitudes, behaviours, and practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 Transformative Change Accord (more information on the Accord can be found here) signed by the Province of British Columbia and the First Nations Leadership Council.

CONTACT INFORMATION:

Additional information about the PHSA Indigenous Cultural Competency Training Program is available online at www.culturalcompetency.ca, or from Cheryl Ward, Provincial Lead for Indigenous Cultural Competency Training (cward-02@phsa.ca).

34. Interior Health Authority (IHA)

Implementation Year: Wednesday, February 3, 2010 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the need to make changes to the way a health region plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population. The Interior Health Authority (IHA) in British Columbia has developed and implemented the Aboriginal Health & Wellness Strategy, 2010–2014, which recognizes that the gap between the health status of Aboriginal people and other residents.

CONTACT INFORMATION:

Additional information on IHA's Aboriginal Health Program and the Aboriginal Health & Wellness Strategy, 2010–2014 can be found at www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/default.aspx.

35. 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

36. Health Quality Ontario's Home Care Indicator Reporting

Implementation Year: Friday, February 12, 2010 - 00:15	Location: Ontario	Practice Website: http://www.hqontario.ca/

SNAPSHOT:

This innovative practice aims to measure and publicly report on the quality of home care services and client satisfaction. Since 2010, Health Quality Ontario publicly reports on quality home care indicators through HQO's home care public reporting website.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Health Quality Ontario Email address: mailto:info@hqontario.ca Phone number: 416-323-6868

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

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

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

Practice Description:

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

Impact:

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

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

Applicability/Transferability

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

Contact Information:

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

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

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

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

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

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

Primary Health Care Charter

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Policies and Governance**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	**Emerging**

Snapshot: This innovative practice establishes strategic directions for primary care in British Columbia and involves the provincial government and a broad range of stakeholders.

Practice Description:

Recognizing the potential contribution of primary care to population health and health system sustainability, the provincial government developed a *Primary Health Care Charter* in collaboration with key stakeholders. The Charter documented progress during the previous five years and established a strategic agenda for advancing primary care. The Charter, which was released in 2007, sets out a series of guiding principles, articulates priorities, and identifies priority populations.

Principles

- Improving patient health outcomes will drive what we do.
- Patients and families assume the role of partners in their care.
- A population-based approach will ensure inequities and needs are identified and addressed.
- We will reorient health services to align with the patient's journey through a patient-centred integrated health system.
- Family physicians are the cornerstone of primary health care. They are part of a broader community network and professional team that includes nurse practitioners, public health staff, community nurses, midwives, pharmacists, mental health workers, dietitians, specialists, and many other health professionals and non-governmental organizations who work as a team with patients and their extended families.
- Patients should receive accessible, appropriate, efficient, safe, quality care at the right time, in the right setting, by the right provider.
- Patients and their clinicians must receive key information to make decisions at the point of care, and decision support also must be available for managing patient populations.
- The ministry will implement the expanded chronic care model through structured collaborative approaches, because this model has derived the best results in clinical improvement and system change in B.C.

Priorities for System Change

1. improved access to primary care;
2. increased access to primary maternity care;
3. increased chronic disease prevention;
4. enhanced management of chronic diseases;
5. improved coordination and management of co-morbidities;
6. improved care of the frail elderly; and
7. enhanced end-of-life care.

Priority Populations

- maternity patients;
- people at risk for or living with chronic conditions;
- the frail elderly;
- people living with mental ill health or addictions;
- Aboriginal people; and

- people approaching end of life.

Key initiatives and anticipated results for 2007/08 were identified for each priority. The Charter included a commitment to issue progress reports and revise the Charter annually. Resources were committed to implementation by a variety of stakeholders, including the British Columbia Medical Association. Although the Charter has guided subsequent policy initiatives, no annual reports or revisions have been posted.

Impact:

An assessment of the costs and savings of this practice has not been completed at this time. This innovative practice has been implemented since 2007 and does not have a completed evaluation at this time. However, some of the initiatives outlined as part of the strategic directions of the Charter have been individually evaluated.

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

Applicability/Transferability

The practice informant did not identify other practices that the Primary Health Care Charter had adapted from and was unaware if the practice was used as a model elsewhere.

The success of this specific program is dependent on the willingness of leadership to work collaboratively with stakeholders and document vision, strategic objectives, and implementation activities; knowledge of the health care system and the broader context to identify stakeholders; effective design for the process of intense engagement and consultation with stakeholders; and expertise to produce a multi-stakeholder document that identifies all organizations.

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

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

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Physician Assistants in Manitoba

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

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

Practice Description:

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

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

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

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

Impact:

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

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

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

• the ability of primary care practices to accept new patients;

• patient access (i.e. timeliness of care);

• improved continuity of care for patients across the continuum (e.g., hospital, community, personal care home);

• improved patient/family communication in community and hospital settings; and

• reducing patient volumes in high-intensity care settings.

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

Applicability/Transferability:

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

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

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Patients as Partners—Patient Voices Network

LOCATION:		**HEALTH THEME:**	**Health Policies and Governance**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

Snapshot: This innovative practice improves health care through patient, family, and caregiver engagement in voice, choice, and representation in health reform and quality improvement. The practice was launched province-wide in British Columbia and involves patients, families, and caregivers working in partnership with health system decision-makers. The Institute for Healthcare Improvement's Triple Aim is a guiding principle of the Patient Voices Network.

Practice Description:

The Patient Voices Network (PVN) is a Patients as Partners initiative of the Ministry of Health. The PVN is administered by ImpactBC, a non-profit organization funded by the Ministry of Health to support health care improvement. PVN's work is guided by a provincial committee that includes health authority representatives, health care providers, non-governmental agencies, and patient partners. PVN recruits network members, helps build their skills, and supports patients, families, and caregivers to use their experiences to contribute to health system decision-making. PVN offers in-person orientation workshops to prepare PVN volunteers for their role as patient partners with decision-makers. It also matches volunteers with opportunities to work with health care providers and decision-makers, including the Ministry of Health, health authorities, the BC Medical Association, the General Practice Services Committee, physician joint clinical committees, and other non-governmental and community organizations. The network currently has over 1,500 volunteers who have been matched with more than 900 engagement opportunities.

Based on a model developed by the International Association of Public Participation, Patients as Partners defines five categories of patient and public engagement:

- Inform – Patients receive balanced and objective information to help them understand the problem, alternatives, opportunities, and/or solutions.
- Consult – Patient feedback is obtained on analysis, alternatives, and/or decisions.
- Involve – Physicians working directly with patients throughout a process to ensure that patients' concerns and feedback are consistently understood and considered.
- Collaborate – Patients participate as equal partners in each aspect of the decision, including the development of alternatives and the identification of a solution.
- Empower – Final decision-making is in the hands of the public.

The Network helps match volunteers to opportunities based on their desired level of engagement and their specific needs.

Impact:

This innovative practice has been implemented since 2009. Quality improvement initiatives, plan-do-study-act (PDSA) cycles, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health, lower costs, and better patient and provider experience.

Applicability/Transferability

The practice informant did not indicate other practices that Patients as Partners adapted from. However, New Brunswick is in the process of implementing a similar program, although not in collaboration with Patients as Partners.

The success of this specific program is dependent on establishing supportive, trusting, and collaborative partnerships with a variety of stakeholders (Patients as Partners Initiative); building the capacity of patients to participate; implementing guidelines and criteria for volunteers; and measuring performance continuously.

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

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Midwifery in Ontario

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

Snapshot: This innovative practice expands the accessibility and choice of maternal and newborn care through the use of midwives. The practice was launched across Ontario and involves provincial government funding of midwifery education and payment for the provision of midwifery services.

Practice Description:

Legislation establishing midwifery as a regulated profession and providing for the registration of midwives in Ontario was proclaimed in December 1993. The Ontario Midwifery Education Program was established in 1993 as a collaborative four-year baccalaureate program at three universities. The program is currently undergoing expansion from 60 to 90 places per year. The Midwifery Act was amended in 2011 to expand midwives' scope of practice, including intubation of newborns and an expanded drug list.

The core tenets of midwifery care are continuity of care, informed choice, and choice of birthplace. Ontario midwives have hospital admission and discharge privileges and access to physician referrals for consultation or transfer of care. They provide primary care to women during pregnancy, labour, and delivery, and care to mothers and babies during the first six weeks after birth. Two midwives attend the birth, whether in a home or a hospital. The College of Midwives specifies eligibility criteria for home birth and prescribes the conditions that require consultation with or transfer of care to a physician.

The number of midwives practising in the province increased from 71 to 693 between 1994/95 and 2013/14. More than half of Canadian midwives work in Ontario. Midwife-attended births increased from 1,800 to over 24,000 (12% of births in the province) during the same period. Midwifery program expenditures have grown from $23.7 million in 2002/03 to $125.48 million in 2013/14.

Impact:

A midwifery program evaluation comparing the outcomes of midwifery care and family physician obstetrical care was conducted by the Ministry of Health and Long-Term Care in 2003. However, the report of that evaluation is not publicly available. Personal testimonials, observations, tracking data, and research and evaluation from other jurisdictions suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

No rigorous assessment of the costs and savings of this practice has been completed at this time.

Applicability/Transferability

Midwifery has been adapted from numerous jurisdictions internationally and is a legal and regulated profession in seven other provinces and one territory: British Columbia (1998), Alberta (1998), Quebec (1999), Manitoba (2000), Northwest Territories (2005), Saskatchewan (2008), Nova Scotia (2009), and New Brunswick (2010).

The success of this specific program is dependent on:

• provincial investment in midwifery positions;

• support from stakeholders and providers;

• building human resource capacity through education and training; and

• the willingness of hospitals to integrate midwives (e.g., hospital privileges, policies on the number of midwives and deliveries; cost for midwives; cost of uninsured patients).

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Integration of Primary Health Care Nurse Practitioners (PHC NPs)

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

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

Practice Description:

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

Education

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

Regulation

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

NP Practice

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

Impact:

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

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

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

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

Applicability/Transferability

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

The success of this specific program is dependent on:

• educating patients, providers, and insurance companies about the role and responsibilities of nurse practitioners and NPLCs;

• establishing effective governance structures, administration, and organizational development (e.g., interprofessional team functioning, information technology);

• engaging nursing stakeholders;

• providing appropriate NP compensation;

• optimizing roles within the team; and

• aligning financial incentives to ensure specialists are not disadvantaged by referrals from NPs.

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

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Full Service Family Practice Incentive Program

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

Snapshot:

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

Practice Description:

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

• providing care to patients with diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, and hypertension, according to clinical guidelines;

• delivering babies (low-volume obstetrics);

• training for maternity care skills;

• developing clinical action plans and discharge plans for frail elderly, palliative care patients, patients with mental illness, or patients with co-morbidities;

• developing plans for high-risk patients with two or more chronic illnesses;

• conducting health risk assessments of patients in targeted populations;

• providing ongoing management services to mental health patients; and

• promoting shared care with specialists and interprofessional health care providers.

Impact:

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

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

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

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

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

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

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

Applicability/Transferability

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

The success of this specific practice is dependent on:

• establishing formal structures (committees) that allow for collaboration among all partners (ministry, medical association, and regional health authorities);

• consulting with primary care physicians on their support needs;

• building a program that is based on evidence;

• creating an environment that allows for changing incentives over time as needed;

• access to data that allows for analysis of gaps in service and continuous evaluation of incentives;

• innovative approaches that allow for the inclusion of comprehensive incentives within a fee-for-service payment structure; and

• willingness of primary care providers to participate in the initiative.

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Centres de la santé et des services sociaux (CSSSs)

LOCATION:	Quebec	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

Snapshot: This innovative practice improves the accessibility, coordination, and integration of health and social services in Quebec. The practice was launched in 95 local areas covering the entire province, and it involves a broad range of health and social service organizations and providers.

Practice Description:

CSSSs were created by merging health organizations in each local health region (Centres locaux de services communautaires, CLSCs), including residential and long-term care centres, family medicine, and hospitals, under a single governance structure. The goal of CSSSs is to move from service-based responsibility to population-based responsibility in order to improve the health and well-being of geographically defined populations. CSSSs are organized according to ten programs: public health, general services, people with impairments related to aging, physical disability, intellectual disability, pervasive development disorders, youth in difficulty, dependencies, mental health, and physical health. Some CSSSs have implemented interprofessional teams for chronic conditions such as diabetes, depression, and chronic obstructive pulmonary disease. CSSSs enter into service agreements with partners in their local services network (including rehabilitation centres, child and youth protection centres, private medical clinics and offices, community organizations, private home-care services, community-based pharmacies, private residences with services for older persons, and resources available through the public health and social services infrastructures) to provide services to the residents of their region. Primary health care services in these local networks are delivered mainly through physician-run practices and some CLSCs.

Impact:

Initial evidence of this restructuring effort indicates that this governance structure has facilitated greater integration between health and social care sectors, and that it has facilitated population-based planning and service delivery, alignment between organizational structures and strategic vision, introduction of preventive and health promotion interventions, investment of time and resources to assist primary care practices with information technology, accreditation, orphan-patient referrals to family physicians, formalization of integrated service networks, and building intersectoral partnerships to meet the needs of the community. On the other hand, this approach has resulted in additional bureaucracy and hierarchies. Further work is required to remove silos between clinical services and establish adequate clinical governance mechanisms (including implementing information systems, shared patient records, guidelines, and care protocols).

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

Applicability/Transferability

The practice informant did not identify other specific practices that CSSSs in Quebec had been adapted from and was unaware if the practice has been used as a model elsewhere.

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External Source: http://sante.gouv.qc.ca/systeme_sante_rn_bref/csss

Blended Payment Arrangements for Primary Care Physicians in Ontario

LOCATION:	Ontario	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

Snapshot: This innovative practice aligns physician remuneration methods with the health system goals of improving access, appropriateness, and quality of care. The practice was launched in Ontario and has gradually expanded to include 70% of family physicians in the province.

Practice Description:

Blended payment arrangements available to family physicians in Ontario include various combinations of capitation (payment per patient per month), fee-for-service, salary, and targeted payments. Capitation is the principal component of the Family Health Organization and Family Health Network payment models, which include 39% of family physicians in the province. Capitation payments are adjusted for the age and sex of enrolled patients. Fee-for-service is the main element in the Family Health Group and Comprehensive Care Model payment arrangements, which account for another 29%. The Rural and Northern Physician Group Agreement and the remuneration models for physicians working in community-sponsored family health teams (2% of family physicians) are salary-based. All payment models include special fees or premiums (which vary across models) for providing priority services (such as reproductive care, palliative care, and home visits). They also include graduated pay-for-performance for achieving specified levels of preventive care coverage, including toddler immunization, seniors' influenza vaccination, cervical cancer screening, mammography, and colorectal cancer screening, among enrolled patients. All models have incentive fees for the management of patients with diabetes and congestive heart failure, and for smoking cessation.

By 2012 only 24% of Ontario family physicians remained in traditional fee-for-service practice, half of whom were in a focused practice (e.g., emergency department, psychotherapy, hospital medicine, sports medicine or long-term care) rather than comprehensive primary care practice. Total payments to primary care physicians increased by 32% between 2006/07 and 2009/10, related in large part to the introduction of new reimbursement models. In addition, average payments to primary care physicians increased at a higher rate than those to specialist physicians.

There is growing recognition that age- and sex-adjusted capitation does not adequately capture variation in need for primary care services among primary care practice populations. The most recent agreement between the Ministry of Health and Long-Term Care and the Ontario Medical Association includes a commitment to introduce an "acuity modifier" to address variation in health care need beyond that captured by age and sex.

Impact:

This innovative practice was first implemented in 2002 and does not have a full evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and studies suggest that the practice can lead to improved performance and has the potential to produce positive outcomes on health.

In an econometric study, Hurley and colleagues assessed Ontario physicians' responses to financial incentives, including preventive care pay-for-performance bonuses and special payments for priority services (e.g., obstetrical deliveries, prenatal care, hospital care, palliative care, in-office technical procedures, home visits, and care of patients with serious mental illness) above specified thresholds. Using a controlled before-after design, the study found that the pay-for-performance incentives led to an increase over baseline levels in the provision of four of five preventive services: 5.1% for seniors' influenza vaccination, 7% for Pap smears, 2.8% for mammography, and 56.7% for colorectal cancer screening (Hurley, DeCicca, Li, & Buckley, 2011). There was no detectable response to the special payments for priority services above threshold levels.

Kiran et al. (2012) examined the impact of the diabetes incentive code (introduced in 2002) on the quality of diabetes care using health administrative data. The incentive code can be billed up to three times per year and requires the primary care physician to maintain a diabetes flow sheet tracking key interventions, including cholesterol testing, HbA1c testing, and eye examinations.

Receipt of all three monitoring tests rose from 16% in 2000 to 27% in 2008, and patients with higher numbers of incentive code billings in the period from 2006 to 2008 were more likely to receive recommended testing. However, they were also more likely to have received testing before the incentive code was introduced. At the patient level, the rate of improvement in testing levels was no greater in the two years after the first incentive code was billed than in the prior two years. In multivariable regression analysis, receipt of recommended testing was higher in capitation-based blended payment models than in fee-for-service-based models.

Tu, Cauch-Dudek, and Chen (2009) assessed hypertension management during 2004/05 by Ontario physicians working in salaried (Community Health Centre), capitation-based blended-payment and traditional fee-for-service practices.After controlling for patients' sociodemographic characteristics and co-morbid conditions, treatment and control rates were found to be higher in the capitation model practices, which were more likely than the fee-for-service practices to employ nurses and nurse practitioners.

Kantarevic, Kralj, and Weinkauf (2011) found that Family Health Group (fee-for-service-based blended-payment model) physicians provided more services and visits, saw more patients, made fewer referrals, and treated more complex patients than did traditional fee-for-service physicians, suggesting that the incentives included in this model increase physicians' productivity. Effects on quality of care were not assessed.

In a study of after-hours care in a single northern Ontario community, Howard et al. (2008) observed a lower six-month prevalence of emergency department use by patients of Family Health Network physicians (capitation-based blended-payment model), compared with patients of physicians in Family Health Groups (fee-for-service-based blended-payment model) and traditional fee-for-service practices.In a study of after-hours telephone information provided by Ontario family physicians, Howard and Randall (2009) found that physicians participating in blended payment models—all of which require and financially reward physicians to provide after-hours care to enrolled patients—were more likely than physicians in conventional fee-for-service practice to suggest that patients use an after-hours clinic operated by the group or network with which the physician was affiliated (32% versus 10%). They were also less likely to provide no instructions (11% versus 26%) or only to suggest using an emergency department, using an urgent care centre, or calling 911 (13% versus 24%).

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

Applicability/Transferability

Various forms of blended remuneration arrangements for primary care physicians are being implemented widely in Canada and internationally.

The success of this specific practice is dependent on:

• articulating clear expectations on service delivery in contractual agreements with physicians;

• establishing defined metrics for accountability in contractual agreements with physicians;

• investing in significant resources to engage physicians; and

• developing a model that is team focused rather than physician focused.

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Quality Improvement Policy Framework for First Nations

LOCATION:	National	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:		**FRAMEWORK CATEGORY:**	

SNAPSHOT: This innovative practice provides policy tools to help guide continuous quality improvement in government health care policy and program development. The practice was launched by Health Canada's First Nations and Inuit Health Branch (FNIHB) in 2012 to establish a national system of culturally relevant accreditation for on-reserve First Nations and Inuit health and treatment services in Canada and is being implemented by a small group of staff and an external training consultant.

PRACTICE DESCRIPTION:

FNIHB's Quality Improvement Policy Framework (QIPF) builds on the branch's vision and activities to establish a national system of culturally relevant accreditation for on-reserve First Nations and Inuit health and treatment services in Canada. The QIPF provides a common understanding of what quality means to FNIHB through an integrated, branch-level approach for use by headquarters and regional staff. The intent is for quality improvement to be embedded throughout all aspects of FNIHB programming. Specifically, the framework aims to:

- demonstrate leadership and commitment to improving the quality of First Nations and Inuit health services;
- better align quality improvement activities and efforts across FNHIB; and
- achieve quality and value in services and programs through coordinated, continuous quality improvement.

The framework elements include a vision, purpose, guiding principles, and six dimensions of quality:

- accessible
- client-centred
- culturally competent
- effective
- efficient
- safe

It is anticipated that full implementation will be achieved in 2017, approximately five years after the launch date. Implementation is being driven by the Model for Improvement and includes the use of plan-do-study-act cycles. Seven key factors have been identified to help guide implementation activities: strong leadership, clear quality improvement plans, effective communication of quality improvement activities, motivation and the will to improve, performance measurement and evaluation, appropriate implementation support, and celebration and recognition of success.

Throughout the implementation phase, a Quality Improvement and Accreditation Unit will coordinate the necessary training and assistance required to help program teams learn how to develop and implement quality improvement plans. This unit will also launch a user guide and approach key influencers, such as the FNIHB's change management group, to help promote the framework. In the first year of implementation, voluntary early adopters were sought, including primary care policy staff and staff from other program areas. In the second year, training will be provided by an external expert and by FNIHB staff.

IMPACT:

FNIHB's Quality Improvement Policy Framework was implemented in the fall of 2012 and does not have an evaluation at this time.

APPLICABILITY/TRANSFERABILITY:

The foundation of the policy framework is based on an extensive review of quality improvement initiatives and approaches in Canada (e.g., provincial health quality councils) and internationally, such as in the United Kingdom, the United States, and Sweden. Additional research on Aboriginal health–specific quality improvement looked at models in Australia, New Zealand and the US. This initiative is theoretically applicable and transferable to other settings seeking to begin quality improvement initiatives.

Several lessons learned may help others apply this practice to other settings:

- When developing the framework, including government staff from a variety of departments at the working level will help align the content of the emerging framework with related initiatives (such as accreditation policy frameworks and quality improvement tools at the service delivery level).
- Consulting with external experts to review the framework can help to improve credibility in the Canadian context.
- Implementation requires time, change management, and training of staff.
- It is important to anticipate the limited availability of resources that are required to implement a quality improvement framework during times of federal economic restraint.

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Patient Navigation Program for Low-Income Women with Breast Cancer: Seminal Innovation at Harlem Hospital, New York City

LOCATION:	International	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice addresses barriers low-income women experience when seeking screening, diagnosis, and treatment of breast cancer. The practice was launched in New York City at the Harlem Hospital Center and involved members of the community trained in patient navigation.

PRACTICE DESCRIPTION:

The first Patient Navigation program was developed in New York City to reduce disparities in access to diagnosis and treatment of cancer, particularly among poor and uninsured minorities. This program was informed by findings from the American Cancer Society's (ACS's) *Report to the Nation on Cancer in the Poor in 1989* and was funded by a grant from the ACS.

The main purpose of the inaugural program was to eliminate barriers to timely screening, diagnosis, treatment, and supportive care for breast cancer. This model differs from other models of patient assistance, such as hospital-based social workers or patient advocates, by focusing on one health condition rather than the broader objective of improving health in general. Navigators develop relationships with patients to identify, anticipate, and help to alleviate barriers, including issues with:

- finances;
- language, communication, and information;
- missed appointments and lost results;
- culturally appropriate care;
- geographical distance; and
- fear and emotions.

The first patient navigators at the Harlem Hospital Center were primarily lay people selected from the community. No particular level of formal education was required, but navigators were culturally attuned to the community being served, very knowledgeable about the health care system, and highly connected with critical decision-makers in the system. Since 1990, the patient navigation model has expanded along with the credentials of navigators, who are frequently experienced health care professionals or graduates of patient navigation training programs. The Harold P. Freeman Patient Navigation Institute in New York City offers a certificate of completion program in patient navigation provided by its namesake, the founder of patient navigation.

IMPACT:

Research performed at Harlem Hospital compared the health outcomes of economically disadvantaged African-American women treated for breast cancer before and after patient navigators were introduced. Following the implementation of the Patient Navigation program, the five-year survival rate increased from 39% to 70%. These results were published in the *Journal of the American College of Surgeons* and *Cancer.* Two major factors are believed to account for the improved results in Harlem: providing free/low-cost breast examinations, which led to early detection of abnormal findings, and patient navigation, which ensured timely diagnosis and treatment.

While there are no data available on the costs and savings of the original Patient Navigation program, in general the costs of navigation depend on the needs and goals of the program. For programs that only require navigation of medical system resources, lay people may be employed at a lower cost. If a program requires a more highly trained navigator, such as an oncology nurse, costs rise accordingly. The National Cancer Institute and the ACS are sponsoring a nine-site Patient Navigation

Research Program, an ongoing evaluation of the program's impact and cost-effectiveness.

APPLICABILITY/TRANSFERABILITY:

Patient navigation was first implemented in Harlem to address the disparities in treatment of breast cancer among African-American women. However, to date, patient navigation is used, implemented, and applicable across a broad spectrum of cancers, chronic diseases, and at-risk populations, including Aboriginal peoples, Asian communities, and rural residents.

Since the seminal innovation in 1990, hundreds of different Patient Navigation programs have been established throughout the United States and in jurisdictions around the world, including Canada, Australia, and Europe. In the United States, the inaugural practice served as the model for the 2005 Patient Navigator Outreach and Chronic Disease Prevention Act, which authorized the spending of US$25 million to set up navigation services in poor and rural communities across the country.

Shortly after patient navigation services were implemented in New York, Cancer Care Nova Scotia began implementing a similar service, the Nova Scotia Cancer Navigation program. The goal of that program is to improve quality of care by arming patients with information, lending them support, and coordinating their appointments. A 2004 formal evaluation report published by Cancer Care Nova Scotia confirmed that the program significantly benefited cancer patients and their families in dealing with the emotional turmoil, informational needs, and logistical challenges associated with having cancer. Navigator programs have now been established in nearly all provinces in Canada.

PRACTICE WEBSITE:

http://www.hpfreemanpni.org/

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

Piloting the Use of Equity-focused Health Impact Assessment (EfHIA) as a Planning Tool in Manitoba

LOCATION:	Manitoba	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the need to plan for population health and health equity impacts of policies, programs, and services outside of the health sector. An equity-focused health impact assessment Manitoba pilot in 2011 while planning for the implementation of a proposed parenting program—the Teen Positive Parenting Program (Triple P).

PRACTICE DESCRIPTION:

An equity-focused health impact assessment (EfHIA) is a planning tool used to assess the unanticipated and systemic impacts of policies and/or plans, strategies, decisions, programs, or services that have a bearing on the social determinants of health and differential outcomes, particularly for more marginalized groups in society. The standard steps of this EfHIA framework include (1) screening, (2) scoping, (3) identification of potential impacts, (4) assessing impacts, (5) developing recommendations, and (6) evaluating/monitoring changes. The framework requires an explicit equity analysis at each step. The pilot project used the framework to analyze the plan for a proposed parenting program (described below) by:

- focusing the assessment on certain health equity dimensions, in this case expected access to and outcomes from the program;
- gathering information on potential impacts via a literature review, a demographic/health profile of the target population, community focus groups, and interviews with officials from Healthy Child Manitoba (HCM);
- an assessment of the potential impacts (such as not being universally culturally appropriate); and
- making recommendations for ways to promote greater equity in access and outcomes (e.g., for indigenous elders and organizations) via the development of supplementary content and training modules.

The program assessed was the Positive Parenting Program (Triple P) geared to parents and caregivers of teenagers. The Triple P is a parenting support system to prevent and treat behavioural and emotional problems in children and teenagers. Since 2005, the government of Manitoba has been implementing the Triple P under its HCM Strategy. The initial focus was on families with children under the age of 12. In 2011, HCM considered expanding the Triple P to serve parents of teenagers. Because the proposed program would be population based, with voluntary uptake by agencies across the province, it was thought that an EfHIA screening of the program could identify the potential for health inequities.

The practice involves a purposeful and systematic approach to equity-focused health impact analysis as applied to policy and program planning. The Public Health Agency of Canada provided funding and was an active collaborator in the project.

IMPACT:

In the pilot project, recommendations presented to government officials for alternative actions to promote greater equity were well received. It was determined these recommendations would be addressed in the revised implementation planning for this program and included as planning considerations for other programs. Since the parenting program that was assessed has yet to roll out, the pilot EfHIA assessment conducted in Manitobadoes not have a completed outcome evaluation at this time. Personal testimonials and observations suggest this practice has the potential for positive impacts on health.

APPLICABILITY/TRANSFERABILITY:

Health impact assessment with an equity focus is growing in popularity in Canada. EfHIA and similar approaches are increasingly being implemented in Australia, New Zealand, and the United Kingdom, and the World Health Organization has

called for health equity impact assessments of all economic agreements, market regulations, and public policies. Manitoba's approach builds on the success of the 2004 Australasian Collaboration for Health Equity Impact Assessment's framework.

Some of the challenges and lessons learned from the pilot project include:

- The nature of the program being assessed lent itself to proximal impacts (e.g., access) versus long-term impacts on health.
- There is an inherent challenge in engaging parents from groups that are often marginalized.
- The broad range of evidence to amalgamate and analyze, given the comprehensive nature of the EfHIA, can be challenging to synthesize and weigh.
- While HCM was willing to put the Teen Triple P program "under the microscope" of an EfHIA, other government departments or agencies might not be willing to do the same.

As well, the researchers noted that the absence of an established EfHIA infrastructure and local assessors in Manitoba meant the pilot reflected a learning-by-doing experience. Researchers recommended strengthening capacity for EfHIA in Manitoba. The HCM office is currently discussing how best to collaborate with other system partners to develop a set of common tools for capacity building.

PRACTICE WEBSITE: http://www.gov.mb.ca/healthychild/pdre/pop_based.html

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

Personal Communication:

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Other:

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External Source: http://www.gov.mb.ca/healthychild/pdre/pop_based.htm

Healthy Development Index: Evaluating Municipal Planning from a health-Impact Perspective

LOCATION:	Ontario	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the need for planning tools to support the development of a healthy built environment. The Healthy Development Index was developed in Ontario in 2009 and involved a research team, municipal government stakeholders, and input from private developers.

PRACTICE DESCRIPTION:

The Region of Peel has developed the Healthy Development Index (HDI), a municipal planning tool related to achieving a healthy built environment. The index is an evidence-based tool that supports the evaluation of planning projects for buildings, spaces, landscapes, and transportation systems from a health-impact perspective. The index provides scientific evidence to support the requirement for development plans to adhere to health impact planning criteria and thresholds and to withstand the scrutiny of appeal board hearings.

A research group at the Centre for Research on Inner City Health was tasked to develop the index. Their work included a systematic literature review to identify specific land use elements that had a strong relationship with physical activity of community residents. The seven HDI elements that emerged were (1) density, (2) proximity to services and transit, (3) land use mix, (4) street connectivity, (5) streetscape characteristics (road network, sidewalks), (6) parking, and (7) aesthetics and human scale. These elements have been broken down further into measures. Stakeholder consultations, a policy gap analysis, and validation via geographic information systems (GISs) were undertaken and minimum standards (targets and ranges) were developed. The following is an example of one element, one measure associated to that element, and three of the applicable thresholds:

Core element: 2 (proximity to services and transit)

Measure: Proximity to a variety of services and employment

Development Thresholds (targets and ranges):

- At least 75% of residential units must be no more than 800 m from five or more neighbourhood public services.
- At least 75% of residential units must be no more than 800 m from seven or more neighbourhood retail services.
- The centre of primarily residential communities must be no more than 800 m from the same number of full- and part-time jobs as 50% of the total number of residential dwelling units in the community.

A refinement phase allowed for pilot testing of the targets and ranges against three “new-urbanism-type” site plans and two “traditional suburb” site plans for the Region of Peel. An implementation plan was then developed to integrate the refined targets and ranges into the existing development approval process.

This practice is innovative because it provides a practical tool to integrate considerations for a healthy built environment into the municipal planning process.

IMPACT:

This tool was completed in 2009 and does not yet have a completed outcome evaluation. However, personal testimonials, observations, and research in the development phase suggest that this practice has the potential for positive outcomes on health. The HDI has been incorporated into regional and municipal planning policy, including:

- the Region of Peel's Official Plan (a further amendment to the Official Plan is in progress); and
- the Town of Caledon, the City of Mississauga, and the City of Brampton have passed council resolutions to address health impacts through planning and development applications (on February 14, 2012, May 9, 2012, and June 6, 2012, respectively)

APPLICABILITY/TRANSFERABILITY:

The HDI has not been adapted from another jurisdiction. However, this initiative is theoretically applicable and transferable to other geographic regions. Considerations regarding the applicability and transferability of this practice include

- The HDI is best used as a reference document in conjunction with planning documents, such as Master Plans.
- Giventhe multiple guidelines (e.g., heritage, sustainability, cycling) that planners and councillors must take into account when reviewing development applications, the HDI may have to compete with other agendas.
- Integrating the HDI core elements into a government planning process during an era of "streamlining" can be difficult. The Region of Peel led the development of a supplementary Toolkit* and marketed the HDI to developers.
- Coordinating related priorities and resources between disparate agencies and government departments is a challenge, and municipalities have advocated for provincial guidance
- * In 2011, the Region of Peel and Toronto Public Health sponsored the development of a Health Background Study Framework and Toolkit (HBS Toolkit) to support developers, municipal planning employees, and public health employees in integrating health impact elements into the land use approvals process. The toolkit consists of terms of reference and a user guide. Funding for the HDI and the HBS Toolkit was provided by the Canadian Partnership Against Cancer.

PRACTICE WEBSITE www.peelregion.ca/health/resources/healthbydesign/our-initiatives.htm

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

Personal Communications:

Bursey, G., & Fitzpatrick, S. (interview, July 31, 2013; feedback, August 1, 2013). [Region of Peel].

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Other:

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External Source: www.peelregion.ca/health/resources/healthbydesign/our-initiatives.htm

Geriatric Day Hospital: Improving Health Outcomes of Seniors Living in the Community

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

SNAPSHOT: This innovative practice addresses the issue of improving the health outcomes of senior patients living in the community through an interprofessional, patient-centred approach within a specialized geriatric day hospital setting. This program was launched about 25 years ago in Ontario within the Seniors' Health program at a large hospital.

PRACTICE DESCRIPTION:

The Central Local Health Integration Network (LHIN) in Ontario has a challenge to meet the needs of a rapidly aging population in Central Ontario, including the city of North York. North York has the highest ratio of older adults in the province. North York General Hospital (NYGH) offers a continuum of specialized geriatric services (from in-patients to outpatients) using a unique centralized referral system.

The Geriatric Day Hospital (GDH) program is one of the specialized services that address the complex needs of frail elderly patients. Using an integrated and interprofessional (IP) approach, the GDH is an outpatient medical rehabilitation program that strives to improve the function of frail elderly patients living in the community through the provision and coordination of medical, physical, and social interventions. The program provides care for seniors with medical or mental health problems that threaten their independence or their ability to continue to live safely at home. The interprofessional team consists of geriatricians, nurses, social workers, pharmacists, physiotherapists, occupational therapists, dietitians, recreational therapists, rehab therapists, health care aides, and administrative support.

The GDH program is now offered four mornings a week for typically up to 10 weeks. Originally, the day hospital was a full-time program that was implemented using an interprofessional approach—staff rotated their days of work and had individual cases to manage. The program now runs on a part-time schedule and is delivered in a collaborative IP approach, with consistent daily staff. The program accepts patients that are: 65 or older; have multiple medical, functional, or psychosocial problems; show potential to benefit from a team approach, are not a resident of a long-term care home, and are willing to participate in the group hospital program.

Patients are linked to community programs at discharge in order to promote the continuum of care and encourage a greater quality of life. The program is funded through the Regional Geriatric Program (RGP) of Toronto and the NYGH elder care program.

IMPACT:

The IP team approach and patient-centred goal setting have been shown to be effective in patient care and chronic disease management. The GDH model promotes better efficacy of treatment and is believed by those involved to lead to better outcomes for patients.

The program has been evaluated in terms of both patient outcomes and satisfaction. The day hospital uses a multitude of evaluation tools administered to patient at the beginning and at the end of the program in order to evaluate both subjective and objective outcomes. Evidence-based measurement tools, such as the Goal Attainment Scale (GAS), life satisfaction scale, pain scale, frailty index, Berg balance, Geriatric Depression scale, Montreal Cognitive Assessment, Timed Up and Go (TUG) test, and 2 Min walk test, are used. The significant increase in GAS scores upon completion of the program (when patients meet their treatment goals) reflects achievement of the program goals, as identified by the team in collaboration with patients and families.

Patient satisfaction surveys revealed patients, families, and caregivers were highly satisfied with the GDH program and cited the "team approach" as an integral element in their success. Through GDH, frail elderly patients are empowered to live independently in the community and are more likely to avoid emergency department visits and unnecessary admissions.

APPLICABILITY/TRANSFERABILITY:

With the focus on maintaining older adults in the community, there is a growing need for this model of integrated and comprehensive care in North York and in the Greater Toronto Area. The program also offers a model of interprofessional, patient-centred seniors' care that may be readily applicable to other hospitals and communities throughout Ontario and Canada that are looking to improve care for seniors living in the community.

The day hospital's model of care was designed and implemented using a strong supporting medical and psychiatry framework that calls for the provision of continuing care of frail elderly patients recently discharged from hospital.

The GDH has been working with the RGP and the other day hospitals to stabilize certain processes and outcomes and to improve flow and discharge planning. The NYGH GDH has been a leader in the use of goal attainment scaling, involving families in the patient's program, and having an attending geriatrician on the team and available to the patients.

Challenges:

- operating a full-time program in part-time hours;
- continuous intake of patients to the program throughout the year; and
- balancing adequate patient care and non-patient responsibilities.

Lessons learned:

- over-booking patients in order to maintain the required number;
- administering pre- and post-measures to show the effectiveness of the program;
- following a tight schedule and using a point person to manage scheduling; and
- organizing frequent mass orientation sessions to help screen appropriate patients before starting the program

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Publications:
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Alternative Profiles:

Other:
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External Source: http://www.nygh.on.ca/Default.aspx?cid=1199&lang=1

National Standard for Psychological Health and Safety in the Workplace

LOCATION:	National	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice helps to prevent psychological harm from conditions in the workplace and promote psychological health in the workplace through support. The practice was launched nationally in Canada on January 16 2013, and is being adopted by organizations across Canada.

PRACTICE DESCRIPTION:

Mental health problems and illnesses are the number one cause of disability in Canada, estimated to account for nearly 30% of disability claims and 70% of the total costs. If unaddressed, the impact of mental health problems on lost productivity due to absenteeism, attending work while sick, and turnover will cost Canadian businesses $198 billion over the next 30 years.

The process of addressing this issue began with a Global Business and Economic Roundtable on Addiction and Mental Health, followed by Dr. Martin Shain's work on how law is trending towards employers' increasing responsibility. In 2009, a Consensus Conference was held with business, labour, clinicians, and other stakeholders, at which there was unanimous consensus that Canada needed a national standard to address psychological health and safety in the workplace. From then until the release of the standard on January 16, 2013, the Vancouver group working on this standard sought information about providing a psychologically safer workplace and a technical committee was established to make the standard applicable to any organization.

The resulting Psychological Health and Safety in the Workplace Standard is voluntary and provides systematic guidelines for Canadian employers that will help them develop and continuously improve psychologically safe and healthy work environments for their employees. The main goals of the standard are mental illness prevention and mental health promotion in the workplace. It is intended to help prevent harm to all people in the workplace, whether or not they have had a lived experience with mental illness.

The project to develop the standard was championed by the Mental Health Commission of Canada (MHCC). Development of this standard was undertaken collaboratively by the Bureau de Normalisation du Québec (BNQ) and the Canadian Standards Association (CSA) group. The project was supported through funding by the Government of Canada (Human Resources and Skills Development Canada, Health Canada and the Public Health Agency of Canada, the Great-West Life Centre for Mental Health in the Workplace, and Bell Canada. This standard is unique because it is free and publicly available whereas most standards require payment in order for individuals and organizations to access them. This may change, however, after the first five years of the standard being public, as there may be changes to the document and its funders.

IMPACT:

The intended impact of the National Standard for Psychological Health and Safety in the Workplace is to

- enhance cost effectiveness;
- improve risk management;
- increase organizational recruitment;
- increase retention; and
- ensure corporate and social responsibility.

The MHCC has used the standard internally by establishing a Psychological Health, Safety, and Wellness Committee in March 2012, since they already had drafts of the standard. They also developed a Policy Statement that was approved by the Board of

Directors in June, 2012. It aims to make the MHCC a model organization for the standard. The MHCC also took the following planning steps:

1) employee wellness survey (February 2012);
2) focus groups (July 2012);
3) analysis and report generation (September 2012);
4) wellness and operational indicators developed (December 2012); and
5) 2012/13 and 2013/14 wellness plan and work plan developed and approved (December 2012–January 2013).

This innovative practice has been implemented since January 2013, and does not have a completed evaluation at this time. The MHCC does plan to assess the following indicators in order to ensure it is implementing the standard in a way that has impact:

- benefit medical care expenses;
- wellness program participation;
- leave indicators;
- turnover rates; and
- survey results.

Finally, a management review will be conducted regularly, in which administrative data and the results of the planned repeated employee survey will be reviewed by management as appropriate. Adherence to policy and other objectives and targets is also monitored and reported to management on an ongoing basis.

APPLICABILITY/TRANSFERABILITY:

To date, the MHCC has implemented the Standard in their organization and small, medium and large organizations across Canada in various sectors are using the Standard to guide their efforts in improving psychological health and safety in the workplace. This initiative is designed to be applicable and transferable to other settings.

The Psychological Health and Safety in the Workplace standard is a guide; there is no-one-size-fits-all model for how to use it. The standard will be used differently by each organization—some focusing on policies and processes, some starting with a gap analysis, and some starting with management training. Guiding principles to implementing this practice successfully include:

- commitment by senior management;
- participation by all;
- shared responsibility;
- integration of psychological health and safety; and
- focus on health, safety, awareness, and promotion

For organizations interested in implementing this practice, the MHCC recommends the following actions:

- read the standard and the annexes.
- engage senior management and other key leaders.
- ensure you have a champion.
- use available tools to assess your current situation.
- develop a policy statement on workplace psychological health and safety.
- take advantage of other tools, such as the Action Guide for Employers and the Mental Health First Aid program.

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Other:

CSA Group. (2012). *A standard for psychological health and safety in the workplace*. Retrieved from http://www.csa.ca/cm/ca/en/news/article/standard-for-psychological-health-and-safety-in-the-workplace

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External Source: www.csa.ca/z1003/

Registry of Methods and Tools for Knowledge Translation in Public Health

LOCATION:	National	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice reveals effective resources for knowledge translation, making them easier to find and use for public health purposes.

PRACTICE DESCRIPTION:

The National Collaborating Centre for Methods and Tools (NCCMT) is one of six National Collaborating Centres for Public Health created by the Government of Canada to renew and strengthen public health. After conducting an environmental scan, key informant interviews, and surveys in 2006, the NCCMT identified the need for knowledge translation methods and tools and a quick and easy way to access these resources. This led to the development of the Registry of Methods and Tools in 2007.

The Registry is a free, searchable, online collection of methods (processes) and tools (instruments) for knowledge translation in public health. The purpose of the Registry is to help public health practitioners:

- communicate new knowledge to clients and colleagues;
- support innovation uptake in their organization;
- synthesize and appraise research related to public health;
- apply a new technique for working with community partners; and
- summarize relevant evidence to influence public health policy decisions.

The Registry contains summary statements of knowledge translation methods and tools to help busy practitioners use evidence in their practice. The Registry identifies and describes effective resources for knowledge translation, making them easier to find and use.

The first phase of the Registry's development involved setting priorities. In the second phase, an International Advisory Group and a development team were structured to design processes for locating methods and tools, assessing resources for inclusion in the Registry, critically appraising (where possible) the quality of methods and tools, and creating summary statements for public health users. The process of searching for resources has since expanded to include a list of search strategies, an inclusion screening tool, a data extraction tool (measurement and descriptive information (MADI) tool), and a summary writing template.

The Registry is funded through the Public Health Agency of Canada and is hosted at McMaster University. This practice is unique in that it has an interactive and expanding online database of resources that specifically supports different types and stages of knowledge translation activities relevant to public health.

IMPACT:

To build this Registry, an initial search was conducted in 2006, covering relevant knowledge translation resources from 1985 to 2006. A second search was done in 2011 for literature from 2007 to 2010. The NCCMT screened 43,000 citations and finally included 140 citations. Between January 1 and November 30 of 2012, over 32,945 visitors from more than 190 countries accessed the Registry. Published results from an evaluation of the Registry included 286 surveys and 19 interviews, which indicated that the practice is valued and useful, but would benefit from a more intuitive indexing system and refinements to the summaries.

Descriptive statistics illustrated how survey participants have accessed and used resources in the Registry. Nearly 85% (184/217) of survey respondents were aware of the Registry and 92 % (162/177) indicated that they would visit the Registry again in the future. Evaluation results highlighted the need to improve users' experiences related to searching for appropriate

knowledge translation resources. Although most survey respondents (67%; 120/179) indicated they were able to access relevant methods and tools in the Registry, one third (33%; 59/179) were neutral or negative with respect to being able to find resources. Many people (43%; 24/56) indicated that lack of time prevented effective searching, while others thought their key barriers were related to not understanding how to search (34%; 19/56) and not knowing what resources were available to be found (27%; 15/56). Some interview respondents had also encountered challenges when trying to locate relevant resources.

APPLICABILITY/TRANSFERABILITY:

Although this practice has not been applied elsewhere, the NCCMT's Registry of Methods and Tools attracts a broad audience. Website statistics monitored by Google Analytics from January 1 to November 30, 2012, indicate almost half of users originate from Canada (43% of 45,081 visits). Many other visitors are based in the United States (19%) and the United Kingdom (9%), with the remaining users located in 188 other countries worldwide. Further, many participants (68%; 122/179) indicated they have shared methods and tools found on the Registry with colleagues, and 42% (73/175) have used a Registry resource in their work.

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Publications:

Peirson, L., Catallo, C. & Chera, S. (2013). The registry of knowledge translation methods and tools: A resource to support evidence-informed public health [Abstract]. *International Journal of Public Health*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23392560

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External Source: http://www.nccmt.ca/registry/index-eng.html

Transitioning Patients between BC Cancer Agency and Vancouver – Acute Services

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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Other:

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

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

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

Community and Rural Health Planning Framework: Health Service Planning through the Community Assessment Service Response (CASR) Model

LOCATION:	**Alberta**	**HEALTH THEME:**	**Health Policies and Governance**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice provides a standardized approach to planning community and rural health services across Alberta.

PRACTICE DESCRIPTION:

Beginning in November 2010,a provincial planning framework was developed and implemented in the Alberta Health Services (AHS). The Community and Rural Health Planning Framework provides a standardized approach to planning community and rural health services across Alberta. The framework integrates new planning approaches with past planning undertaken by the former regional health authorities and builds on the unique strengths of each rural community.

The framework follows the Community Assessment and Service Response (CASR) model, which outlines a planning process that begins with the collection and validation of community data and ends with specific community recommendations. The assessment process identifies top population health needs, current health services, and gaps in health service delivery. The goal of the framework is to give each rural community a voice in health planning by identifying top health priorities within their own community.

The key to this framework is that those living, working, and accessing health services in a local geographic area are the ones identifying priorities and solutions. Communities are selected for focused CASR planning support using an evidence-based triage tool. Population health and site/service utilization data are gathered and presented to zone leadership. Key community members (community members, health staff, physicians, elected officials) are identified to provide local context and perspective to planning for their geographic community. Top health needs, solutions, and action items are developed with community members. Once approved by AHS leadership, these strategies are implemented by those living and working in the community.

IMPACT:

Action plans have been developed for the communities involved thus far, with solutions such as booking control of a respite bed to community care access to increase respite options and aligning home care offices among neighbouring communities to increase home care support. Feedback surveys are distributed to participants after each engagement session. Internal team evaluations have also been developed to gauge success of the process and point out areas for improvement. These features are part of an overall CASR evaluation framework.

Approximately 1,200 completed surveys were collected from participants in Phase I to III; the response was overwhelmingly positive. For instance, 93.1% of respondents felt that they could contribute their ideas during the session, and 87.4% found the process valuable. Internal team members/zone leaders found the process valuable, stating that the flexibility of the framework allowed them to tailor their process to the specific needs of their communities.

A three-year service plan outlining the process and action items are provided to the community for accountability and to keep participants engaged. With respect to ensuring long-term sustainability, the intent is to revisit these communities in the future to reassess their top priorities as population demographics and health care needs change.

APPLICABILITY/TRANSFERABILITY:

The CASR process is based on community engagement principles that could be used for health needs assessments in diverse settings. The framework represents a success story of empowering rural communities to engage in health planning. Local-level findings have been used to drive not only local planning but also zone and provincial planning, and to align provincial strategies and priorities with local health needs.

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Information last updated on: April 2, 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

- Gyennin, N. (2012). Content developed from an abstract submission for the Health Council of Canada National Symposium on Integrated Care.

External Source: http://www.albertahealthservices.ca/community&ruralplanning.asp

Policy Readiness Tool

LOCATION:	Alberta	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice aims to assess a municipality's readiness to implement health public policies.

PRACTICE DESCRIPTION:

The Policy Readiness Tool is a self-administered questionnaire that can be used to assess a municipality's readiness for policy change. Included with the questionnaire is a series of strategies for working with municipalities at different stages of readiness for policy change and a resource list for additional information. The purpose of the Tool is to help advocates and policy-makers encourage municipalities to adopt healthy public policies and increase their capacity to make such changes. It is designed for use by individuals, organizations, and municipalities interested in creating healthier communities.

Municipalities are classified according to their readiness for policy change as being

- innovators;
- in the majority group; or
- late adopters.

For each level of readiness, the Tool identifies key strategies and resources that can be used to encourage and support the adoption of healthy public policies. These include

- smoke-free public spaces regulations;
- injury prevention (e.g., helmet bylaws);
- nutrition policies (e.g., in schools or recreation facilities);
- social planning policies; and
- location/implementation of new green spaces or facilities.

The Policy Readiness Tool was developed with support from the Alberta Policy Coalition for Chronic Disease Prevention (APCCP). The APCCP represents a range of practitioners, policy-makers, researchers, and community organizations that have come together to coordinate efforts, generate evidence, and advocate for policy change to reduce the rates of cancer and other chronic diseases in the province of Alberta, Canada.

The Policy Readiness Tool was created using Rogers' Diffusion of Innovation Theory. First, a literature review was conducted to better understand the characteristics of different types of policy "adopters." These characteristics were compiled into a pilot questionnaire to assess a municipality's readiness for policy change. The questionnaire was then tested with municipal representatives throughout Alberta. The APCCP team will continue to evaluate it to assess its utility in different policy environments.

The material on the suggested strategies appropriate to each level of readiness was collected through interviews with members of the APCCP's Provincial Advisory Group, a diverse and intersectoral group with significant expertise in the use of policy to build healthier communities. Advisory Group members were asked about strategies that they use in their work with municipalities at different stages of readiness for policy change. These strategies were summarized and grouped into themes to accompany the Policy Readiness Tool.

Funding for this project was provided through the Alberta Policy Coalition for Cancer Prevention (2009–2011), which was funded by Alberta Cancer Prevention Legacy Fund (Alberta Health Services). In October 2011, the organization underwent a name change to Alberta Policy Coalition for Chronic Disease Prevention.

IMPACT:

The Policy Readiness Tool was downloaded approximately 550 times in 2012. The Tool has been used with chief administrative officers and elected officials at the municipal level. The APCCP is currently testing and evaluating the utility of the Tool across issues, policy contexts, and jurisdictions. The results from this evaluation, which is funded by Killam Trusts, University of Alberta, are forthcoming. The goal of this phase of testing is to tailor the Tool to different levels of decision-making and different contexts. The Tool is also being revised to be more applicable to schools and primary care network settings.

APPLICABILITY/TRANSFERABILITY:

Requests to use the Tool have been received from municipalities in Alberta, Quebec, and Ontario. The Tool has also been profiled by other organizations, including the Canadian Partnership Against Cancer and National Collaborating Centre for Methods and Tools.

The strengths of the Tool include building personal and community-level capacity related to involvement in the policy process, addressing resource capacity issues of organizations through strategic targeting, and building knowledge through intersectoral collaboration. One of the limitations of the Tool is that it is based on a unidirectional theory of diffusion that moves forward in time and results in a static instrument explaining a dynamic process. This means that policy change may still be in progress when the Tool is used to assess "readiness," so users must be cautious when implementing this innovative practice. The Tool is also limited in that it is best applied to simple, straightforward, single-issue cases of policy change. Although complex cases can be assessed with the Tool, users must be flexible and leave room to act on the unexpected because of the constant changing nature of the policy process.

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

Publications:

- Nykiforuk, C.I.J., Atkey, K.M., Nieuwendyk, L.M., Raine, K.D., Reed, S., & Kyle, K. (2011). Policy Readiness Tool: Understanding a municipality's readiness for policy change and strategies for taking action. Edmonton, AB: School of Public Health, University of Alberta. Retrieved from http://policyreadinesstool.com/wp-content/uploads/Policy-Readiness-Tool_English.pdf?

Other:

- Nykiforuk, C. & Reed, S. (March 19, 2013). *The Policy Readiness Tool*. [Presentation Slides]. Retrieved from http://www.chnet-works.ca/index.php?option=com_phocadownload&view=category&download=605%3A329-march-19-2013-nccmt-spotlight-on-kt-methods-and-tools-6-policy-readiness-tool-policy-readiness-tool-from-the-university-of-albertas-school-of-public-health&id=22%3Afireside-chat-presentations-and-recordings-2013&Itemid=13&lang=en
- Nykiforuk, C. & Reed, S. (March 19, 2013). *The Policy Readiness Tool*. [Presentation Audio]. Retrieved from http://www.chnet-works.ca/index.php?option=com_phocadownload&view=category&download=612%3A329-march-19-2013-audio-recording-nccmt-spotlight-on-kt-methods-and-tools-6-policy-readiness-tool-policy-readiness-tool-from-the-university-of-albertas-school-of-public-health-&id=22%3Afireside-chat-presentations-and-recordings-2013&Itemid=13&lang=en

External Source: http://policyreadinesstool.com/

First Nations Health Authority

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

SNAPSHOT: This innovative practice transfers all service delivery to improve the health and well-being of First Nations peoples, to eliminate gaps in health between First Nations people and other British Columbians, and to provide a role for meaningful involvement of First Nations in decision-making regarding the health of their peoples. Launched in 2012, the First Nations Health Authority will design and deliver all federally funded health programs and services for British Columbia.

PRACTICE DESCRIPTION:

In 2012, the First Nations Health Authority (FNHA) was created in BC to reform First Nations health care. This is the first provincial FNHA in Canada. The FNHA evolved out of a series of health plans agreed to by the federal and provincial governments, including the 2006 *Transformative Change Accord: First Nations Health Plan*, the 2007 *Tripartite First Nations Health Plan*, and the 2011 British Columbia Tripartite Framework Agreement on First Nation Health Governance.

The FNHA will have authority over service delivery within the BC First Nations Health governing structure, and the British Columbia Tripartite Framework Agreement on First Nation Health Governance mandates the FNHA to design and deliver all federally funded health programs and services for British Columbia. Currently, these are administered by Health Canada, First Nations Inuit Health Branch–Pacific Region.

The purpose of transferring all service delivery to the FNHA is to improve the health and well-being of First Nations peoples, to eliminate gaps in health between First Nations people and other British Columbians, and to provide a role for meaningful involvement of First Nations in decision-making regarding the health of their peoples. Over time, using evaluation results and citizen input, the goal is to modify and redesign current federal health programs and services to make them more appropriate for First Nations' needs.

The FNHA is considered innovative because it puts decision-making around health and health services into the hands of the First Nations people. This is the first time that all First Nations in a province have come together under a common political mandate for a shared outcome. Further, extensive group consultation and public input directly informed the governance structure of the FNHA, which is the mechanism for this agreed-upon model of service delivery. To determine the role and structure that the FNHA would take, 120 regional meetings with First Nations leaders, people, and health professionals were held.

With respect to the service delivery roll out of the FNHA, a phased approach has been developed to ensure that the community is engaged at every step along the way. The three phases of the roll out are:

- **Transfer:** All Health Canada's First Nations programs and services in BC will be transferred to the FNHA by October 1, 2013. Through this period the FNHA will "buy back" certain services until it is able to establish the necessary infrastructure.
- **Transition:** A five-year transition period will allow the FNHA to offer seamless delivery of care. Ongoing monitoring, evaluation, and practical improvements will be made in this phase.
- **Transformation:** The FNHA will transform First Nations programs and services to meet First Nations' needs by, for example, improving integration with the provincial systems and regional health authorities and further including traditional medicine and practice).

IMPACT:

The parties recognized early on that this initiative is a truly tripartite effort and that improving First Nations and Aboriginal health is a joint responsibility. With this in mind the parties have agreed to jointly evaluate the implementation of the Framework Agreement every five years. The items to be included in these evaluations are articulated in the 2011 Tripartite Framework

Agreement on First Nations Health Governance:

"The Parties shall, within eighteen (18) months of the signing of this Agreement, prepare an evaluation plan and begin collecting data and reports to track at least the following:

(a) Health indicators:

(i) life expectancy at birth;

(ii) mortality rates (deaths due to all causes);

(iii) Status Indian youth suicide rates;

(iv) infant mortality rates;

(v) diabetes rates;

(vi) childhood obesity rates;

(vii) number of practising First Nations health care professionals who are registered or otherwise accepted members of recognized health professions under the BC *Health Professions Act*; and

(viii) any other additional indicators, including wellness indicators supported by the governance stakeholders; namely the Tripartite Committee, the FNHC and the FNHDA.

(b) Governance, tripartite relationships and integration:

(i) the effectiveness of the new Health Governance Structure described in section 4; and

(ii) the effectiveness of the new federal, provincial and First Nation relationships set out in section 6.

(c) A tripartite evaluation report will be finalized within one year following the first five year period of the Transfer of Federal Health Programs. The report shall be made public.

In addition, the FNHA will provide for the preparation of an independent evaluation every five (5) years that includes review of the FNHA's:

(i) plans and programs;

(ii) organizational structure and organizational effectiveness; and

(iii) management of First Nation Health Provider relationships and health benefit (former FNIHB) provider relationships."

These evaluations, which will address the purpose and intent of this Agreement, will be carried out within the wider context of the health partnership with BC First Nations. Evaluation reports will be available to the FNHA members, the governments of Canada and British Columbia, and the public.

APPLICABILITY/TRANSFERABILITY:

The British Columbia FNHA works closely with a similar health authority in Alaska, which is currently celebrating their 15th year in service. Alaska offers a good basis for lessons learned due to the similarity of its demographics to those of the First Nations people living in BC (with respect to, e.g., remoteness of tribes and multitude of languages). Although Alaska has not experienced a significant change in health indicators since committing to culturally appropriate service delivery, there are moderately positive outcomes occurring and an overall satisfaction among Alaskan Native users.

The BC FNHA considers itself a "learning" organization that will support First Nations across Canada that are interested in exploring the creation of similar authorities. Saskatchewan achieved a tripartite Memorandum of Understanding, and Manitoba First Nations leaders have expressed interest in the model of service delivery that the FNHA offers. The goal is to use the outcomes of the evaluation to inform the spread of the FNHA to other contexts in Canada and abroad.

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

- First Nations Health Authority. (2008–2011). *About the FNHA*. http://www.fnhc.ca/index.php/iFNHA/
- First Nations Health Council & First Nations Health Authority. (2012, December 17). *Quarterly transition update*. http://www.fnhc.ca/index.php/news/press_releases/
- Tripartite Committee on First Nations Health. (2012). *Together in Wellness: 2011/2012 Tripartite Committee on First Nations Health interim annual report*. http://www.fnhc.ca/pdf/together-in-wellness_2011-12_interim_report.pdf
- MacKenzie, D. (personal communication: interview and feedback, January 10, 2013). [First Nations Health Authority].

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Information was last updated on: January 14, 2013

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

Thrive! A Plan for a Healthier Nova Scotia

LOCATION:	Nova Scotia	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice focuses on creating supportive environments and policies that promote physical activity and healthy eating. Launched in Nova Scotia in 2010, this strategic program plan uses a whole-government and multi-sector approach to address the issue.

PRACTICE DESCRIPTION

Nova Scotia currently has one of the highest incidences rates for f chronic disease in all of Canada. In addition, one in three children and youth are overweight or obese, and rates of unhealthy eating, sedentary behaviour, and inactivity are high. In 2010, the Nova Scotia government committed to developing a childhood obesity prevention strategy. Thrive! A Plan for a Healthier Nova Scotia is part of a broad prevention platform; its specific focus is on creating supportive environments and policies that promote physical activity and healthy eating. The plan uses a whole-government and multi-sector approach to address the issue. The following government departments are involved in the initiative: Transportation and Infrastructure Renewal, Agriculture, Education, Justice, Environment, Community Services, Natural Resources, Service Nova Scotia & Municipal Relations, Energy, and Health and Wellness. Interdepartmental committees have been created to look at what is being done within and across departments, and to ensure consistent messaging and support across departments.

The Thrive! plan's four strategic directions are (1) support a healthy start for children and families, (2) equip people with skills and knowledge for lifelong health, (3) create more opportunities to eat well and be active, and (4) plan and build healthier communities. These directions are built on a foundation of social policy, the objective of which is to develop mechanisms to ensure that provincial decision-making is consistent with healthy public policy. This can be achieved by embedding health impact assessment into public health legislation and across departments. Each of the directions has a specific set of objectives with actionable items. The directions and actions are based on scientific evidence and expert and public consultation.

Thrive! is supported by a broad engagement strategy that includes regular reporting to the public on progress.

IMPACT

The Government of Nova Scotia is currently developing a comprehensive evaluation plan. They have identified a number of short-term, intermediate, and long-term outcomes. Short-term (one to three years) outcomes look at planning, policy, and investment (e.g., process indicators—who is involved, what activities are taking place). Intermediate (three to five years) outcomes focus on changes in environments that support healthy behaviours. Long-term (five to 10 years) outcomes focus on improved health behaviours (i.e., sustainable upward/downward trends in rates of healthy eating, physical activity, unhealthy eating, and sedentary behaviour). Ultimate (10+ years) outcomes focus on a healthier population (e.g., a reduction in preventable chronic disease).

The Department of Health and Wellness is collaborating with researchers and stakeholders to design an evaluation framework for Thrive! They will identify indicators, measures, and tools that are needed to evaluate the implementation and impact of Thrive! at multiple levels. The Department of Health and Wellness is interested in learning how Thrive's whole-government collaborative approach is changing social and economic policy, how the program will unfold, and how Thrive! will contribute to changing environments, behaviours, and health outcomes.

APPLICABILITY/TRANSFERABILITY

This plan builds on the success of Healthy Eating Nova Scotia and Active Kids Healthy Kids. Thrive! will help Nova Scotia respond to national priorities as laid out in Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights. The plan has not been adapted from another jurisdiction or been implemented elsewhere.

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

- https://thrive.novascotia.ca/about-thrive
- Whitby, C. (personal communication: interview and feedback, January 21, 2013). [Thrive! Implementation Coordinator, Nova Scotia Department of Health and Wellness]
- Nucklaus, K., (personal communications: interview and feedback, January 21, 2013). (Senior Policy Analyst, Nova Scotia Department of Health and Wellness)
- Ryan, P. (personal communications: interview and feedback, January 21, 2013). (Senior Policy Analyst, Nova Scotia Department of Health and Wellness)

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Information last updated on: January 22, 2013

External Source: https://thrive.novascotia.ca/about-thrive

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

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

- National Musculoskeletal Models of Care Working Group. (2012, Fall). *Tool for developing and evaluating models of care*. http://www.arthritisalliance.ca/docs/bod/201211272330_moc_EN.pdf
- Canadian Medical Association. (2011, December 5). *A collection of referral and consultation process improvement projects.* http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Advocacy/Referrals/ReferralProjectCollection.pdf

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Information last updated on: March 4, 2013

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

Health Quality Council of Alberta—Systematic Systems Analysis: A Practical Approach to Patient Safety Reviews (SSA: PSR)

LOCATION:	Alberta	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the issue of conducting appropriate reviews of health service quality and patient safety issues. Launched by the Health Quality Council of Alberta in 2004, this methodology is use to conduct retrospective reviews of care where one or more patients suffered harm; or where one or more patients were nearly harmed in a close call.

PRACTICE DESCRIPTION:

As part of its mandate, the Health Quality Council of Alberta (HQCA) may be requested to conduct reviews of health service quality and patient safety issues. The HQCA has conducted 12 reviews since its inception in 2004, and has since developed and refined its structured review processes. The approach is focused on systems, and all reviews are disciplined, systematic, and thorough.

Systematic Systems Analysis: A Practical Approach to Patient Safety Reviews (SSA: PSR) is one methodology used for conducting reviews. It was developed for health care reviews and draws on aviation and human factors investigation techniques. It is a theory-based method that helps users consider critical health care system factors in their review. The methodology encourages a systemic view of the health care system by considering “how all parts of the health care system play a role” rather than focusing on “only one particular factor in isolation.”

The SSA: PSR methodology is designed to conduct retrospective reviews of care and of the following types of patient safety events:

- One or more patients suffered harm.
- One or more patients were nearly harmed in a close call.

The methodology is characterized by a three-phased approach: (1) collect information, (2) analyze information, and (3) recommend improvements that can be scaled up or down as needed. Phase 2 involves organizing the information gathered, analyzing it to identify system deficiencies, and then testing the findings for its system perspective. A tool, called a SAFER (Systems Analysis and Factor Evaluation Review) matrix, is used to carry out these tasks in an iterative way. The SAFER matrix is designed to support systematic analysis that is focused at the systems level. Another tool is a set of factor review questions (FRQs)that correspond to the five rows of the SAFER matrix, and help with deeper analysis of system factors. Phase 3 of the review is guided by a structured approach to recommending improvements.

Recent HQCA quality assurance reviews that followed the SSA: PSR methodology include

- a review of operations of ground emergency medical services in Alberta (report released March 4, 2013);
- a review of the Safety Implications for Patients Requiring Medevac Services to and from the Edmonton International Airport (*2011); and*
- a review of the Quality of Anatomical Pathology Specimen Preparation and Interpretation 2010–11.This review was conducted for Rockyview General Hospital, Calgary Laboratory Services Diagnostic and Scientific Centre, and Royal Alexandra Hospital. ***(2012)***

IMPACT:

As with most review methodologies, the SSA: PSR has not been formally evaluated. However, it has been revised over a number of years of use and has received positive feedback from current users.

APPLICABILITY/TRANSFERABILITY:

The HQCA has plans to implement an education program about the SSA: PSR. An evaluation that will include evaluating the education process and the ease of the use of the SSA: PSR methodology will be conducted.

The SSA: PSR methodology draws on systematic reviews conducted in aviation as well as human factors investigation techniques, with a focus on a systems-level of analysis. The SSA: PSR methodology has been developed and applied over three decades, and was used extensively in the former Calgary Health Region for a large number of reviews (of diverse size and scope).

The HQCA has piloted two educational opportunities for training in the SSA: PSR methodology. The first is a two-and-a-half day workshop; it was piloted in Calgary with participants from a number of jurisdictions in Canada. The second is a five-day university certificate course that is offered in partnership with the University of Calgary Faculty of Medicine . It was recently piloted in Winnipeg Health Region. Students in this certificate course receive practical, hands-on training in the SSA:PSR methodology and conduct an review. This certificate course is suitable for application in diverse settings.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Cowell, J. (November, 2012). *Health system investigations: Quality assurance reviews [and] health inquiries*. Presentation to Canada's Virtual Forum on Patient Safety and Quality Improvement. Retrieved from http://static.gowebcasting.com/documents/files/events/event_00001152_EtipxVlZ.pdf

Duchscherer, C., & Davies, J.M. (2012). *Systematic systems analysis: A practical approach to patient safety reviews.* Calgary: Health Quality Council of Alberta. Retrieved from http://www.hqca.ca/assets/files/HQCA%20SSA%20Patient%20Safety%20Reviews%20FINAL%20June%202012.pdf

Harvie, M., *Quality and Safety Education Lead, Health Quality Council of Alberta.* (personal communication, February 25, 2013).

Health Quality Council of Alberta . (2011). *Review of the safety implications for patients requiring medevac services to and from the Edmonton International Airport*. Retrieved from http://publications.hqca.ca/preview/167

Health Quality Council of Alberta. (2012). *Rockyview General Hospital and Calgary Laboratory Services Diagnostic and Scientific Centre and Royal Alexandra Hospital: Review of the quality of anatomical pathology specimen preparation and interpretation 2010–11*. Retrieved from http://hqca.ca/assets/files/HQCA_Review_Anatomical_Pathology_October_2012.pdf

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Information last updated on: February 25, 2013

External Source: http://www.hqca.ca/assets/files/HQCA%20Review%20FINAL%202011-2012%20(no%20signature).pdf

Transformation by Design in Ontario

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

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

Content adapted from the following sources and relevant websites:

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

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Information last updated on: November 26, 2012

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

Edmonton Oliver Primary Care Network—Pharmaceutical Strategy

LOCATION:	Alberta	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses post-discharge issues that are related to medications. In 2009 the pharmacists, with support of the other health professionals in the Edmonton Oliver Primary Care Network developed a primary care strategy to improve medication management after hospital discharge and reduce medication-related errors. The physicians felt that integration of a clinical pharmacist into practices would assist in identifying and implementing processes to support patients during these transitions of care.

PRACTICE DESCRIPTION:

The Edmonton Oliver Primary Care Network (EOPCN) was established in February 2006 and has grown to include 100 physicians in 13 clinics serving a population of over 100,000 patients. In 2009 the pharmacists, with support of the other health professionals in the EOPCN, developed a primary care strategy to improve medication management after hospital discharge and reduce medication-related errors. The EOPCN physician-led working group identified a need to determine when patients were discharged from hospital back into the community. Since many issues post-discharge are related to medications, the physicians felt that integration of a clinical pharmacist into practices would assist in identifying and implementing processes to support patients during these transitions of care.

This initiative focuses on high-risk patients discharged from all acute care hospitals in the Alberta Health Service Edmonton Zone who are over age 60 (or anyone who was admitted to hospital with a cardiac-related event), have at least one long-term condition, and are currently taking either five or more medications or one high-risk medication. Using Netcare, Alberta's provincial electronic health record, a family physician list of hospitalized patients is generated and patients who are discharged are identified. Using an assessment and follow-up algorithm, a pharmacist identifies patients as either low or high risk to encounter post-discharge issues with medication management. The pharmacist contacts those who are high-risk. A telephone assessment is done within two days and an intervention is either provided over the phone or plans are made to see the patient at home or at an upcoming clinic visit. Standardized assessment and intervention tools are used, and the patient's electronic medical record is updated to provide current information for the next visit to the family physician.

IMPACT:

A database of 233 patients discharged from the hospital in 2011 and meeting the criteria for higher risk of medication management problems was analyzed with respect to patient demographics, length of hospital stay, identified admission problem, number and type of interventions by the pharmacist, and record of drug-related problems (patient and/or system level). A patient survey was also completed in 2012.

Patients contacted have typically been hospitalized for an average of 12 days with almost five changes per patient made to the pre-hospital medication profile—most commonly starting of a new drug. The most frequent interventions by the pharmacist result from intentional or unintentional non-adherence by the patient, confusion with generic and brand names, and incomplete or inaccurate discharge instructions. Interventions included starting or stopping drugs, changing dose times, and adjusting dosages. Most patients (62%) were contacted by phone only, with just over 20% contacted in-person after the call. The patient telephone survey indicates very high satisfaction with the pharmacist-led program. Patients were surprised and pleased at the level and quality of service provided.

In order to reach those patients most at risk and be economically sustainable, the program has refined its processes to include the use of other staff to monitor hospital patients and complete the initial screening of those who should be contacted by the pharmacist.

APPLICABILITY/TRANSFERABILITY:

The success of this program in identifying people at risk, potentially harmful medication issues, and the need for early intervention should be considered important for the integration of hospital- and community-based care. Several primary care networks in Alberta have worked with the EOPCN to adopt a similar program. This intervention is transferable to any other setting where primary care teams could include a pharmacist working with a family physician and other providers.

Content was adapted from the following sources and relevant websites:

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

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British Columbia's Clinical Care Management (CCM)

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Policies and Governance**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice is designed to harness the collective energy and commitment of healthcare providers across a province to promote guideline-driven care and clinical best practice. Launched in 2010, this program takes a system-wide approach, with participation from BC's Ministry of Health, regional health authorities and the BC Patient Safety and Quality Council (BCPSQC) to to improve the quality, safety and consistency of key clinical services and improve patient experiences of care.

PRACTICE DESCRIPTION:

British Columbia's Clinical Care Management (CCM) initiative began in 2010 as a key part of British Columbia's *Innovation and Change Agenda* which supports innovation and transformation across the entire health system, including all areas of care (health promotion and prevention, community care, acute care and end of life care).

As a "Key Result Area" of the *Innovation and Change Agenda,* CCM pursues the goal of "implementing a guideline-driven, evidence informed, clinical care management system to improve the quality, safety and consistency of key clinical services and improve patient experiences of care." To achieve this goal, CCM takes a system-wide approach, with participation from BC's Ministry of Health, regional health authorities and the BC Patient Safety and Quality Council (BCPSQC). It is a shared strategy that involves everyone working together for the common goal of better quality care.

CCM is designed to harness the collective energy and commitment of healthcare providers across the province to promote guideline-driven care and clinical best practice. It provides a provincial forum to identify, establish and promote clinical best practice guidelines by connecting physicians with provincial decision makers. Across the province, Clinical Expert Groups have been formed to review clinical evidence, develop practice standards and recommend province-wide adoption of guidelines, protocols and quality improvement metrics. Guidelines and practice standards are essentially developed from the ground-up with clinician input from the inception of the process, right through to implementation. The connection between the Clinical Expert Groups and the CCM Steering Committee – comprised of senior Ministry leadership (Assistant Deputy Minister), health authority vice presidents of quality / medicine, and the Chair of the BCPSQC – ensures that clinicians have the ability to raise quality of care barriers, opportunities and successes to senior leadership. This connection between senior decision makers and frontline clinicians helps ensure improving quality of care for patients remains the central mandate of the CCM initiative.

To date, CCM has identified eleven Clinical Care Areas (CCA): Hospital care for seniors (48/6), antimicrobial stewardship, stroke, sepsis, surgical site infection, surgical checklist, hand hygiene, heart failure, venous thromboembolisms, medication reconciliation, and critical care related to glycemic control. To support the Clinical Expert Groups for each CCA a provincial quality lead is appointed by the BCSPSQC. Quality Leads are experts in change management, engagement and coordination, and they support guideline development and implementation from a provincial perspective, ensuring appropriate communication and coordination among regional health authorities. In addition, they speak on behalf of the clinical expert group that champions guideline driven care in the focused topic area. The role of the BCPSQC as part of the CCM structure is to engage with physicians and nurture these eleven clinical expert groups. As the BCPSQC is an independent organization it is able to have honest and open discussions with clinical experts about priority areas of health care and then take that information to the Ministry of Health for province wide implementation. The BCPSQC helps connect physicians and the Ministry of Health by providing change management, communications and engagement activities across the province.

IMPACT:

Clinical Care Management's structure of integrated decision making between physicians and policy officials for quality improvement has not been formally evaluated at this time.

APPLICABILITY/TRANSFERABILITY:

Many high performing health care systems have adopted a system-wide approach to establishing, promoting, and implementing evidence based clinical best practices. British Columbia's Clinical Care Management's approach has reviewed models implemented in other health systems, notably Intermountain Health Care in Utah.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Contact List for the CCM: http://www.bcpsqc.ca/quality/documents/ClinicalCareManagementContactDirectory.pdf#page=9

CCM Data Guide: http://www.bcpsqc.ca/quality/documents/CCM%20Data%20Guide%202012%20v1.0.5.pdf

Document outlining targets (April 2, 2012):
http://www.bcpsqc.ca/quality/documents/CCM-Principles-for-Target-Setting-v13-ApprovedbySC.pdf

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Write-up information last updated on: January 28, 2012

EXTERNAL LINK: www.clinicalcaremanagement.ca

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

National Surgical Quality Improvement Program (NSQIP)

LOCATION:	National, International	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice addresses the need for outcomes-based measures of surgical care. Launched by the US Department of Veterans Affairs in 1999, this program can be used by participating institutions to evaluate their own patient outcomes and quality indicators, make valid, informative comparisons to other sites, and set targets for improvement.

PRACTICE DESCRIPTION:

Originally developed by the United States (US) Department of Veterans Affairs, the National Surgical Quality Improvement Program (NSQIP) is offered through the American College of Surgeons (ACS) across North America and internationally. ACS NSQIP is the first validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care.

Participating hospitals submit surgical data (i.e. safety and quality indicators) to a central NSQIP database, so that relevant data on surgical practice at participating hospitals can be analyzed to evaluate the current status of surgical quality and to direct improvement in priority areas of surgical safety and quality.

The two cornerstones of NSQIP involve the use of risk-adjusted data and 30-day follow-up with post-operative patients to collect data on post-surgery infection rates and readmissions . All data submitted to the NSQIP database are adjusted for patient variables that could influence surgical site infections and other patient outcomes (e.g., obesity, age, co-morbidities). The database can therefore be used by participating institutions to evaluate their own patient outcomes and quality indicators, make valid, informative comparisons to other sites, and set targets for improvement. Further, trained surgical clinical nurse reviewers follow-up with patients 30 days post-operation to inquire about infections and other post-surgery outcomes to ensure accurate measurement. Hospitals enrolled in NSQIP receive their risk-adjusted data in comprehensive, semi-annual, and real-time reports, allowing hospitals to monitor quality improvement efforts and compare surgical outcomes with over 500 other hospitals that are participating in the NSQIP program. This allows hospitals to compare themselves to their peers and make changes and improvements to better patient care and safety.

IMPACT:

ACS NSQIP has been the subject of numerous formal evaluations since its inception. The initiative has resulted in significant benefits and improved outcomes in the US Department of Veterans Affairs and in private hospitals in the United States. For example, a study in the *Annals of Surgery* (2009) involving 118 ACS NSQIP hospitals concluded that the program helped each hospital prevent between 250 to 500 complications per year. In addition, 82% of those hospitals saw improvement in morbidity levels and 66% saw improvement in mortality levels. Hospitals that have significantly improved their performance or sustained excellent performance over time are asked to share their experience with ACS NSQIP. This feedback is combined with the data collected during structured site visits to produce a continually updated set of best practices that is disseminated to all participating ACS NSQIP sites across the country in the published annual report.

APPLICABILITY/TRANSFERABILITY:

Following the successful use of NSQIP among Veterans Affairs hospitals in the United States, the ACS launched a pilot study in 1999 to determine the feasibility of implementing NSQIP in the private sector. The pilot study involved three hospitals and found that after the first year the data collection processes and the risk-adjustment models produced were valid for the non-VA environment. A second pilot, launched in 2001 and funded by the Agency for Healthcare Research and Quality (AHRQ), demonstrated that NSQIP also functioned very well in reducing morbidity and mortality in private sector hospitals.

Beginning in 2004, the American College of Surgeons brought the NSQIP initiative into the private sector in the United States,

expanding to include over 380 hospitals. The ACS and external reviewers continue to evaluate the program and its outcomes at numerous levels of analysis.

In 2006, three publicly-funded hospital sites from Fraser Health Authority in British Columbia (BC) were the first Canadian sites to join the ACS NSQIP. Since then, the program has expanded to include 24 sites in the province. Outside of BC, other participating Canadian hospitals include, but are not limited to: Jewish General Hospital in Montreal (Quebec), the Ottawa Hospital (Ontario) , and hospital sites of the University Health Network in Toronto (Ontario). The British Columbia Patient Safety Quality Council (PSQC) continues to provide support to NSQIP sites across Canada.

Content was adapted from the following sources and relevant websites:

Hall, B.L., Hamilton, B.H., Richards, K., Bilimoria, K.Y., Cohen, M.E., and Ko, C.Y. (2009). Does surgical quality improve in the American College of Surgeons National Surgical Quality Improvement Program. *Annals of Surgery, 205*(3), 363–376.

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

http://site.acsnsqip.org/program-specifics/data-collection-analysis-and-reporting/

http://site.acsnsqip.org/participants/

http://site.acsnsqip.org/program-specifics/nsqip-history/

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EXTERNAL LINK:

http://site.acsnsqip.org/program-specifics/nsqip-history/

External Source: http://site.acsnsqip.org/program-specifics/nsqip-history/

Toronto Virtual Ward

LOCATION:	**Ontario**	**HEALTH THEME:**	**Health Policies and Governance**
HEALTH SECTOR:	**Acute Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice addresses the period after discharge from hospital which can be very difficult for patients, and adverse events are common. Unplanned readmission to hospital is a frequent, expensive, and potentially avoidable adverse event. In March 2010, the Toronto Virtual Ward was implemented in central Toronto through a multi-institutional partnership among St. Michael's Hospital, Women's College Hospital, the University Health Network, Sunnybrook Health Sciences Centre, and the Toronto Central Community Care Access Centre (CCAC). Virtual wards use the daily routines and staffing of a hospital ward to deliver care at home to patients at high risk of unplanned hospital readmission.

PRACTICE DESCRIPTION:

The period after discharge from hospital can be very difficult for patients, and adverse events are common. Unplanned readmission to hospital is a frequent, expensive, and potentially avoidable adverse event. In Ontario, approximately one-third of patients discharged from internal medicine wards are readmitted to hospital within 90 days. The Ontario Ministry of Health and Long-Term Care (OMHLTC) estimates that these readmissions cost the province over $700 million each year.

In March 2010, the Toronto Virtual Ward was implemented in central Toronto through a multi-institutional partnership among St. Michael's Hospital, Women's College Hospital, the University Health Network, Sunnybrook Health Sciences Centre, and the Toronto Central Community Care Access Centre (CCAC). Virtual wards use the daily routines and staffing of a hospital ward to deliver care at home to patients at high risk of unplanned hospital readmission. Patients receive the best elements of hospital care, such as interprofessional team-based care, shared notes, a single point of contact, 24-hour access to a physician, and increased coordination of specialist, primary, and home and community care for several weeks after discharge. The Toronto Virtual Ward supports general internal medicine patients for two to eight weeks after discharge from hospital, after which patients are discharged to their primary care provider.

The process for admission to the Toronto Virtual Ward begins in hospital. A LACE index is used to quantify patients' risk of readmission or death within 30 days of discharge, to help clinicians identify those individuals who might benefit from more intensive post-discharge care.[1] Patients with a LACE score greater than or equal to 10 are offered care through the virtual ward for the post-discharge period. Patients are managed by a virtual ward team, comprised of a physician (usually a general internist), a pharmacist, two care coordinators, nursing support, and a team assistant/ward clerk. Physicians rotate onto the virtual ward team for three-week blocks at a time. The Toronto Virtual Ward team meets daily at Women's College Hospital, and most members of the team (except the physician and hospital-based nurse) work for the CCAC. Care includes telephone support, dietary and medication counselling, education to improve self-management of chronic disease, medication reconciliation, home safety assessments, and home visits by physician, nurse, and care coordinator. It also includes care coordination with other health care providers (including family doctor), social supports, addictions counselling, lab work, and specialists. The virtual ward team meets for office-based medical rounds every day for approximately one hour to share updates on patients and determine next steps in the plan of care. Patients are discharged from the virtual ward once their health and social care management plan has been optimized and ongoing care by their primary care provider and community-based supports has been fully established.

The University of Toronto's Department of Medicine provided start-up funding for the initiative, and the OMHLTC, the Toronto Central Local Health Integration Network, and each of the institutional partners provide operational funding. The OMHLTC, the Canadian Institutes of Health Research, and the Green Shield Canada Foundation are funding the evaluation component.

IMPACT:

A randomized controlled trial is currently being conducted to assess the efficacy of the virtual ward compared to usual care. Patients are randomized to either the virtual ward or usual care on the day of hospital discharge, and followed for one year. The primary outcome measure is readmission to hospital or death within 30 days of discharge. Secondary outcome measures include readmission or death, readmission, death, emergency department visits, long-term care admission, and death at 30 days, 90 days, 6 months, and one year after discharge. It is hypothesized that the virtual ward will reduce readmission rates by

approximately one-third.

This initiative has demonstrated that several independent organizations can collaborate at the point of care in an attempt to provide functionally integrated care. It has also demonstrated that complex health service interventions can be evaluated rigorously. From a clinical perspective, the virtual ward has raised awareness about the fragmentation of care for older adults with complex health needs and the challenges associated with care transitions from hospital to home. Anecdotal evidence has shown that patient, family, and staff satisfaction is very high. Results of the randomized controlled trial are expected in the summer of 2013.

APPLICABILITY/TRANSFERABILITY:

The implementation of the Toronto Virtual Ward has influenced the development of virtual wards and other post-hospital care models in other jurisdictions, including Singapore, the United States, the United Kingdom, and elsewhere in Canada.

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Relevant websites:

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

1. van Walraven, C., Dhalla I.A., Bell, C., Etchells, E., Stiell, I. G., Zarnke, K., … Forster, A.J. (2010). Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. *Canadian Medical Association Journal, 182*(6), 551–557.doi:10.1503/cmaj.091117

External Source: http://www.gim.utoronto.ca/Research/vward.htm

Inter-Organizational Partnership for Medical Complexity: The Integrated Complex Care Model

LOCATION:	Ontario	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses the fact that children with medical complexity (CMC) are a growing population characterized by serious chronic conditions, functional limitations, multiple family-identified needs, and high resource utilization, requiring services from a variety of providers across numerous settings. Recognizing the need for integrated care for this population, The Hospital for Sick Children (SickKids) has engaged in a series of voluntary partnerships since 2009 that surround the child and family that supports the delivery of community-based holistic care that is accessible, continuous, comprehensive, compassionate, coordinated, patient- and family-centred, and culturally effective.

PRACTICE DESCRIPTION:

Children with medical complexity (CMC) are a growing population characterized by serious chronic conditions, functional limitations, multiple family-identified needs, and high resource utilization, requiring services from a variety of providers across numerous settings. Although accounting for only 0.67% of all of Ontario's children, CMC interface frequently with the entire continuum of care (i.e. acute, home, primary, and rehabilitation sectors) and are among the highest users of health care services in the province (accounting for one third of all child health spending). It is therefore imperative to promote integration that allows people to navigate the complex labyrinth of services and providers, creates value, reduces costs, and ultimately improves child and family outcomes. Recognizing the need for integrated care for this population, The Hospital for Sick Children (SickKids) has engaged in a series of voluntary partnerships since 2009 with local hospitals, Community Care Access Centres (CCAC), Children's Treatment Centres, and Local Health Integration Networks (LHIN) in Toronto, Barrie, Orillia, Mississauga, and Brampton to develop an Integrated Complex Care Model (ICCM) for CMC.

ICCM creates a circle of partnerships that surround the child and family that supports the delivery of community-based holistic care that is accessible, continuous, comprehensive, compassionate, coordinated, patient- and family-centred, and culturally effective. Formulated around the concept of a "key worker," the model acknowledges the need for a lead who can navigate across health care and other systems (education, social services, financial resources, recreation, transportation, etc.) and assume responsibility for ensuring coordination, communication, and follow-through with the plan of care. A cornerstone of this model is a written care plan created in partnership with the family and available to health care providers across the continuum of care.[1]

IMPACT:

These initiatives have been evaluated using an iterative series of mixed-method studies, including semi-structured interviews and focus groups with key stakeholders (families, health care practitioners, and health care managers) and pre-/post-assessment of outcomes (family impact, family-centredness of care, child quality of life, and health resource utilization) using standardized measures at baseline and up to one year after enrolment.

Rigorous evaluation of this model has shown that health care system costs per patient per month can decrease, driven primarily by fewer in-patient days in the tertiary care setting. Parents and providers both report being able to receive care close to home as a key benefit. Enablers to an integrated model of care include leadership, dedication to the partnership and to forming new working relationships, protected clinical time, role and responsibility clarity for key workers, and effective communication and engagement strategies targeting relevant stakeholders. Policy barriers limiting inter-organizational sharing of client information and collaboration with families impede implementation, as do funding streams organized around episodic care encounters. Families perceive the care coordination to be useful, and appreciate an electronic care plan that reflects both the medical and psychosocial aspects of their child's care.[2]

APPLICABILITY/TRANSFERABILITY:

There are a growing number of integrated complex care models throughout Canada, but their size, scope, and sustainability

remain limited in current funding models. As medical care continues to become more specialized, leveraging expertise developed at specialized centres to community settings has become essential and has been instrumental to the evolution of the ICCM.

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Information last updated on: November 19, 2012

1. Cohen, E., Bruce-Barrett, C., Kingsnorth, S., Keilty, K., Cooper, A., & Daub, S. (2011). Integrated Complex Care Model: Lessons learned from inter-organizational partnership [Special issue]. *Healthcare Quarterly, 14*: 64–70.

2. Cohen, E., Lacombe-Duncan, A., Spalding, K., MacInnis, J., Nicholas, D., Narayanan, U.G., … Friedman, J.N. (2012). Integrated complex care coordination for children with medical complexity: A mixed-methods evaluation of tertiary care-community collaboration. *BMC Health Services Research, 12*, 366. doi: 10.1186/1472-6963-12-366

External Source:
http://www.sickkids.ca/PaediatricMedicine/What-we-do/Complex-Care-Clinic/Index.html#ComplexCareProgram

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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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

Cancer Care Ontario's Provincial Patient and Family Advisory Council

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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Telephone number: 613-728-2238, ext. 225

Information last updated on: November 8, 2012

Relevant websites:

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

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

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

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

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

WRHA Framework for Action: Cultural Proficiency & Diversity

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

SNAPSHOT: This innovative practice emphasizes the need to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. Developed in the Winnipeg Regional Health Authority in 2011, The Framework for Action is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the interests and experiences of a diverse population and authentically engaging and collaborating with community.

All the services at the Winnipeg Regional Health Authority that were developed to support Aboriginal people are now within the context of a larger framework for cultural proficiency and diversity. The framework came from the recognition that in a system of this size, it's easy to silo. We wanted to retain the strength of all activities, but also recognized the need for a framework that supported the cultural proficiency of the organization, so that we wouldn't further marginalize already marginalized populations.

– Dr. Catherine Cook, Vice President, Population and Aboriginal Health, WRHA

The Winnipeg Regional Health Authority (WRHA) has demonstrated its commitment to enhance cultural safety for First Nations, Inuit, and Métis people, and to improve health outcomes for the Aboriginal population. WRHA's Aboriginal Health Programs (AHP) have focused on building WRHA's capacity to respond to the Aboriginal community's needs. The reach and impacts of AHP's activities are being strengthened by the recent introduction of a system-wide *Framework for Action: Cultural Proficiency & Diversity*, a comprehensive plan designed to enable WRHA to deliver the best possible health care to all people, regardless of cultural identity or language proficiency.

WRHA serves residents of Winnipeg and surrounding rural areas, northwestern Ontario, and Nunavut. First Nations, Inuit, and Métis people constitute a significant and growing proportion of the population in each of these regions, and the city of Winnipeg is home to the largest community of urban Aboriginal people in Canada. As is true across the country, significant inequities exist between the health status of First Nations, Inuit, and Métis people and other residents. Working collaboratively with other WRHA programs and departments and with community and government organizations, AHP brings a coordinated approach to the needs of First Nations, Inuit, and Métis people and communities, and provides a wide range of services. To enhance the health care experiences and cultural safety of First Nations, Inuit, and Métis patients, AHP facilitates patients' access to spiritual and cultural care, traditional healing, and interpreters in local Indigenous languages. In addition, it connects patients with community resources, offers advocacy services, and supports effective and comprehensive discharge planning and coordination. AHP also leads and participates in activities that enhance the cultural competency and cultural proficiency of health care providers, WRHA staff members, and the organization as a whole, including workforce development activities and education that builds staff members' awareness and understanding of First Nations, Inuit, and Métis people's cultures, historical experiences, and culturally distinct approaches to health and wellness.

The AHP, Human Resources, Community Developent, and Research and Applied Learning departments are executive sponsors, leading the development and implementation plan for WRHA's *Framework for Action: Cultural Proficiency & Diversity*. The region served by WRHA includes a large Aboriginal population (as noted above), and is home to a significant and growing number of newcomers to Manitoba. In response to the complex needs of the increasingly diverse population it serves, WRHA identified the development of cultural proficiency as a key strategic priority. The *Framework for Action* was completed and approved in 2011. WRHA is now in the process of implementing the framework.

The *Framework for Action* is ambitious, comprehensive, and innovative, and it emphasizes the importance of including the interests and experiences of a diverse population and authentically engaging and collaborating with community. It calls for system-wide organizational, structural, and clinical interventions, with the goal of transforming WRHA from a "one size fits all" health care system to one that responds to the needs of a diverse population.

- Organizational interventions focus on developing a representative workforce and leadership for WRHA. WRHA's actions

in this area have included a preferred Aboriginal hiring philosophy, outreach, recruitment, and retention activities for Aboriginal staff, and a respectful workplace policy and campaign.

- Structural initiatives focus on making the health care system more client-friendly and culturally appropriate for all clients. WRHA's actions in this area have included forming a multi-year partnership with a local tribal council to identify and develop an action plan to address gaps and challenges to health system access for Aboriginal people; establishing Community Health Advisory Councils (which report directly to the WRHA Board) and other processes to support public engagement and input; providing access to Aboriginal traditional healing services and health and wellness supports; putting in place Aboriginal patient advocacy and discharge coordination supports; providing interpreter services for all language constituencies; establishing community-based ACCESS centres ("one stop shops" for health and social service delivery) throughout the region; and establishing the BridgeCare Clinic for recently arrived, government-sponsored newcomers to Manitoba.
- Clinical interventions focus on helping health care providers gain the knowledge, skills, and tools they need to effectively manage the impacts of culture on clinical practice. WRHA's actions in this area have included Aboriginal awareness training and other cultural proficiency and diversity workshops for staff members, and partnership in the Dignity in Care initiative, which provides practitioners with practical ideas and tools to support the development of a culture of compassion and respect in WRHA.

One of the lessons learned at AHP has been that, in spite of the fact that the board and senior management at WRHA have consistently supported, championed, and resourced the program's activities, AHP is still, to some extent, marginalized as a "special" program. As Dr. Cook, WRHA's Vice-President, Population and Aboriginal Health, commented, "It's important that all of the programs *think* about the Aboriginal population, *think* about the diversity of the population when they're planning their work.… They still think that somebody will tell them if they need to do it. That's been a challenge." Lasting change will require changes in knowledge, attitudes, values, policies, and practices at all levels of the organization. The framework is designed to support that kind of transformation, by building on the organization's strengths and successes, bringing a commitment to cultural proficiency to all staff, and integrating and embedding cultural proficiency as an essential characteristic of WRHA's system.

WRHA has accumulated considerable evidence to demonstrate the impacts of framework-related activities undertaken by AHP and other departments. It has documented and published anecdotal information that demonstrates support for the activities described above, and strengthened and extended its community partnerships. Aspects of AHP and other WRHA programming (including workforce development, service delivery, program development, partnerships and collaboration, and accountability) have been adopted and used by organizations in Manitoba, Saskatchewan, Australia, and New Zealand.

CONTACT INFORMATION:

Additional information on WRHA's Aboriginal Health Programs is available at http://wrha.mb.ca/aboriginalhealth/index.php. WRHA's *Framework for Action: Cultural Proficiency & Diversity* can be found at http://www.wrha.mb.ca/community/commdev/files/WRHA_cpd_framework_final.pdf.

Provincial Health Services Authority's (PHSA) Aboriginal Health Program

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

SNAPSHOT: This innovative practice delivers a facilitated online training program that acts as an educational bridge to transform attitudes, behaviours, and practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 Transformative Change Accord (more information on the Accord can be found here) signed by the Province of British Columbia and the First Nations Leadership Council.

We think there is room to address health disparities from an educational perspective—that training can actually create change. Our objective is transformation in health care. We want to participate in that and we believe that there is an appetite in health care workers to change. When people are provided with the opportunity, they're behind it. Health care workers are forward thinking, and they have a high readiness for Indigenous Cultural Competency Training and an understanding that things need to be done differently. The status quo isn't working and they are ready to learn what can be done differently.

– Cheryl Ward, Provincial Lead

Indigenous Cultural Competency Training, Provincial Health Services Authority

In British Columbia, the Provincial Health Services Authority's (PHSA) Aboriginal Health Program delivers a unique facilitated, online training program that acts as an educational bridge to transform attitudes, behaviours, and—most importantly—practice in health care. The PHSA Indigenous Cultural Competency (ICC) training program was developed in response to the 2006 *Transformative Change Accord* (more information on the Accord can be found here) signed by the Province of British Columbia and the First Nations Leadership Council. The *Transformative Change Accord* and ICC training both seek to reduce disparities between the health status of First Nations people and that of other BC residents. The accord includes a commitment from the partners to develop a curriculum for cultural competency and establish mandatory training for staff of the Ministry of Health and regional health authorities in BC. The ICC program provides that training. By placing the ICC training online, PHSA has the capacity to provide foundational cultural competency training to all 100,000 health care workers in the province.

The objectives of the ICC training are to increase knowledge, enhance awareness, and promote the development of cultural competency skills in learners, and to develop culturally safe health care environments. Participants proceed through online courses in cohort groups with the support of a facilitator. The curriculum is interactive and based on transformative learning models. The training gives participants an opportunity to learn about the present-day experiences of Indigenous people and historical experiences that continue to affect psycho-social determinants of health for this population; to self-reflect, and recognize and undo unconscious biases and stereotypes; and to draw on leading evidence-based cultural safety practices to develop new approaches for health service delivery that can be implemented in the real-world context of their work environment.

The combination of a custom-designed online training platform (incorporating a wide range of materials and activities that engage people with a variety of learning styles) and guidance from highly skilled and knowledgeable facilitators enhances safety and responsibility for learners, and offers an ideal environment for both learning and unlearning. This has been a critical component of the program's success. Participants have described feeling shock, horror, disbelief, and anger as they learned about the history of Indigenous Peoples in Canada. Some wonder how they could have performed their jobs without knowing and understanding the ongoing effects that this history has on the health status and health experiences of Indigenous people. In the safe learning environment of ICC training, participants are able to recognize their own connections to that history and its implications for practice, take the time and space they need to reflect on and process what they are learning, and deepen their understanding through interactions with other students in their cohort and the facilitator. PHSA has also recognized that while its core training programs have been very successful in meeting the learning needs of non-Indigenous people, Indigenous learners have distinct needs, particularly with respect to cultural safety during the learning process. To support these needs, PHSA has established a protocol through which Indigenous learners can complete the training in cohorts in which all participants are

Indigenous people, and have access to both facilitators and an Elder throughout the training.

PHSA understands that cultural competency is developed through a lifelong learning process, and the ICC foundational courses as only the first leg of that journey. PHSA is launching a post-training website where graduates will be able access supporting resources for each module, connect with Elders, and continue their relationships with the facilitation team. The ICC training addresses some of the more challenging and fundamental issues (such as the residential school system, Indian hospitals, and the historical legacy of inequality and inequity) that affect all First Nations in British Columbia. It lays a strong foundation that regional health authorities and health organizations can build on by providing additional training that reflects more local needs, including teachings from First Nations people in the region they serve. As Cheryl Ward observed, “We’ve heard about people going in to do training and asking inappropriate, disrespectful, and hurtful questions. We want to give them the information they need to not ask those questions, so that when they learn from First Nations or other Aboriginal people, they can do so in a respectful way.”

The ICC training has been extremely successful. Completion rates for trainees are very high, demand for the training is growing, and internal and external evaluations have indicated that the curriculum, content, and facilitation meet learners’ needs. PHSA has also gathered considerable anecdotal evidence of the positive impacts of the training. Participants who have completed the training have reported that it has helped transform both their own practice and practice within their units. In addition to the core ICC health training course for health professionals and the core ICC for allied professionals, PHSA offers a core ICC mental health training module, and is currently developing new modules. These include modules on decolonizing anti-racism (which will equip learners with tools for anti-racist action) and narratives and counter-narratives (which will tackle pervasive harmful narratives about Indigenous Peoples that are circulated through, for example, the media, education system, criminal justice system, and everyday interactions among Canadians). PHSA is also consulting with colleagues in two other provinces who are interested in establishing similar activities.

The success of the ICC training program is related to several key factors, including (as already noted) the 2006 *Transformative Change Accord: First Nations Health Plan*, and the unique structure of the training. The process through which the training was developed has also played a critical role in its success. The provincial lead for ICC training assembled a skilled team to develop and implement the program. Early in the development process, Indigenous scholars, academics, front-line people, community members, and thought leaders came together to form a provincial think tank that explored what the training should be and how it should be developed. PHSA drew on that guidance as they laid out the syllabus. Other Indigenous and non-Indigenous leaders in health have supported the program from its inception, stepping up to contribute at various points throughout development and implementation. Strong leadership from PHSA’s senior management team (including Leslie Arnold, PHSA VP and President of BC Mental Health & Addiction Services, the project’s executive sponsor, and Leslie Varley, Director, PHSA Aboriginal Health, under whose direction the training program was developed) has also been invaluable to the program’s success.

Once the training package took shape, a year was devoted to piloting, evaluating, and refining the training before it was finally rolled out. Since the ICC program began formally delivering training, the facilitation model and facilitation team members have proven to be “must haves” for program success. The facilitation model used in the training is one of its unique features. The model includes protocols to guide, assess, and respond to the online interaction of students, and tools to support collaboration among facilitation team members and enable them to work effectively with the large volume of learners. The facilitators consistently demonstrate their commitment to participants’ learning, to the goals and objectives of the ICC training program, and to the social justice ends that the training will help achieve.

Additional information about the PHSA Indigenous Cultural Competency Training Program is available online at www.culturalcompetency.ca, or from Cheryl Ward, Provincial Lead for Indigenous Cultural Competency Training (cward-02@phsa.ca).

Interior Health Authority (IHA)

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

SNAPSHOT: This innovative practice addresses the need to make changes to the way a health region plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population. The Interior Health Authority (IHA) in British Columbia has developed and implemented the Aboriginal Health & Wellness Strategy, 2010–2014, which recognizes that the gap between the health status of Aboriginal people and other residents.

Dollars have to be applied to closing the health disparity gap—money, resources, and people. Highlighting those gaps and knowing some of the reasons they are there, when communities can't access care because it's not available or because they don't want to use the services that are available—those things are wide open for people to see and they can't be ignored. Once you put that information out there, you can't sweep it under the carpet. You have to take action to address it.

– Dion Bedard, Aboriginal Health, Interior Health Authority

The Interior Health Authority (IHA) in British Columbia has made significant changes to the way it plans, delivers, and governs health services, following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and, ultimately, to improve the health status of that population.

Aboriginal people constitute nearly 7% of the population in IHA's service region, home to 55 First Nations and 13 Métis Chartered Communities. IHA recognizes that the gap between the health status of Aboriginal people and other residents cannot be closed without also addressing inequities in health determinants, collaboration with Aboriginal people to identify and develop health care solutions that will meet their needs, and change across IHA's care and service continuum. The organization, working in partnership with First Nations, Urban Aboriginal, and Métis people, has developed and implemented the *Aboriginal Health & Wellness Strategy 2010–2014*. The strategy set goals in five strategic areas:

- Develop a sustainable Aboriginal Health Program. Action in this area includes ensuring that services are aligned between a new province-wide First Nations Health Authority (to be fully operational in July 2013) and Interior Health, contracting with Aboriginal communities to provide programs and services identified by the communities, and standardizing Aboriginal Patient Navigators positions.
- Ensure Aboriginal people's access to integrated services. Action in this area includes advocating for services that meet community-identified needs, considering the implications to and for Aboriginal people and communities in strategy development and implementation, and recruiting and retaining Aboriginal employees.
- Deliver culturally safe services across the care and service continuum. Actions in this area include providing Aboriginal Patient Navigators, providing space for sacred or ceremonial activities, integrating cultural practices in the provision of care, and having staff participate in the provincial Indigenous Cultural Competency Training program. IHA brings a cultural safety lens to its activities, emphasizing its responsibility to provide inclusiveness, accessibility, adaptability, acceptability, and accountability to all people in the region.
- Develop an information, monitoring, and evaluation approach for Aboriginal health. Action in this area includes implementing a voluntary Aboriginal self-identification initiative for both clients and employees, monitoring key performance indicators, and evaluating selected initiatives.
- Ensure ongoing and meaningful Aboriginal participation in health care planning. Action in this area includes establishing formal relationship documents with local First Nations, and engaging the community through the Aboriginal Health & Wellness Advisory Committee (a subcommittee of IHA's board of governors that has 14 members from First Nations, Métis, and urban Aboriginal communities).

Interior Health's ability to make system-wide changes was enhanced significantly when, in 2007, the Aboriginal Health Transition Fund (AHTF) provided support to a three-year project that enabled IHA to bring Aboriginal Patient Navigators on staff, add staff positions to its Aboriginal Health program, begin the self-identification initiative, and develop Aboriginal human resources policy. These activities generated momentum for change, and when AHTF support ended, IHA allocated funding in its own budget to sustain positions and activities developed through the project.

IHA's transformation is inseparable from the context in which it is taking place—the 2007 *Tripartite First Nations Health Plan* (TFNHP), signed by the First Nations Leadership Council of BC, the Province of BC, and the Government of Canada. The plan recognizes Aboriginal rights and title, and formalizes a commitment to implement a First Nations health governance model in the province (with a new First Nation Health Authority operational in July 2013). The plan also includes 35 action items for which the parties share responsibility (more information on the TFNHP can be found at http://www.healthcouncilcanada.ca/tree/Aboriginal_Report_EN_web_final.pdf#page=30).

IHA has taken action in several areas to comply with TFNHP and with its own strategy. Aboriginal Health has been established as a core program of IHA's Community Integration program, expanding its influence on activities. IHA has moved more employees through the Indigenous Cultural Competency training program than any other health authority in the province, and the baseline data that IHA collects through the Aboriginal self-identification initiative for employees have improved its ability to recruit and retain Aboriginal employees.

The client Aboriginal self-identification initiative will provide an evidence base for further change. When fully implemented, the initiative will enable IHA to track individual clients through their service experience. Data describing the experience of Indigenous clients will be anonymized and shared with local First Nations to support planning processes. Over the long term, the data will help First Nations evaluate the impacts of their own health investments on, for example, community members' use of hospital services.

IHA is well prepared for the introduction of the First Nations Health Authority. IHA has already signed Letters of Understanding (LOUs) with two of the seven First Nations in the region, and is in the process of establishing similar relationship documents with the other five. The LOUs acknowledge inherent Indigenous rights, and empower the First Nations to work directly and as equal partners with IHA. The seven First Nations and the Métis Nation of British Columbia are forming a regional executive table, with which IHA will also work collaboratively.

One of IHA's most significant strengths—and challenges—in the transformation process has been its relationships. IHA has established strong relationships with its Aboriginal partners, but recognizes that there is still work to be done. IHA rightly acknowledges that sustainable change to health outcomes cannot happen without change to determinants of health, a process that will require IHA to develop new relationships with municipalities and organizations that are mandated to address determinants. As one manager stated, "Relationship management is crucial and understanding what that means in an Indigenous context is vital.… It's really understanding what 'All My Relations' means in an Indigenous sense."

CONTACT INFORMATION

Additional information on IHA's Aboriginal Health Program and the *Aboriginal Health & Wellness Strategy, 2010–2014* can be found at www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/default.aspx.

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/

Health Quality Ontario's Home Care Indicator Reporting

LOCATION:	Ontario	**HEALTH THEME:**	Health Policies and Governance
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice aims to measure and publicly report on the quality of home care services and client satisfaction. Since 2010, Health Quality Ontario publicly reports on quality home care indicators through HQO's home care public reporting website.

PRACTICE DESCRIPTION

Health Quality Ontario (HQO) is an independent agency dedicated to reporting to the public about the quality of Ontario's publicly funded health system, supporting continuous quality improvement, and promoting health care based on the best scientific evidence available.

In December 2008, the Ontario government tasked HQO with measuring and publicly reporting on the quality of home care services and client satisfaction. In 2010, The Ontario Ministry of Health and Long-Term Care's Excellent Care for All Act mandated HQO to monitor and report to Ontarians on health services, health status of the population, and health system outcomes, to support continuous quality improvement, and to promote evidence-based health care. As a result, Ontario is the first, and currently only, province to report publicly on quality home care indicators through HQO's home care public reporting website.

Most of the data are gathered by the RAI-HC assessment tool, which has been implemented across all Community Care Access Centres (CCAC) in Ontario, and is reported by HQO. The RAI-HC is used by home care professionals to assess the strengths, preferences, and needs of home care clients so that a person-centred care plan can be developed, and the proper services can be provided. RAI-HC assessments have been tested in several countries, including Canada, and were found to be reliable and valid.

Indicators are listed by provincial results and by CCAC on the HQO website. Most data are only available for long-stay home care clients—46% of all clients—since they are the only clients who are assessed with the RAI-HC assessment. Public reporting on home care indicators encourages transparency and accountability and facilitates quality monitoring. These indicators are also reported in HQO's annual report, Quality Monitor, along with ideas for improvement and examples of success.

Home care data across Ontario have been collected through the RAI-HC since 2005, and have been reported on publicly through the home care website and the Quality Monitor for three years. A working group of provincial home care associations, stakeholders, and clinical and scientific experts were consulted through a consensus building process to decide on a set of key home care quality indicators for reporting on the quality of home care services in Ontario. The website was recently refreshed in March 2012 with new information and now includes results for 11 home care quality indicators on important topics such as wait times, falls, and—for the first time ever—client experience.

These indicators are reported for the public, providers, and policy-makers. The public can use the indicators to understand more about home care services; providers can use them to compare their performance to others and improve their processes; and policy-makers can use them to understand trends and inform policy. Although there are currently no plans to evaluate the impact of these indicators on quality improvement processes, there have been continued discussions with the working group which have led to improvements in the way these indicators are reported, including the current goal to report this data at the provider level.

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