Health Innovation Portal:
Archive of Innovative Practices

Theme: **Health Promotion and Disease Prevention (Vol. 2)**

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 Promotion and Disease Prevention**	**FRAMEWORK CATEGORY:**	**All**
HEALTH SECTOR:	**All**	**SEARCH RESULTS:**	**47 results out of 124**

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

2. Vancouver Coastal Health Transgender Health Program: A Provincial Resource for Transgendered, Gender-Diverse and Allied Community

Implementation Year: Wednesday, November 27, 2013 - 10:30	**Location: British Columbia**	**Practice Website: www.transhealth.vch.ca**

SNAPSHOT:

This innovative practice addresses the availability of information and resources for people with questions concerning transgender health issues. The practice was launched in British Columbia in one community health centre and involves a community counsellor, office administrator, and a medical director.

CONTACT INFORMATION:

Name: Lorraine Grieves Title: Manager Organization: Vancouver Coastal Health, Transgender Health Program Email address: Lorraine.grieves@vch.ca Telephone number: 604-714-3771 ext. 2318 Information last updated on: August 23, 2013

3. Taima Tuberculosis (TB): Increasing Awareness and Screening of Tuberculosis in Nunavut

Implementation Year: Sunday, November 27, 2011 - 10:30	**Location: Nunavut**	**Practice Website: http://taimatb.tunngavik.com/**

SNAPSHOT:

This innovative practice addresses the disproportionately high incidence rate of tuberculosis (TB) in Nunavut. The practice was launched in Iqaluit, Nunavut, and involved a public health team of registered nurses and Inuktitut-speaking community TB champions.

CONTACT INFORMATION:

Name: Deborah Van Dyk RN, MScN Title: Project Coordinator, Taima TB Organization: Ottawa Hospital Research Institute Email address: dvandyk@ohri.ca Telephone number: (867) 222-5026 Information last updated on: August 23, 2013

4. Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS): Applying a Treatment-as-Prevention Model of Care

Implementation Year: Saturday, November 27, 2010 - 10:30	Location: British Columbia	Practice Website: http://www.stophivaids.ca/

SNAPSHOT:

This innovative practice addresses the health of people living with HIV/AIDS and reduces the risk of transmission of the disease. The practice was launched in British Columbia and involved 16 interprofessional health care teams at primary care clinics in Vancouver's downtown east side.

CONTACT INFORMATION:

Name: Christina Clarke Title: Project Director, HIV Quality Improvement Network Organization: BC Centre for Excellence in HIV/AIDS Email address: cclarke@cfenet.ubc.ca Telephone number: (604) 682-2344 ext. 66546 Information last updated on: August 8, 2013

5. SkinSafe: A High School–Based Educational Program to Reduce Skin Cancer Prevalence Among Teens and Young Adults

Implementation Year: Sunday, November 27, 2011 - 10:15	Location: British Columbia	Practice Website: http://www.skinsafe.info/

SNAPSHOT:

This innovative practice addresses the increasing prevalence of skin cancer among teens and young adults. The practice was launched in high schools across British Columbia and involves medical doctors, medical students, and undergraduate volunteers.

CONTACT INFORMATION:

Name: Lawrence Haiducu Title: UBC Medical Student Organization: UBC Faculty of Medicine Email address: haiducu@interchange.ubc.ca Telephone number: 604-575-9022 Information last updated on: August 23, 2013

6. Home for Life Program: Mobilizing community volunteers to enable seniors to stay at home

Implementation Year: Sunday, November 27, 2011 - 09:45	Location: Ontario	Practice Website: http://www.homeforlifesgb.com/

SNAPSHOT:

This innovative practice is a volunteer-driven community program that helps connect seniors choosing to live at home with appropriate health care services and other resources. The practice was launched across South Georgian Bay, Ontario, in 2011 as a collaborative initiative among six organizations across the continuum of care.

CONTACT INFORMATION:

Name: Albert Henriques Title: Executive Director Organization: South Georgian Bay Community Health Centre Email address: ahenriques@southgeorgianbaychc.ca Telephone number: 705-422-0900 ext. 103 Information last updated on: July 24, 2013

7. Saskatchewan First Nations Aboriginal Diabetes Initiative Action Plan

Implementation Year: Thursday, November 26, 2009 - 10:00	Location: Saskatchewan	Practice Website:

SNAPSHOT:

This innovative practice addresses the need to reduce the incidence and effects of type 2 diabetes in First Nations people. The practice was launched in all 78 First Nations in Saskatchewan, involving representatives of these communities and of Health Canada.

CONTACT INFORMATION:

Name: Barbara MacDonald, RN, BSN, CDE Title: Community Health Services Nurse Consultant Organization: Primary Care and Clinical Services, First Nations and Inuit Health, SK Region, Health Canada Email address: barbara.macdonald@hc-sc.gc.ca Telephone number: (306) 780 5747 Information last updated on: July 15, 2013

8. Youth caring for elders and preventing elder abuse–Carcross /Tagish First Nation Health and Wellness Department

Implementation Year: Saturday, November 26, 2011 - 09:45	**Location: Yukon**	**Practice Website: http://www.ctfn.ca/**

SNAPSHOT:

This innovative practice addresses the need to build family, community, and provider capacity to care for elders and enable them to stay safely and longer in their homes. Implemented in 2011, a remote Yukon community took a strategic approach to making youth more responsible, reducing elder abuse, and strengthening the home care program.

CONTACT INFORMATION:

Name: Roberta Shepherd Title: Outreach Program Manager Organization: Carcross/Tagish First Nation Email address: roberta.shepherd@ctfn.ca Telephone number: 867 821-4251 Ex 8232 Information last updated on: September 25, 2013

9. Sip Smart! BC™

Implementation Year: Saturday, November 7, 2009 - 11:30	**Location: British Columbia**	**Practice Website: www.bcpeds.ca/sipsmart**

SNAPSHOT:

Launched in 2009, this innovative practice promotes awareness of the negative health consequences of drinking sugary drinks and promotes the consumption of healthier beverage choices. Program development required a project office, content developers, school liaisons, and trainers.

CONTACT INFORMATION:

Name: Stephanie Stevenson Title: Executive Director Organization: BC Pediatric Society Email address: S-Stevenson02@cw.bc.ca Telephone number: 604-875-3101

10. British Columbia Women's Hospital and Health Centre's Power to Push Campaign: Know Your Options, Take Control

Implementation Year: Sunday, November 7, 2010 - 11:30	**Location: British Columbia**	**Practice Website: http://www.powertopush.ca/**

SNAPSHOT:

This innovative practice lowers Cesarean birth rates in British Columbia and educates expecting mothers on safer birthing options. The practice was launched in British Columbia at the BC Women's Hospital and involved a team of obstetricians, gynecologists, midwives, family doctors, researchers, nurses, and other health care professionals.

CONTACT INFORMATION:

Name: Jan Christilaw Title: President of BCWH, CTF Project Sponsor Organization: BCWH Email address: N/A Telephone number: 604-875-2424, extension 6387

11. Health Equity Impact Assessment (HEIA) Tool

Implementation Year: Wednesday, November 6, 2013 - 15:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative tool supports organizations (within and outside of the health sector whose work can affect health outcomes) to plan for health equity in policy development and program delivery. The Health Equity Impact Assessment (HEIA) tool was launched publicly by the Ontario Ministry of Health and Long-Term Care in 2011.

CONTACT INFORMATION:

Name: HEIA project team Title: Community and Population Health Branch Organization: Ontario Ministry of Health and Long-Term Care Email address: HEIA@ontario.ca Telephone number: N/A

12. Men's Health Program: Engaging Men in Northern BC with Their Health

Implementation Year: Sunday, November 6, 2011 - 15:45	Location: British Columbia	Practice Website: men.northernhealth.ca

SNAPSHOT:

This innovative practice addresses health concerns of men living in northern BC through an interactive website. The Men's Health Program was implemented in 2011 and involved one Men's Health coordinator.

CONTACT INFORMATION:

Name: Brandon Grant Title: Men's Health Coordinator Organization: Northern Health Email address: Brandon.Grant@northernhealth.ca Telephone number: (250) 645-6348

13. MSH-CARES: Markham Stouffville Hospital CAesarean section Reduction Strategy

Implementation Year: Saturday, November 6, 2010 - 15:30	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice reduces rates of unnecessary interventions (such as Caesarean section) during labour and birth for low-risk women delivering in a hospital setting. The program and strategy were launched in 2010 in a community hospital in southern Ontario.

CONTACT INFORMATION:

Name: Esther Shoemaker Title: PhD (c.) Organization: University of Ottawa Email address: ebaum038@uottawa.ca Telephone number: 613-366-8000

14. Mindcheck.ca: A Provincial Resource for Youth with Mental Health Issues

Implementation Year: Wednesday, November 6, 2013 - 15:15	Location: British Columbia	Practice Website: http://mindcheck.ca/

SNAPSHOT:

This innovative practice connects youth to mental health resources and a community of support in order to achieve earlier detection of poor mental health. The practice was launched in British Columbia in four communities and involved representatives from several mental health organizations, educators, researchers, youth representatives, sponsors, and representatives from various community agencies.

CONTACT INFORMATION:

Name: Karen Tee Title: Manager Organization: Child, Youth and Young Adult Mental Health and Substance Use Email address: Karen.tee@fraserhealth.ca Telephone number: N/A Information last updated on: Friday August 30, 2013

15. Mind, Exercise, Nutrition ... Do It ! (MEND)

Implementation Year: Friday, November 5, 2010 - 15:00	Location: Alberta	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of childhood obesity. The program is delivered in communities by local agencies with trained personnel supported by Alberta Health Services. It is provided at no cost to participants and gives families a comfortable and supportive environment to interact and learn how to make healthy lifestyle choices.

CONTACT INFORMATION:

Name: Farah Bandali Title: Manager, Healthy Childhood Growth Organization: Alberta Health Services Email address: farah.bandali@albertahealthservices.ca Telephone number: 403-943-9719

16. For My Health! Program: Identifying risk factors for poor mental and physical health

Implementation Year: Thursday, November 5, 2009 - 14:30	Location: British Columbia	Practice Website: http://www.cmha.bc.ca/how-we-can-help/workplace/formyhealth

SNAPSHOT:

This innovative practice improves the mental and physical health of workers through health risk screening. The practice was launched in British Columbia at the BC Cancer Research Centre. It involved 50 employees, and health coaches such as nutritionists, physicians, counsellors, and dietitians.

CONTACT INFORMATION:

Name: Julie Kaisla Title: N/A Organization: Canadian Mental Health Association, BC Division Email address: N/A Telephone number: 604-688-3234 ext. 244.

17. Healthy Minds/Healthy Campuses Initiative

Implementation Year: Friday, November 5, 2010 - 14:15	Location: British Columbia	Practice Website: http://healthycampuses.ca/

SNAPSHOT:

This innovative practice aims to improve mental health and lower substance abuse among post-secondary students across British Columbia. The practice was launched on several campuses and involved a team of students, faculty, campus professionals, administrators, government representatives, researchers, and community members.

CONTACT INFORMATION:

Name: Shaylyn Streatch Title: Coordinator Organization: Healthy Minds/Healthy Campuses Email address: shaylyn.streatch@cmha.bc.ca Telephone number: 604.688.3234 ext. 287 Information last updated on: Friday August 30, 2013

18. Atii!: A Comprehensive Healthy Living Intervention for Children, Youth, and Families in Inuit Communities in Nunavut

Implementation Year: Thursday, February 3, 2011 - 14:00	Location: Nunavut	Practice Website:

SNAPSHOT:

This innovative practice addresses health outcomes and health literacy among Inuit children. The practice was launched in 2011 in Nunavut and involved a project coordinator, a game facilitator, and an administration person.

CONTACT INFORMATION:

CONTACT INFORMATION: Name: Gwen Healey Title: Executive Director Organization: Qaujigiartiit Health Research Centre Email address: gwen.healey@qhrc.ca Telephone number: (867) 975-2476

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

Smartphone Technology

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

20. I COUGH Program: Using ACS NSQIP Data to Develop a Standard of Care for Post-Operative Pneumonia Prevention

Implementation Year: Thursday, October 7, 2010 - 13:30	Location: International	Practice Website:

SNAPSHOT:

CONTACT INFORMATION:

Name: David McAneny Title: Medical Doctor Organization: Boston University Medical Centre, Section of Surgical Oncology and Endocrine Surgery, Department of Surgery Email address: david.mcaneny@bmc.org Telephone number:

21. 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

22. 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

23. Fraser Health Psychosis Treatment Optimization Program (PTOP): Community mental health support services for treatment-resistant psychosis among Schizophrenia patients

Implementation Year: Friday, October 7, 2011 - 13:00	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of providing community management and support services for schizophrenia patients with treatment-resistant psychosis (TRP). The program was launched in July 2011 in one health authority (Fraser Health) and involves a central clinic and three community service teams.

CONTACT INFORMATION:

Name: Dr. Terry Isomura Title: Program Medical Director, Mental Health and Substance Use Organization: Fraser Health Authority Email address: terry.isomura@fraserhealth.ca Telephone number: 604-587-4453

24. Comprehensive Unit-based Safety Program (CUSP) at Royal Columbian Hospital: Improving hospital workplace culture and safety

Implementation Year: Sunday, October 7, 2012 - 11:45	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of improving hospital workplace culture and safety outcomes. The practice was launched in British Columbia in one clinical setting and involved a team of surgeons, senior hospital executives, and clinical staff such as clinicians, registered nurses, nurse practitioners, and residents.

CONTACT INFORMATION:

Name: Michael Arget Title: Consultant Organization: Fraser Health, Quality Improvement Email address: Michael.arget@fraserhealth.ca Telephone number: N/A

25. The Caregiver Support Project: A Self-Directed Care Model to Improve Resiliency among Seniors' Informal Caregivers

Implementation Year: Friday, October 7, 2011 - 11:30	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of improving the resiliency of at-risk caregivers of seniors living at home. The practice was launched in Ontario and involved 321 caregivers and 80 care coordinators.

CONTACT INFORMATION:

Name: Natalie Warrick, MSc Title: Project Coordinator Organization: Alzheimer Society of Toronto Email address: nwarrick@alzheimertoronto.org Telephone number: (416) 640-6317

26. Active Choices: A Physical Activity Telephone Support Program

Implementation Year: Wednesday, February 3, 2010 - 11:00	Location: British Columbia	Practice Website: http://www.selfmanagementbc.ca/activechoicestelphonesupportprogram

SNAPSHOT:

This innovative practice addresses the issue of sedentary lifestyles in adults. A 1:1 telephone program, supporting regular aerobic exercise by participants, was launched in British Columbia in 2010. Resources include a staff coordinator and volunteer program "coaches."

CONTACT INFORMATION:

Name: Angela Sealy Title: Coordinator, Active Choices Program Organization: University of Victoria, Centre on Aging Email address: angela.activechoices@shaw.ca Telephone number: 604-522-1492 or 1-877-522-1492

27. A GP for Me: An Initiative to Match British Columbians with Family Doctors

Implementation Year: Wednesday, February 3, 2010 - 11:00	**Location: British Columbia**	**Practice Website: http://www.agpforme.ca/**

SNAPSHOT:

This innovative practice addresses the issue of strengthening the primary health care system and improving health outcomes by helping people who want a family doctor to get one. The pilot project was launched in British Columbia in three communities and involved approximately 300 family physicians.

CONTACT INFORMATION:

Name: Jonathan Agnew Title: Executive Director, Practice Support & Quality Organization: BCMA Email address: jagnew@bcma.bc.ca Telephone number: (604) 638-2833

28. VivoSpace: Using social media for chronic disease management

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

29. Community Health Centre (CHC) Collaborative Framework for Elder Abuse Detection and Intervention

Implementation Year: Friday, February 3, 2012 - 00:30	**Location: Ontario**	**Practice Website: N/a**

SNAPSHOT:

This innovative practice addresses the issue of elder abuse, which has been defined by the World Health Organization as single or repeated acts, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older person.

CONTACT INFORMATION:

Name: Jennifer Josephson Title: Seniors and Community Health Worker Organization: Brock Community Health Centre, www.brockchc.ca Email address: jjosephson@brockchc.ca Telephone number: (705) 432-3322 Information last updated on: July 4, 2013

30. The Sherbourne Health Centre Infirmary: Cancer care for homeless or underhoused populations

Implementation Year: Wednesday, March 2, 2011 - 00:45	**Location: Ontario**	**Practice Website: http://www.sherbourne.on.ca/programs/infirmary.html**

SNAPSHOT:

This innovative practice addresses the issue of housing individuals who are homeless or underhoused and who have cancer or other acute medical conditions. The practice was launched in Ontario in one clinical setting in Toronto and involves a coordinated team of the Community Care Access Centre (CCAC), oncologists, and Sherbourne Health Centre staff.

CONTACT INFORMATION:

Name: Dr. Laura Pripstein Title: Medical Director Organization: Sherbourne Health Centre Telephone number: 416-324-5064 Information last updated on: June 14, 2013

31. 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

32. All-Access Dentistry: Specialized Geriatric Dental Services

Implementation Year: Wednesday, March 2, 2011 - 00:45	**Location: Ontario**	**Practice Website: http://www.runnymededentalcentre.com/**

SNAPSHOT:

This innovative dental practice addresses the issue of enhancing access to oral care for people with limiting physical, medical, or cognitive conditions. The clinic aims to smoothly integrate dental clinic services for a spectrum of patients, including the most complex cases. The practice was launched in Ontario in January 2011 in an independently owned specialized dental clinic operating in a hospital setting.

CONTACT INFORMATION:

Name: Dr. Natalie Archer Title: Organization: Runnymede Dental Centre Email address: runnymededental@drarcher.ca Telephone number: 416-763-2000 Information last updated on: May 1 2013

33. Using Photography to Reduce Hospital Based Infections

Implementation Year: Wednesday, March 4, 2009 - 01:00	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice uses photography as a means to reduce the rate of hospital based infections. The practice was launched in British Columbia in one clinical setting and involved a team of registered nurse practitioners and hospital administrators. One practitioner is needed to capture the visual data; other administrators and practitioners can then formulate appropriate recommendations.

CONTACT INFORMATION:

Name: Patricia Marck Title: Professor and Director, Associate Dean Organization: School of Nursing, Faculty of Health and Social Development University of British Columbia Okanagan Campus Email address: patricia.marck@ubc.ca Telephone number: 250-807-8417 Information last updated on: May 31, 2013

34. Reducing Urinary Tract Infections Among Surgical Patients

Implementation Year: Monday, February 7, 2011 - 00:00	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to reduce catheter-associated urinary tract infections among surgical patients. The practice was launched in British Columbia in Peach Arch Hospital and involved four surgical staff nurses, a National Surgical Quality Improvement Program (NSQIP) consultant, a clerk, a surgical clinical reviewer, a surgery manager, and some input from staff from the emergency department, infection control, and operating room.

CONTACT INFORMATION:

Name: Susann Camus Title: NSQIP Quality Improvement Consultant Organization: Fraser Health Email address: Susann.Camus@fraserhealth.ca Telephone number: N/A

35. Young Carers Program of Hospice Toronto

Implementation Year: Thursday, February 3, 2011 - 00:15	**Location: Ontario**	**Practice Website: http://ycptoronto.weebly.com/**

SNAPSHOT:

This innovative practice aims to strengthen young carers through the integration of child/youth and adult services to work together in a way that identifies young carers and connects families to supportive services.

CONTACT INFORMATION:

Name: Larisa MacSween Title: Manager-Young Carers Program Organization: Hospice Toronto Email address: larisa.macsween@hospicetoronto.ca Telephone number: 416-364-1666 Information last updated on: April 17, 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

37. Strong and Steady Falls Prevention Program

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

38. Prevention Olympics

Implementation Year: Wednesday, February 3, 2010 - 00:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to improve the identification and delivery of preventive care to patients within targeted populations. The initiative was launched in Ontario in 2010 within the practice of an academic family health team.

CONTACT INFORMATION:

Name: Erica Battram Title: Clinical Manager Organization: The Ottawa Hospital Academic Family Health Team Email address: ebattram@toh.on.ca Telephone number: 613-798-5555 x. 17774

39. 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

40. 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

41. Health Upwardly Mobile (HUM) Inc.

Implementation Year: Friday, February 3, 2012 - 00:45	Location: Alberta	Practice Website: http://www.healthupwardlymobile.net/

SNAPSHOT:

This innovative practice aims to improve the care of mental health and addiction patients through a holistic approach that takes into account all aspects of the persons content. This approach was implemented by various health care providers across Calgary beginning in 2012.

CONTACT INFORMATION:

Name: Ms. Sue Newton Title: Vice President and Operations Director Organization: Health Upwardly Mobile (HUM) Inc. Email address:suenewton@humassociates.net

42. Shared Care Strategy for Patients with Chronic Diseases—Patients in Care, Providence Health Centre

Implementation Year: Thursday, February 4, 2010 - 00:45	Location: British Columbia	Practice Website: http://www.healthcouncilcanada.ca/tree/symposium2012/C1_CareCoordinationWorkshop_Wilson_EN.pdf

SNAPSHOT:

This innovative practice consisted of several projects all aimed at facilitating a seamless patient experience through better collaboration between health care providers. Launched in April 2010 in two health authorities in British Columbia, the core of initiatives are to strengthen relationships between family practitioners (FPs) and specialists to ensure that referrals are timelier and to avoid duplicating effort and resource utilization.

CONTACT INFORMATION:

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

43. Frontenac Community Mental Health and Addiction Services and Providence Care - System Collaboration: Transitioning Clients from In-Patient to Community

Implementation Year: Tuesday, February 1, 2011 - 00:30	Location: Ontario	Practice Website: http://www.pccchealth.org/cms/sitem.cfm/our_sites/mental_health_services/

SNAPSHOT:

This innovative practice targets long stay, mental health patients returning to their communities. Launched at the Providence Care Hospital in Ontario in 2011, the transition project was designed to encourage joint planning and system redevelopment with the client at the centre of all activities. The goal of this transition project is to create a smooth transfer and seamless service for clients returning to the community from hospital, and to ensure excellent integrated services.

CONTACT INFORMATION:

Name: Alan Mathany Title: Director of Systems Development Organization: Frontenac Community Mental Health and Addiction Services, and Providence Care-Mental Health Services Email address: amathany@fcmhs.ca Telephone number: 613-544-1356, x 4213

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

45. Diabetes Clinical Indicator Database

Implementation Year: Thursday, February 3, 2011 - 01:00	Location: Ontario	Practice Website: http://www.thehealthline.ca/displayservice.aspx?id=15525

SNAPSHOT:

This innovative practice facilitates translating diabetes clinical guidelines into practice. While health care providers have an excellent awareness of the guideline targets and recognize the need for action, the move to more aggressive treatment is lagging. The South West Diabetes Regional Coordination Centre (RCC) responded to identified needs by supporting the development and implementation of an application to assist in the tracking and use of quality measures.

CONTACT INFORMATION:

Name: Catherine Statton Title: Regional Administrator, Regional Coordination Centre Organization: South West Community Care Access Centre Email address: catherine.statton@sw.ccac-ont.ca Telephone number: 519-374-8001

46. Alberta Healthy Living Program

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

SNAPSHOT:

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

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47. First Nations Telehealth Manitoba

Implementation Year: Thursday, February 3, 2011 - 00:15	**Location: Manitoba**	**Practice Website: http://www.mbtelehealth.ca/wnArchive2011.html**

SNAPSHOT:

This innovative practice addresses the needs of populations that live in isolated communityies with limited or no road access, away from physician services. Launched in Manitoba in 2011, telehealth hopes to bridge geographic and jurisdictional divides, giving these remote populations access to patient education, primary health care, and specialties.

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Eastern Health Chronic Disease Prevention and Management Emergency Department Pilot Project

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

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

Practice Description:

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

• in-home nursing assessment;

• education related to the patient's chronic disease(s), self-management skills, and medication management (including medication reconciliation);

• development of an alternate plan of care other than an ER visit for non-urgent/non-emergent issues;

• falls prevention;

• referral to or consultation with other health care providers or programs; and

• follow-up by the nurse by phone and/or home visits.

Impact:

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

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

Applicability/Transferability:

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

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

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

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

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

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

Vancouver Coastal Health Transgender Health Program: A Provincial Resource for Transgendered, Gender-Diverse and Allied Community

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice addresses the availability of information and resources for people with questions concerning transgender health issues. The practice was launched in British Columbia in one community health centre and involves a community counsellor, office administrator, and a medical director.

PRACTICE DESCRIPTION:

The Transgender Health Program (THP) is the only program in British Columbia dedicated to providing transgendered specific information services to individuals and health care providers. The THP provides support to individuals via phone, email, its website, in person, as well as in some direct-service group formats. The program also serves the community by providing health care professionals with information and consultation opportunities to help them support their clients and provide the best quality care. THP services are free, anonymous, and confidential. Individuals do not need a physician's referral, BC Care Card, or ID to access this low-barrier service.

THP staff are able to support all gender diverse people whether or not they desire medical or surgical services, and they work with children, families, youth, and adults. THP work also happens by way of community development initiatives and capacity building projects. Specifically, the THP aims to:

- help individuals in BC with a transgendered health–related question find accurate information and resources;
- create a community-based network of transgendered-friendly health and social service practitioners around BC;
- develop educational and practice resources to support allied trans* health and social service practitioners across BC;
- provide capacity building support and professional development opportunities to allied health and social service practitioners across BC; and
- provide direct services in Vancouver that foster community and healthy supports for members of the transgendered community (e.g., trans* youth drop-in, caregiver/parent support group, and adult support groups).

It is important to note that the THP does not provide transgender primary health care or assessments and is not able to offer specialized medical support. There is no one-stop resource or clinic for this type of care in BC. Rather, the THP helps individuals and allied health care providers access relevant health care information and navigate the health care system so they are able to get all of their needs met.

The THP was launched by Vancouver Coastal Health in 2003 after a year of consultation with the transgender community and with health professionals experienced in transgender health care. The THP replaces the Gender Dysphoria Program at Vancouver Hospital, which closed in 2002, and represents a shift from a hospital-based system of care to a community-based system of care.

IMPACT:

The THP was evaluated one year after implementation and a report on utilization rates was published by Vancouver Coastal Health. In its first year the THP provided support, information, referrals, and advocacy to over 450 clients, from a total of 1,634 client contacts. From its earliest development, the THP has been a collaborative partnership encouraging input from the community, key stakeholders, and allied health service providers. It continues to explore collaborations and partnerships to build service capacity and represent a voice of support and anti-oppression for the transgendered community.

As of August 2013 the THP has completed engaging with key stakeholders and is reviewing feedback that has been collected from over 300 community members and allied service providers. A new plan based on strategic priorities and best opportunities for service provision and community capacity building is currently being developed and reviewed for implementation starting in October 2013.

APPLICABILITY/TRANSFERABILITY:

The Transgender Health Program has not been adapted from another setting; rather, it replaces the Gender Dysphoria Program, which was established at Vancouver General Hospital in the early 1980s. The THP program works in close collaboration with primary care clinics and other services that are accessed by the transgendered community. As it moves forward, the THP will use communication technologies (including the web) and allied health care provider networks to make relevant information available across BC and create provider capacity-building opportunities province-wide. The THP information hub and community development model is theoretically applicable and transferable to other settings. Having the THP located in a major urban centre where there are other at need groups and related services is a marked benefit, and it is useful that the THP is connected to international networks related to transgendered health care.

The THP has a very limited budget and fewer than three full-time staff members. In order to provide service across BC it has been relevant to be strategic about how to use staff and how to create a manageable scope of service. In the past and as the program moves forward, it is imperative to build on partnerships and networks, and to access granting opportunities to expand options for the THP's programming and services.

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Information last updated on: August 23, 2013

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

Personal Communications:

Jedrzejowski, H. (review and feedback, August 20, 2013). [Transgender Health Program].

Publications:

Goldberg, J.M. (2004, July). *First year report: Transgender health program*. Retrieved from http://transhealth.vch.ca/resources/library/thpdocs/0407yearend.pdf

Other:

Vancouver Coastal Health. (n.d.). *Transgender health program*. [Brochure]. Retrieved from http://www.vch.ca/media/Transgender%20Health%20program%20Pamphlet.pdf

External Source: www.transhealth.vch.ca

Taima Tuberculosis (TB): Increasing Awareness and Screening of Tuberculosis in Nunavut

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

SNAPSHOT:

This innovative practice addresses the disproportionately high incidence rate of tuberculosis (TB) in Nunavut. The practice was launched in Iqaluit, Nunavut, and involved a public health team of registered nurses and Inuktitut-speaking community TB champions.

PRACTICE DESCRIPTION:

The incidence of active tuberculosis (TB) in Nunavut is disproportionately high. According to the Public Health Agency of Canada, Nunavut's TB rate in 2010 was 304 per 100,000, compared to 4.6 per 100,000 in the rest of Canada. Taima TB—Inuktitut for "Stop TB"—is an innovative public health campaign that aims to reduce the rate of TB infection by targeting residential areas at high risk for TB with door-to-door education, screening, and treatment. The program specifically targets latent TB infections (LTBI), a method that can significantly diminish the number of people who go on to have active TB disease. Taima TB, whose motto is "You may not know you have TB—Get tested, get treated before you get sick," was piloted in Nunavut's capital, Iqaluit, with a view to enhance the territory's existing preventive efforts in the fight against TB.

The unique features of the Taima TB project include:

- an approach specifically tailored to Inuit culture;
- an awareness campaign using social media strategies, including web-based material, YouTube videos, and a Facebook page;
- introducing and determining the feasibility of a new diagnostic test for LTBI;
- a proactive approach to screening and treatment that targets specific high-risk areas; and
- strong community engagement and active participation at every level and stage of the project.

The project was delivered in two phases. Phase I involved raising community-wide awareness of TB, and included a focus group, a local media campaign, a community feast, and a YouTube challenge. Phase II was a six-month door-to-door education, screening, and treatment campaign targeting households in residential areas at high risk for TB. The project was funded by the Public Health Agency of Canada as part of the National Lung Health Framework Phase II, and the Government of Nunavut.

IMPACT:

Qualitative and quantitative data were collected throughout the pilot project and results were released in a 2012 Progress Report. During Phase I, the general awareness campaign, there was an increase in passive LTBI screening, which refers to individuals who present to public health clinics as walk-ins to get tested for TB. The number of walk-ins increased from an average of 25 per month (over the four years prior to Taima TB) to an average of 50 people per month during the general awareness campaign.

During Phase II, a TB champion and a TB nurse delivered TB education to 444 people in their home. One third were not eligible for screening; the remaining two thirds were screened for LTBI. Approximately one third of those tested positive and were recommended LTBI treatment. Treatment results will be published shortly. In addition to these performance measures, a new blood test for the diagnosis of LTBI was piloted and shown to be feasible in Iqaluit.

Taima TB represents a new approach in the fight against TB, one focused on community-based education and precisely targeted screening and treatment campaigns. It will take further application of a variety of TB control strategies to control TB in Nunavut in the future. The manner in which successful features of Taima TB can be integrated into the local TB program

requires further work and discussion with territorial TB policy-makers.

APPLICABILITY/TRANSFERABILITY:

Taima TB's approach to reducing TB in Nunavut has not been adapted from another jurisdiction. Based on the pilot's success, in 2012 the Taima TB group received a grant from the Canadian Institute of Health Research (CIHR) to facilitate knowledge translation and expand the Taima TB awareness campaign to five other communities in Nunavut that have increased rates of TB. The research team is using the tools developed under the Taima TB project to further empower community members with TB knowledge in both Inuktitut and English. Currently they are engaging with local public health teams to focus TB awareness activities on high school students. Further discussion of the results of Taima TB, including challenges and lessons learned, will be published shortly. Please refer to the Taima TB website for updates.

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

Personal Communications:

Van Dyk, D. (feedback and review). [Taima TB].

Publications:

Alvarez, G.G. (2012, March 12). *Taima TB progress report*. Retrieved from http://taimatb.tunngavik.com/files/2012/04/Bilingual-PROGRESS-REPORT-TAIMA-TB-Final-Version-March-12-2012.pdf

Other:

Canadian Institutes of Health Research. (2012, March 22). *Fact sheet—Harper government helps tackle tuberculosis in Nunavut*. Retrieved from http://www.cihr-irsc.gc.ca/e/45087.html

Canadian Nurses Association. (2012, June). Bringing the community together to beat TB in Nunavut. *Canadian Nurse*. Retrieved from http://www.canadian-nurse.com/index.php?option=com_content&view=article&id=732%3Abringing-the-community-together-to-beat-tb-in-nunavut&catid=4%3Aperspectives&Itemid=39&lang=en

External Source: http://taimatb.tunngavik.com/

Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS): Applying a Treatment-as-Prevention Model of Care

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT:

This innovative practice addresses the health of people living with HIV/AIDS and reduces the risk of transmission of the disease. The practice was launched in British Columbia and involved 16 interprofessional health care teams at primary care clinics in Vancouver's downtown east side.

PRACTICE DESCRIPTION:

Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) began as a pilot project to screen more people for HIV, bring eligible individuals into treatment programs, and support people with HIV/AIDS to stay on treatment. The pilot specifically targeted hard-to-reach individuals in Vancouver's inner city area (downtown east side) and in Prince George. These sites were chosen because their rates of HIV-related morbidity, mortality, and transmission were disproportionately high relative to the rest of BC.

Access to a treatment for HIV infection—highly active antiretroviral therapy (HAART)—is suboptimal in BC, despite research indicating that it improves clinical outcomes, reduces transmission risk, and improves life expectancy among people living with HIV/AIDS. The STOP HIV/AIDS pilot was intended to test the treatment as prevention strategy: if more people living with HIV in a community are on effective anti-HIV treatment, the community viral load will be lowered, resulting in fewer new HIV infections.

The pilot project was funded with $48 million over four years with funding disbursed to Northern Health (NH), Vancouver Coastal Health (VCH), the BC Centre for Excellence in HIV/AIDS (BC-CfE), Provincial Health Services Authority (inclusive of the BC CDC and BC Women's Hospital), and Providence Health Care (PHC). The pilot phase concluded in 2013 and the program is now being implemented province-wide.

The specific goals of STOP HIV/AIDS are to:

- ensure timely access and retention to high quality and safe HIV/AIDS care and treatment;
- reduce the number of new HIV/AIDS diagnoses;
- reduce the impact of HIV/AIDS through effective screening and early detection;
- improve the patient experience in every step of the HIV/AIDS continuum; and
- demonstrate system and cost optimization.

STOP is made up of numerous interconnected and discrete community-based, clinic-based, and policy-focused programs. Multiple stakeholders are involved and collaborate to run these programs, including community organizations, health care professionals, Aboriginal organizations, and individuals living with HIV.

IMPACT:

Provincial-level monitoring and evaluation is ongoing by the BC-CfE, while Vancouver STOP partners VCH and PHC report on results at the population level in the Vancouver Health Service Delivery Area (HSDA). Results from the Vancouver HSDA during the fourth quarter of 2012 indicate that compared to the average since STOP,

- HIV lab testing volumes increased 24%.

- The proportion of patients prescribed anti-retroviral treatment increased significantly.
- The mean community viral load of all known HIV-positive individuals decreased significantly.

In Prince George, HIV testing at the Central Interior Native Health Society increased by almost 200%. The percentage of clients on anti-retroviral medication increased from 41% to 78%.

An economic evaluation of the net benefit of HAART in BC was published in *AIDS*, the official journal of the International Aids Society. The study found that expanding HAART coverage from 50% to 75% of clinically eligible British Columbians could deliver a net benefit of up to $900 million over 30 years by preventing new infections and averting future treatment costs. The province has committed $19.9 million annually to expand STOP across BC.

APPLICABILITY/TRANSFERABILITY:

Within the STOP pilot, a structured learning collaborative was launched by the BC-CfE using the Institute for Healthcare Improvement's Breakthrough Series collaborative methodology. The collaborative was launched in December 2010, and open to any health authority willing and able to support teams to participate. Seventeen sites around BC were engaged through this collaborative. Every health authority (inclusive of funded and unfunded regions) that participated in the collaborative had positive gains in a number of quality indicators. The collaborative transitioned to the HIV Quality Improvement Network in January 2012 to focus on sustainability, and work is under way to launch a second-phase collaborative.

The STOP pilot ended in March 2013, at which point a provincial expansion to all health authorities began. In June 2013, Northern Health was recognized as a Gold Apple Winner in the category of collaborative solutions at the Excellence in BC Health Care Awards for their role in involving collaborative partners in implementing the STOP HIV/AIDS awareness campaign during the pilot phase. Based on the success of the treatment as prevention model of care, similar projects have been launched in Washington, D.C., New York City, and San Francisco, although in isolation from the work being done in BC. Outside of North America, China has adopted a similar type of program to control the spread of HIV.

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Information last updated on: August 8, 2013

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

Publications:

Chu, T., Demlow, E., Gustafson, R., & Sandhu, J. (2013). *STOP HIV/AIDS quarterly monitoring report: 1 October through 31 December, 2012*. Retrieved from http://www.vch.ca/media/Q4_STOP_HIV_AIDS_Quarterly_Monitoring_Report.pdf

Gilbert, M. & Heath, K. (2012). *STOP HIV/AIDS pilot project quarterly indicators report: 1 April through 30 June 2012*.

Johnston, K.M., Levy, A.R., Lima, V.D., Hogg, R.S., Tyndall, M.W., Gustafson, P., … Montaner, J.S. (2010). Expanding access to HAART: A cost-effective approach for treating and preventing HIV. *AIDS, 24*(12), 1929–1935. Retrieved from http://journals.lww.com/aidsonline/Fulltext/2010/07310/Expanding_access_to_HAART__a_cost_effective.15.aspx#

Other:

BC-CfE. (2010, November). *Expanded HIV treatment will cut costs, prevent new infections: BC study*. Retrieved from http://www.cfenet.ubc.ca/news/in-the-news/expanded-hiv-treatment-will-cut-costs-prevent-infections-bc-study

Johnston, C. (2012). *The STOP HIV/AIDS project: Treatment as prevention in the real world*. Retrieved from

http://www.catie.ca/pif/spring-2012/stop-hivaids-project-treatment-prevention-real-world

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

SkinSafe: A High School–Based Educational Program to Reduce Skin Cancer Prevalence Among Teens and Young Adults

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT:

This innovative practice addresses the increasing prevalence of skin cancer among teens and young adults. The practice was launched in high schools across British Columbia and involves medical doctors, medical students, and undergraduate volunteers.

PRACTICE DESCRIPTION:

Skin cancer is the most common form of cancer in Canada. Skin cancers are largely preventable, yet they are becoming more prevalent among teens and young adults. In 2011, a province-wide skin health education campaign, SkinSafe, was launched through the Department of Dermatology at the University of British Columbia. It is estimated that up to 50% of a person's lifetime sun exposure occurs before 18 to 21 years of age. SkinSafe focuses on ultraviolet radiation exposure among teens and young adults because this is the most significant modifiable risk factor contributing to the development of skin cancer.

SkinSafe is innovative in its presentation style, which differs from traditional public educational approaches used to curb skin cancer incidence among young adults. The program is delivered through interactive, personalized classroom presentations, designed by medical students under the guidance of faculty in the Department of Dermatology, and delivered by undergraduate students. The program, which is run solely by volunteers, targets the high school population with student-to-student engagement on topics such as skin physiology; skin damage, wrinkling, and burning; skin cancer pathogenesis and appearance; skin self-examination; tanning bed dangers; and prevention strategies. SkinSafe has been implemented in nearly 100 high schools across British Columbia.

IMPACT:

Some 4,622 high school students across British Columbia participated in the SkinSafe presentations during the pilot phase. Researchers documented each participant's baseline knowledge, attitudes, and behaviours relating to skin cancer and UV protection. One year after attending the education series, researchers surveyed the long-term impact on participants' skin health knowledge and practices. This evaluation was published in 2013 in the *Journal of the American Academy of Dermatology*.

Participants' average skin cancer knowledge score—an assessment of their level of understanding of skin cancer development, detection, and prevention—was significantly increased compared to baseline (78.1% vs. 60.6%). The biggest behavioural changes were noted in the favouring of sunless tanning products over tanning beds, as well as the percentage of students who had conducted a skin self-examination in the past month. The percentage of students who understood SPF values and the need for dual UVA/UVB protection in sunscreens was also significantly improved, as was the proportion who applied sunscreen to frequently overlooked areas of the body, such as the lips and the back. Finally, the study indicated that SkinSafe participants have a decreased annual sunburn incidence compared to baseline (23.5% vs. 52.6%).

APPLICABILITY/TRANSFERABILITY:

SkinSafe is the first initiative of its kind in Canada and it is sustained yearly through the enthusiasm of undergraduate and medical student volunteers. The success of SkinSafe in British Columbia has resulted in the expansion of the initiative into other Canadian provinces, as well as a partnership with the Canadian Cancer Society to promote the concepts of skin health and sun safety in the community.

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Information last updated on: August 23, 2013

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

Personal Communications:

Haiducu, M.L. (feedback and review, August 21, 2013). [SkinSafe].

Publications:

Haiducu, M.L., & McLean, D. (2013). SkinSafe: An evaluation of the long-term impact of a province-wide sun safety and skin cancer high school education campaign. *Journal of the American Academy of Dermatology, 68*(4), AB92.

Other:

Haiducu, M.L., Sotoodian, B. and McLean, D. (2012)SkinSafe: A Report of the Early Success of a Province-wide Sun Safety and Skin Cancer Education Campaign. [Poster Presentation]. Retrieved from http://www.ubcmj.com/pdf/ubcmj_3_2s_2012.pdf

Haiducu, M.L. & McLean, D.I. (2012, March 15). *Impacting health habits through personalized education: The case of excessive UV exposure among teenagers.* [Abstract submitted to the UBC Medicine Research Forum]. Retrieved from http://www.ubcmj.com/pdf/ubcmj_3_2s_2012.pdf

External Source: http://www.skinsafe.info/

Home for Life Program: Mobilizing community volunteers to enable seniors to stay at home

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice is a volunteer-driven community program that helps connect seniors choosing to live at home with appropriate health care services and other resources. The practice was launched across South Georgian Bay, Ontario, in 2011 as a collaborative initiative among six organizations across the continuum of care.

PRACTICE DESCRIPTION:

Home for Life is a new program in South Georgian Bay (Collingwood, Blue Mountains, Wasaga Beach and Stayner), Ontario that engages volunteers to help frail seniors stay at home. The program connects seniors with the resources they need to maintain their health and wellness, relieving pressure on long-term care facilities and hospitals in the community and enabling seniors who want to stay in their homes to do so. Home for Life is a volunteer-driven program supported by a collaborative of local health professionals and community organizations.

To develop the program, six organizations from across the continuum of care came together to engage the community to help seniors stay at home (Georgian Bay Family Health Team, Collingwood General & Marine Hospital, the North Simcoe Muskoka CCAC, South Georgian Bay Community Health Centre, Community Connection Central East Ontario, and the County of Simcoe's Sunset Manor Long-Term Care facility). Over 100 patients, informal caregivers, community residents, and front-line providers were engaged to identify priorities that could make the biggest difference to seniors staying at home, given that there was no extra funding available.

This group identified, implemented, and continues to operate two volunteer-driven services that support local residents:

Buddies for Seniors

The service involves in-person visits by volunteers to help frail seniors put in place health and other services they need to stay at home. Once a senior calls the program, a Home for Life buddy sets up an appointment to visit the home for a confidential review of the hurdles being experienced. The program recognizes that finding services is often too complex and stressful for many seniors to navigate alone. By connecting seniors with appropriate services, the program helps seniors stay in their homes, avoid trips to the hospital, and minimize conditions in their environment that may put them at risk. These services are often health care services, but also include those related to transportation, home maintenance, and socialization. Volunteers may also offer friendly visits or assist with household chores.

Technology Training

This program helps isolated seniors learn to use technology to enable them to stay in contact with family, friends, and others in their support network. Technology trainers teach seniors how to use computers, email, Skype, and the Internet.

Program funding was provided by the North Simcoe Muskoka LHIN for December 2012–2013. This supports two full-time positions (program manager and volunteer coordinator) and a part-time administrative assistant.

IMPACT:

Formal evaluation processes are currently being put in place, although there is much anecdotal evidence that this program is having a positive impact. For example:

- Seniors previously lacking help and assistance are being identified and supported.
- Seniors who are not yet in crisis situations are getting appropriate services to proactively maintain their health.

- Both services address loneliness and isolation in community-dwelling seniors. This improves physical and mental functioning, and reduces the use of health care workers for social contact.
- Many of the volunteers are themselves seniors and volunteer to keep active and engaged in their community. The program has also begun outreach to youth volunteers in the community.

The program is believed to have value-add for both seniors who are able to pay for services and those who are not. Those who can pay are quickly connected with the right service, while those who cannot receive free volunteer support. This includes myriad activities such as free home safety assessments, installation of safety devices, grocery shopping, yard work, and small home repairs. Both experiences will be evaluated.

Although a formal savings analysis has not been conducted yet, South Georgian Bay anticipates that as the program evolves it will save the health and long-term care systems up to $1 million annually, and continue to generate additional savings as it expands.

APPLICABILITY/TRANSFERABILITY:

While Home for Life currently serves only four communities in South Georgian Bay, speaking engagements, the program's website, and the program's Facebook page are bringing in more calls from surrounding areas from Barrie to Owen Sound. The program is theoretically applicable to other communities and its positive results are likely to be replicated there. The program has also received interest from other organizations—several community health centres are currently investigating and/or implementing all or part of this program.

The Home for Life process is theoretically applicable to both urban and rural communities. Urban applications may choose to use pre-existing sub-communities such as ethnic communities, religious communities, and neighbourhoods. The volunteer-driven community care model can also be adapted for use with other populations, such as vulnerable youth or those facing mental health and addiction issues.

Considerations and suggestions for implementing this program:

- Home for Life has an easy-to-replicate business model and is volunteer-driven.
- An important challenge is reaching out to and educating doctors, local agencies, seniors, and others, which is done through speaking engagements and advertisements.
- Another major challenge is that most seniors who need help cannot afford available services and waiting lists for free services are extensive. In adopting the program, it is important to attract volunteers who enjoy helping seniors and are willing to carry out these services for free.
- Retaining staff in key positions helps to ensure stability of the program and support for volunteers. Volunteer training should be simple, meaningful, and flexible.
- Be prepared for volunteer turnover and changes in seasonal availability. Be welcoming to a range of volunteers—Home for Life started primarily with senior volunteers but quickly shifted to a younger demographic to provide opportunities for community youth.
- Celebrate successes and work hard on building partnerships and promoting the program through all forms of media, community or religious groups, organizations, and websites.

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Information last updated on: July 24, 2013

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

Personal Communications:

Henriques, A. (review and feedback, July 2013).

Other:

Henriques, A. Abstract submission to the Health Council of Canada's National Symposium on Integrated Care (2012).

External Source: http://www.homeforlifesgb.com/

Saskatchewan First Nations Aboriginal Diabetes Initiative Action Plan

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

SNAPSHOT: This innovative practice addresses the need to reduce the incidence and effects of type 2 diabetes in First Nations people. The practice was launched in all 78 First Nations in Saskatchewan, involving representatives of these communities and of Health Canada.

PRACTICE DESCRIPTION:

The Saskatchewan First Nations Aboriginal Diabetes Initiative (ADI) Action Plan provides a strategy for diabetes care and management. The goals of the plan are to reduce the incidence and effects of type 2 diabetes in First Nations people and, ultimately, to improve glycemic control and quality of life for people with diabetes. The plan targets seniors and other community members in Saskatchewan First Nations and provides strategies, information, and tools that will allow people with diabetes to manage their health and wellness more effectively.

Initiatives to address the impacts of elevated rates of type 2 diabetes in the First Nations population typically focus on physical activity and nutrition. The Saskatchewan First Nations ADI Action Plan calls for a substantial paradigm shift that moves away from treating sickness (an acute care model) to managing wellness (a chronic care model), and that engages Health Canada in health promotion rather than just the provision of funding. The plan was developed in consultation with First Nations people and draws on the Discovery Learning Model, a model of care developed in Arizona. First Nations communities host three-day in-community training sessions to prepare health care professionals and community health workers to become managers of diabetes. The training transfers knowledge and skills to participants in areas such as diabetes testing and motivational interviewing techniques that focus on patients' needs. The training is not targeted for the general public butrather, trains health workers (a significant proportion of whom are people with diabetes) to deliver education and care on reserve.

The plan meets the distinct needs of First Nations seniors by building knowledge about and understanding of diabetes at a community level, supporting self-management at an individual level, and providing a strength-based model for diabetes care and management. The plan has been developed and implemented in partnership with Saskatchewan First Nations, with guidance and direction from Elders. The ADI Action Plan is not likely to become a permanent program, but it has the potential to generate lasting change. To date, 500 participants representing First Nations and Health Regions throughout the province have completed the training.

The plan is supported by funding from the federal Aboriginal Diabetes Initiative.

IMPACT:

This innovative practice has been implemented since March 2009 and does not have a completed evaluation at this time. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. An informal measure of the plan's success may be the level of uptake in the three-day training sessions, each of which has been overbooked. There have also been reports of changes in the behaviour of providers and health care workers who have participated in the training.

The practice is expected to generate savings both over the short term (for example, improved self-care and management by people with diabetes should generate reductions in hospital visits) and the long term (improved self-care and management by people with diabetes should reduce risks and the incidence of diseases associated with diabetes).

APPLICABILITY/TRANSFERABILITY:

The Saskatchewan First Nations ADI Action Plan incorporates the Discovery Learning Model developed in Arizona, which was modified in collaboration with First Nations communities in Saskatchewan to meet their distinct needs. The practice informant

was unaware whether The First Nations ADI Action Plan had been used as a model for developing similar initiatives, although programs throughout Canada, as well as programs in the United States, have reached out to learn more about the Action Plan. Lessons learned that might affect the applicability or transferability of the program include the importance of looking closely at the context in which you might apply the model, ensuring that you understand it well, and designing a system or plan that fits that context and leads towards the outcomes you are seeking.

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Personal Communications:

MacDonald, B. (interview and feedback, July 15, 2013). [First Nations and Inuit Health, SK Region].

Other:

MacDonald, B., Engel, K., Climenhaga, D., Compton, K., Quewezance, S., & Langley, S. (2013). *Diabetes care and management in Saskatchewan First Nations: A province-wide approach*. [Presentation Notes]. Retrieved from http://prezi.com/f0fc6g2fi3w3/mho-presentation/

Youth caring for elders and preventing elder abuse–Carcross /Tagish First Nation Health and Wellness Department

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

SNAPSHOT: This innovative practice addresses the need to build family, community, and provider capacity to care for elders and enable them to stay safely and longer in their homes. Implemented in 2011, a remote Yukon community took a strategic approach to making youth more responsible, reducing elder abuse, and strengthening the home care program.

PRACTICE DESCRIPTION:

The main concern that needed to be addressed was the need to build family and community capacity to care for elders in order to more effectively meet elders' needs and relieve some of the workload burden on the home care program. There was a need to reach out to families, support them in taking care of their elders, and address elder abuse.

To break the generational cycle of youth dependence on social assistance and to reduce drug and alcohol abuse, a transitional employment program named the Outreach Program was implemented. Because of the need to build capacity in caring for elders, it was decided that elders' needs would be put first when identifying work opportunities for youth. Youth were assigned an outreach worker and together they developed a case plan to identify goals and aspirations for education and experience. Some examples of the work that the youth do for elders includes collecting, cutting, and stacking wood for elders to heat their homes; making sure the snow is removed from their driveway; maintaining their yards; checking the house for safety issues; doing repairs; putting up handrails; and helping elders with tanning hides. In exchange, the youth were paid well ($15 an hour) and received a job reference to help get them on track. They learned about responsibility and that *social assistance* is temporary assistance for those in difficult situations, not a way of life.

Different strategies were put into place to address elder abuse. The main type of this abuse was financial abuse by an adult, child, or grandchild. Individuals were spending their temporary financial assistance on alcohol and drugs, and then expecting the elder to feed and shelter them. These individuals were informed that the government and community were aware of the abuse and would not tolerate it. Recipients of temporary financial assistance are now given purchase orders (POs) in the name of an outreach worker, to prevent recipients who suffer from addiction from selling their POs. If necessary, the purchase order is divided in half, so only half of the amount can be spent in the first two weeks of the month, leaving the other half available for the last two weeks. Otherwise, if all of the food was purchased at once, the individual could sell the food for cash.

The Outreach Program was also strengthened through multiple initiatives. Staff worked collaboratively with families to help them better understand and fulfill their responsibilities to elders, and they visited elders in their homes to hear about their concerns and needs. Vehicles were purchased to take elders to their medical appointments and outreach workers accompanied them as advocates, to make sure the elders understood correctly the information they were given. Other traditional activities such as berry picking were also organized. These initiatives are supported by the Carcross/Tagish First Nation government. This community is unique in its approach to try out-of-the-box solutions to address multiple and complex issues in the community.

IMPACT:

This innovative practice does not have a formal evaluation completed at this time. Personal accounts and discussions with staff, family, and elders indicated that the Transitional Employment Program has made a big difference in helping elders remain in their homes. To reduce social isolation, weekly community teas were organized, which brought together First Nations and non–Aboriginal elders; people who've been neighbours for years but never socialized are now becoming friends.The elders are also happier and less frustrated because they can get out in winter, now that their driveways are cleared sooner. They have wood to heat their homes and their homes are safer. The youth are making progress in terms of becoming responsible, and they are able to apply for jobs outside of their community because they have a reference. Monthly interagency meetings are now

bringing together the Health and Wellness Department with other agencies to improve collaboration, and the capacity of home care workers has been strengthened through training activities and improved pay to support retention.

Although it's a relatively new strategy, the purchase orders appear to be working. The outreach workers see that there is food in the homes and the elders are happier. Overall, families are encouraged and supported to take more responsibility for elders' care. Family members have expressed thanks; they appreciate the shared responsibility and feel less stress because they know there is a team of people involved in the well-being of their elders. This gives them the motivation to be involved because it's not so overwhelming.

APPLICABILITY/TRANSFERABILITY:

This innovative practice was adapted from a best practice model from the United States. The Chief, Carcross/Tigish First Nations staff, and a Yukon Government Education representative visited Chelsea Massachusetts to learn about the model and how it enables youth to return to school or work. Factors that would impact success and applicability/transferability are that self-government allows for flexibility to meet community-specific needs. Key components for success include self-government; strong support from the First Nations government for elders, outreach workers, and home care workers; universal agreement that elders' needs are a priority; teamwork; and lots of communication.

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Personal Communications:

Shepherd, R. (interview and feedback, August 14, 2013). [Carcross/Tagish First Nation].

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

Sip Smart! BC™

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: Launched in 2009, this innovative practice promotes awareness of the negative health consequences of drinking sugary drinks and promotes the consumption of healthier beverage choices. Program development required a project office, content developers, school liaisons, and trainers..

PRACTICE DESCRIPTION:

Sip Smart! BC™ was initiated in 2007 through the BC Healthy Living Alliance, the BC Pediatric Society and the Heart and Stroke Foundation of BC & Yukon. It was launched in 2009 with funding from the BC government. The goal of the program is to increase children's awareness about the negative health effects from drinking sugar-sweetened beverages. The program was developed over a two-year period and piloted with over 230 classes of students in grades 4, 5, and 6. Development required a project manager, content developers, school liaisons, and training staff. The program involves school-based lessons and activities to educate children about sugary drinks and making healthy drink choices. The Sip Smart! BC™ *Teacher Resource Guide* (TRG) contains five interactive lessons and a series of assessment tools. The content is aligned with the BC Ministry of Education's prescribed learning outcomes (i.e. curriculum standards) for grades 4 to 6. Nine key messages are repeated multiple times throughout the program, to support learning and retention. The Heart and Stroke Foundation (through the HeartSmart Kids™ program) and Action Schools! BC distributed initial printed materials until inventories were depleted, and TRG materials are available for download by individual BC teachers. Other online resources include a booklet for families (available in English, French, Punjabi, and Chinese), a presentation for parent advisory groups, and a one-hour introductory session for teachers or school administrators. Currently, the BC Pediatric Society and Heart and Stroke Foundation cooperate in overseeing the program operations.

This practice is considered to be innovative for its integration into a larger provincial strategy (Healthy Schools BC), which uses a comprehensive school health approach. As well, it is easy for teachers to use, and it engages students with its fun and educational activities.

IMPACT:

In 2009, the Sip Smart! BC™ pilot was part of a formal outcome evaluation. A cluster control study was conducted to determine the impact of the program on participants' knowledge of sugary drinks and healthy drink choices, and on their beverage consumption. According to the results, which were based on self-reported data, students had increased knowledge, decreased preferences for sugary drinks, and reduced sugar intake from beverages. Findings of the six-month follow-up confirmed the program decision to increase the number of lessons from three to five while maintaining program content, to reinforce key educational messages for a longer time period.

APPLICABILITY/TRANSFERABILITY:

Sip Smart!™ is being implemented elsewhere in Canada, including Quebec, Northwest Territories, New Brunswick, and Ontario. In 2010, Quebec started to contextualize and pilot the program. During phase 1, over 600 teachers and health professionals received training and were given the teaching materials. The Quebec pilot project and program evaluation led to adaptations according to the Quebec Education Program and the Healthy Schools approach. As well, some activities and education tools were modified for the Quebec context. Program materials were produced in English and in French. Funding to support adaptation and spread of the program to Quebec and Northwest Territories was provided by the Public Health Agency of Canada and the Canadian Partnership Against Cancer's Coalitions Linking Action and Science for Prevention (CLASP) called the Collaborative Action on Childhood Obesity.

Other "Lessons learned" include:

(British Columbia)

- Teachers were attracted to the Sip Smart!™ program because the lessons were free and connected to the provincial curriculum.
- Key success factors included extensive stakeholder consultations, implementing formative evaluation findings throughout the development process, conducting ongoing marketing activities, and engaging passionate champions.
- Since the depletion of grant funds, the Heart and Stroke Foundation continues to produce and distribute copies of the booklet for families to BC students and families, and the BC Ministry of Health reprinted materials distributed by Action Schools! BC.

(Quebec)

- Differing sugar content of certain drinks (such as slushies) led to adaptions of classroom materials.
- For efficiency, an online training module is being developed as an alternative to face-to-face training.
- Northern Aboriginal communities in Quebec indicated they are aligning the Sip Smart!™ program with the “Drop the Pop” campaign.

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Zellinsky, P. (interview, July 31, 2013; review August 20, 2013). [BC Pediatric Society].

Dumoulin, E. (interview, July 2, 2013; review, August 1 and 20, 2013). [Heart and Stroke Foundation].

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External Source: www.bcpeds.ca/sipsmart

British Columbia Women's Hospital and Health Centre's Power to Push Campaign: Know Your Options, Take Control

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice lowers Cesarean birth rates in British Columbia and educates expecting mothers on safer birthing options. The practice was launched in British Columbia at the BC Women's Hospital and involved a team of obstetricians, gynecologists, midwives, family doctors, researchers, nurses, and other health care professionals.

PRACTICE DESCRIPTION:

While Caesarean births are safe, research has shown that they can expose women and their babies to health risks they do not face with normal vaginal birth. In British Columbia, Cesarean birth rates were at an all-time high of 30% in 2010. The BC Women's Hospital (BCWH) Cesarean Task Force (CTF) launched the Power to Push (PTP) Campaign and Best Birth Clinic in September 2010, to lower the Cesarean birth rate at BCWH and to provide women and their families throughout the province with information about their childbirth options.

The campaign is a public education initiative that integrates medical consultation, an interactive website, and social media platforms to lower the overall Cesarean birth rate at BCWH in Vancouver. BCWH offers women consultations with obstetricians and gynecologists at their Best Birth Clinic. Consultations are tailored to the woman's prior births, health condition, and preferences in order to properly advise for the safest birth possible. Likewise, educational materials such as labour support handouts are available in multiple languages at the clinic and on the Power to Push Campaign website. For maternity care providers, protocols are available for early, active, and second-stage labour management. Lastly, the campaign has a very active online presence through social media sites, blogs, and its website, where women are encouraged to share their birthing stories, interact with specialists, and help promote safer birthing practices throughout their province.

IMPACT:

The PTP Campaign has been formally evaluated in the CTF's report *BCWH Cesarean Task Force: Initiatives and Achievements—The First Two Years: 2010–2012*. The evaluation outlines the resources created to promote the campaign, such as blogs and pamphlets, as well as the effectiveness of these resources. The social media campaign, for example, proved to be highly successful. Currently, the campaign has more than 1,000 Facebook followers and 1,300 Twitter followers, making PTP one of the most-followed birth-related social networking accounts. These sites have been effective in sharing educational materials and stories.

By September 2012, the Best Birth Clinic had more than 400 appointments, with the majority (57%) of referrals being made by midwives, mostly in Vancouver and Lower Midland (33%). A few women self-referred to the clinic almost exclusively to discuss the option of vaginal birth after having a Cesarean section.

The effect of the campaign on the Cesarean birth rate has not been published; however, some studies have been initiated based on the campaign. For example, the CTF conducted a randomized controlled trial examining the effect of doulas (labour assistants) on intrapartum outcome for vaginal birth after Cesarean section. After counselling, 65% of women chose to attempt vaginal birth after Cesarean section, and 60% of those women were successful.

APPLICABILITY/TRANSFERABILITY:

The PTP Campaign has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. A team of consultants (obstetricians, gynecologists, midwives, and nurses) is required to run the clinic and provide evidence-based educational materials. Knowledge in social networking and

online promotions/marketing is also essential to successfully facilitate the public education component of the campaign.

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BC Women's Hospital. (n.d.). *BC Women's Hospital Cesarean task force: Initiatives and achievements—The first two years: 2010–2012*. Retrieved from http://issuu.com/powertopush/docs/bcwh_ctf_report_final_2

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

Health Equity Impact Assessment (HEIA) Tool

LOCATION:	**Ontario**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative tool supports organizations (within and outside of the health sector whose work can affect health outcomes) to plan for health equity in policy development and program delivery. The Health Equity Impact Assessment (HEIA) tool was launched publicly by the Ontario Ministry of Health and Long-Term Care in 2011.

PRACTICE DESCRIPTION:

The HEIA tool enables policy-makers and health and community service planners to assess initiatives and investments to ensure that potential unintended (population) health impacts are considered and addressed in a structured and formalized process. The long-term goal of impact assessment is to reduce health disparities, particularly for vulnerable and/or marginalized groups. HEIA is intended to be used by a wide range of stakeholders, such as the Ontario Ministry of Health and Long-Term Care (MOHLTC), local health integration networks, public health units, and health service providers.

The HEIA tool consists of a workbook, an assessment template, and the complementary resources described below, all of which are available in both English and French.

Content includes:

- a description of HEIA, who should use it, and how and when it should be used;
- an explanation of the five steps of conducting an HEIA: scoping, potential impacts (identified), mitigation (recommendations), monitoring (impact of mitigation strategies), and dissemination (results and recommendations); and
- examples and prompts to illustrate how to complete each section of the template.

Complementary resources to support the use of the tool include:

- the *French Language Services Supplement*, which outlines requirements for organizations whose work falls under the French Language Service Act;
- The *Public Health Unit Supplement*, which describes considerations for units' use of the tool, including how it relates to their work to meet Ontario's Public Health Standards requirements; and
- resources on the HEIA website.

As well, a collaboration between the MOHLTC and the Centre for Addiction and Mental Health has resulted in:

- the Centre for Addiction and Mental Health developed a self-paced online training module on how to use the tool (available at [: HEIA Online Training Module]); and
- an online community of interest for HEIA, which enables interested users to share their knowledge, evidence, results, and questions [HEIA Community of Interest].

The practice is innovative because:

1) It is flexible. A single template and a common language on health equity can be used by users across multiple sectors.

2) The template's simplicity and complementary training materials make the HEIA less intimidating than it might be for users without a background in this area and methodology.

3) The HEIA allows users to consider the needs of and impacts on intersecting sub-populations (e.g., a francophone who is a senior citizen), rather than focusing on only one dimension of the determinants of health.

IMPACT: The HEIA tool is undergoing longer-term evaluation. The initial process and impact evaluations, as well as feedback and testimonials from current and past users, have identified the benefits of implementing use of the tool and the tool's potential for positive effects on program/policy decisions as they relate to health equity. Unanticipated additional benefits found when completing the HEIA are the tool's ability to create a "corporate memory" on why decisions and investments were made, and its role as a catalyst for working with different colleagues and organizations to discover solutions that would not have been considered without the HEIA.

The flexibility of the tool allows organizations to incorporate its use as they see fit, and this encourages uptake. Examples of innovative use of the tool include its integration into strategic planning processes, grant funding competition evaluations, and the development of new patient/client service models.

APPLICABILITY/TRANSFERABILITY:

Impact assessment processes, particularly with a population health/social or equity impact focus, are increasingly being adopted in Canada and internationally. HEIA and similar approaches have been implemented in jurisdictions such as Australia, New Zealand, and the United Kingdom, and its use is endorsed by the World Health Organization.

There are some early "lessons learned" in the development and implementation of the HEIA tool that may assist others in implementing the HEIA tool in their own organizations:

- Champion organizations, support from sector leaders, and support from senior management assist greatly with promotion and uptake.
- It is especially important in the scoping stage to establish time and staff requirements and scope of the HEIA approach (i.e. desktop, rapid, comprehensive).
- Embedding HEIA into higher-level strategies and deliverables (such as an organization's strategic or operational plan) creates a more supportive environment for the completion and uptake of the results from HEIAs.

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Personal Communications:

HEIA project team. (interview, July 19, 2013; review, August 21, 2013). [Ontario MOHLTC].

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Men's Health Program: Engaging Men in Northern BC with Their Health

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice addresses health concerns of men living in northern BC through an interactive website. The Men's Health Program was implemented in 2011 and involved one Men's Health coordinator.

PRACTICE DESCRIPTION:

Men in the north do not live as long as those in other parts of British Columbia. Specifically, men living in the north have higher rates of cancer, suicide, occupational deaths, and chronic disease, and have lower rates of health care utilization. Men's health is important for the well-being of individuals, and because healthier men contribute to healthier families and communities. With population health in mind, BC's Northern Health Authority made men's health a focus area, and in 2011 launched the Men's Health Program.

To guide the direction of the Men's Health Program, Northern Health (NH) held focus groups with key stakeholders in seven northern communities. A common concern that emerged was a need for communication tools that address health concerns while engaging men in a straightforward, pragmatic, and fun way. To address that gap, NH developed and launched an interactive website in 2012 that they anticipate will educate and encourage men to prioritize their health and lifestyle. Key components of the Men's Health website include:

- healthy recipes;
- health quizzes;
- MANual with information about nutrition, active living, and health screenings;
- "Tales from the Man Cave" blog;
- monthly contests;
- facts and statistics around men's health; and
- stories and testimonials from northern men

In addition to the website, the Men's Health Program posts regularly on Twitter and Facebook, and holds radio campaigns to promote health screening events. These include screenings for family health history, blood sugar, blood pressure, and cholesterol checks. The program's ultimate goal is to improve the health status, quality of life, and life expectancy for men living in the north.

IMPACT:

This innovative practice was implemented in the spring of 2011, and does not have a evaluation or an assessment of the costs and savings at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice has the potential to produce positive outcomes on men's health and the broader goals and objectives of population health.

The program is seeking sustainable partnerships with community-based organizations and industry, and there have been over 70 presentations to community groups across the region. The Men's Health Program has provided health screening to over 2,000 men for blood pressure, blood sugar, and cholesterol, in addition to raising awareness on the website, TV and radio commercials, social media, and health fairs. In June 2013, the Men's Health Program was recognized as a top innovation at the Excellence in BC Health Care Awards.

APPLICABILITY/TRANSFERABILITY:

The Men's Health Program is one of the few programs in Canada strictly devoted to men's health. This practice has not been adapted from another jurisdiction or implemented elsewhere. However, it is theoretically applicable and transferable to other settings. Over the past two years, program staff have travelled to other health authorities in BC to speak about the Men's Health Program. Participants who attended these workshops and presentations have provided feedback and expressed the desire to implement similar, geographically appropriate programs dedicated to addressing the health concerns of men.

There is also interest in this program internationally. In December 2012, BC's Chief Medical Officer and the Men's Health Program Coordinator gave a presentation about the program at the International Public Health Conference in Colombo, Sri Lanka. The key challenge in developing a men's health program in other health regions—in Canada and internationally—is that it requires organizational commitment, community consultation with stakeholders, and the application of key recommendations generated through a comprehensive consultation process.

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Personal Communications:

Grant, B. (feedback and review, August 14, 2013). [Men's Health Program]

Publications:

Northern Health. (2011, September). *Community consultation on men's health: What we heard*. Retrieved from: http://men.northernhealth.ca/Portals/4/pdfs/mens-health-matters-web-nov11.pdf

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External Source: men.northernhealth.ca

MSH-CARES: Markham Stouffville Hospital CAesarean section Reduction Strategy

LOCATION:	**Ontario**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Acute Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice reduces rates of unnecessary interventions (such as Caesarean section) during labour and birth for low-risk women delivering in a hospital setting. The program and strategy were launched in 2010 in a community hospital in southern Ontario.

PRACTICE DESCRIPTION:

Unnecessary interventions such as Caesarean section (CS) during childbirth are expensive and can cause unnecessary harm to mothers and infants. The Markham Stouffville Hospital CAesarean section REduction Strategy (MSH-CARES) was developed to reduce rates of unnecessary interventions during labour and birth for low-risk women, and to thereby save associated health care costs. The strategy is comprised of a collection of individual evidence-based interventions that promote and support normal birth by influencing patient behaviour, health care provider behaviour, and institutional policies.

In April 2010, an interprofessional task force at Markham Stouffville Hospital in Ontario developed a strategy to reduce the use of CS and other interventions during low-risk labour and birth. Components of the strategy were implemented in stages from April 2010 to January 2011 and are ongoing. The strategy includes (1) a public awareness campaign to inform women about their choices during birth and the hospital's monthly CS rate; (2) an audit and feedback process to track and report on providers' individual CS, induction, and trial of labour after a previous CS rates; (3) a Birth Options group information session for patients with a history of CS (which helps inform women about all appropriate birth options before they make a final choice); and (4) a policy that stipulates that post-date inductions of labour are not to be booked prior to 41 weeks plus 3 days gestation.

High use of CS among low-risk pregnant women is a problem that is embedded in a complex social system that consists of individuals, clinical practice patterns, and unit policies. The problem of high CS proportions must therefore be addressed at different levels (patients, providers, administrators, unit policies) simultaneously. MSH-CARES is coordinated and synergistic, it targets multiple system levels, and its individual interventions are combined and sequenced within and across levels of the system.

IMPACT:

To date, MSH-CARES has been pilot tested using data available at MSH. Concurrently, a more robust analysis is taking place using data from the Better Outcomes Registry & Network Ontario (BORN) in order to capture the overall impact of MSH-CARES on rates of labour and birth interventions and maternal and newborn outcomes.

A complete evaluation of the program is being undertaken, including a:

- clinical outcomes evaluation (effect on rates of interventions during childbirth);
- process evaluation (experiences of birthing women, providers, and administrators);
- economic evaluation (versus routine care); and
- scale-up assessment (whether MSH-CARES can be adopted in other hospitals in Ontario).

Since it's implementation, the strategy has led to encouraging preliminary data related to clinical outcomes, including a reduction in the hospital's annual proportion of CS (from 29.6% in 2008 to 25% in 2012), and a greater number of vaginal birth after Caesarean (VBAC) attempts (from 15% in 2008 to 38% in 2012). The proportion of CS births in the hospital for June and July 2013 was as low as 20%.

Patient satisfaction with the Birth Options session was also high: 60% of participants were "very satisfied" with the presentation session overall, 90% were satisfied with the presenter, and 81.4% indicated that the information presented was "new to me."

An evaluation of the economic impact and cost-effectiveness of this strategy has not been completed at this time.

APPLICABILITY/TRANSFERABILITY:

During the one-year preliminary evaluation of MSH-CARES, a second hospital in Ontario, the Queensway Carleton Hospital (CQH) in Ottawa, began to implement the strategy in April 2012. An evaluation of the strategy at CQH will follow subsequently, and the positive results observed at MSH are theoretically applicable to this second setting.

The MSH-CARES strategy is theoretically applicable and transferable to other acute care hospitals across Ontario and Canada. Another eight hospitals in Ontario have expressed interest in adapting the strategy to their setting.

One challenge has been adapting the strategy in real-time to improve its uptake. While this is understandable from a clinical perspective, it creates a challenge for researchers evaluating the strategy.

One example is that the Birth Options sessions were originally designed to be promoted by providers, who would send women to the session. After attendance began to drop significantly, the administration decided on a new approach: women are now invited to the session upon registration with the hospital, which has helped increase the numbers of participants.

A second lesson is the importance of leaders. At both MSH and QCH, the chiefs of obstetrics fully believe in the strategy and promote it in their unit.

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Mindcheck.ca: A Provincial Resource for Youth with Mental Health Issues

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice connects youth to mental health resources and a community of support in order to achieve earlier detection of poor mental health. The practice was launched in British Columbia in four communities and involved representatives from several mental health organizations, educators, researchers, youth representatives, sponsors, and representatives from various community agencies.

PRACTICE DESCRIPTION:

Seventy-five percent of mental health and substance use issues begin by age 24 and often go unrecognized and untreated. In the spring of 2010, the government of British Columbia launched the project Mindcheck.ca as part of Fraser Health's Youth and Young Adult Mental Health and Substance Use Early Intervention Pilot Project in the communities of Surrey, White Rock, Delta, and Langley. Mindcheck.ca is a public awareness program focused on youth and young adults. The program increases recognition of the early symptoms—feelings, thoughts, and behaviours—that a youth or young adult may experience or that a parent, teacher, or friend may observe, of a mental health or substance use issue. Support includes education, self-help tools, website links, and assistance in connecting to local professional resources. Recommendations are reflective of results generated by easy-to-use screening tools. Families, friends, and professionals who work with young adults can also visit the site to find support.

The project has been supported by the Ministry of Children and Family Development, the Canadian Mental Health Association, Youth Net, Surrey School District, Kwantlen Polytechnic University, Douglas College, and numerous other community organizations. In the fall of 2011, the Canucks for Kids Fund pledged $50,000 to BC Mental Health and Addiction Services through the BC Children's Hospital Foundation in memory of long-time Canucks forward Rick Rypien. The Canucks involvement is currently helping to promote mindcheck.caand support the "In One Voice" video submission campaign.

IMPACT:

Progress on this initiative is found on the practice's website and in Surrey's periodic health fact sheets. To date, the awareness campaign has grown to include a larger online presence through its new component, *Speak Up,* launched in 2012. *Speak Up* includes expansion of the targeted education, a youth peer network, and a dedicated online space.

An evaluation of the website has been conducted and by engaging youth in the evaluation process, several areas of improvement have been highlighted and action plans designed. Since then, the website has been redesigned to include a more interactive and engaging home page, language changes that reflect a more youthful tone, improved functionality/access, revision of the psychosis screening tool, a newly designed Learn More section, and an improved Results and Feedback page.

The website also includes numerous personal testimonials and videos, and is supported by the Canucks through public service announcements found on the web and in local newspapers. The site has grown to become a provincial resource. However, aside from a growing presence and testimonials, the impact of the website on youth mental health statistics and indicators is not yet published.

APPLICABILITY/TRANSFERABILITY:

Mindcheck.ca has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. The website would need to be designed with a team of webmasters, social media experts, youth, psychiatrists, youth workers, and educators.

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Mind, Exercise, Nutrition … Do It ! (MEND)

LOCATION:	Alberta	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses the issue of childhood obesity. The program is delivered in communities by local agencies with trained personnel supported by Alberta Health Services. It is provided at no cost to participants and gives families a comfortable and supportive environment to interact and learn how to make healthy lifestyle choices.

PRACTICE DESCRIPTION:

The MEND initiative was launched in Alberta in 2010, as part of the Provincial Obesity Program. MEND is an innovative, multicomponent, evidence-informed, and community-based program focused on the prevention of and early intervention into childhood obesity for children aged two to 13 years and their families. The program focuses on behaviour change, physical activity, and nutrition knowledge. MEND sessions include a range of educational and fun activities, such as active play to promote physical activity, learning how to buy healthy foods via grocery store tours, healthy eating and mealtime routines, and setting goals to encourage healthy habits as a family.

The collection of MEND programs includes:

- MEND 2–4: a healthy lifestyle prevention program for children ages two to four of any weight, 10 weeks (10 sessions) long, at 90 minutes per week;

- MEND 5–7: a healthy lifestyle prevention and early intervention program for children ages five to seven years with a body mass index (BMI) over the 85th percentile, 10 weeks (10 sessions) long, at 105 minutes per week;

- MEND 7–13: an early intervention program for children ages seven to 13 years with a BMI over the 85th percentile, 10 weeks (20 sessions) long, at four hours per week; and

- MEND World: to support MEND 7–13 graduates for two years after the program, with fun online games, activities, and free magazines.

Program participants are recruited through multiple strategies including self-identified and health professional referrals.

The Alberta MEND program was grant funded from 2010 to 2013. The initiative was developed to adapt, test, and implement MEND programs across the province, including select Aboriginal communities, to address childhood obesity. Key deliverables of the three-year initiative included:

- Adapt MEND 2–4, 5–7, 7–13, and MEND World programs to the Canadian context.

  - Implement MEND 2–4, 5–7, and 7–13 programs across Alberta.
  - Adapt and pilot MEND in the First Nations community and Métis Nation of Alberta.
  - Design and conduct a process and outcome evaluation of the initiative.

During the period from 2010 to 2013, 730 participants (365 children and 365 parents/caregivers) took part in 47 MEND programs, delivered by 19 community agencies across Alberta.

IMPACT:

The results of a randomized control study of a MEND initiative in the United Kingdom (2010) showed the program had a positive impact on health outcomes, including significant reductions of BMI and waist circumference in children. It also led to increased levels of physical activity and improvements in nutrition, self-esteem, and confidence. Outcomes were sustained over time.

In Alberta, a three-year evaluation of the MEND pilot has been completed. Feedback gathered from the children and families engaged in the programs indicates that the programs were favourably received by participants. As well, health outcomes data suggest positive changes in weight status, physical activity, cardiovascular health, healthy eating, and self-esteem.

APPLICABILITY/TRANSFERABILITY:

The MEND intervention in Alberta builds on the success of the original initiative (http://www.mendcentral.org), which was developed and implemented in the UK in 2004. MEND is the largest community-based child obesity prevention and weight management program in the world. Programs operate in approximately 320 locations in the United States (www.mendfoundation.org), the UK, Australia, New Zealand, and Canada. Worldwide, over 80,000 children have participated in MEND programs. In Canada, a number of provinces, including British Columbia and Saskatchewan (www.childhoodobesityfoundation.ca/MEND) have also implemented the program.

Currently, qualitative research is underway to study the effectiveness of the scale-up and spread of MEND in Canada. A CIHR-sponsored study led by a Simon Fraser University researcher is collecting data, at baseline and one year into implementation, to evaluate the effectiveness of the scale-up and spread of MEND. It will also identify the implementation barriers and enablers.

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For additional information, go to http://www.albertahealthservices.ca and search for MEND.

For My Health! Program: Identifying risk factors for poor mental and physical health

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice improves the mental and physical health of workers through health risk screening. The practice was launched in British Columbia at the BC Cancer Research Centre. It involved 50 employees, and health coaches such as nutritionists, physicians, counsellors, and dietitians.

PRACTICE DESCRIPTION:

In 2009, the Canadian Mental Health Association's BC Division and ImpactBC partnered with the Provincial Health Services Authority to develop an interactive health event that would help citizens of BC—particularly workers—improve their mental and physical health. Together, they launched *For My Health!,* a free program that includes risk-factor screening, evidence-based health education, and goal-setting. The program uses a series of hands-on, confidential screening stations to identify participants at risk for leading causes of disability and lost productivity in the workplace. The stations address issues such as mental health (depression and anxiety) and physical health (weight, diabetes, cardiovascular health, etc.). To address the sensitivity around mental health screening, the project assessment team developed an online screening questionnaire that is distributed to participants on iPads. After the screening stations, participants meet one-on-one with a coach to review results and set a health improvement goal.

For My Health! was tested for the first time in December 2009, when 50 employees piloted the event at the BC Cancer Research Centre in Vancouver.

IMPACT:

Information on the program and related accomplishments can be found on the website of the Canadian Mental Health Association, BC Division.

In 2013, *For My Health!* was named the Golden Apple Winner in the Workplace Health Innovation category of the Excellence in BC Health Care Awards. The award recognizes the efforts of health care employees who provide quality care and support to the people of this province and acknowledges excellence and innovation in publicly funded health care. For My Health! received the award since it engaged males and unionized workers in a resource industry (a population that typically underutilizes preventative health care services) in improving their mental and physical health.

The screening of the 278 participants showed that 78% were men, 28% of participants had high-risk body mass index, 33% of participants were at moderate or higher risk for anxiety, and 25% were at moderate or higher risk for depression. Specialized action items were created for these individuals to address those risk factors.

As a result, 33% of high-risk employees saw an improvement in their blood pressure, 60% of high-risk employees experienced a reduction in their cholesterol levels, and 40% of smokers reported having quit. In addition, physical activity increased by 50% and 67% of employees reported better eating habits.

APPLICABILITY/TRANSFERABILITY:

In November 2011, For My Health! debuted at Lakeland Mills in Prince George. Thirty people participated and survey results from the event showed that over 80% of participants felt comfortable answering personal health questions and rated the program as excellent; 100% said they would recommend the program to friends.

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Healthy Minds/Healthy Campuses Initiative

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice aims to improve mental health and lower substance abuse among post-secondary students across British Columbia. The practice was launched on several campuses and involved a team of students, faculty, campus professionals, administrators, government representatives, researchers, and community members.

PRACTICE DESCRIPTION:

In 2010, the government of British Columbia released *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*. As part of the plan, the Canadian Mental Health Association BC Division and the Centre for Addictions Research of BC joined as lead partners of the Healthy Minds/Healthy Campuses Initiative, which specifically targets a post-secondary population.

Healthy Minds/Healthy Campuses addresses mental health and substance use on campuses by leveraging knowledge mobilization among campuses and other key stakeholders in British Columbia. The program supports students as they deal with major adjustments associated with college life that may contribute to anxiety, depression, or reliance on alcohol or other psychoactive substances. It does this by facilitating dialogue and action among members of the Community of Practice, a group of people who share the common goal of promoting campus mental health and reducing risky substance use. Together, they share their own experiences, discuss strategies they've tried, consider new ideas, keep an active online presence, run yearly summits, and share resources across campuses.

IMPACT:

Progress and updates on this initiative are shared on the practice website and reported in government documents, such as BC's *Healthy Minds, Healthy People* annual progress reports.

These reports indicate that this initiative is growing across the province. Healthy Minds/Healthy Campuses has established partnerships with 23 post-secondary institutions in BC and over 27 other agencies or groups associated with this work. In a 2012 provincial scan of anti-substance abuse programs at post-secondary schools, researchers found that 15 of the 16 institutions participated in the Healthy Minds/Healthy Campuses Community of Practice.

One way of stimulating the Community's growth is through the annual summit that the Community runs for stakeholders and students. For example, in 2012 the summit convened 150 students, student service professionals, faculty, administrators, and government and community partners to discuss mental health and substance use on campuses.

Through these discussions and summits, individual campuses have identified their strengths and weaknesses in ensuring a healthy environment for their students and staff. For example, Simon Fraser University (SFU) has made progress in realizing a vision of a healthy campus community by addressing classroom well-being, identifying healthy campus community champions, and undertaking research into how classroom environments can play a role in enhancing student well-being. Knowledge produced and shared the work at SFU will benefit other campuses in the Healthy Minds/Healthy Campuses network as well.

Overall, the program has helped campuses work together to improve early detection and care, to promote stigma-free environments, and to develop policies and influence norms that affect student mental health every day. Given the positive impact of this initiative and its growing popularity in British Columbia, in 2012 British Columbia's Health Minister announced further funding of $500,000 over the next two years to support the initiative.

APPLICABILITY/TRANSFERABILITY:

Healthy Minds/Healthy Campuses has not been adapted from another jurisdiction or implemented elsewhere. However, similar initiatives have been launched in the United States (at Oregon University and UCLA) and in other (for example at the University of Toronto, Ontario). All campuses make use of a task force or Community of Practice that initially scans the environment and

then meets regularly to discuss gaps in programs offered and to formulate policies and action plans to improve the campus environment for students and staff.

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External Source: http://healthycampuses.ca/

Atii!: A Comprehensive Healthy Living Intervention for Children, Youth, and Families in Inuit Communities in Nunavut

LOCATION:	Nunavut	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice addresses health outcomes and health literacy among Inuit children. The practice was launched in 2011 in Nunavut and involved a project coordinator, a game facilitator, and an administration person.

PRACTICE DESCRIPTION:

The Atii! (Let's do it!) project is a school-based initiative aimed at improving the ability of Inuit children to make healthy choices about food and activity, and to carry this knowledge forward with them into adolescence and adulthood. The program was designed by and for Inuit youth and is founded on Inuit knowledge, foods, and language. The game divides participants into teams that spin a wheel (similar to those used in television game shows) and compete in trivia and game challenges. Three separate pilots of the Atii! game were conducted in November 2011, and the program lasts one day in each school. The research team conducted the game with classroom teachers participating as assistant facilitators.

The specific goals of the program are to:

- educate Inuit children about healthy choices;
- improve health literacy in Inuktitut;
- engage children in a fun health promotion activity;
- promote and evaluate a local intervention developed by young, motivated Inuit youth workers; and
- hire and train local youth (up to 30 years of age) to lead and implement the project.

The Atii! game is a creative, innovative way to engage children in health education, and is grounded in Inuit knowledge, foods, games, and language. The program is the result of a partnership between the Qaujigiartiit Health Research Centre (QHRC), the Qikiqtani Inuit Association, the University of Toronto, and Nunavut Tunngavik Inc. The mandate of the QHRC is to improve Northern health outcomes through community-driven, Northern-led research and program development. A Nunavut-based graphic design company was hired to produce the game, and the game manual was developed in English and Inuktitut.

IMPACT:

A survey was distributed pre- and post-game for each session in each school to assess children's general knowledge and level of enthusiasm for the game's subject matter. Researchers found that, following Atii! game play, the children's level of enthusiasm on the subjects of nutrition, physical activity, Inuit cultural knowledge, and health increased. Observations collected during the game play indicated that the children enjoyed participating the in Atii! intervention, as did the teachers and community workers who were present. Researchers found that while children had a good knowledge of the link between physical exercise and health, there was an opportunity to improve children's knowledge of the role of traditional Inuit foods in improving and maintaining health. Despite excellent knowledge and vocabulary on this subject, children did not identify traditional Inuit country foods as a source of health.

The results of the evaluation were published in a report published by the QHRC and were presented at the International Polar Year conference in Montreal in April 2012. To date, there has not been an evaluation of the costs and long term benefits of the practice.

APPLICABILITY/TRANSFERABILITY:

The Atii! Healthy Living intervention is one of nine projects under the Government of Canada's Innovation Strategy: Achieving Healthier Weights in Canada's Communities. In January 2013, the QHRC received two-year funding from the Public Health Agency of Canada to extend the Atii! intervention to two additional communities in Nunavut. It is too early to tell whether the results of the initial pilot have been replicated in these sites, but this initiative is theoretically applicable and transferable to other settings.

PRACTICE WEBSITE:n/a

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Galloway, T., & Healey, G. (2012, January). *Atii Gameshow: Healthy living intervention for school children in Nunavut. Evaluation report*. Retrieved from http://www.qhrc.ca/sites/default/files/Atii%20Gameshow%20Evaluation%20Report%20-%20Galloway%20and%20Healey%20-%20JAN%202012.pdf

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

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

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

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

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

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

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Other:

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

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

I COUGH Program: Using ACS NSQIP Data to Develop a Standard of Care for Post-Operative Pneumonia Prevention

LOCATION:	International	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses the need to decrease the number of post-operative respiratory complications as well as ventilator dependency. The practice was launched in the United States in Boston Medical Centre's two campuses and involved an interprofessional team composed of surgeons, surgical residents, internal medicine physicians, nurses, quality improvement and infection control experts, respiratory therapists, and physical therapists.

PRACTICE DESCRIPTION:

Respiratory complications—including pneumonia and ventilator dependency—are among the most common complications that occur after operations. Data from the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) can be used to track these complications and compare performance on respiratory risk factors to those in other institutions. For example, upon consulting their NSQIP data, Boston Medical Centre (BMC) learned that their hospital had a greater than expected incidence of post-operative pulmonary complications as well as venous thromboembolic (VTE) complications. This was a problem that needed to be dealt with, but little data existed for best-practice guidelines regarding post-operative pulmonary care. An audit of clinical practice revealed inconsistent patient education regarding the importance of and instruction in incentive spirometry. There was no formal pre-operative education, and patients' families usually were not included in the discussion. Physicians' orders for nurses regarding post-operative mobilization were irregular or absent. Consequently, in August 2010, BMC decided to develop their own program called I COUGH to track indicators of pulmonary care, decrease the number of patients with post-operative pneumonia by 50%, and reduce ventilator dependency in these patients.

I COUGH stands for incentive spirometry, coughing/deep breathing, oral care, understanding (patient and staff education), getting out of bed at least three times daily, and head-of-bed elevation. The program addresses respiratory care and education. By getting patients more active after their operations, it also focuses on VTE prevention. Prior to admission, patients receive brochures and view a video on the importance of participating in I COUGH. They are also given instructions on how to use the incentive spirometer. Post-surgery, BMC nurses care for patients based on pulmonary care orders they receive electronically from surgeons. This helps guide the standardized care of patients.

Since the program is hard-wired into the computerized physician orders, the I COUGH program steps are automatically ordered for all patients.

IMPACT:

Progress throughout the implementation of I COUGH was monitored and findings have been reported in various medical newspapers, at NSQIP conferences, and in an article in the peer-reviewed *JAMA Surgery Journal.*

The findings showed that the intervention reduced the likelihood of pneumonia after surgery (2.13 O/E versus 1.58 OR, respectively) and of unplanned intubation (2.10 O/E versus 1.31 OR, respectively) at the institution. After the introduction of I COUGH, an established standardized order set, along with nursing documentation requirements, showed that patients and their families were being educated by nurses and surgeons as a routine practice in multiple settings (pre-operative clinics, pre-operative holding area, and post-operative units). Mobilization now occurs in a standardized fashion.

The costs of serious complications can range from $18,000 to $52,000 per event. BMC has estimated a gain of at least $1 million in savings from these interventions.

APPLICABILITY/TRANSFERABILITY:

The program was created by BMC and is a registered service mark of BMC Corporation. It has since been implemented by the Vancouver Coastal Health Authority (VCH). In September 2012, Vancouver General Hospital in VCH also used NSQIP data and identified post-operative pulmonary complications as an area of concern. They decided to use I COUGH as an audit tool and used Plan-Do-Study-Act (PDSA) cycles to focus on spirometry, education, and coughing/deep breathing as their target areas. By promoting I COUGH, Vancouver General Hospital has engaged their staff in reducing post-operative pneumonia rates in general surgery, vascular, and otolaryngology patients by 50% as of June 2013. Results from their intervention have not yet been published. Implementation of I COUGH requires the support of medical staff with expertise and influence to spearhead the initiative and a strong focus on staff education and engagement.

PRACTICE WEBSITE: n/a

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News-Medical.net. (2012, October 5) *I Cough program reduces likelihood of respiratory complications in surgical patients*. Retrieved from http://www.news-medical.net/news/20121005/I-COUGH-program-reduces-likelihood-of-respiratory-complications-in-surgical-patients.aspx

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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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Personal Communication:

Cohen, B., Feldgaier, S., & Serwonka, K. (interview, July 17, 2013; review July 31, 2013). [Feldgaier & Serwonka: Government of Manitoba; Cohen: University of Manitoba].

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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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Personal Communications:

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Alternative Profiles:

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

Fraser Health Psychosis Treatment Optimization Program (PTOP): Community mental health support services for treatment-resistant psychosis among Schizophrenia patients

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses the issue of providing community management and support services for schizophrenia patients with treatment-resistant psychosis (TRP). The program was launched in July 2011 in one health authority (Fraser Health) and involves a central clinic and three community service teams.

PRACTICE DESCRIPTION:

The PTOP program started in July 2011 as a community regional program prototype in Fraser Health with a central regional psychosis clinic and three community service teams. Following the pilot year, it was adopted as a permanent program. The purpose of this program is to assess and treat patients with treatment-resistant psychosis (TRP) in Fraser Health to reduce their admissions to hospital and to emergency departments, and to improve their health outcomes and quality of life.

Schizophrenia is estimated to affect approximately one per cent of the population, representing more than 15,000 men and women residing in the Fraser Health region. Approximately one third of these individuals (5,000 patients) will have TRP and will be eligible for the PTOP. Failure to adequately manage this patient group increases days in hospital, contributes to lost years of productivity, and leads to premature death from untreated medical conditions and suicide.

The PTOP provides a wrap-around model of care that improves access for assessments and follow-ups, care coordination for patients, and support for clozapine starts throughout Fraser Health. Collaboration between mental health and primary care professionals improves the medical management of TRP patients, thereby decreasing the morbidity and mortality of this patient group through better metabolic monitoring and management. PTOP teams provide a collaborative, interprofessional approach to the management of individuals with a poor response to treatment by encouraging earlier identification, evidence-based planning, support during implementation, and monitoring of treatment.

IMPACT:

In alignment with a provincial trend, the PTOP provides an opportunity for treatment in the community rather than in hospitals. This eases the disruption to the patient's life by reducing hospital stays. Benefits of the PTOP are: reduced emergency department visits and hospitalizations; improved quality of life for patients with TRP, including reduced suicide risk; improved personal and social functioning; and reduced burden on the hospital, community, and mental health system of care through improved treatment outcomes.

Consultations with psychiatrists, mental health care clinicians, family physicians, and clients informed the development of this program model. It is also supported by a review of the best practice literature.

The PTOP pilot (from July 2011 to March 31, 2012) had 194 referrals with 164 patients registered for the TRP portion. Patients in the TRP arm of the pilot had a 91% reduction in emergency visits (from 33 to 3 visits post-PTOP), and a 76% reduction in hospital admissions (from 51 pre-PTOP to 12 post-PTOP). This is an 80% reduction in hospital days post-PTOP intervention (1,455 patient hospital days pre-PTOP to 286 patient hospital days) and an 89% reduction in alternate level of care days. Although the cost savings during the pilot have not been fully analyzed yet, indicators point to significant cost savings.

Over 370 patients were assessed and supported through the PTOP between July 2011 and March 2013. Of these patients, 141 were started on clozapine in the community whenever possible. Patients in the PTOP from 2012 to 2013 have continued to

show decreased hospital admissions (72%) and decreased emergency department visits (66%). These patients have improved functioning and quality of life as assessed by improvement in BPRS, role functioning, and GAP and SOFA scores at three months and six months post-PTOP compared to the baseline.

APPLICABILITY/TRANSFERABILITY:

The design of the program rested on a strong foundation of documented best practices from Great Britain, Australia, and New Zealand that provided a platform from which the PTOP could be developed.

The PTOP was piloted in four communities and has since expanded to include all communities in the Fraser Health region. It is a prototype model in BC and has the potential to expand to other health authorities in the province and be applied in communities across Canada. As well, the experience of developing and implementing the PTOP can provide learnings for other programs interested in designing interprofessional teams to serve a vulnerable client population in a community model.

Fraser Health remains committed to improving quality of life for patients with serious mental illness by supporting programs like PTOP and sharing learnings with other health care providers. Currently, Fraser Health is in early discussions with other health authorities in British Columbia to form a network to support the development of this type of program in their health region.

Some 'lessons learned' for the design and implementation of the PTOP:

Fraser Health's PTOP evaluation found that crucial to the success of PTOP was a highly skilled and dedicated interprofessional team that worked collaboratively to develop and implement the program in a very short span of time. The team was flexible and open to adapting and modifying processes throughout the duration of the program, which allowed them to address barriers in real time. As well, working with physicians from other countries (UK, Australia, New Zealand) who had worked in programs similar to the PTOP provided access to their hands-on experience with the design, implementation, and sustainability of this kind of program.

Rapid development of the PTOP, as well as the ability to quickly address identified challenges, was facilitated by frequent steering committee meetings that provided a forum for discussion for the entire team. Furthermore, communication with mental health service providers throughout the Fraser Health region was critical to the PTOP's success. These communications informed psychiatrists and case managers about the PTOP's existence and the services provided, which was a necessary precondition for referrals.

PRACTICE
WEBSITE:
http://physicians.fraserhealth.ca/resources/mental_health_and_substance_use/psychosis_treatment_optimization_program/psychosis_treatment_optimization_program

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Personal Communications

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Publications

Alternative Profiles

Other

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Comprehensive Unit-based Safety Program (CUSP) at Royal Columbian Hospital: Improving hospital workplace culture and safety

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice addresses the issue of improving hospital workplace culture and safety outcomes. The practice was launched in British Columbia in one clinical setting and involved a team of surgeons, senior hospital executives, and clinical staff such as clinicians, registered nurses, nurse practitioners, and residents.

PRACTICE DESCRIPTION:

The Royal Columbian Hospital (RCH) is the 430-bed tertiary trauma centre for Fraser Health Authority, which serves 36% of the population of British Columbia. Despite being a prominent trauma centre, RCH is an example of a medical centre that has experienced poor teamwork and a poor safety climate. In spring 2012, RCH administered the Safety Attitudes Questionnaire (SAQ), which addresses climate, job satisfaction, stress recognition, working conditions, and perceptions of senior and local management. Results from the SAQ indicated suboptimal scores in surgical services and a culture risk score well below the "danger" threshold. In order to change their workplace's culture and improve patient outcomes, RCH launched the Comprehensive Unit-based Safety Program (CUSP) in the Department of General Surgery in 2012.

CUSP is designed to change a unit's workplace culture through education, awareness, access to organizational resources, and a toolkit of interventions. The CUSP framework consists of five steps:

1) Train staff in the science of safety and the basic principles of safe design.

2) Engage staff to identify defects by reviewing incident reports, and asking them how the next patient will be harmed and what can be done to prevent that harm.

3) Establish senior executive partnerships by inviting executive members to interact with staff on the unit and discuss safety issues with them at monthly safety rounds.

4) Continue to learn from defects.

5) Implement tools for improvement and measure compliance.

At RCH, the surgical team identified surgical site infections (SSIs) as a focal area for intervention. They conducted the five steps of the CUSP framework to determine the most pertinent risk factors for SSIs and implemented CUSP tools for improvement to address those specific risk factors.

IMPACT:

Findings from the RCH program have been presented at the BCPSQC Quality Forum and the CUSP has been evaluated in numerous sources, including peer-reviewed journals and the United States based Agency for Healthcare Research and Quality (AHRQ).

The first safety assessment identified traffic as the leading cause for patient harm, since traffic presents distractions and disrupts the surgical site, leading to increased SSIs. By using a data collection tool, RCH tracked the number of times doors were open during a patient's stay as well as the number of people on site. A total of eight cases were observed and results indicated that for each surgical hour, the door was open for 11.53 minutes, with the greatest time in C-section cases. This translates into airflow disruption 19% of the time. This identified the need to decrease crowdedness in the operating room and focus on

measures that decrease traffic flow during procedures.

In a second survey assessment, RCH tracked progress and displayed compliance through a tracking chart. The chart was displayed in the unit's hallway and allowed various health care professionals to comment on how the unit was doing in various metrics related to SSIs. Formal results on the effect of this CUSP intervention on actual SSI rates have not been published.

APPLICABILITY/TRANSFERABILITY:

The CUSP intervention at RCH has been adapted from the 2003 Keystone Project, which implemented CUSP in 100 intensive care units in Michigan. The project targeted clinicians' use of five evidence-based procedures, recommended by the Centers for Disease Control and Prevention, to reduce rates of catheter-related bloodstream infections. Results from the Keystone Project have reported a reduction in rates of infection by two thirds in the first three months and savings of nearly $200 million in the program's first 18 months. Since then, CUSP has been implemented in over 40 units in The Johns Hopkins Hospital as well as hospitals across all 50 states in the US. RCH is also planning to adapt the CUSP for units beyond general surgery. CUSP has been used to target a wide range of problems: patient falls, hospital-acquired infections, and medication administration errors, to name a few.

To ensure successful implementation of CUSP at any institution, the hospital must prepare at least two months prior to CUSP kick-off by doing the following:

- Assemble an interdisciplinary unit-based safety team.
- Partner with a senior executive.
- Conduct a culture assessment.
- Gather unit-specific information.

The Johns Hopkins Center for Innovation provides a two-day training session, online consulting, and a CUSP introduction webinar for those interested in implementing CUSP at their institutions.

PRACTICE WEBSITE: n/a

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The Caregiver Support Project: A Self-Directed Care Model to Improve Resiliency among Seniors' Informal Caregivers

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice addresses the issue of improving the resiliency of at-risk caregivers of seniors living at home. The practice was launched in Ontario and involved 321 caregivers and 80 care coordinators.

PRACTICE DESCRIPTION:

Canada's population is aging, and informal caregivers—family and friends who provide unpaid assistance with tasks such as transportation and personal care—are becoming increasingly important to the well-being of seniors. The Caregiver Support Project (CSP) was designed to support caregivers at risk for burnout due to physical, emotional, social, or financial burdens. The program was implemented in 2011, funded by the Toronto Central LHIN as part of the Aging at Home strategy of the Ontario Ministry of Health and Long-Term Care.

The CSP allows caregivers to identify their needs, prepare a budget for goods and services that would facilitate their work, and receive funding of up to $1,500 per year. Caregivers who are unable to self-manage are connected with a professional care coordinator. The program differs from classic self-directed care, where funds that are typically paid to service provider agencies are granted to consumers to pay for and manage their own care. Consumers (in this case caregivers) guide the care planning and take on the role of expert. The CSP uses a variant, best characterized as a "supported self-directed" model of care. In this model, caregivers exercise decision-making with access to a professional care coordinator—a registered nurse, a physiotherapist, an occupational therapist, or a certified social worker—whose knowledge of support options can help inform planning.

The Alzheimer Society of Toronto developed and implemented the CSP with the primary goal of helping at-risk and distressed caregivers of senior persons living at home. Participants included care recipients aged 55 and over living in the Toronto Central LHIN who were receiving 10 or more hours of direct care per week from an informal caregiver. The final phase of the pilot project concluded in March 2013. Of 321 caregivers who participated, 203 remain active more than 18 months after enrolment.

IMPACT:

The research team conducted an evaluation of the project's implementation and its effects on caregivers, care recipients, care coordinators, and the health care system. Questionnaires were mailed to caregivers one month and six months after care plans were implemented with respective return rates of 81% (n=214) and 69% (n=184). Over this time frame, caregiver satisfaction remained high (9.1 out of 10), and stress remained relatively stable at 4.26 out of 10. Caregivers reported feeling more empowered, appreciated, and validated in their caregiving role (*n*=193). According to the evaluation, over 60% of persons receiving care stayed in their current living environment and potentially enjoyed a better quality of life as a result of the specific interventions. A formal assessment of the costs and savings of this practice has not been completed at this time.

Throughout the pilot, caregivers were permitted to use funding to hire relatives to increase the number of available providers. The project team observed that family caregivers were able to communicate in the same language and were available on days and times not typically offered by traditional care providers. Informal observations support the literature, which discusses increased satisfaction and greater positive outcomes for caregivers and care recipients when family members can be paid.

APPLICABILITY/TRANSFERABILITY:

The supported self-directed care model applied in the CSP is unique. However, there are several dimensions of the project which are similar to other programs for caregivers operating across Canada. Local, provincial, and national initiatives and organizations that informed key dimensions of this project include:

- the Veterans Independence Program;
- Family Service Toronto;
- Wesway Respite Care;
- Nova Scotia's Caregiver Benefit Program;
- the Canadian Caregiver Coalition;
- Manitoba's Primary Caregiver Tax Credit; and
- the Seniors Managing Independent Living Easily (SMILE) program.

The project team identified five basic lessons from which jurisdiction wanting to establish similar programs could benefit from:

- Focus on the "triad"—caregivers, care recipients, and care coordinators.
- Be flexible and responsive to caregivers' expressed needs for support.
- Streamline assessment procedures.
- Establish a clear implementation plan.
- Revisit the plan and revise as circumstances change.

A final key lesson learned is that clear program administration protocols, such as how funds are delivered to clients, must be established at the outset. The CSP set up services directly with the client's vendor of choice, while other programs use a variety of different approaches, such as issuing vouchers redeemable at selected providers. The project team is currently working on an article that will provide more information on the challenges and lessons learned that affect the applicability and transferability of the practice.

PRACTICE WEBSITE: n/a

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Personal Communications:

Warrick, N. (feedback and review, July 18, 2013). [Alzheimer's Society of Toronto]

Publications:

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Other:

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Active Choices: A Physical Activity Telephone Support Program

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice addresses the issue of sedentary lifestyles in adults. A 1:1 telephone program, supporting regular aerobic exercise by participants, was launched in British Columbia in 2010. Resources include a staff coordinator and volunteer program "coaches."

PRACTICE DESCRIPTION:

The Active Choices program was developed by the Stanford University Prevention Research Center to address the issue of sedentary lifestyles in older adults. The British Columbia version of the program serves adults of all ages who want to be more active and who have no related medical issues and are physically able to engage in aerobic exercise. This six-month 1:1 telephone support program matches participants with a coach, to support the creation and implementation of an individualized plan for regular cardiovascular exercise. The coach/participant pair has a face-to-face meeting initially, and up to 12 telephone coaching sessions. Participants also receive health tips and newsletters by mail or email. Coaches provide support by teaching goal setting and problem solving strategies, helping participants develop an individualized personal activity plan, monitoring goals and progress, and linking participants with community resources.

The program is funded by the BC Ministry of Health and offered free of charge to participants; training for coaches is also free. While participants do not need a doctor's referral, extensive screening is done and some individuals are asked to have their physician complete a medical clearance form. Over 400 people have completed the program since its inception. In 2012/13 the program was supported by one provincial program coordinator, and 200 volunteers who are practicing coaches. Coaches receive a standardized coaching manual and receive one day of training on topics such as coaching and facilitation skills, behaviour change principles, and the fundamentals of moderate physical activity. Coaches are also given ongoing training and support (webinars, annual gathering, etc.). Participants and coaches are recruited via a provincial website, www.selfmanagementbc.ca, a toll-free line, advertising, promotional materials sent to doctors' offices and pharmacies, presentations, and participant word of mouth.

IMPACT:

This innovative practice was implemented in 2010 but neither a completed outcome evaluation nor a formal assessment of costs and savings has been conducted at this time.

Personal testimonials, observations, and US-based evaluations suggest that this practice has the potential for positive outcomes on health. For example, Wilcox et al. (2008) used a pre-post quasi-experimental design to evaluate the program as part of the Robert Wood Johnson Foundation's (RWJF) *Active for Life* initiative, in which the program was implemented by four diverse organizations. The results showed significant increases in moderate- to vigorous-intensity physical activity, total activity, satisfaction with body appearance and function, and decreases in body mass index (BMI). Six months after completion, participants had generally sustained their improvements. The RWJF *Active for Life* initiative showed similar outcomes across its four delivery organizations: a YMCA in Chicago, a Church Health Center in Memphis, and a health department and Blue Shield in California. As well, the fidelity of program delivery processes was maintained, for the most part, during implementation.

Another study into the effectiveness of an Active Choices program in six regions of New York State found statistically significant improvements in physical activity levels over time. Of the 500 participants who completed the six-month program, most reported exercising at least four days per week by the project's end. As well, the program was successfully adapted to use volunteer coaches at some sites. However, in the NY state initiative, participation rates were a challenge. Only 50% completed the program; 10% dropped out after the first session, and the remaining 40% dropped out within the first three months.

APPLICABILITY/TRANSFERABILITY:

The BC Active Choices program builds on the success of Stanford University's work. However, the program in BC targets adults in a larger age range to maximize program reach. Some of the other challenges and lessons learned that would affect applicability/transferability of the practice include:

- Information sessions in targeted areas (e.g., Vancouver Island) were important for uptake during early implementation.
- Participant uptake in rural BC has been limited, although it is easier to attract volunteer coaches in rural areas.
- Partnerships (e.g., in the area of workplace wellness) have been important to recruitment.
- The program has begun using a Train the Trainer approach, for program efficiencies.

PRACTICE WEBSITE http://www.selfmanagementbc.ca/activechoicestelphonesupportprogram

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Personal Communications:

Sealy, A. (interview, July 22, 2013; review, August 1, 2013). [University of Victoria, Centre on Aging]

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External Source: http://www.selfmanagementbc.ca/activechoicestelphonesupportprogram

A GP for Me: An Initiative to Match British Columbians with Family Doctors

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

SNAPSHOT: This innovative practice addresses the issue of strengthening the primary health care system and improving health outcomes by helping people who want a family doctor to get one. The pilot project was launched in British Columbia in three communities and involved approximately 300 family physicians.

PRACTICE DESCRIPTION:

The premise for this innovative practice is that a strong primary care system with a foundation of continuous doctor-patient relationships leads to better health outcomes for patients. As of 2013, however, approximately 176,000 British Columbians are looking for a family physician. A GP for Me aims to provide all British Columbians who want a family doctor with access to one, and to better support and reward family physicians who commit to delivering long-term care for their patients.

A three-year pilot project, A GP for Me was launched in June 2010 and involved three Divisions of Family Practice in White Rock-South Surrey, Prince George, and the Cowichan Valley. A GP for Me facilitates community-based professional networks of family physicians, health authorities, and community partners to work together to develop plans for improving local primary care capacity, including mechanisms for finding doctors for patients who are looking for one.

A GP for Me will not be an instant solution for everyone who is looking for a doctor now. However, over time it is expected to improve the primary care system by establishing ongoing patient-physician relationships. Once these relationships exist it is possible to introduce more efficient ways to care for patients, such as phone consultations over routine matters. Phone consultations save time for physicians and give them the option of taking on new patients. A GP for Me also provides incentives for doctors to take on patients with complex health conditions, such as cancer, severe disabilities, or mental health challenges.

The program is funded by the General Practice Services Committee (GPSC), a collaboration between the BC Medical Association and the Ministry of Health.

IMPACT:

Results from the pilot project have been collected and published on the initiative's website. Collaborative local efforts at the three sites produced new primary care clinics, increased physician recruitment, expanded family practice capacity, and developed more interprofessional teams. As a result, since 2010 more than 9,400 patients have found family doctors. In White Rock, the initiative matched 4,500 people with family doctors, thereby eliminating the wait for a family doctor. The Cowichan Valley Division of Family Practice found primary care providers for 1,100 patients. In Prince George, 3,800 patients were matched with family doctors, and a new clinic opened in July 2012 to provide regular care to patients without a family doctor.

The expansion of A GP for Me province-wide is being supported by $132.4 million in funding. The funding is available on two levels:

- $40 million over three years to Divisions of Family Practice to improve primary care capacity locally and evaluate the number of people looking for doctors; and
- $60.5 million over two years towards increasing the efficiency of individual practices, including fees for phone consultations and for taking on new patients, with different fees for average versus complex patients.
- The remaining $31.9 million is being allocated towards supporting existing care by family physicians in hospitals.

APPLICABILITY/TRANSFERABILITY:

Based on the success of the pilot, A GP for Me expanded province-wide in April 2013.

A GP for Me is part of the General Practice Services Committee's suite of programs—including the Practice Support Program—that aim to improve the care patients receive and how doctors deliver it. Based on the success of the pilot program, A GP for Me is being implemented in divisions of family practice throughout BC. So far, 20 divisions are involved at various stages in applying for funding to participate in A GP for Me. Some of those have started a rigorous assessment and planning process as a first step in defining the extent of the issue in their regions. After this, an implementation plan will be submitted to enable the participating divisions to try innovative approaches to find primary care providers for traditionally 'hard to attach' people.

It is too early to evaluate the results of this program in other areas, but there is the potential for the positive results in the initial 3 pilot sites to be replicated throughout the province. The GPSC website provides a variety of supports and resources for both patients and physicians interested in learning more about the program, including billing tutorials and a FAQ section.

PRACTICE WEBSITE:

http://www.agpforme.ca/

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Personal Communications:

Bales, D. (feedback and review, August 23, 2013). [A GP for Me].

Publications:

Cavers, B. (2013). How "A GP for Me" will help improve BC's primary care system. *BC Medical Journal, 55*(3), 160.

Other:

General Practice Services Committee. (2013). *A GP for Me/Attachment initiative*. Retrieved from http://www.gpscbc.ca/attachment-initiative

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

VivoSpace: Using social media for chronic disease management

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

Media and Graphics Interdisciplinary Centre (MAGIC), UBC. (n.d.). *VivoSpace: An online social network to motivate health behaviour change*. Retrieved from http://www.magic.ubc.ca/pmwiki.php?n=Projects.E-HealthCare

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

Community Health Centre (CHC) Collaborative Framework for Elder Abuse Detection and Intervention

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the issue of elder abuse, which has been defined by the World Health Organization as single or repeated acts, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older person.

PRACTICE DESCRIPTION:

The Community Health Centre (CHC) collaborative framework for elder abuse detection and intervention is based on a partnership between Durham Regional Police Service and Brock CHC (in northern Durham region) that began in 2011. The approach consists of (1) ongoing education about elder abuse and related community development activities with the regional police, the regional government, and other community partners, and (2) direct outreach to seniors. The framework is used in a rural community with a high proportion of seniors, a lack of services, and poor transportation infrastructure. It targets people aged 65 and over living in the community, including in retirement homes.

This framework uses a community development approach to address the need to integrate health and community resources to detect and intervene in situations of elder abuse. For example, CHC staff give local presentations to community organizations, seniors' groups, and the Durham Regional Police Platoon Training to promote awareness and make the case for CHC involvement in well-being checks for at-risk seniors. The framework builds on police interventions for seniors' safety issues or caregiver criminal issues, laying charges under aspects of the Criminal Code that relate to physical, financial, psychological, verbal, or sexual abuse and/or neglect. The CHC is involved by (1) accompanying police in well-being checks of individual seniors at risk, and (2) performing any follow-up required to address a senior's support needs, such as connecting them with primary health care and making referrals to community services such as in-home support, housing, food services, and others.

Key members of the virtual team implementing the framework are: the seniors and community health worker from the Brock Community Health Centre, designated police officers from the Durham Regional Police Service, and the elder abuse advisor from the Region of Durham. The Durham Elder Abuse Network (DEAN), an organization of health and social service providers that come together to advocate on issues relating to elder abuse and seniors safety, also plays a role in implementing this framework. The DEAN works with consultants at the Ontario Network for the Prevention of Elder Abuse (ONPEA), which is funded by the Ontario government. Members of the virtual team can communicate with other members of the Durham Elder Abuse Network to seek additional community resources for seniors at risk, on a case-by-case basis. Funding sources for implementing the framework include the base budgets for staff of key partner organizations.

This approach is considered to be innovative because it uses the community health centre model within the community and takes a holistic approach to addressing seniors' needs. At the community level, it breaks down silos by building on the expertise of professionals from different service sectors—police, health care, regional government, and others.

IMPACT:

This innovative practice has been in place since 2011 and does not have a completed evaluation at this time. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health and cost savings for the police force, if the initial intervention and follow-up resolves the abuse situation and does not require follow-up police visits.

APPLICABILITY/TRANSFERABILITY:

The CHC Collaborative Framework for elder abuse detection and intervention has neither been adapted from another

jurisdiction nor implemented elsewhere, but key informants have indicated that the leadership of the Durham Regional Police, the support offered by the regional government in its funding of an elder abuse advisor, and the mandate of the Brock CHC to address the needs of the community have all contributed to the success of the initiative. This framework is theoretically applicable and transferable to other settings, and CHCs with a mandate to serve seniors can play a key role in creating frameworks such as this in their area.

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Personal Communication:
Josephson, J. (Interview and feedback, July 4, 2013). [Brock Community Health Centre].

Other:
Josephson, J., Rankin, T., & Gomez, J. (2013, June). *Creating a collaborative approach to elder abuse intervention: The role of the CHC in educating and responding to elder abuse*. Presentation at the Primary Health Care Conference, Toronto.

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External Source: N/a

The Sherbourne Health Centre Infirmary: Cancer care for homeless or underhoused populations

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

SNAPSHOT:

This innovative practice addresses the issue of housing individuals who are homeless or underhoused and who have cancer or other acute medical conditions. The practice was launched in Ontario in one clinical setting in Toronto and involves a coordinated team of the Community Care Access Centre (CCAC), oncologists, and Sherbourne Health Centre staff.

PRACTICE DESCRIPTION:

The Sherbourne Health Centre Infirmary is a short-term cancer care unit where people of all ages who are homeless or underhoused may stay while recovering from an acute medical condition, illness, or injury. The Infirmary program provides a safe space where clients are able to rest and recover in a comfortable, supportive environment.

Health care is provided by an interprofessional team including consulting physicians, nurses, and a case manager for homeless and underhoused persons. It operates seven days a week, 24 hours a day, providing recuperative and holistic health care to clients who are expected to recover in a short period of time from a medical condition and do not require hospital care. Whenever possible, morning admissions are preferred so that clients can have a smooth transfer or transition into the program. The initiative has produced integrated care from a coordinated team to ensure a seamless transition between hospital (when care is no longer need), shelter, and infirmary settings.

The Sherbourne Health Centre Infirmary program is intended to augment already existing health care available through hospital and community sites. The intent of the program is to enhance the recuperative or recovery options for people who are homeless or underhoused, with a focus on individuals with health issues requiring short-term stays. The Infirmary program is not intended to replace other needed forms of health care such as emergency or urgent assessment, crisis, mental health, or addiction services.

IMPACT:

There is no formal evaluation of the practice at this time, but personal accounts, internal program measures, and observation indicate positive outcomes.

Since 2011, 20 homeless people—men and women aged 30 to 70, with different types of cancer and varying prognoses—have received treatment. In 2012, the Sherbourne Health Centre was announced as an Innovation Award Winner by the Cancer Quality Council of Ontario for developing this practice to provide chemo and radiation therapies to individuals experiencing homelessness, or those with no real “home.” These patients face significant barriers to accessing mainstream treatment. Even those in shelters or rooming houses lack a sufficiently safe or hygienic environment, and cannot appropriately dispose of the toxic chemotherapeutic waste. The Infirmary has enabled Ontario oncologists to confidently implement treatment plans for a number of homeless or vulnerably housed individuals who may otherwise have been refused treatment or struggled to fit into care options.

APPLICABILITY/TRANSFERABILITY:

The Sherbourne Health Centre Infirmary Program has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings.

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Sherbourne Health Centre. (n.d.). *Infirmary program referral guide 2009/2010*. Retrieved from http://www.sherbourne.on.ca/PDFs/inf-guide/referralguide.pdf

Association of Family Health Teams of Ontario. (2012, December 6). Sherbourne and North York FHTs honoured for their work by Cancer Quality Council of Ontario. [News Release]. Retrieved from http://www.afhto.ca/news/sherbourne-and-north-york-fhts-honoured-for-their-work-by-cancer-quality-council-of-ontario/

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External Source: http://www.sherbourne.on.ca/programs/infirmary.html

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

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External Source: www.csa.ca/z1003/

All-Access Dentistry: Specialized Geriatric Dental Services

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

SNAPSHOT:

This innovative dental practice addresses the issue of enhancing access to oral care for people with limiting physical, medical, or cognitive conditions. The clinic aims to smoothly integrate dental clinic services for a spectrum of patients, including the most complex cases. The practice was launched in Ontario in January 2011 in an independently owned specialized dental clinic operating in a hospital setting.

PRACTICE DESCRIPTION:

The Runnymede Dental Centre (RDC) provides access to oral care and offers a branch of dentistry for people with physical, medical, or cognitive conditions that limit their ability to receive routine dental care. The dental centre provides patient-focused dental care to Runnymede patients, staff, and the broader community, and opened at the Runnymede Health Centre (RHC) in January 2011.

The RDC objectives are to improve access to care and to offer quality dental services to all in need. The clinic is designed to meet the unique challenges and needs of patients who require specialized care, and does so through specialized equipment and processes. The office operatories are uniquely outfitted with Hoyer Lift wheelchair transfer equipment and air-compressed floating dental chairs, and they are set up for patients on continuous oxygen. The new dental clinic has space for a support person or family member to accompany patients while they undergo treatment, as well as moveable dental chairs. Unlike the stationary dental chairs in most dental clinics, these seats can be moved aside in the treatment room. This is particularly beneficial for patients with specialized wheelchairs that tilt and recline, as it allows them to be treated in their wheelchair without being moved. RDC also helps coordinate patient appointments and offers shuttle services to patients in the community, fostering independence and convenience for those unable to attend on their own.

An initial oral pre-screening and assessment is offered to patients at no charge. Following the assessment, the dental centre provides written treatment recommendations and a cost breakdown of services. Payment arrangements for dental services are between the dentist and the patient or substitute decision-maker.

Since 2012, RDC has been raising awareness of its unique services and increasing the size of the practice, targeting RHC patients, staff, and members of the community. Additionally, the dental clinic and RHC have been working together on a strategic plan to ensure that all new admissions and their alternative decision-makers are informed of and given access to the on-site dental care services. The RDC is in a stage of informing and offering dental care services to surrounding long-term care facilities (LTCs), nursing homes, and independent living residents.

IMPACT:

This innovative dental practice was implemented in January 2011 and does not have a completed formal evaluation at this time. However, RDC has received significant positive feedback, and observations suggest that this practice has the potential for positive outcomes on health.

The practice meets the needs of the community—it was the numerous requests by patients, alternative decision-makers, and staff that prompted RDC to start building relationships and offer specialized, comprehensive dental services in a hospital setting. Patient and provider testimonials indicate that accessing the clinic has increased patient quality of life. The RDC has been successful in providing oral health care to a population that would otherwise be unable to access this type of care due to physical or medical limitations. The importance of a mouth free of disease, infection, and plaque is of paramount importance for heart health and overall health. Patients report increased comfort and accessibility during the dental visit, improved oral hygiene, and satisfaction with their appearance, sociability, and the sense of community in the clinic.

The plaque scores and the disease, pain, and infection findings have dramatically decreased since RDC began servicing RHC patients on a part-time basis in 2011. A second important impact is that oral hygiene awareness has significantly improved since the opening of RDC. For example, RDC has organized annual training sessions on oral care for all RHC staff. Thus, with improved awareness and education, a greater number of patients in RHC and the community are learning about the importance of oral health and prevention, as well as accessing dental services regularly rather than on an emergency basis.

Finally, frequent preventative visits and examinations provide comfort and cost savings, and help minimize emergency visits and unnecessary pain and discomfort. The set-up costs, systems, and training for such a specialized clinic are greater than a general dental practice, so the key is growing the clinic and increasing awareness.

APPLICABILITY/TRANSFERABILITY:

Given the success of RDC in its RHC setting, a similar clinic is being established in downtown Toronto. Although this second clinic does not have the same facilities or equipment as the hospital setting, the approach to providing integrated oral health care for a diverse population of patients has been adapted. The original practice at RDC is also growing as awareness about its specialized services increases. Additionally, RDC is looking to provide mobile dental services to bedridden in-patients at the RHC.

RDC has received many requests for information from outside long-term care and other facilities about the importance of oral health and to offer their residents the clinic's services. Expanding this practice beyond its original setting will help improve accessibility to dental care for LTC facilities, increase LTC staff training in the important of oral health, and promote regular dental visits as an important component of disease prevention and health promotion.

The greatest challenge for RDC remains accessing and informing those who could most benefit from the services offered by RDC—such as LTC-facility residents and patients unable to obtain independent transportation—and advising them of the choices available for their care.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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Alternative Profiles:

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

External Source: http://www.runnymededentalcentre.com/

Using Photography to Reduce Hospital Based Infections

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice uses photography as a means to reduce the rate of hospital based infections. The practice was launched in British Columbia in one clinical setting and involved a team of registered nurse practitioners and hospital administrators. One practitioner is needed to capture the visual data; other administrators and practitioners can then formulate appropriate recommendations.

PRACTICE DESCRIPTION:

Due to rising rates of infections associated with health care, elevated morbidity levels, lengths of stay, and health care costs in British Columbia, a team of researchers and nurse practitioners decided to incorporate visual research methods to lower infection rates. Visual research methods use photography as data to help identify areas of concern and communicate.

Visual research methods focus on four pillars for improvement:

1) communal understanding of the culture, history, and resources of the work environment;
2) appropriate documentation of observations made in the work environment;
3) self-monitoring and accountability through policy; and
4) learning to use new methods to improve practices.

In January 2009, the research team at the University of British Columbia Okanagan Campus Clinic met for the first time to identify goals for incorporating visual research methods into the clinic. The priorities for improvement were established and a practitioner was sent into the work space to take photos with commentary in April 2009. This helped identify how best to capture the images and what areas might require more attention. In January 2010, a second discussion was held around how to use the photographic data to make appropriate recommendations for the clinic. A year later, once all the photos were taken, the group reconvened to draft recommendations for improving practices in the hospital setting. Recommendations were shared with decision-makers and published by April 2011, after which the interventions were put into practice by fall 2011.

IMPACT:

Progress as depicted in photographs was consistently documented through visual media and through statistical representations (such as tables, charts, graphs, etc.) and published in research presentations. The photographs highlighted problems with dirty storage workarounds, signage workarounds, disorganized isolation carts, inappropriate garments, inefficient use and storage of supplies, call-system workarounds, and damaged equipment. Identification of these problems using the visual documents became the basis for recommendations related to equipment storage modifications and process redesign.

As a consequence, new sinks and showers were installed, a wipeable call bell cord replaced the defective one, more protected storage space was created, newly reupholstered chairs replaced damaged ones, and wall repairs were made where appropriate. The research team tracked the effects of implementing the visual research method on methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococci (VRE) bacteria cases. They observed that both MRSA and VRE cases decreased by October 2011, following the intervention period. Evidently, the restorative approach appropriately identified areas of concern and served as a basis for subsequent process modifications.

APPLICABILITY/TRANSFERABILITY:

Given the success of the intervention, visual research methods were further implemented in the University of British Columbia's Infection Control Professional Department to track improvements in five units during an outbreak. It was recommended that

these methods be incorporated into quarterly workplace safety inspections. Further, the practice is now being piloted in two clinical units at the Ottawa Hospital in Ontario (project led by C. Backman, Chair of the Sustainability of Best Practices Guidelines).

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Marck, P. *Exploring infection control with participatory visual research methods: A restorative approach.* [Presentation Notes]. Retrieved from http://qualityforum.ca/wp-content/uploads/2013/02/A4-Patricia-Marck1.pdf

Reducing Urinary Tract Infections Among Surgical Patients

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Acute Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT:

This innovative practice aims to reduce catheter-associated urinary tract infections among surgical patients. The practice was launched in British Columbia in Peach Arch Hospital and involved four surgical staff nurses, a National Surgical Quality Improvement Program (NSQIP) consultant, a clerk, a surgical clinical reviewer, a surgery manager, and some input from staff from the emergency department, infection control, and operating room.

PRACTICE DESCRIPTION:

The National Surgical Quality Improvement Program (NSQIP) is a resource that provides high-quality surgical data and methods to improve surgical care. Peace Arch Hospital began using NSQIP in July 2011, and within the first year of its implementation, non-risk-adjusted data indicated that urinary tract infection (UTI) rates among surgical patients at Peace Arch Hospital were higher than the NSQIP average. Consequently, Peace Arch Hospital mobilized an interprofessional team of health care providers in April 2012 to reduce catheter-associated UTIs among surgical patients by 50% by December 2012. This would require the use of NSQIP and other best practices, such as the Fraser Health catheter-associated UTI guidelines. Other goals included enhanced education in NSQIP and UTI prevention management, empowerment of nurses, and enhanced collaboration among health care providers. This is a unique practice in that it not only makes use of the NSQIP but also incorporates other best practices, including the Institute of Health Improvement's Plan-Do-Stop-Act (PDSA) approach and a quality dashboard, in order to achieve higher-quality care.

The team began by articulating these goals in a charter and then began implementing the NSQIP and Fraser Health UTI best practices. To increase participation and ensure adherence to best practices, the team held a UTI best-practices contest to test employee knowledge, promoted UTI prevention through flyers and other educational resources, and organized health care team huddles.

IMPACT:

In order to track improvements, document changes, and identify areas for improvement, the team used several documenting best practices. Several action plans were enforced, such as using silver-tipped catheters, and the PDSA cycle was used to test the effectiveness of the change. Also, the team measured changes using a quality dashboard, which included full documentation of various UTI prevention practices on a monthly basis. Capturing these data required improving the Peace Arch Hospital Kardex system and tailoring it to be more relevant to nurses, who were at the forefront of data collection.

All of these best practices ensured high-quality tracking, documentation, and reporting of findings, which were released in presentations. The findings indicated that the hospital was on track with its 50% reduction goal. Secondary outcomes such as enhanced collaboration and communication have also been met.

APPLICABILITY/TRANSFERABILITY:

This intervention has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. Several key lessons were learned that would be useful for future application, such as the importance of the QI consultant in keeping the team and hospital on track, getting a supportive manager on board, and contacting key people to join the team. Finally, understanding change management theory and recognizing that the NSQIP data are highly useful in tracking outcomes and promoting change in hospital practices are also important factors in successfully implementing this practice.

NSQIP is being used in other BC hospitals and has been used in similar initiatives such as the Clinical Care Management

Initiative, which aims to lower surgical site infections.

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Other:

Susann Camus, S., Gabriel, P., & Sperandeo, D. (2013, February 28). *Using NSQIP data and best practices to reduce urinary tract infections among surgical patients at Peace Arch Hospital*. [Presentation Notes]. Available at http://www.slideshare.net/bcpsqc/c2-susann-camus

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Young Carers Program of Hospice Toronto

LOCATION:	**Ontario**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT:

This innovative practice aims to strengthen young carers through the integration of child/youth and adult services to work together in a way that identifies young carers and connects families to supportive services.

PRACTICE DESCRIPTION:

Throughout Canada, well-hidden from the public's view, are scores of isolated young carers. It is estimated that 12% of all children and youth in Canada are providing care for a family member coping with an illness, a mental or physical disability, a substance addiction, or a language barrier. This vulnerable and often marginalized group frequently suffers from social exclusion, bullying, and low academic achievement. All of this has considerable effects on the mental health system, not to mention the immediate negative impact that unsupported young carers may have on the family unit and its overall ability to care for a family member living with an illness or disability.

The Young Carers Program of Hospice Toronto supports children and youth, who out of necessity have assumed a significant caregiving role for a parent, grandparent, or sibling. Program objectives include goals such as validation of young carers' roles to increase self esteem; enhancing knowledge transfer and integration with health and social child/youth and adult agencies and services; and creation of a national young carers initiative in Canada.

Resilience in young carers is built by creating opportunities for mutual support, fun, and optimal development through social, recreational, skill development and educational programming. Rotating programs, drop-in nights, and special events are offered throughout Toronto for carers 18 and under, and hosted through other organizations such as TDSB, Holland Bloorview Kids Rehabilitation Hospital, Ronald McDonald House Toronto, and other various partners. Programs include group activities, expressive arts, sports, fieldtrips, homework assistance and more.

This program was funded by the Government of Canada's Social Development Partnerships Program, Jays Care Foundation, Ontario Trillium Foundation and TD Securities Underwriting Hope Charity Auction.

IMPACT:

A program evaluation took place in the early fall of 2012 whereby surveys to participants and partners were completed and collected. At that time 97 members were registered with the YCP; 20 of them transitioned out of service or moved away. In addition, the program has served on at least a "one time basis" approximately 100 non-registered young carers, and another 50 community children through programs, workshops, and events. The YCP has run 11 weekly programs, 9 workshops, 18 special events, and 3 day camps.

The overall feedback confirmed that the YCP is providing a significant service to young carers in Toronto. The results showed that over half of the YCP members felt significantly better about themselves and their caring role since participating in the YCP. Parents of YCP members identified that the YCP has made a difference to their family by providing young carers with opportunities for them to feel important, and parents identified positive feelings about the program. The main barriers to YCP members accessing the programs included transportation and program times. Parents identified that programs closer to their homes would enable their children to attend YCP programs and events more easily.

Despite YCP being at its early stage in implementing young carers services, feedback from families has so far reaffirmed the outcomes and evaluation findings from young carers projects in the UK. Although the activities run by young carers programs, including YCP, are child-centered, the benefits reaped from such programs provide indirect support to the family as a whole.

The Young Carers Program was awarded the Toronto Community Foundation's Vital Youth Award in 2012.

APPLICABILITY/TRANSFERABILITY:

The Young Carers Program was inspired by the success of the Young Carers Initiative (YCI) designed and implemented by the Alzheimer Society in the Niagara Region. The original YCI was based on a highly successful model based in the UK; now operating for over 20 years and with 350+ chapters nationally. Australia offers similar supports to those of the UK, providing respite, information and services, programs and peer support. They have also started an annual festival. The United States have small support groups in Florida who also offer similar services as well as programs aimed at helping to teach young carers how to provide care.

In 2007, Hospice Toronto began working on adapting the YCI model to the urban setting. The Young Carers program is the first such urban young carers project in Canada. It serves as a role model for the young carers Canada movement, which also includes the Powerhouse Project and the Youth Caregivers Project from the Cowichan Family Caregivers Support Society in British Columbia. The Young Carers program developed an implementation toolkit can help replicate this program in multiple community settings nationally. The toolkit is complete and the program is currently exploring options for printing and publishing. Additionally, national partner organizations, as well as professionals looking to support this specific population have been in contact with the Young Carers Canada Steering Committee, expressing interest in adopting the program for implementation in diverse settings.

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http://ycptoronto.weebly.com/index.html

http://ycptoronto.weebly.com/who-we-are.html

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Integrated Care for Individuals with Severe and Persistent Mental Illness

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

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Strong and Steady Falls Prevention Program

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

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Prevention Olympics

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT:

This innovative practice aims to improve the identification and delivery of preventive care to patients within targeted populations. The initiative was launched in Ontario in 2010 within the practice of an academic family health team.

PRACTICE DESCRIPTION:

Preventative health care is one of the building blocks of primary care. However, despite the high rates of preventable illness there is not enough emphasis on health promotion. The situation was compounded by the lack of continuity with various providers often appearing to work in isolation from one another. In 2010, the team organized a collegial yet competitive prevention initiative (Prevention Olympics) based on the five preventive practice priorities in Ontario, to improve our practice performance through a coordinated, interdisciplinary system that identified and delivers preventive care to patients within the targeted populations due for screening.

The prevention initiative involved the following steps:

1) Established and published baseline performance of each provider, based on data in the electronic medical record (EMR)

2) Identified patients requiring preventive practices

3) Brainstormed and performed education blitz to providers on processes to improve prevention services

4) Communicated outreach to patients

5) Created four clinical teams for friendly competition

6) Data tracked and reconciled with EMR

7) Publicized results weekly (over ~8 wks) and identified areas of priority

The Ontario MOH criteria dictated which patients were to be targeted for the five preventive practice priorities in Ontario (immunizations, influenza, breast, colon, and cervical cancer screening). The targeted age groups and timelines for each were based on current best practice guidelines (ie. mammogram every 2 years). An important objective of the initiative was to put a system in place, whereby it would be possible to patients who required any type of preventative screening). Using the Electronic Medical Record, a protocol was created in order to run reports identifying eligible patients (by age, gender, etc.) and then breaking it down further highlight those patients that were due for the screening(s). A spreadsheet was used to track patients that had completed screening, as well as those due for outstanding tests.

While setting up the original prevention initiative as a “friendly competition” between four clinical teams encouraged participation, the lasting impact of the practice is the development of a protocol to identify patients due for screening, coordinate their care, and track follow-up in order to ensure provincial screening priorities are met. No additional funding was provided for this initiative and the practice was established to be integrated into and to help optimize normal clinic practice.

IMPACT:

The practice has not been formally evaluated. Feedback from patients has been positive and statistics continue to improve annually. For example, as a result of an interdisciplinary team approach, the physician practices experienced 20-30% improvements in uptake of prevention activities by patients such as colon cancer screening and immunizations. In addition to this success we have made other improvements to our health promotion and prevention strategies.

Anecdotally, patients expressed increased satisfaction with our initiative and appreciation for our proactive care. With patients and providers more engaged, we were able to deliver more preventive services as well as providing accurate data reconciliation to correctly identify the patients we needed to target. Each year, prevention screening continues to improve.

APPLICABILITY/TRANSFERABILITY:

This innovative approach has now expanded to include the Diabetes Program, helping to ensure diabetic patients are getting their A1C tests completed annually. The practice has also been shared with other local family health teams. This approach can theoretically be adopted within other primary care and specialty care teams. Key aspects included: baseline data measures, whole team planning for change, and follow-up of implementation strategies and impact.

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Information last updated on: May 3 2013

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communications:

Battram, E. (Feedback and review, May 3, 2013). [Ottawa Hospital Academic Family Health Team]

Publications

Alternative Profiles:

Other:

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

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/

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

Health Upwardly Mobile (HUM) Inc.

LOCATION:	**Alberta**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice aims to improve the care of mental health and addiction patients through a holistic approach that takes into account all aspects of the persons content. This approach was implemented by various health care providers across Calgary beginning in 2012.

PRACTICE DESCRIPTION:

While the ideas related to body-mind-spirit in the context of health and disease are ancient, it is only recently that bio–psycho-social–spiritual paradigms have become a standard. When treating mental health and addiction patients, health care providers often focus on symptom management and/or behaviour rather than using a holistic approach that takes into account all aspects of the person in the context of whatever disease process may be underneath. Many patients describe how unique Health Upwardly Mobile's (HUM's) approach is to assessment and treatment—not just in Calgary but provincially and nationally. This is based on their personal experiences in the health care system, past and present.

At HUM, all new patients complete a three-part comprehensive assessment that includes meetings with a registered nurse, registered psychologist, and physician, all of whom have specialized knowledge and skills in the areas of addiction, mental health, chronic pain, and occupational health. Psychological testing and blood and/or urine testing are also done as part of this process. The assessment is holistic and explores bio, psycho-social, and spiritual dimensions of individuals before treatment recommendations are made. For patients struggling with addiction, mental health, and chronic pain, we treat the whole person—rather than just focusing on behaviour or medication management—using individual and group therapy.

IMPACT:

HUM's approach is evidence-based and evaluations of the practice have been based on personal accounts and testimonials. These evaluations have also included informal observations of HUM's contribution to health care, specifically addiction, mental health, and chronic pain care. Patients are referred to HUM from various areas of the medical system when no other opportunities for care exist. These patients are often struggling with addiction or chronic pain and have exhausted public system resources. Local health care providers who refer long-term patients to HUM clearly view HUM as a resource they can trust. In addition, patients are eager to have a team of professionals supporting them with their holistic health care needs.

APPLICABILITY/TRANSFERABILITY:

HUM developed out of the experience of various health care providers who saw the need for a program that emphasizes the importance of comprehensive assessment and holist recovery rather than focusing exclusively on behavioural and medication management.To our knowledge, there are no other interprofessional programs that place a strong emphasis on initial assessment, holistic recovery, and continuing care for patients with addiction, mental health, and chronic pain issues. However, the HUM model could be replicated and transferred elsewhere. Parts of this model are being implemented by various health care providers across Canada (Alberta and Ontario specifically), and the US, who have learned of the HUM program at provincial, national, and international medical conferences.

Content was adapted from the following sources and relevant websites:

http://www.healthupwardlymobile.net/

External Submission from Paige Abbott, HUM

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External Source: http://www.healthupwardlymobile.net/

Shared Care Strategy for Patients with Chronic Diseases—Patients in Care, Providence Health Centre

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

SNAPSHOT: This innovative practice consisted of several projects all aimed at facilitating a seamless patient experience through better collaboration between health care providers. Launched in April 2010 in two health authorities in British Columbia, the core of initiatives are to strengthen relationships between family practitioners (FPs) and specialists to ensure that referrals are timelier and to avoid duplicating effort and resource utilization.

PRACTICE DESCRIPTION:

Ensuring maximum patient satisfaction is the ultimate goal of any health care provider. It requires a multi-pronged approach that focuses on timely access to care, an organized communication model, improving health outcomes, and ensuring that patients can manage their condition independently after hospital discharge. The health care community of British Columbia has recognized the need to devise a more organized and coordinated approach to health care delivery. In April 2010, the Shared Care Committee—a partnership of the BC Medical Association and Ministry of Health—Providence Health Care (PHC) and Vancouver Coastal Health launched a two-year joint initiative to establish a shared care approach to delivering health services to patients with complex chronic conditions. The purpose of this initiative was to facilitate a more comfortable and accessible experience for patients with chronic diseases by focusing on improving health outcomes, reducing per capita costs, and improving communication. The core of this initiative was strengthening relationships between family practitioners (FPs) and specialists to ensure that referrals are timelier and to avoid duplicating effort and resource utilization.

The initiative consisted of several projects all aimed at facilitating a seamless patient experience through better collaboration between health care providers. The first of these projects, the Rapid Access to Consultative Expertise (RACE) telephone advice line, is a telephone technology that allows FPs rapid access to specialists and thereby avoid unnecessary wait times, ER visits and face-to-face consultations. FPs can choose from a list of specialty services and have their call routed directly to the specialist's pager to ensure rapid consultations. Similarly, an acknowledgement of referral mechanism was put in place to promote a more effective telephone-based referral system for FPs with an emphasis on ensuring the timely receipt of the referral. These efforts were also elaborated on to include Shared Care Planning, a line of communication between FPs and specialists following the consult, which was not in practice prior to this initiative. Finally, the self-management project was designed to engage patients in establishing their own health goals and action plan. This patient-centred approach provides a more tailored and effective plan for self-management.

A highly organized implementation plan was devised. It included several diverse stakeholder groups and advisory groups that met multiple times per year to discuss a wide range of topics from IT support to physicians' opinions on the feasibility of the communicative model in their daily practice.

IMPACT:

The Shared Care strategy is evaluated through individual evaluations of each of its component projects, rather than as whole strategy. Each project was first put through the Plan-Do-Study-Act Cycle of prototype design, trials, and implementation, to observe its efficacy and determine gaps in the framework at round-table discussions. A formal evaluation of each project was conducted to qualitatively and quantitatively assess the initiative's success and impact on patient outcomes.

As an example, the RACE project was formally evaluated using measures such as questionnaires, online surveys, and interviews with the FPs and specialists. These two groups of health care providers generally found RACE to be an excellent tool that filled the gap in communication. The online survey indicated that 90% of FPs and specialists were aware of RACE and of those who participated in the RACE trial, 95% would recommend it to their colleagues. They noted that it reduced their patients'

emergency department visits (32% avoided visits), reduced face-to-face consultations with specialists (60% avoided consultations), and reduced unnecessary specialist referrals, and 83% believed it helped manage their health care delivery. Overall, RACE was effective at enhancing timely communication between FPs and specialists, given that of the more than 600 calls that were logged by 2012, 80% were answered within 10 minutes. The RACE system has won the Institute of Public Administration of Canada /Deloitte Public Sector Leadership Award, and the Health Employers Association of British Columbia Top Innovation Gold Apple Award.

The Shared Care Strategy is correlated with an increased referral acknowledgement to 77%; similar gains were observed in management of care using Share Care Planning. Interviews with patients have brought to light their satisfaction with their quality of care and improved navigation through the medical system. The trials have demonstrated that a coordinated approach using effective models of communication can enhance the patient's journey, improve emergency department flow, reduce costs (by up to $200 per call), and increase specialty capacity.

APPLICABILITY/TRANSFERABILITY:

The success of this initiative has encouraged more participation and utilization in BC. The RACE project was piloted in the cardiology unit; given its success, it was then expanded to 11 specialty services in 2012. The acknowledgement of referral system has been successfully implemented in several Providence Health Care chronic disease clinics, private specialty clinics, and broader provincial programs. Share Care Planning has been implemented both regionally and provincially and overall, the Shared Care Strategy innovative practice initiative has engaged over 1500 FPs and 200 specialists.

Although there are other referral practices being implemented across Canada and internationally, many of them are led by nurse specialists. The Share Care Strategy is the only initiative that provides GPs and their patients with direct real-time telephone access to specialists, and is a practice that could be adopted in other provinces and territories.

Content was adapted from the following sources and relevant websites:

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

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

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

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

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

Frontenac Community Mental Health and Addiction Services and Providence Care - System Collaboration: Transitioning Clients from In-Patient to Community

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice targets long stay, mental health patients returning to their communities. Launched at the Providence Care Hospital in Ontario in 2011, the transition project was designed to encourage joint planning and system redevelopment with the client at the centre of all activities. The goal of this transition project is to create a smooth transfer and seamless service for clients returning to the community from hospital, and to ensure excellent integrated services.

PRACTICE DESCRIPTION:

In anticipation of a new Providence Care Hospital in Kingston, Ontario, the number of mental health beds at Providence Care–Mental Health Services (PC-MHS) will be reduced by one third by December 2013. Frontenac Community Mental Health and Addiction Services (FCMHAS) will provide community residences for many of the clients returning to the community, most of whom will require significant clinical and housing supports. The project is targeted at long stay, dual diagnosis or forensic in-patients. Interprofessional treatment teams will provide services to each client for as long as necessary. System collaboration and integration will enhance system capacity to enable future clients to avoid hospitalization.

In the past, real service integration was missing from efforts to return people to the community. Discharges lacked continuity between hospital and community living. Clients were served by the PC-MHS or FCMHAS, but not particularly well as a combined effort. This transition project was designed to encourage joint planning and system redevelopment with the client at the centre of all activities. The goal of this transition project is to create a smooth transfer and seamless service for clients returning to the community from hospital, and to ensure excellent integrated services. The project was started in the fall of 2011 and will be completed by December 2013.

A Client Transition Working Group (CTWG) was created with staff from both PC-MHS and FCMHAS, and included employees from residential, intake, inpatient, Assertive Community Treatment Teams, property operations, and senior management. The CTWG meetings were designed based on Providence Care's participatory leadership model, appreciative inquiry techniques, and executive coaching principles to solicit involvement in the planning process. The results have been significant with respect to getting commitment from all those involved in this process. Interprofessional treatment teams are being created with staff from various parts of the system to provide service to clients regardless of whether they are in hospital or community.

The CTWG has developed an individual service team model that builds on the strengths and work of both organizations and aims to bridge gaps and overcome challenges for each client. It enables the individual to form relationships with a team who will work with them to define the transition plan and provide care to the client throughout the process. The team will include the client, family or substitute decision-maker, in-patient staff, outpatient ACT team staff, residential staff, and others as needed. A recovery framework will be used.

IMPACT:

The transition project will be evaluated based on its success related to the long-term stability of clients living in the community. The project will be evaluated by Dr. Terry Krupa, Queen's University, over 2013. The project is still in process and will not be fully completed until all clients have been transferred to the community by approximately December 2013. However, the model being used has already yielded significant results related to the cooperation and planning between hospital and community services. It has been stated that people are "excited" about this process even though they may not be affected by its outcomes at a personal level.

APPLICABILITY/TRANSFERABILITY:

The participatory leadership model offered by Providence Care is applicable to all health systems. The World Café techniques allow for significant contributions to planning at all levels of a system or across systems. It is not a consultation model, but rather a participation model that yields a high level of active engagement from all involved. The information that is "harvested" after each planning is rich in applicability and practical in nature. People truly feel they are part of the process and become invested because they feel they have been heard.

Content was adapted from the following sources and relevant websites:

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

http://www.fcmhas.ca/

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Information last updated on: December 18, 2012

External Source: http://www.pccchealth.org/cms/sitem.cfm/our_sites/mental_health_services/

Red Deer Primary Care Network's Health Basics Program

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

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

PRACTICE DESCRIPTION:

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

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

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

Design:

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

Target audience:

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

IMPACT:

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

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

Changes in BMI and waist measure:

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

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

Changes in physical activity and eating habits:

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

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

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

Additional evaluation planned for 2011/12:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

Diabetes Clinical Indicator Database

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice facilitates translating diabetes clinical guidelines into practice. While health care providers have an excellent awareness of the guideline targets and recognize the need for action, the move to more aggressive treatment is lagging. The South West Diabetes Regional Coordination Centre (RCC) responded to identified needs by supporting the development and implementation of an application to assist in the tracking and use of quality measures.

PRACTICE DESCRIPTION:

Canadians have had access to diabetes clinical practice guidelines for nearly 20 years. Despite this, there has been limited success in translating the guidelines into practice. While health care providers have an excellent awareness of the guideline targets and recognize the need for action, the move to more aggressive treatment is lagging.

The South West Diabetes Regional Coordination Centre (RCC) responded to identified needs by supporting the development and implementation of an application to assist in the tracking and use of quality measures. The RCC created the Diabetes Clinical Indicator Database© (D-CID) to enable diabetes education programs (DEPs) to track and identify trends in clinical and outcome measures. D-CID expedites:

- managing key patient information;
- providing enhanced chronic disease care;
- tracking improvements in the number of patients receiving care according to the clinical practice guidelines;
- generating statistics on program effectiveness and variances; and
- identifying clear gaps in clinical documentation.

D-CID provides users with real-time utilization data and enables them to respond by adjusting their model of care to better support their specific population. D-CID accelerates the shift from reactive care to planned, proactive care and encourages a population-based approach that improves the overall quality of care.

D-CID features a simple interface for clinicians to use when entering their patient information. It also offers a report depot (which houses population-based data) and a clinical dashboard.

IMPACT:

The Canadian Diabetes Association's Clinical Practice Guidelines recommend screening for retinopathy (for those with diabetes) every 1-2 years (Canadian Diabetes Association, 2008). The same guidelines recommend screening for neuropathy once yearly. However, according to the Ontario Diabetes Strategy, the percent of Ontarians confirmed with diabetes who have actually received a retinal eye exam in the past two years is only 73.5% (MOHLTC, 2011).

Analysis of the medical records within practice settings indicated inconsistent practices in terms of documentation of retinal eye exam and foot exam testing.

Use of D-CID has led to improved documentation of both retinal and foot exams (For those sites that have elected to track retinal and foot exams, 100% of their patient records have documentation as to whether a retinal eye exam and foot exam have been completed).

In addition, the Canadian Diabetes Association's Clinical Practice Guidelines recommend that self-management education (that incorporates goal setting) be incorporated into diabetes programming for all individuals.

Use of D-CID has led to improved documentation of self-management goals. 38% of patients now have a documented goal.

D-CID has also yielded efficiencies in program administration, reducing the overall time spent collating and recording statistics by 97%. All DEPs are expected to report to the Ministry of Health and Long Term Care on a quarterly basis:

- The number of new patients seen;
- The number of re-admits/visits/cancellations/no shows;
- The type/age/gender of patients; &
- Their wait times.

This work of reporting stats to the Ministry has historically been completed manually; typically this process has taken between 9-15 hours to complete every quarter. D-CID has enabled practices to achieve efficiency improvements (reduces time spent tracking and reporting data manually; and reduces the time spent calling for lab work).

This has been achieved by using resources wisely (additional funding is not required to successfully and sustainably implement D-CID).

There has been no need, by any party, to submit a request for funding in order to pilot or successfully implement D-CID. In addition, D-CID requires limited information technology (IT) support as the software is Microsoft Access based and is customized to the end user's needs at install. Existing IT support (within the DEP) manages concerns as they arise (much as they support current hardware or software applications). In addition, The South West CCAC has offered Diabetes Regional Coordination Centres a royalty-free licence to use the D-CID with Diabetes Education Programs in their respective regions.

In addition, at this year's OHA Health Achieve conference, the South West Diabetes RCC was honoured with the Leading Practices Award under the category of Innovation for its submission on the Diabetes Clinical Indicator Database (D-CID).

To date, local evaluations have occurred at each individual site based on clinical and process indicators pre-/post-D-CID implementation:

- #% of diabetes patients with HbA1C £ 7%
- #/% diabetes patients with a documented foot exam
- #/% of diabetes patients with a documented retinal eye exam
- #/% of diabetes patients with an LDL £ 2 mmol/L
- #/% of diabetes patients with a blood pressure £ 130/80 mm Hg
- #/% of high risk patients with HbA1C > 9%, LDL > 3 mmol/L and BP > 130/80 mmHg
- #/% referrals to diabetes education, reported by physician
- Average "length of stay" for diabetes education
- #/% of patients with a documented self-management goal; & self-management goal attainment rates
- Process cycle time regarding the tracking/reporting data and other administrative tasks i.e. calling physicians offices' for copies of lab work

A comprehensive, formal analysis of all sites is underway. Our intent is to publish our resultant findings in peer review journals.

APPLICABILITY/TRANSFERABILITY:

The Diabetes Clinical Indicator Database (D-CID) is currently being used (and has demonstrated consistent results i.e. improved documentation of both retinal and foot exams, improved documentation of self-management goals, and efficiency improvements (time spent tracking and reporting data; time spent calling physician's offices for lab work)) in multiple locations, including Prince Edward Island, the South West LHIN region, the Erie St. Clair LHIN region, the Waterloo Wellington LHIN region, and the Central and Central West LHIN regions in Ontario.

Content developed from the following sources and relevant websites:

http://www.healthachieve.com/Awards/Leading%20Practices%20Presentations/Diabetes%20Clinical%20Indicator%20Database.pdf

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External Source: http://www.thehealthline.ca/displayservice.aspx?id=15525

Alberta Healthy Living Program

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

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

PRACTICE DESCRIPTION

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

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

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

IMPACT:

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

Content adapted from the following sources and relevant websites:

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

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

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

First Nations Telehealth Manitoba

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

SNAPSHOT: This innovative practice addresses the needs of populations that live in isolated communityies with limited or no road access, away from physician services. Launched in Manitoba in 2011, telehealth hopes to bridge geographic and jurisdictional divides, giving these remote populations access to patient education, primary health care, and specialties.

PRACTICE DESCRIPTION:

First Nations communities across Manitoba are greatly benefiting from telehealth, mainly because of partnerships among First Nations communities and leadership, health care facilities and providers, the provincial government, Health Canada, Canada Health Infoway, and Broadband Communications North.

In Manitoba, roughly half of the on-reserve population lives in isolated communities with limited or no road access, and another 10% lives in semi-isolated communities hours away from physician services. Telehealth bridges geographic and jurisdictional divides, giving these remote populations access to patient education, primary health care, and specialties such as psychology, respiratory (using digital stethoscopes), oncology, dermatology, psychiatry, nephrology, and surgical pre-admission screening. Telehealth also improves education and professional development for health care providers and supports contact between patients in hospital in the three major cities in Manitoba—Winnipeg, Brandon, and Thompson—and family members back home.

The Manitoba experience demonstrates how it is possible to overcome many challenges, such as the lack of broadband coverage in remote locations; staff not being familiar with the technology; not having enough staff to handle the workload; the high initial cost of establishing telehealth sites; and the difficulties of working across jurisdictions (First Nations, federal, provincial, regional health authority). These barriers were generally overcome by adhering to a series of guiding principles:

- having a shared vision and common goal among the partnership members, while being respectful and valuing multiple perspectives
- actively engaging and supporting local health care providers and community leaders early in the readiness assessment and implementation processes
- providing ongoing support to the telehealth users and being responsive to arising issues and concerns
- acting quickly and efficiently on short-term funding opportunities when available
- keeping senior leadership apprised of progress, with transparency and accountability to parent organizations
- providing accurate and timely statistics on service use
- integrating with MBTelehealth (shared service rather than duplication)
- having First Nations and Health Canada representation on the provincial telehealth advisory committee investing substantially in connectivity provision by Broadband Communications North, an Aboriginal service provider dedicated and committed to supporting broadband needs of remote and rural First Nations communities, and the Provincial Data Network managed by the Province of Manitoba

With more than 1,500 clinical telehealth sessions in the last year spread over 26 sites in First Nations communities, and with more under development, telehealth in Manitoba is expected to continue to grow.

External Source: http://www.mbtelehealth.ca/wnArchive2011.html