Health Innovation Portal:
Archive of Innovative Practices

Theme: **Patient Centered Care (Vol. 1)**

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Selected Search Output Table (December 17, 2013)

SEARCH TERMS:	**N/A**	**LOCATION:**	**All**
HEALTH THEME:	**Patient Centered Care**	**FRAMEWORK CATEGORY:**	**All**
HEALTH SECTOR:	**All**	**SEARCH RESULTS:**	**27 results out of 79**

1. Pharmacists Practising in Family Health Teams

Implementation Year: Tuesday, December 9, 2003 - 16:00	**Location: Ontario**	**Practice Website: http://www.health.gov.on.ca/en/pro/programs/fht/fht_progress.aspx**

SNAPSHOT:

Family Health Teams (FHTs) were introduced in Ontario in 2003 and were designed to address issues related to accessibility and quality of primary care. The goal of involving pharmacists in FHTs was to improve appropriate medication therapy management, particularly given the prevalence of chronic illnesses. There are now approximately 150 pharmacists in Ontario practising with FHTs.

CONTACT INFORMATION:

Name: Lisa Dolovich Title: Research Director and Professor, Department of Family Medicine Organization: McMaster University Email address: ldolovic@mcmaster.ca Telephone number: (905) 525-9140 ext 28509 Information last updated on: October 15, 2013

2. Longitudinal Elderly Person Shadowing Project

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

3. Patient Enrolment with a Primary Care Provider

Implementation Year: Tuesday, December 9, 2003 - 15:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice involving patient enrolment in a primary health care practice formalizes an ongoing relationship between primary care providers and patients; provides the basis for population-based funding, capitation-based provider payment, and primary care performance measurement; and facilitates pro-active preventive care and chronic disease management. The practice has been implemented in Ontario in most primary care settings and involves more than three quarters of Ontario residents and primary care physicians.

CONTACT INFORMATION:

Phil Graham Manager, Family Health Teams and Related Programs Primary Care Branch Negotiations and Accountability Management Division

Ontario Ministry of Health and Long-Term Care Telephone: 416-212-0832 Email: Phil.Graham@ontario.ca

4. Community Health Centres in Ontario

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

5. Alberta Access Improvement Measures (AIM)

Implementation Year: Friday, December 9, 2005 - 14:30	**Location: Alberta**	**Practice Website: http://www.albertaaim.ca**

SNAPSHOT:

This innovative practice helps family physicians, speciality care physicians, and Alberta Health Services programs and their teams reduce or eliminate wait times, improve office efficiency, and improve patient care by using quality improvement methods. The initiative has involved 19 learning collaborative supporting improvement teams across Alberta, including 614 family physicians from 133 primary care clinics.

CONTACT INFORMATION:

Steven Clelland Director, Alberta AIM Email: steven.clelland@albertahealthservices.ca Telephone: 780-342-8823

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

7. Bridging Relationships Across Interprofessional Domains (BRAID)

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

SNAPSHOT:

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

This innovative practice aims to improve the competencies of advanced clinical practitioners delivering care for patients with arthritis. The interprofessional program was launched in 2005 at St. Michael's Hospital, in collaboration with the Hospital for Sick Children in Toronto, and now has over 37 graduates working in diverse clinical settings across Ontario.

CONTACT INFORMATION:

Name: Dr. Katie Lundon BScPT, MSc, PhD or Dr. Rachel Shupak MD, FRCP(C) Title: Program Director-General Organization: Advanced Clinician Practitioner in Arthritis Care, St. Michael's Hospital Email address: k.lundon@cogeco.ca Information last updated on: August 1, 2013

10. Traditional Healing, Medicines, Foods and Supports Program (THMFS) and Aging at Home Elder Care Continuum, Sioux Lookout Meno Ya Win Health Centre (SLMHC)

Implementation Year: Friday, November 26, 2004 - 10:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice is improving the health and well-being of Elders in remote and isolated communities in northwestern Ontario through the delivery of culturally safe care and the development of a continuum of linked community-based and institutional services. Initiated by Sioux Lookout Meno Ya Win Health Centre (SLMHC), the practice is rooted in a collaborative strategy among First Nations leadership and communities, the LHIN, provincial and federal governments, health organizations, providers, and clients.

CONTACT INFORMATION:

Name: Heather Fukushima Title: Director, Long-Term Care and Service Development and Traditional Program Organization: Sioux Lookout Meno Ya Win Health Centre Email address: hfukushima@slmhc.on.ca Telephone number: (807) 737-2700 Information last updated on: June 26, 2013

11. Supporting Métis seniors and families—Métis Nation of Ontario (MNO) community centres

Implementation Year: Friday, November 26, 1993 - 10:15	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the need to support Métis senior citizens who are at risk of falling through the cracks of a complex health system. The first

community centres were established in the mid-1990s, with the remaining centres developing since that time. Programming involves partnerships with different ministries, Aboriginal groups and the volunteer sector. Care delivery involves interdisciplinary health staff, community centre workers and volunteers.

CONTACT INFORMATION:

Name: Wenda Watteyne, Title: Director of Healing and Wellness Organization: Métis Nation Ontario Email address:wendaw@metisnation.org Telephone number: 613.798.1488 Information last updated on: October 23, 2013

12. Kahnawake Home and Community Care Services; Culturally Competence Case Management

Implementation Year: Wednesday, November 26, 2003 - 10:00	**Location: Quebec**	**Practice Website: http://www.kscs.ca/taxonomy/term/5/all**

SNAPSHOT:

This innovative practice addresses the need to provide a better continuum of care for First Nations seniors and others in their home community of Kahnawake (population 9,500). It provides services in clients' homes and involves a 10-member home care nursing team, an 18-member home health aide team, a seven-member hospital-based Day Program team, an Adult and Elders Service Counsellor, two Day Program Animators, two Elders Case Workers, administrative staff, a kitchen team, a maintenance and security team, and the program's manager.

CONTACT INFORMATION:

Name: Mike Horne Title: Program Manager, Kahnawake Home and Community Care Services Organization: Kahnawake Shakotiia'takehnhas Community Services Email address: mikeh@kscskahnawake.ca Telephone number: (450) 632 5499 ext: 115 Information last updated on: July 17, 2013

13. Community health aides help with nursing shortages, continuity of care, and cultural safety

Implementation Year: Monday, November 26, 2007 - 10:00	**Location: Newfoundland & Labrador**	**Practice Website: http://www.nunatsiavut.com/index.php?option=com_content&view=frontpage&Itemid=1&lang=en**

SNAPSHOT:

This innovative practice addresses concerns about the recruitment and retention of nurses, and about the continuity and cultural safety of care for Inuit seniors.

CONTACT INFORMATION:

Name: Tina Buckle Title: Community Health Nursing Coordinator Organization: Nunatsiavut Government, Dept. of Health and Social Development Email address: tina_buckle@nunatsiavut.com Telephone number: (709) 896-9750 ext 232 Information last updated on: September 30, 2013

14. Home care program for everyone, on- or off-reserve, Bella Coola

Implementation Year: Monday, November 26, 2007 - 09:30	**Location: British Columbia**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the need for equal access to integrated home and community care for Aboriginal seniors on-reserve. The practice was launched in Bella Coola and involves an interprofessional team of federal home care workers, provincial home care workers, and band-employed workers.

CONTACT INFORMATION:

Name: Glenda Phillips Title: Manager, Home & Community Support Organization: Bella Coola General Hospital Email address: glenda.phillips@vch.ca Telephone number: 250-799-5311 Information last updated on: September 30,2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

17. InSite: Vancouver's Medically Supervised Injection Facility

Implementation Year: Tuesday, October 7, 2003 - 13:45	**Location: British Columbia**	**Practice Website: http://supervisedinjection.vch.ca/**

SNAPSHOT:

This innovative practice addresses problems associated with illegal drug use, such as transmission of blood-borne diseases, fatal drug overdoses, and community safety. The practice was launched in Vancouver, British Columbia, in one clinic and involved a team of nurses, counsellors, mental health workers, and peer support workers.

CONTACT INFORMATION:

Name: Monika Stein Title: Manager, Harm Reduction Program Organization: Vancouver Coastal Health Email address: monika.stein@vch.ca Telephone number: n/a

18. Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA): A Group Therapeutic Approach to Decreasing Suicidal Behaviour in Ontario

Implementation Year: Wednesday, January 20, 1999 - 02:00	**Location: Ontario**	**Practice Website: N/a**

SNAPSHOT:

This innovative practice addresses decreasing suicidal behaviour among people who have attempted suicide at least twice. The practice was launched at a teaching hospital in Toronto, Ontario, in 1999. It is run by two professionally licensed facilitators trained in the intervention and a peer facilitator who has graduated from the program.

CONTACT INFORMATION:

Name: Yvonne Bergmans Title: Suicide Intervention Consultant Organization: St. Michael's Hospital – University of Toronto Email Address: Bergmansy@smh.ca Telephone Number: 416-864-6060 ext. 4078 Information Last Updated On: June, 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

20. Seniors Home Health Program (SHHP)

Implementation Year: Monday, February 3, 1997 - 00:30	**Location: Ontario**	**Practice Website: http://www.ajhs.ca/primary-health-care-services/seniors-home-health-program-shhp**

SNAPSHOT:

This innovative practice addresses the issue of finding ways to keep frail, isolated, and/or homebound seniors in their own homes and out of long term care and emergency rooms, as safely and for as long as possible. The program was launched in Ontario in 1997 out of one community health centre.

CONTACT INFORMATION:

Name: Margaret Cheung Title: Director of Primary Health Care Organization: Anne Johnston Health Station Email address: margaretc@ajhs.ca Telephone number: 416-486-8666 x.246 Information last updated on: May 3, 2013

21. Telehomecare in Ontario

Implementation Year: Saturday, February 3, 2007 - 01:00	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to provide care to patients in their home by offering a remote monitoring unit to transmit their blood pressure, weight and other measurements from home to the physicians office on a daily basis. Launched in 2007, Ontario is currently implementing a provincial telehomecare expansion program.

CONTACT INFORMATION:

Name: Laurie Poole Title: Vice President, Telemedicine Solutions Organization: Ontario Telemedicine Network Email address: lpoole@otn.ca Telephone number: 416-446-4110 ext. 4233

22. Primary Care Memory Clinics: An Innovative, Integrated Model of Care to Improve Capacity and Quality of Health Care for Seniors in Family Practice

Implementation Year: Friday, February 3, 2006 - 00:15	**Location: Ontario**	**Practice Website: http://www.ncbi.nlm.nih.gov/pubmed/20977435**

SNAPSHOT:

This innovative practice was created to resolve dementia care gaps in primary care by offering a clinic where service is targeted at allowing for quick and accurate assessment of memory loss in patients. The Primary Care Memory Clinic was established in 2006 in the Centre for Family Medicine Family Health Team (FHT) in Kitchener, Ontario.

CONTACT INFORMATION:

Name: Linda Lee Organization: Centre for Family Medicine Family Health Team Email address: joelinda5@rogers.com Telephone number: 519-783-0023

23. An Innovative Behavioural Outreach Service and Day Program for Persons with Acquired Brain Injury and Challenging Behaviours

Implementation Year: Thursday, February 3, 2000 - 01:00	**Location: Ontario**	**Practice Website: http://www.westpark.org/Services/ABICommunityOutreachService.aspx**

SNAPSHOT:

This innovative practice targets survivors of acquired brain injury (ABI), that show behavioural changes which adversely affect their relationships with family members, friends, co-workers, and others. The Acquired Brain Injury Behaviour Services at West Park Healthcare Centre, in Toronto, Ontario, provides community outreach behaviour therapists to help survivors, their families, and caregivers learn strategies to manage challenging behaviours following an ABI.

CONTACT INFORMATION:

Name: Gary Gerber Title: Clinical Director, Acquired Brain Injury Behaviour Services Organization: West Park Healthcare Centre Email address: gary.gerber@westpark.org Telephone number: 416 243-3600 2615

24. Regina Qu'Appelle Health Region's (RQHR) Aboriginal Home Care Program

Implementation Year: Friday, February 3, 2006 - 00:30	**Location: Saskatchewan**	**Practice Website: http://www.healthcouncilcanada.ca/rpt_det.php?id=437**

SNAPSHOT:

This innovative practice aims to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. Launched in the Regina Qu'Appelle Health Region's (RQHR), the program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

CONTACT INFORMATION:

Additional information about this program is available online at http://www.rqhealth.ca/programs/comm_hlth_services/homecare/homecare.shtml.

25. Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)

Implementation Year: Friday, February 3, 2006 - 00:45	**Location: Quebec**	**Practice Website: http://www.prismaquebec.ca/cgi-cs/cs.waframe.index?lang=2**

SNAPSHOT:

This innovative practice addresses many of the challenges of delivering comprehensive health care services to an aging population. In 2006, a model of integrated care called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) was launched throughout Quebec.

CONTACT INFORMATION:

Name: Hebert Rejean Title: Principal Investigator Organization: PRISMA Email address: rejean.hebert@USherbrooke.ca Telephone number: (819) 821-5112 Last updated: N/A

26. Home First

Implementation Year: Saturday, February 3, 2007 - 00:30	**Location: Ontario**	**Practice Website: http://www.lhincollaborative.ca/Page.aspx?id=1902**

SNAPSHOT:

This innovative practice addresses the issue of of Alternate Level of Care (ALC) patients waiting for beds in long-term care facilities. In the last few years, Ontario has developed a Home First program that sends patients back to their communities and homes with intensive case management.

CONTACT INFORMATION:

Name: Liane Fernandes Title: Interim Senior Director Organization: LHINCollaborative Email address: liane.fernandes@lhins.on.ca Telephone number: 416-969-3891 Last updated: 30 November 2012 (checked November 30)

27. Patients as Partners

Implementation Year: Saturday, February 2, 2002 - 00:30	**Location: British Columbia**	**Practice Website: http://www.impactbc.ca/patients-as-partners**

SNAPSHOT:

This innovative practice addresses the need to help patients constructively share both positive and negative experiences as a voice for improvement to ensure patient experiences can inform system, program, and practice improvements. Patients as Partners is both a policy and philosophy of the British Columbia Ministry of Health. It offers an opportunity for patient engagement in redesign through the partners who deliver Integrated Primary and Community Care.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Impact Health Improvement Action Society of BC Email address: info@impactbc.ca Phone number: 604.742.1772

Pharmacists Practising in Family Health Teams

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

SNAPSHOT: Family Health Teams (FHTs) were introduced in Ontario in 2003 and were designed to address issues related to accessibility and quality of primary care. The goal of involving pharmacists in FHTs was to improve appropriate medication therapy management, particularly given the prevalence of chronic illnesses. There are now approximately 150pharmacists in Ontario practising with FHTs.

PRACTICE DESCRIPTION:

Family Health Teams (FHTs) are comprised of physicians and other health care professionals, including pharmacists. Each FHT offers seven-days-a-week access to care, providing a range of services determined by community needs. Interprofessional involvement is made possible through blended payment models, including a combination of capitation, fee for service, bonuses for achieving prevention targets, and special payments to expand care services such as palliative, home, or pre-natal care. Pharmacists' role in the FHTs has been growing as they work to ensure better prescribing practices and care for the whole patient through comprehensive assessments and follow-ups.

FHTs are organized through the local health integration network and funded by the Ministry of Health and Long-Term Care. Identified stakeholders include the Ontario Pharmacists Association and the Association of Family Health Teams of Ontario, Primary Care Pharmacists Specialty Network.

IMPACT:

The greater involvement of pharmacists in FHTs has been supported by evidence generated by the Seniors Medication Assessment Research Trial (SMART) study, which was conducted in 2000 (see http://spep.phm.utoronto.ca/spep/SMARTPROJECTSUMMARYSPEP.htm). This study involved 1,554 patients referred to a pharmacist for comprehensive assessment in the first 24 months alone. SMART was randomized and designed to determine effectiveness of pharmacy consulting on physician prescribing behaviours. Qualitative reporting indicated fewer drug-related problems and greater physician compliance to pharmacist recommendations (72.3%, 790/1093). SMART provided a strong base for subsequent programming. Funding was provided by the Health Transition Fund, part of Health Canada, and the Ontario Ministry of Health and Long-Term Care.

The regular monitoring and evaluation of FHTs has demonstrated largely positive results with respect to patient satisfaction and job satisfaction. The Ontario government is investing $300 million annually in FHTs; however, evidence of the cost-effectiveness of this model is not yet publically available.

APPLICABILITY/TRANSFERABILITY:

The findings from SMART informed the development of Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics (IMPACT) (see http://www.impactteam.info/impactHome.php), which also contributed to an evidence base for increased pharmacist involvement. This program was designed to provide a demonstration of how pharmacists could be integrated into the primary care office setting to ultimately improve patient outcomes through optimal drug therapy. During the implementation period of 2004–2006, pharmacists were working two to three days a week for 31 months in seven family practice sites across Ontario. Altogether, there were seven pharmacists and 70 physicians to cover approximately 150,000 patients. Primary responsibilities for pharmacists in this program included conducting individualized patient medication assessments, providing drug information and education, developing office system enhancements to optimize drug therapy, and facilitating integration activities. While this model also produced positive reporting, efforts were transitioned into the provincial FHT model.

Given the current reach of FHTs and changes related to pharmacist involvement, this primary care model is highly transferable. The establishment of the electronic health record system was noted as a key facilitator to enable communication among different providers. Next steps will include demonstrating cost-effectiveness or return on investment on a provincial level.

CONTACT INFORMATION:

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Telephone number: (905) 525-9140 ext 28509

Information last updated on: October 15, 2013

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

Publications:

Dolovich, L. (2012). Ontario pharmacists practicing in family health teams and the patient-centered medical home. *Annals of Pharmacotherapy*, *46*(Suppl 1), S33–S39. Retrieved from

http://www.impactteam.info/documents/LDolovich2012.pdf

Farrell, B., Dolovich, L., Emberley, P., Gagné, M.A., Jennings, B., Jorgenson, D., … Woloschuk, D. (2012). Designing a novel continuing education program for pharmacists: Lessons learned. *Canadian Pharmacists Journal, 145*(4), e7–e16. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3567806/

Farrell, B., Pottie, K., Haydt, S., Kennie, N., Sellors, C., & Dolovich, L. (2008). Integrating into family practice: The experiences of pharmacists in Ontario, Canada. *International Journal of Pharmacy Practice, 16*(5), 309–315. Abstract retrieved from http://onlinelibrary.wiley.com/doi/10.1211/ijpp.16.5.0006/abstract

Ontario Ministy of Health and Long-Term Care. (2013). Family health teams: Guide to interdisciplinary provider compensation. Retrieved from http://www.health.gov.on.ca/en/pro/programs/fht/docs/fht_inter_provider.pdf

Personal Communications:

Dolovich, L. (October 15, 2013).

Alternative Profiles:

CareFirst. (n.d.). *Patient centered medical home (PCMH)*. Retrieved from https://member.carefirst.com/individuals/patient-centered-medical-home/patient-centered-medical-home-pcmh.page

External Source: http://www.health.gov.on.ca/en/pro/programs/fht/fht_progress.aspx

Longitudinal Elderly Person Shadowing Project

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

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

factors contributing to this program's success and continuation.

CONTACT INFORMATION:

Name: Jenny Basran

Title: Regional Health Authority Geriatrics Program Director

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

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Telephone number: 306 655 8925

Information last updated on: November 5, 2013

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

Publications:

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

Personal Communications:

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

Alternative Profiles:

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

Patient Enrolment with a Primary Care Provider

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

Snapshot: This innovative practice involving patient enrolment in a primary health care practice formalizes an ongoing relationship between primary care providers and patients; provides the basis for population-based funding, capitation-based provider payment, and primary care performance measurement; and facilitates pro-active preventive care and chronic disease management. The practice has been implemented in Ontario in most primary care settings and involves more than three quarters of Ontario residents and primary care physicians.

Practice Description:

Patient enrolment is a process in which patients are formally registered with a primary care organization, team, or provider. Patient enrolment facilitates accountability by defining the population for which the primary care organization or provider is responsible, and it facilitates a longitudinal relationship between the patient and provider. Formal patient enrolment with a primary care provider lays the foundation for a pro-active, population-based approach to preventive care, chronic disease management, and systematic practice-level performance measurement and quality improvement. It clearly establishes primary health care providers as health stewards for a defined population rather than providers of services to those who present themselves for care.

Formal patient enrolment is a feature of several primary care physician remuneration and organizational models, including capitation-based blended payment (family health organizations (FHOs) and family health networks(FHNs)), fee-for-service-based blended payment (family health groups, comprehensive care management), and salary-based blended payment (rural and northern physician group agreements, blended salary). In nurse practitioner–led clinics and community health centres, patients register with the organization.

Patient enrolment is voluntary for both patients and physicians. Patients are not required to enrol, even if their regular primary care physician participates in a patient enrolment model. Physicians cannot refuse to enrol a patient because of the patient's health status or level of care based on guidelines of the College of Physician and Surgeons of Ontario. When a patient enrols with a primary care physician, the patient agrees to seek care first from the enrolling physician' practice, unless the patient is travelling or experiencing a health emergency. Enrollment with a primary care physician has grown from less than 600,000 in 2002 to 10.1 million (74% of the Ontario population) in June 2013.

Impact:

This innovative practice has been implemented widely in Ontario since 2002 and does not have a completed evaluation at this time. An evaluation is underway of patient enrolment in FHGs and FHOs; it is expected to be completed in 2014. Because patient enrolment is linked to specific provider payment and organizational models, the impact of patient enrolment per seis impossible to assess in the Ontario context. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

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

Applicability/Transferability

Patient enrolment has been adapted from other international jurisdictions and was implemented in Quebec in 2002.

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Community Health Centres in Ontario

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

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

Practice Description:

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

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

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

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

Impact:

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

Applicability/Transferability

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

The success of this specific program is dependent on:

• significant investment of resources;

• consistent oversight of CHCs;

• similar compensation being provided to all physicians;

• basing evaluations on comprehensive data; and

• targeting programs and services to the needs of the community.

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Alberta Access Improvement Measures (AIM)

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

Snapshot: This innovative practice helps family physicians, specialty care physicians, and Alberta Health Services programs and their teams reduce or eliminate wait times, improve office efficiency, and improve patient care by using quality improvement methods. The initiative has involved 19 learning collaborative supporting improvement teams across Alberta, including 614 family physicians from 133 primary care clinics.

Practice Description:

Alberta AIM's mission is "to support health care teams to create a culture of improvement through the use of evidence informed principles, resulting in access to care that is both timely and effective." The program, funded by Alberta Health and Alberta Health Services, is governed by a multi-stakeholder partnership that includes Alberta Health, the Alberta Medical Association, Toward Optimized Practice, the Primary Care Network Project Management Office, and family physicians. Each practice-based improvement team, which includes physicians, other health professionals, and office staff, completes a program that extends over 10 to 12 months. During that period, the teams attend five two-day face-to-face learning sessions, and are supported by AIM faculty, a facilitator, measurement resources, and tools for data collection and use. Teams are expected to hold weekly meetings and submit monthly reports to monitor progress and share successes.

Evolution of the program includes implementation of increased use of virtual program delivery and efforts to ensure that physicians, providers, and programs can maintain the gains made while in the formal training portions of the program.

Impact:

According to outcomes data collected by Alberta Health Services, the impact of the program includes:

- Many primary care teams have been able to reduce delays for next-available appointments (TNAs) to less than five days, with some reaching same-day access.
- Many specialty are teams were able to reduce delays for TNAs to less than 30 days, with some reaching near same-day access.
- Improvement team members have shown an increase in satisfaction with clinic access across all collaboratives.
- Primary care teams were able to reduce their cycle time (time from a patient's arrival to departure) by as much as 30% for short appointments and 36% for long appointments.
- Primary care teams were able to reduce no-shows by as much as 33%.
- Specialty care teams were able to reduce no-shows by as much as 31%.

The results of improved TNAs are supported by staff perceptions of improved access.

Improvement team members were asked to rate their satisfaction with clinic access before and after one year of the AIM program. Primary care teams and specialty care teams in multiple collaboratives demonstrated significant improvements in staff satisfaction regarding clinic access.

Initial population-level assessment of the impact of the program has been attempted. Indications are that AIM participation in primary care clinics affects other areas of the system, including reduced emergency department visits (Alberta AIM, 2013). Narrative accounts provided by participating clinics and physicians are available at www.albertaaim.ca.

Although an assessment of the costs and savings of this practice has not been completed at this time, micro-level evaluations with individual physicians and practitioners are suggestive of cost-neutrality and perhaps cost reductions associated with access and clinical improvements.

Applicability/Transferability:

Alberta AIM has been adapted from the work of Mark Murray & Associates and the Institute for Healthcare Improvement's *Breakthrough Series*. Similar quality improvement initiatives targeting primary care have been mounted in many jurisdictions throughout Canada, including British Columbia, Saskatchewan, Manitoba, Ontario, and Nova Scotia.

The success of this specific program is dependent on:

• leadership engagement (physician, clinic, program, funders, partners, and stakeholders);

• development of local and provincial capacity (including but not limited to Alberta-based faculty, local practice facilitators, measurement support, and access to other knowledge-based resources); and

• dedicated focus on alumni support to sustain improvement gains and continuing progress while managing incoming new improvement teams.

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

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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Bridging Relationships Across Interprofessional Domains (BRAID)

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

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

PRACTICE DESCRIPTION:

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

1) to facilitate and increase the capacity for health educators to deliver the interprofessional education for collaborative patient-centred practice model;

2) to increase the competencies of learners and health professionals across disciplines to effectively participate in collaborative health care teams;

3) to increase opportunities for learners and health professionals across disciplines to apply interprofessional education competencies to interprofessional teamwork; and

4) to identify and share better practices for the delivery of interprofessional education initiatives.

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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Oncology Patient-Navigator Nurse (infermière pivot en oncologie)

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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Advanced Clinician Practitioner in Arthritis Care Program (ACPAC)

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

SNAPSHOT: This innovative practice aims to improve the competencies of advanced clinical practitioners delivering care for patients with arthritis. The interprofessional program was launched in 2005 at St. Michael's Hospital, in collaboration with the Hospital for Sick Children in Toronto, and now has over 37 graduates working in diverse clinical settings across Ontario.

PRACTICE DESCRIPTION:

The ACPAC program was developed to address issues related to the accessibility to arthritis care specialist services for people living with rheumatoid arthritis and osteoarthritis, and to shift towards a more patient-centred, interprofessional approach to care delivery. The goal of the ACPAC program is to provide comprehensive, advanced education in rheumatology and orthopedics by optimizing the scope of existing health human resources. This post-licensure, academic and clinical-education training program targets physical therapists, occupational therapists, and advanced nurses wishing to advance their knowledge and practice in musculoskeletal/arthritis care. The standardized curriculum, which is offered by over 90 multidisciplinary faculty members in Ontario, applies rigorous training and evaluation standards. Individuals who go through the program receive a certificate of completion from the Department of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto. Graduates of this program are expected to provide effective triage, advanced history taking and physical examination, interpretation of laboratory and diagnostic imaging, early detection/initiation of treatment monitoring and follow-up, assessment of appropriate medications and complications, and patient education in the context of musculoskeletal disorders with the goal of improved overall efficiency of care.

To date, the Ontario Ministry of Health and Long-Term Care has provided the majority of the ACPAC program's funding, supplemented by individual tuition fees. The program is endorsed by the Arthritis Alliance and the Canadian Rheumatology Association. Other key stakeholders include The Arthritis Society, industry, and academia (Continuing Education and Professional Development, Faculty of Medicine, University of Toronto).

IMPACT:

Impact assessments have been targeted at health care providers participating in the program. These assessments involve continuous feedback surveys administered to ACPAC students at baseline, midpoint, and at six and 12 months after graduation. Outcome measures were designed prior to the implementation of the program and have helped to inform the program design for subsequent years. Particular areas of interest for these evaluations include determining changes in necessary role competencies, developing best practice standards, and identifying barriers and enablers for recent graduates carrying out their new roles in diverse clinical settings.

From surveys conducted and published in 2011, 100% of graduates were satisfied with the program and found it highly relevant to their clinical practice. System-level evaluations have indicated improvements in access, particularly in rural and remote regions, perceived impact on patient outcomes, and opportunities for further role promotion and expansion. Extensive health services evaluation of ACPAC program graduates can be found in the ACPAC System Level Outcome Report (http://www.stmichaelshospital.com/pdf/programs/acpac-executive-summary.pdf), which was presented to the Ontario Ministry of Health and Long-Term Care in January 2012.

The ACPAC program has won a number of awards, including the Colin Woolf Award for excellence in course development from the Department of Continuing Education Professional Development in 2007, the Ted Freedman Award for excellence in design and delivery of formal, post-licensure health care education training in Ontario in 2008, and the Innovations in Human Health Resources Award from the Ontario Ministry of Health and Long-Term Care in 2009.

APPLICABILITY/TRANSFERABILITY:

Based on the positive impact reported since the ACPAC program's implementation, another five-year commitment of financial support from the Ontario Ministry of Health and Long-Term Care and in-kind support from the identified stakeholders is currently being sought. During this transition time, the Arthritis Society has generously funded the program for 2013/2014. The focus will be on developing a national framework for standardized post-licensure training in arthritis care, maintaining the University of Toronto as the central site, and potentially expanding affiliations with other academic sites to establish branches in western and eastern Canada. As this program continues to evolve, areas to address will include barriers faced at institutional and professional regulatory levels, access to and efficiency of care, and cost indicators. In terms of facilitators, medical directives and administrative support have been reported to help overcome legal issues in order to have the most appropriate care provider delivering the services required, reducing direct dependency on physicians and increasing overall system efficiency. Program directors emphasize the importance of the trickle-down effect of ACPAC graduates, whose presence has the potential to change the way arthritis care is delivered in their respective places of practice across diverse clinical settings.

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Information last updated on: August 1, 2013

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

Publications:

Lundon, K., Shupak, R., Reeves, S., Schneider, R., & McIlroy, J.H. (2009). The Advanced Clinician Practitioner in Arthritis Care program: An interprofessional model for transfer of knowledge for advanced practice practitioners. *Journal of Interprofessional Care, 23*(2), 198–200. Retrieved from http://informahealthcare.com/doi/pdf/10.1080/13561820802379987

Alternative Profiles:

Chronic Disease Management. (n.d.). *ACPAC: Advanced Clinician Practitioner in Arthritis Care program 2013–2014*. Retrieved from www.chronicdiseases.ca/arthritis

Personal Communications:

Lundon, K. (emails, August 1, 2013).

External Source: http://chronicdiseases.ca/arthritis/

Traditional Healing, Medicines, Foods and Supports Program (THMFS) and Aging at Home Elder Care Continuum, Sioux Lookout Meno Ya Win Health Centre (SLMHC)

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

SNAPSHOT

This innovative practice is improving the health and well-being of Elders in remote and isolated communities in northwestern Ontario through the delivery of culturally safe care and the development of a continuum of linked community-based and institutional services. Initiated by Sioux Lookout Meno Ya Win Health Centre (SLMHC), the practice is rooted in a collaborative strategy among First Nations leadership and communities, the LHIN, provincial and federal governments, health organizations, providers, and clients.

PRACTICE DESCRIPTION:

SLMHC is a unique model of care in the province with a specific mandate among Ontario's hospitals to care for the First Nations population in a culturally safe manner. SLMHC operates a 60-bed health centre, a 20-bed long-term care/extended care facility, and the Out of the Cold Shelter. *Menoyawin* is an Anishnabe term that connotes health, wellness, and well-being—a state of wholeness in the spiritual, mental, emotional, and physical make-up of the person. SLMHC is recognized as an emerging centre of excellence for culturally integrated care and culturally safe care based on the menoyawin model of care.

With its roots in the signing of a historic four-party agreement (1997) by First Nations, the municipality, and the federal and provincial governments, the Traditional Healing, Medicines, Foods and Supports Program (THMFS) began in 2004/2005 with the goal of embedding cultural competency, cross-cultural fluency, and cultural safety into the fabric of the organization to address medical errors and cultural errors that threatened patient safety. The Aging at Home Elder Care Continuum has its roots in this unique model of care.

The goal of the THMFS program is to achieve cultural integration in health services. The program guides fundamental changes in the areas of Odabiidamageg (governance and leadership), Wiichi'iwewin (patient, resident, and client supports), Andaw'iwewin (traditional healing practices), Mashkiki (traditional medicines), and Miichim (traditional foods). Within each of these areas, many initiatives are underway to involve staff throughout the organization and entrench cultural safety in all aspects of program and service delivery.

Concerns about the health, quality of life, and safety of Elders, the high numbers of alternate level of care (ALC) patients, a critical lack of long-term care (LTC) beds for the service area, and long wait lists prompted the SLMHC to bring together multiple partners to commission an environmental scan (2009) with the support of funding from the Aboriginal Health Transition Fund (AHTF). The scan identified pervasive gaps in health care services across the continuum of care, with particular concerns about scarcity of Elder-appropriate services to support them in the community. It also provided an inventory of services and resources available, insight into practices that are working, and recommendations for change.

The scan laid the foundation for an Aging at Home Elder Care Continuum, which continues to develop. Currently, a full basket of services under each of the following areas has been identified: home and community care, patient and family support, support service coordination, respite, community supportive housing, nursing station, northern physician services, regional hospital services, regional long-term care facilities (LTCF), education, and transportation. SLMHC has implemented video-visitation and telephysio through links provided by Keewaytinook Okimakanak (KO) Telememedicine and the Ontario Telemedicine Network. The program serves traditional food; incorporates traditional, cultural, medical, and spiritual practices; and provides social and recreational activities, Elders Gathering visits and translation services.

The THMFS program is unique in its comprehensive approach to achieving cultural integration throughout the organization. Many of the tools, such as the Patient Focused Communication Tool and the Cross-cultural Patient Safety framework and model represent leading edge work on the topic. The exclusive focus on planning for Elders is also unique; most local, regional, and provincial health plans do not focus on the elderly. Finally, the collaborative, multi-partner approach with stakeholders committed from across 28 communities to planning an Aging at Home Elder Care Continuum is also different from usual practice.

IMPACT:

Evaluations of the THMFS program based on surveys (board, management, and staff), reviews of SLMHC incident reports, and the Patient-focused Communication Tool are demonstrating improvements. Generally, efforts to create a culturally safe environment are resulting in improved patient safety, decreased medical errors, better processes for addressing patients' issues, and improved satisfaction (clients, board, employees). More specifically,

• Development of a cross-cultural patient safety (CCPS) analytical framework and implementation of a CCPS model is leading to development of cultural safety indicators.

• Phased implementation (over four years) of a cultural competency program (Bimaadiziwin) for staff is improving knowledge and awareness

• A new training and certification program for interpreters has resulted in increased use of the service by providers.

• Increased availability of ceremonial practices and traditional food and medicines is improving patient comfort, satisfaction, and well-being.

Implementation of the THMFS program follows an iterative process and so it continues to develop.

The Aging at Home Elder Care Continuum continues to develop, but positive impacts are notable in many areas. For example, telemedicine reunites families and video-visitation reduces client isolation; the program supports remote family council meetings, facilitated assessment, and placement of residents for LTC, including pre-placement diagnosis and treatment of potential LTCF residents; community Elder care workers and personal support workers have access to training; and stroke survivors have improved access to rehabilitation. With the introduction of ceremonial practices and traditional food, medicines, and social and recreational activities, there are improvements in patients' recovery. Community efforts to collect wood for Elders is helping them stay in their homes, and the Assess and Restore program provides personal support workers, physiotherapy, and occupational therapy, with interpretation, to support discharge back to community or improve quality of life in the LTCF.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that SLMHC had adapted from and were unaware if the practice was used as a model elsewhere. The cultural competency program (Bimaadiziwin) builds on identified best practices but is unique in its design for the SLMHC. SLMHC initiatives are theoretically applicable and transferable to other settings. Important lessons are that (1) leadership, sustained collaboration, a shared long-term vision, mutual support, shared resources, and solid buy-in at the funding/policy level are required, (2) better data about First Nations Elders' health is required to support development of a continuum of linked services, as is more information about practices that are working well in communities, and (3) better coordination between the currently separate federal and provincial programs is a must.

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

Comarty, H. (January 2009). *An introduction to Sioux Lookout Meno Ya Win Health Centre: An emerging centre of excellence for culturally integrated health care in northwestern Ontario*. [Poster Presentation].

Walker, R., St. Pierre-Hansen, N., Cromarty, H., Kelly, L., & Minty B. (2010). Measuring cross-cultural patient safety: Identifying barriers and developing performance indicators. *Healthcare Quarterly, 13*(1), 64–71. Abstract retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20104040.

Walker, R., St. Pierre-Hansen, N., Cromarty, H., Kelly, L., & Minty B. (2010). *Measuring cross-cultural patient safety. Achieving cultural safety in health services: Moving beyond cultural competence*. [Poster Presentation.]

Woolner, F., Timpson, J., Mombourquette, L., & Wood, L. (2009). *Elder care environmental scan in Sioux Lookout zone First Nations*: Prepared for the Sioux Lookout Meno Ya Win Health Centre. Retrieved from http://www.slmhc.on.ca/assets/files/traditional-healing/elder_care_environmental_scan.pdf

Personal Communications:

Cromarty, H. (interview and feedback, June 14, 2013). [Special Advisor for First Nations Health Care, Meno Ya Win Health Centre].

Linkewich, B. (interview and feedback, June 25, 2013). [Vice President of Health Services, Meno Ya Win Health Centre].

Supporting Métis seniors and families—Métis Nation of Ontario (MNO) community centres

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

SNAPSHOT:

This innovative practice addresses the need to support Métis senior citizens who are at risk of falling through the cracks of a complex health system. The first community centres were established in the mid-1990s, with the remaining centres developing since that time. Programming involves partnerships with different ministries, Aboriginal groups and the volunteer sector. Care delivery involves interdisciplinary health staff, community centre workers and volunteers.

PRACTICE DESCRIPTION:

One-third of all Aboriginal people in Canada are Métis. The Métis population is also one of the fastest growing populations in Canada, having doubled in the past 10 years or so. It is also an older population compared to other Aboriginal groups. Many Métis seniors are also experiencing significantly higher rates of chronic disease and other complex conditions compared to non-Métis Ontarians. Because Métis people also fall under a different legislative and regulatory structure than do other Aboriginal groups, they do not have the same access to provincial and federal programming supports available to other Aboriginal Canadians such as the Non-Insured Health Benefits program. Many older Métis also have limited incomes and live in more remote and rural areas, compounding problems of access.

It is for all these reasons that the Métis Nation of Ontario (MNO) developed an innovative, family-centred model of community-based care, founded upon the Métis way of life, and built around the unique needs of the Métis clientele. Situated in 18 historical Métis communities across the province of Ontario, MNO community centres were established to serve as important cultural and service hubs that connect Métis citizens to one another, as well as to essential health services and supports within their local areas. They provide much-needed and very tangible support to Métis senior citizens who are at heightened of falling through the cracks in our complex health care system.

The MNO community centres are especially important in providing Métis seniors with much-needed cultural and social supports, as well as assistance in accessing essential health and medical services. Some of the MNO centres also offer specialist services such as foot care clinics for seniors and other Métis people suffering from diabetes. MNO community centre workers are also very actively involved in outreach with Métis seniors and other MNO citizens in need of assistance, visiting their homes on a regular basis to help with meal preparation, house maintenance, and other tasks of daily living, and to provide important social and cultural support. Through the MNO Medical Transportation Program that has been put in place, Métis seniors can also receive assistance in traveling to and from their medical and other appointments. The MNO`s model of community care is founded on a holistic, family-centred, and uniquely Métis approach to health and well-being that has deep roots in the very community-minded Métis culture and way of life.

The MNO service model is unique in the province in both its scope and conceptualization, and has been hailed as a best practice by their governmental partners. MNO works very closely with its provincial government partners and other Aboriginal groups in the development of its programming. MNO receives support through different ministries including the Ministry of Health and Long Term Care's Community Support Services Program, the Ministry of Aboriginal Affairs, and the Ministry of Children and Youth Services, among others. Programs and services are also supported by the MNO's large volunteer base, which includes the MNO Provincial Councils, the MNO Youth Council, and MNO Senators. **IMPACT:**

This innovative practice was first implemented in 1993, with the ongoing development of new community centres since that time. MNO's internal Health Activity Tracking System (H.A.T.S), established for reporting, accountability and evaluation purposes, together with regularly commissioned independent evaluations, indicate that the community centres are having positive impacts on Métis citizen's health and well-being. They are providing critical assistance and support for seniors, particularly those in

more rural and remote areas. They also provide an essential cultural base where Métis seniors can meet with other community members, receive appropriate support and care and link to essential services and programs in the broader community. The centres and their activity within the broader community has also led to an increased awareness of and respect for Métis peoples' culture, unique history, needs and aspirations across the province of Ontario. Most importantly, the MNO centres provide a haven for culturally safe community care for the Métis elders of Ontario.

APPLICABILITY/TRANSFERABILITY

The practice informant did not identify other practices that MNO had adapted from and were unaware if the practice was used as a model elsewhere. However, MNO is regularly approached by provincial ministries to assist in the development and implementation of both Métis and non-Métis Aboriginal policies, programming and services.Two key characteristics of the MNO approach which have contributed to its success are the holistic, needs-driven and culturally-based nature of its community programming and services , and the MNO commitment to collaboration and working closely with government and other Aboriginal partners to address known gaps and to build more effective and integrated care models for Aboriginal populations. Together with committed Métis leadership, the ability to build effective, culturally-based teams with appropriate training for all front line staff and and the direct involvement of Métis community members, including seniors and support from a large volunteer base, are among the key factors contributing to success.

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Information last updated on: October 23, 2013

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

Personal Communications:

Storm J. Russell and Wenda Watteyne, Métis Nation Ontario (personal and other communications, October, 2013).

Kahnawake Home and Community Care Services; Culturally Competence Case Management

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

SNAPSHOT:

This innovative practice addresses the need to provide a better continuum of care for First Nations seniors and others in their home community of Kahnawake (population 9,500). It provides services in clients' homes and involves a 10-member home care nursing team, an 18-member home health aide team, a seven-member hospital-based Day Program team, an Adult and Elders Service Counsellor, two Day Program Animators, two Elders Case Workers, administrative staff, a kitchen team, a maintenance and security team, and the program's manager.

PRACTICE DESCRIPTION:

Kahnawake Home and Community Care Services (KHCCS) strives to provide an enhanced continuum of care to address the health needs of First Nations seniors and other clients living at home in the Mohawk community of Kahnawake in Quebec. The program was implemented in 2000, when Health Canada initiated the Home and Community Care program. The new initiative offered improved funding and less restrictive guidelines, enabling the development of a home care program that met the real-life needs of Kahnawake seniors.

KHCCS connects clients and their families with on-reserve services that include home nursing care, personal care, primary care, tertiary care, palliative care, respite, day programs, and mental health services. It also helps clients to access programs such as income security. The program also oversees the operation of a 25-bed long-term care facility. The program was enhanced in 2005 with the introduction of a case management approach, and the establishment of single window access to services. Incoming clients are assigned to a case manager who completes an initial assessment, identifies resources the client needs, and then makes appropriate referrals. Clients are reassessed at six-month intervals. After each assessment, an interprofessional team develops a strategy to meet any service needs that have changed. The case manager follows clients from intake through discharge planning, ensuring that appropriate resources are in place to support seniors' wellness when they return home or transfer to an alternate level of care.

KHCCS offers First Nations seniors access to home care services (including both home care workers and nurses) 365 days a year, along with access to an unusually comprehensive continuum of on-reserve services. For example, home care nurses work closely with physicians to provide palliative care services, which typically enable seniors to stay at home till the last few days of their life. Home care aides have been delegated responsibility for some aspects of medical care, enabling them to, for example, dispense medications or change bandages. Family members who are primary caregivers can access respite (in the form of day programs for seniors and short-term respite care services) through the home care program. The home care team includes mental health nurses who counsel Elders struggling with issues such as depression, grief, or unresolved trauma. KHCCS can meet the majority of needs their clients might have, and usually can implement services within 24 hours of a request. Staff retention rates are extremely high; 90% of staff members have 10 years of service or more. Most staff members are from the community, and relate well to clients' needs.

IMPACT:

This innovative practice was implemented in 2000. Data on the KHCCS home care program have been included in evaluation data collected by the local hospital, but the KHCCS data cannot be disaggregated. The home care program has, however, been accredited three times since 2006. KHCCS's adoption of a case management approach (in which a comprehensive assessment of client needs ensures that services are not delivered where they are not needed) has enabled the program to maximize efficiency and, at the same time, deliver quality care. This enables cost savings.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Kahnawake Home and Community Care Services had adapted from and were unaware if the practice was used as a model elsewhere. However, the program has been contacted or visited by representatives of numerous First Nations communities in Quebec, some of which have adapted and implemented aspects of the program. Important lessons learned during the development and implementation of this program include that it is unsafe to assume that what works in one place or time will work everywhere or all the time. Even successful programs must be constantly ready to respond to the changing contexts in which they are delivering services, and the changing needs of the communities they serve. It is also important to think outside the box and be open to unusual ways to accomplish what needs to be done.

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Information last updated on: July 17, 2013

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Personal Communications:

Horne, M. (interview and feedback, July 17, 2013). [Kahnawake Shakotiia'takehnhas Community Services].

External Source: http://www.kscs.ca/taxonomy/term/5/all

Community health aides help with nursing shortages, continuity of care, and cultural safety

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

SNAPSHOT: This innovative practice addresses concerns about the recruitment and retention of nurses, and about the continuity and cultural safety of care for Inuit seniors.

PRACTICE DESCRIPTION:

A couple of factors prompted the creation of the community health aide position. It was difficult to recruit and retain nurses, and there were concerns about the continuity of care for the residents of Nunatsiavut, a region in Newfoundland and Labrador, especially the seniors receiving service through the Home and Community Care program.

The community health aide model borrows from the past in Labrador and the present in Alaska, where community health aides deliver primary care in remote communities. The new position was created out of necessity and allows Nunatsiavut to deliver culturally safe, cost effective care. For example, where there were two nurses there is now one nurse and one aide, a skill mix that provides continuity of care.

When the Grenfell Mission first came to Labrador, the doctors and nurses hired local women “aides” to assist in all areas of care. The tradition continued, and in 1996, when the Labrador Inuit Association assumed responsibility for nursing in what is now Nunatsiavut, the public health aides came over as well.

The community health aide has an expanded role in public health and in home and community care and is supported by the Nunatsiavut government. In the home and community care program, the community health aides function as the nurses’ “right hands” because they fill so many roles, including supporters, cultural advisors, and planners. They manage the home support workers, go with the nurse on client visits if interpretation is needed, order equipment and supplies, schedule appointments, sterilize equipment, complete month-end reports, and anything else that doesn’t require a nurse to do. The nurse is then able to concentrate on direct client care. The aides also do independent home visiting to support the programs both when a nurse is in town and when the position is vacant.

Just as important, they are the cultural advisors to new nurses. They are trusted in the community, and any new nurse who is accompanied by an aide is accepted. They know everything about the people in the community, including where to find them on any particular day to ensure they come to appointments.

When the community does not have a nurse, the aide functions as the eyes and ears of the community. The aides know when to alert staff to a senior’s condition and when to bring in nursing care. The aides make the appointments and set everything up for the nurses.

From an elder care perspective, the aides can often spend more time with clients than a nurse can, establish and maintain personal connections with clients, and speak the clients’ language. Often, elders are alone in their communities because families have moved away. Community health aides are advocates for elders and support them with a range of issues including elder abuse (which is a big problem), especially financial abuse. They are also familiar with the regional health and long-term care centres in Happy Valley-Goose Bay, so they can describe them to elders and their families, and help them become comfortable with any transitions.

IMPACT:

Evidence of success is based largely on personal accounts, observations, and regular monitoring of seniors’ health and safety at home. Personal observations and testimonials suggest that this program is extremely successful. The community health aide position allows for managing with fewer nurses. For example, in the largest community, instead of having three nurses and one aide, there are two nurses and two aides and it has been possible to maintain programming in a community with no nurse. The

community health aides are a very stable workforce. They live in the community, are committed to the communitythere is very little turnover. If an aide were to leave, there are people in the communities waiting for these jobs. It is hard to quantify or describe the value they bring, however, essentially, it would not be possible to deliver care without them, and clients would be less willing to receive care.

APPLICABILITY/TRANSFERABILITY:

This innovative practice was adapted from Alaska but the practice informant did not identify any other practice that used this as a model for developing a similar initiative However, lessons learned from this practice suggest that it is theoretically applicable and transferable to other settings. An important lesson or enabler of success is the fact that Nunatsiavut is self-governing, which allows for flexibility and innovation in developing roles that meet communities' needs. Another enabler is that the aides work in a non-unionized environment. The model is unique in Canada and has not yet spread to other parts of country.

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Information last updated on: September 30, 2013

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Personal Communications:

Turner, G., & Buckle, T. (interview and feedback, August 16, 2013). [Nunatsiavut Government]

External Source: http://www.nunatsiavut.com/index.php?option=com_content&view=frontpage&Itemid=1&lang=en

Home care program for everyone, on- or off-reserve, Bella Coola

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

SNAPSHOT: This innovative practice addresses the need for equal access to integrated home and community care for Aboriginal seniors on-reserve. The practice was launched in Bella Coola and involves an interprofessional team of federal home care workers, provincial home care workers, and band-employed workers.

PRACTICE DESCRIPTION:

Bella Coola is a geographically remote community on the central coast of British Columbia that has limited resources. The community faced several challenges. There was no structured home and community care program or integrated service delivery model between the services available on-reserve and those offered by the province. Complicating the situation were factors such as budget constraints, nursing shortages, lack of nursing supervision, a lack of clarity around staff roles and responsibilities, and differing views about what a home and community care program should look like. Many of the community's youth had left to seek jobs outside this economically depressed community; leaving behind an aging population of seniors who were isolated and without care/support.

A shared vision and model was developed to ensure that First Nations and non–First Nations people, on-reserve and off-reserve, had equal access to care and the option of remaining at home in their community as long as possible. Services are available 365 days a year and there is a fully integrated, culturally safe home and community care program. This program is in a new health centre on-reserve and is used by everyone in the community.

To initiate this work, the first step was to seek approval from the Chief and Council of Nuxalk Nation. Approval was easily obtained because trust had been built over the years with the lead nurse. A community engagement and needs assessment followed, including meetings with the Nuxalk Nation Health Director, Elders, and the RCMP. Meetings were also held between the Chief and Council, Vancouver Coastal Health, the United Church Health Services (an affiliate of Vancouver Coastal Health), and Health Canada's First Nations and Inuit Home and Community Care Program (FNIHCC), which offers home care on-reserve. An agreement was struck that the Nuxalk Nation would deliver services on-reserve and send funding to the home and community care program. Therefore, federal and provincial funding was combined to make a single home care program, where there had been two (the province's program and the federal FNIHCC program) before. The new program was truly a collaborative effort between the United Church Health Services and the Nuxalk Nation Health and Wellness program.

With full community support, integration of all home care programs slowly began in 2007, based on what the clients needed, not whether they lived on- or off-reserve. Everyone in the Bella Coola area uses the on-reserve health centre, whether they are First Nations or not, and whether they live on- or off-reserve. Clinic programs, which are part of the adult day program, include foot care, wound care, blood pressure monitoring, diabetes education and a bath program. The interRAI home care assessment is used to develop a care plan. Also available is an interprofessional palliative care program.

The health centre is a hub for primary health care, telehealth, pharmacy, mental health and addictions, public health, social services, and an administrative office to support patient travel. Doctors and practitioners in the home care program meet weekly to review clients. There are also connections to specialists outside the community. For example, for wound care, Pixalere, a complete wound care management system is used. The Librestream camera system is used for a virtual connection to highly skilled teams, and there is a connection to BC's health information network and medication database, Medinet.

There is no new money for this program. Funding streams were pooled to work around budget restraints, expand capacity, and provide flexibility. This practice, which creates equal access to care through pooled funding; integrated on- and off-reserve programs; and having federal, provincial, and band employed staff all working together in interprofessional teams with clear roles and responsibilities, is unique and very different from usual practice.

IMPACT:

At this time, a formal evaluation of this practice has not been completed. Personal accounts and regular monitoring of clients suggest that the quality of care is improving. Before integration, the on-reserve seniors didn't have access to the same broad range of services. Some benefits of these services include fewer emergency department visits, fewer hospital admissions, and fewer alternate level of care (ALC) clients at Bella Coola General Hospital. People have been transitioned back home after having lived in the hospital for more than a year. There is also reduced patient travel. And, due to improved foot care, no one has had an amputation in years. There is also an effort to hire local health professionals; after they leave for training and education..

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that Bella Coola had adapted from and were unaware if the practice was used as a model elsewhere. Currently, neighbouring communities are interested in developing the same integrated program and sharing ideas. Important lessons learned are: it only takes one person to identify a gap and champion change; Chief and Council must be consulted first—their support is crucial; the federal government, province, regional health authority, and band were willing to explore a different model; staff were hired and developed from within the community; taking a shared care approach with the whole community working together is effective; and the use of technology and assessment tools improves client care.

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Personal Communications:

Phillips, G. (interview and feedback, August 2013). [Bella Coola General Hospital]

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

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

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

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Personal Communications:

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

Publications:

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

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

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

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

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

PRACTICE WEBSITE:

http://www.hpfreemanpni.org/

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Publications:

Freeman, H.P. (2006). Patient navigation: A community based strategy to reduce cancer disparities. *Journal of Urban Health, 83*(2), 139–141.

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Walkinshaw, E. (2011). Patient navigators becoming the norm in Canada. *Canadian Medical Association Journal, 183*(15), 1109-1110.

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

InSite: Vancouver's Medically Supervised Injection Facility

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

SNAPSHOT: This innovative practice addresses problems associated with illegal drug use, such as transmission of blood-borne diseases, fatal drug overdoses, and community safety. The practice was launched in Vancouver, British Columbia, in one clinic and involved a team of nurses, counsellors, mental health workers, and peer support workers.

PRACTICE DESCRIPTION:

Vancouver is home to about 12,000 intravenous (IV) drug users, with more than one third living in the Downtown Eastside (DTES). Injection of illegal drugs is associated with significant health and social consequences for users, their families, and their communities. The consequences include injection-related infections, overdose, blood-borne disease transmission, and exposure to discarded needles, violence, property crime, and the sex trade. In the DTES, three in 10 IV drug users are HIV positive, nine in 10 have hepatitis C, and the overall mortality rate is 14 times that of other BC residents.

InSite, North America's first supervised injection facility (SIF), provides 12 booths where clients inject preobtained illegal drugs under the supervision of nurses and other health care staff. InSite supplies users with clean injection equipment that is safely discarded after use. Nurses provide health care services such as wound care and immunizations, and intervene immediately if an overdose occurs. InSite also has addictions counsellors, mental health workers, and peer staff who connect clients to community resources such as housing, addictions treatment, and other support services. InSite was designed to make health care services accessible to IV drug users. If clients choose to access withdrawal management services, the second floor of the facility houses the detox program called OnSite.

Clients can inject illegal drugs at InSite due to a constitutional exemption from Canada's drug possession laws. InSite operated under this exemption from 2003 to 2008, at which point the federal government declined to renew the exemption. InSite supporters launched a constitutional challenge under section 7 of the Charter of Rights and Freedoms alleging that the refusal violated the life, liberty, and security rights of InSite clients. The Supreme Court of Canada ruled in 2011 to uphold the facility's exemption, allowing InSite to stay open indefinitely. InSite is funded by the BC Ministry of Health through Vancouver Coastal Health, which operates the facility in conjunction with the Portland Hotel Society (PHS) Community Services. Stakeholders who perceive InSite's harm reduction approach as innovative include the Canadian Medical Association, the Canadian Nurses Association, Vancouver City Council, Vancouver Coastal Health (the public health authority), and VANDU (Vancouver Area Network of Drug Users).

IMPACT:

The exemption InSite received in 2003 was granted on the condition that the program undergo rigorous scientific evaluation. The first several years of evaluation resulted in more than 30 studies published in peer-reviewed scientific journals. The evaluation focused on four areas: overdoses, health, the appropriate use of health and social services, and the costs associated with injection drug use.

Evaluation of InSite is ongoing and results so far have indicated a range of benefits, including reduced public injecting, fewer publicly discarded syringes, lower levels of HIV risk behaviours (such as syringe sharing), and increased uptake of addiction treatment. A retrospective population-based study published in *The Lancet* found that fatal overdoses within 500 metres of InSite decreased by 35% after the facility opened compared to a decrease of 9% in the rest of Vancouver. In addition, studies investigating potential harms, such as whether the facility encourages IV drug use by making drug injection easier and more comfortable, have not been supported by evidence.

The costs and savings of the facility were evaluated and the results published in the journal *Addiction.* This study found InSite substantially reduced the incidence of HIV infection among DTES IV drug users. The associated savings in averted HIV-related medical costs are more than sufficient to offset InSite's operating costs. InSite's operational budget was $2,969,440 in

2010/2011.

APPLICABILITY/TRANSFERABILITY:

Safe injection facilities in Switzerland and Germany served as models for InSite. Today, more than 90 SIFs operate in over 60 cities worldwide, including the Netherlands, Spain, Norway, Luxembourg, and Denmark. Australia implemented a pilot SIF in 2001 that became a permanent health service in 2010 following a number of evaluations. International peer-reviewed evidence indicates that SIFs are an effective way of reducing some of the harms of IV drug use, including overdoses, public littering of injecting equipment, infection rates of transmissible diseases, and health care costs.

InSite is currently the only SIF in Canada, although there have been attempts to open similar facilities in Ottawa, Toronto, Victoria, and Montreal. In June 2013, the federal government tabled Bill C65, the Respect for Communities Act. This proposed bill outlines the requirements that any new or existing health service provider must meet to be exempted from drug possession laws in order to provide supervised injection services. The requirements set out in the proposed bill pose significant challenges to the transference of this practice within Canada.

PRACTICE WEBSITE:http://supervisedinjection.vch.ca/

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Publications:

Pinkerton, S.D. (2010). Is Vancouver Canada's supervised injection facility cost-saving? *Addiction,* 105(8), 1429–1436.

Kerr, T., & and Palepu, A. (2001). Safe injection facilities in Canada: Is it time? *Canadian Medical Association Journal, 165*(4), 436–437. Retrieved from http://www.cfenet.ubc.ca/sites/default/files/uploads/publications/insite...

Other:

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Mahoney, K.E. (2012, March). Evidence over ideology. *National: Legal Insights and Practice Trends*. Retrieved from http://www.nationalmagazine.ca/Articles/May-2012/Evidence-over-ideology.aspx

Vancouver Coastal Health. (2009). *From the ground up: Vancouver's supervised injection site's role in accessing treatment and care*. Retrieved from supervisedinjection.vch.ca/media/insite_groundup.pdf

External Source: http://supervisedinjection.vch.ca/

Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA): A Group Therapeutic Approach to Decreasing Suicidal Behaviour in Ontario

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

SNAPSHOT: This innovative practice addresses decreasing suicidal behaviour among people who have attempted suicide at least twice. The practice was launched at a teaching hospital in Toronto, Ontario, in 1999. It is run by two professionally licensed facilitators trained in the intervention and a peer facilitator who has graduated from the program.

PRACTICE DESCRIPTION:

Suicidal behaviour places significant emotional and financial burdens on families, friends, health professionals, and communities, while associated hospitalizations and emergency department visits incur costs to the health care system. The circumstances that lead an individual to attempt suicide are often complex, yet in most cases death by suicide is preventable.

The Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA) is a 20-week outpatient group therapy program first offered at St. Michael's Hospital in Toronto, Ontario, in 1999. Participants must be over the age of 18, linked with mental health services at the time of referral, and have a lifetime history of at least two suicide attempts. Through support, education, and skills development, PISA addresses potential risk factors and areas of psychological deficit known to characterize persons with recurrent suicide behaviour. Staff work with clients to develop a better understanding of their suicide-related thoughts and behaviours, create safer coping strategies to manage intense emotions, and sharpen problem-solving abilities.

PISA differs from other therapeutic interventions because it

- caters to inner-city residents of lower socioeconomic status;
- emphasizes client participation; and
- addresses the varied needs of each client.

The group is facilitated by an interprofessional team that includes students from a range of health professional disciplines. An intervention team leader supervises all facilitators at mandatory weekly meetings, and a senior clinician maintains adherence to the intervention protocol. Weekly sessions at St. Michael's Hospital typically run for 1.5 hours and consist of 8 to 12 clients. Facilitators, excluding the team leader, volunteer their time.

IMPACT:

A three-year pilot study that was begun in 2000 and published in the *Annals of Psychiatry* evaluated this practice to determine whether suicide-related behaviours were significantly reduced following the program. Cognitive, affective, and impulsivity risk factors were measured using the Toronto Alexithymia Scale, the Beck Hopelessness Scale, and the Barratt Impulsivity Scale, respectively. Participants reported more general life satisfaction, perceived themselves as better problem-solvers, and scored themselves lower on alexithymia (the inability to identify and describe emotions in oneself). Results also showed a significant improvement in depression and hopelessness scores, but overall these scores remained in the severe and moderate range. These results suggest that this intervention may be a first step in engaging the patient to seek longer-term help for problems associated with a high risk for suicide.

The costs and savings of this innovative practice have not been evaluated at this time.

APPLICABILITY/TRANSFERABILITY:

In 2010 the National Film Board released a short documentary, directed by Katerina Cizek, about 12 participants' experience in PISA. This exposure has contributed to an increased awareness of the practice. To facilitate the consistent use and delivery of PISA among providers in different jurisdictions, a fourth edition guide outlining the intervention protocol was produced in 2012.

In 2009, the Suicide Research Team at the School of Nursing in Dublin City began a three-year project to implement and evaluate the effectiveness of PISA at decreasing suicide-related behaviour in an Irish context. This will be the first work in Ireland that specifically targets individuals with a history of recurrent suicide attempts. An analysis of the data is currently under way and results are expected to be released in October 2013.

Piloted in November 2010, the Skills for Safer Living program uses a similar model as PISA but offers the group therapy sessions in a community setting, rather than a hospital. With funding from the Waterloo-Wellington Local Health Integration Network ,the program is now offered in Kitchener, Cambridge, and Guelph. A group specifically for youth aged 18 to 30 will run in June 2013, and there are additional plans to run a group for rural residents.

In Vancouver, S.A.F.E.R. (Suicide Attempt Follow-Up Education and Research) ran a version of PISA facilitated by Dammy Albach-Damstrom, president of the Canadian Association for Suicide Prevention. The first cycle ended in May 2013, and a second iteration began in June. In Prince George, the Crisis Prevention, Intervention and Information Centre is in the process of establishing a program for suicide survivors based on the PISA model of group therapy.

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Publications:

Bergmans, Y., & Links, P.S. (2002). A description of a psychosocial/psychoeducational intervention for persons with recurrent suicide attempts. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 23*(4), 156–160. Retrieved from http://www.psycontent.com/content/p312h27902721p33/

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Personal Communications:

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Other:

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External Source: N/a

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

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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Other:

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

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

Seniors Home Health Program (SHHP)

LOCATION:	**Ontario**	**HEALTH THEME:**	**Patient Centered Care**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT:

This innovative practice addresses the issue of finding ways to keep frail, isolated, and/or homebound seniors in their own homes and out of long term care and emergency rooms, as safely and for as long as possible. The program was launched in Ontario in 1997 out of one community health centre.

PRACTICE DESCRIPTION:

Research has well documented the complexity of care for frail seniors. Early identification of changes or deterioration in health will lead to early intervention and possible prevention of hospitalization admission or emergency room visits. It is based on this belief that The Seniors Home Health Program (SHHP) at The Anne Johnston Health Station (AJHS) was developed in 1997 to assist seniors (ages 55 and up) in the AJHS' catchment area. Since then, the SHHP has been providing holistic interdisciplinary health care for over three thousand seniors who are frail, isolated and/or homebound for physical and/or mental reasons.

The goal of the SHHP is to keep frail, isolated, and/or homebound seniors in their own homes, out of long term care and emergency room visit to hospital, as safely and as long as possible. Specifically, The SHHP brings an interdisciplinary team of health providers, this includes: family doctors, nurse practitioners, registered nurses, an occupational therapist, a chiropodist, a registered dietician and a pharmacist directly into a client's home, providing on-going monitoring of their health status as often as required. Before a client is accepted into the SHHP, the requested service provider will visit the client in their home for an intake assessment. Based on the criteria set forth to determine the eligibility of the clients.

The SHHP program serves around 150 to 200 clients annually. Apart from primary care physicians, nurse practitioners and nurses, the team is also supported by a group of allied health professionals. This includes: occupational therapist, dietitian, therapist, health educator, and a pharmacist. The SHHP team also maintains close relationships/partnerships with other community agencies, including Community Care Access Centre (CCAC), Seniors Peoples Resources In North Toronto (SPRINT), and Regional Geriatric Program (RGP).

IMPACT:

Evaluation of SHHP program is on-going. A service providers' meeting is held every 6 weeks to coordinate care, to discuss specific client issues that have arisen, for problem solving and/or case management. A care plan is used as a means to evaluate individual outcomes. Client satisfaction survey is conducted every year.

Feedback from clients and their social networks shows that for seniors, the SHHP greatly reduces anxiety, stress and physical exertion associated with leaving their homes to get to health care appointments in the community. It allows easy access to a multitude of services one might have to pay for privately. The AJHS has discovered that many of the SHHP clients would be unable to pay for these services privately and therefore would go without.

APPLICABILITY/TRANSFERABILITY:

Stemming off of the SHHP philosophy emerged a health promotion program called SAGE (Seniors Achieving Greater Esteem). This is a social program for frail, isolated and/or homebound seniors. The AJHS provides the transportation, attendant care services and a fun-filled afternoon for extremely frail clients who would otherwise be unable to engage in social activity outside of their homes. Many friendships are fostered through this health promotion program.

In the past years, the SHHP philosophy, program design and implementation have been recognized by a number of community health centres and Family Health Teams in the province as a model of care, especially for complex and frail clients and is theoretically transferable to other settings. For planners and jurisdictions interested in adapting the model, some challenges to

delivering SHHP remain. For example, SHHP home visits are time consuming. Providers attempt to organize their home visits for the day in a geographical fashion to minimize the time commuting from home to home. Communication between providers can be a challenge because most of the SHHP work is done in the community, out of the AJHS office. With the use of a completely electronic health record (EHR) providers are able to send e-notes regarding client care and internal referrals can be coordinated with ease. Also, the EHR allows providers to remotely log-in to the AJHS EHR software and access all of a client's medical and demographic information.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communications:

Cheung, M. (Review and feedback, May 3, 2013). [Anne Johnston Health Station].

Publications:

Alternative Profiles:

Other:

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

External Source: http://www.ajhs.ca/primary-health-care-services/seniors-home-health-program-shhp

Telehomecare in Ontario

LOCATION:	Ontario	**HEALTH THEME:**	E-Health
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice aims to provide care to patients in their home by offering a remote monitoring unit to transmit their blood pressure, weight and other measurements from home to the physicians office on a daily basis. Launched in 2007, Ontario is currently implementing a provincial telehomecare expansion program.

PRACTICE DESCRIPTION:

In 2007, the Ontario Telemedicine Network (OTN) launched a phase one telehomecare (THC) pilot program and worked with eight Family Health Teams (FHTs) to enroll over 800 individuals with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD). Individuals had a remote monitoring unit installed in their homes to transmit their blood pressure, weight and other measurements on a daily basis. Telehomecare nurses conducted regular monitoring and health coaching sessions with the goal to help individuals and their caregivers acquire the skills and confidence to better manage their chronic illness.

The phase one program demonstrated that the successful management of chronic disease must occur on a daily basis in the home, community and primary care settings of the individual with a chronic illness, and with the active engagement of individuals and their caregivers. Given the magnitude of chronic diseases in Ontario, the FHT model, while successful for the phase one program, was not entirely scalable. Through this program, only a portion of the province's population impacted by chronic disease could benefit from THC, so moving to a LHIN-wide service delivery model that is accessible to all health care providers will reach a considerably larger population. In recent months, the early adopter LHINs have been working with their health care providers to develop an integrated and coordinated model of care using THC as an enabler. This involves the selection of a host organization (i.e. community care access centre or hospital) to fund a core group of THC nurses. These nurses may be situated within the host organization or distributed across the LHIN, working with primary care and community providers as part of a collaborative team. For THC to work, nurses will need to foster relationships across the care continuum to effectively support patients.

Two of the three LHINs have begun to enroll patients with the goal to have 2200 patients enrolled by March 31, 2013. Given the change management associated with this transformational program, OTN is aggressively supporting the LHINs with their operational, business and clinical requirements, as well as physician engagement and patient recruitment strategies.

IMPACT:

Several studies, including the phase one program, have demonstrated that early identification of exacerbations and enhanced patient self-management skills through the use of THC improves the likelihood of preventable hospitalizations, emergency room visits and long term care admissions.

The evaluation of the phase one program demonstrated high levels of patient and provider satisfaction along with a significant reduction in hospitalization and emergency room visits. FHTs that worked with in collaboration with other health and community providers to coordinate patient care had fewer challenges with patient recruitment and provider adoption.

THETA, ICES and the University of Toronto are developing the evaluation methodology for the expansion program. A number of areas will be measured including patient experience, system impact, costs and models of care.

APPLICABILITY/TRANSFERABILITY:

Leveraging the successful outcomes of the phase one program, OTN is currently implementing a provincial THC expansion program beginning with 3 early adopter LHINs. By year three, upwards of 30,000 individuals will be enrolled across the 14 LHINs.

With the expansion of THC in Ontario, there is an opportunity to redesign the management of chronic disease outside and

beyond healthcare facilities.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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

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Primary Care Memory Clinics: An Innovative, Integrated Model of Care to Improve Capacity and Quality of Health Care for Seniors in Family Practice

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

SNAPSHOT: This innovative practice was created to resolve dementia care gaps in primary care by offering a clinic where service is targeted at allowing for quick and accurate assessment of memory loss in patients. The Primary Care Memory Clinic was established in 2006 in the Centre for Family Medicine Family Health Team (FHT) in Kitchener, Ontario.

PRACTICE DESCRIPTION:

Primary care physicians will be increasingly challenged to meet the health care needs of an aging population. Yet, today's seniors who have complex chronic conditions receive suboptimal quality of care, which results in profound impacts on health system utilization and quality of life for these seniors and their families. Dementia has been described as the most difficult chronic condition to manage, and data from the Canadian Institute of Health Information show that dementia results in over 30% of Alternate Level of Care (ALC) hospitalization days. These data also show that hospitalization costs for this group are among the highest, at $19,302 per hospitalization. Interventions designed for complex chronic conditions have generally been specialist-oriented and poorly integrated into the primary care management of the patient.

The Primary Care Memory Clinic is an innovative model established in 2006 in the Centre for Family Medicine Family Health Team (FHT) in Kitchener, Ontario. The clinic was created to resolve dementia care gaps in primary care by offering a clinic where service was targeted at allowing for quick and accurate assessment of memory loss in patients. Shortly thereafter a training program was developed to assist other FHTs to establish their own independent memory clinics.

The Primary Care Memory Clinic is demonstrating that integration of interprofessional teams led by family physicians can strengthen the role of primary care to better manage memory loss due to dementia. This approach has the potential to improve health outcomes and care coordination, and ensure the use of geriatric specialist and system resource is more efficient.

IMPACT:

A mixed quantitative and qualitative evaluation of the 15 clinics using the Primary Care Memory Clinic model was conducted. It included patient and health professional satisfaction surveys, surveys measuring practice changes in training program participants, chart audits, and interviews with clinic staff and patients.

Across all of the clinics, 582 patients were assessed over a period of one to 35 months. They were seen in a more timely manner (83% seen within two months of referral) than if referred to a specialist (whose wait time is typically six to eight months). The majority of patients received a diagnosis of mild cognitive impairment (27%) or dementia (40%). Rate of referrals for specialist consultation was just 9%, which is consistent with ideal models of chronic disease management and which suggests increased capacity in primary care for dementia care. Patients and caregivers were satisfied with the care received, as were referring physicians, who reported increased capacity to manage dementia as a result of the clinic and reduced burden of care with the availability of "in-house" consultation support. Results have been published in peer reviewed journals (Lee.L, et al).

Independent chart audits conducted by geriatricians verified quality of care. Practice changes reported by clinic members included the increased use of standardized tools, and increased knowledge and confidence regarding dementia assessment and management.

This study demonstrated that primary care–based memory clinics are an effective strategy to ensure timely access to quality

assessment and to manage dementia, with positive impacts on health service utilization and quality of dementia care.

APPLICABILITY/TRANSFERABILITY:

The memory clinic model of care may be implemented in other jurisdictions and can be adapted to existing resources in FHTs. To date, similar memory clinics have been established in 32 primary care settings in southern Ontario.

Additionally, the interprofessional model of care and the associated training program may be adapted to improve the primary care management of other complex chronic conditions of seniors that are associated with disproportionately high use of health care resources.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCE:

- Lee, L. Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care (2012).
- Lee,L et. al. *Enhancing dementia care: a primary care-based memory clinic.* Pub Med, October 2010. http://www.ncbi.nlm.nih.gov/pubmed/20977435

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External Source: http://www.ncbi.nlm.nih.gov/pubmed/20977435

An Innovative Behavioural Outreach Service and Day Program for Persons with Acquired Brain Injury and Challenging Behaviours

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

SNAPSHOT: This innovative practice targets survivors of acquired brain injury (ABI), that show behavioural changes which adversely affect their relationships with family members, friends, co-workers, and others. The Acquired Brain Injury Behaviour Services at West Park Healthcare Centre, in Toronto, Ontario, provides community outreach behaviour therapists to help survivors, their families, and caregivers learn strategies to manage challenging behaviours following an ABI

PRACTICE DESCRIPTION:

After sustaining an acquired brain injury (ABI), survivors may show behavioural changes that adversely affect their relationships with family members, friends, co-workers, and others. In some instances, ABI survivors display challenging behaviours that can include agitation, aggression, irritability, and feelings of anxiety and depression.

The Acquired Brain Injury Behaviour Services at West Park Healthcare Centre, in Toronto, Ontario, provides community outreach behaviour therapists to help survivors, their families, and caregivers learn strategies to manage challenging behaviours following an ABI. The behaviour therapists work in clients' homes or places of residence, including long-term care homes in the Greater Toronto Area. West Park Healthcare Centre also has a day program for ABI survivors that provides social and educational activities, skills training, community outings, and community case management services. Participants attend the day program two to three days per week for a six-month period, and they are also eligible for limited overnight respite stays. The day program's behaviour and rehabilitation therapists are very experienced in working with ABI clients who exhibit challenging behaviours. Funding for the outreach service that began in 2000 is from West Park Healthcare Centre operating funds. The Toronto Central Local Health Integration Network (LHIN) provides separate funding for the day program, which started in 2009.

The behavioural outreach service and the day program are innovative in addressing the needs of ABI survivors. The outreach service's behaviour therapists work with clients and their family members or caregivers in their home to address challenging behaviours that cause distress and often limit clients' ability to be integrated into their home community. This service is not available in the public sector, and clients' needs cannot be adequately addressed in conventional outpatient office therapy. Service is provided for one year or more to ensure that interventions are effective and are maintained. Intervention strategies are customized to address the needs of each client, as each client's behavioural challenges are unique. The goal of intervention is to decrease behaviours that interfere with family and social relationships and to increase community participation. Outreach services reduce the need for in-patient treatment and pharmacological interventions, and enable clients to remain in their home or place of residence.

The day program accepts clients who exhibit challenging behaviours, including agitation, anger, irritability, and wandering. Clients with significant behavioural impairments are usually excluded from ABI day programs and other community programs due to the lack of expertise in managing clients' challenging behaviours. The overall goal of the day program is to reduce participants' social isolation by providing them with social experiences, training, and opportunities to participate in community activities. Participants are expected to be more likely to pursue productive activities in their home community when they leave the day program.

IMPACT:

Outreach services are clinically evaluated for each client. Goal attainment scaling has shown that most clients successfully achieve service goals. Since each client's challenging behaviour is unique, it has proven difficult to use standardized measures to demonstrate behavioural change. Instead, we examine clinical changes in each client's behaviour over the course of treatment, such as frequency of aggression, episodes of agitation, and frequency of participation in productive activities.

Preliminary data for 19 day program participants on standardized measures show a significant increase in community integration, a significant decrease in family burden, and a decrease in challenging behaviours. Family members were very satisfied with the program. These findings were presented at the Toronto ABI Conference in November 2012.

Clients of the outreach service have been very successful in remaining in their homes or places of residence, such as long-term care homes, since their challenging behaviours have decreased. Very few outreach clients have required in-patient treatment for behavioural disorders. In some instances, clients have been able to return to paid or volunteer work. Although we have not formally measured family burden, many family members have commented on the reduced burden of care that is a direct result of outreach services.

We examined official records of health care utilization for day program participants. Participants were not heavy users of the health care system before enrolling in the program, and there were no noticeable changes found during the six months after enrolment. Case management services have successfully connected participants to community services, including medical care and social services when needed. When participants have completed the day program, the case manager links them to other day programs that are not time limited.

APPLICABILITY/TRANSFERABILITY:

In Canada, there are few public sector outreach services that are directed towards community-resident ABI clients. We are aware of other behavioural outreach service providers in the Greater Toronto Area, but these services are usually time limited and not connected to a facility-based rehabilitation program. Most outreach behavioural services are only available for persons with a developmental disability.

Many ABI day programs exist in Canada. The day program at the West Park Healthcare Centre is unique in accepting participants with challenging behaviours and providing behavioural interventions. For example, the day program has successfully reduced challenging behaviours in participants who display verbal and physical aggression who had been excluded from other day programs. The program has also implemented continence and toileting independence training in participants who had been rejected by other programs. As part of an ABI behavioural rehabilitation facility, day program participants have access to community case management, respite care, and consultation with a psychiatrist.

Neither the ABI behavioural outreach service nor the ABI day program have been replicated elsewhere.

Content developed from the following sources and relevant websites:

http://www.westpark.org/Services/ABIAdultDayProgram.aspx

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External Source: http://www.westpark.org/Services/ABICommunityOutreachService.aspx

Regina Qu'Appelle Health Region's (RQHR) Aboriginal Home Care Program

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

SNAPSHOT: This innovative practice aims to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. Launched in the Regina Qu'Appelle Health Region's (RQHR), the program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

Most often, service providers are considered "experts" on what's best for the people they serve. When a problem arises, they develop a program. This can be a recipe for apathy and non-compliance, as well as a poor use of resources. It is critical that the people receiving services have an active voice in clarifying issues, determining solutions, and developing and evaluating programs. Taking the time and flexibility needed to build trust and relationships—particularly with a population that has come to distrust the system—pays huge dividends. Recognizing that individuals have their own priorities and using a holistic approach helps make practitioners more sensitive to where clients are in their lives and their ability to absorb, comprehend, and take action to effectively address health issues.

– Dorothy Lloyd, Eagle Moon Health Office, Regina Qu'Appelle Health Region

The Regina Qu'Appelle Health Region's (RQHR) Aboriginal Home Care program has demonstrated the value of a holistic, patient-centred approach to service provision for urban Aboriginal people.

The Aboriginal Home Care program began after RQHR's Home Care Services recognized that while First Nations and Métis people constituted a significant proportion of the population they served, very few Aboriginal people were accessing Home Care Services. In partnership with RQHR's Eagle Moon Health Office, Home Care Services brought together RQHR managers, First Nations and Métis Elders, knowledge keepers, and health workers to form a working group tasked with identifying why the service gap existed and how it might best be addressed. Based on the working group's findings and with financial support from the Aboriginal Health Transition Fund, Home Care Services developed and implemented the Aboriginal Home Care program.

The program's aim is to improve access to home care services by developing and implementing comprehensive, culturally sensitive, and holistic services, and by improving screening, early detection, and management of chronic disease (in particular, type 2 diabetes and foot care complications) for Aboriginal people. The program has transformed service delivery to First Nations, Inuit, and Métis people, introducing changes that have included:

- strategic relocation of the home care team to offices in the North Central neighbourhood in Regina (where a significant proportion of residents are Aboriginal) along with decentralization of files and referral intake;
- introduction of a position for a community liaison worker. This position is currently filled by an Aboriginal woman who skilfully navigates both traditional and Western ways, builds and strengthens relationships in the community (including relationships between health care workers and their clients), and has helped build community members' trust and confidence in home care services;
- access to traditional healers, as well as increased understanding of and sensitivity to Aboriginal cultural knowledge and practices;
- enhanced case management services, enabling more timely and effective assessments of and responses to clients' needs and returning clients to a more active role in caring for their own wellness;
- flexibility in scheduling, to support client-centred care;
- development and introduction of a holistic assessment tool, used alongside a standard comprehensive assessment tool. Holistic assessment enables practitioners and clients to consider all aspects of well-being (physical, mental, spiritual,

and emotional) and clients' self-identified needs, which has increased communication, trust, and compliance. Attention to clients' emotional and spiritual needs enables clients to draw on their own internal resources and find the strength and motivation to move forward on their path to wellness;

- increased focus on client education that, where possible, engages family and other people who are significant to clients. In this way, clients and their significant others become more deeply involved in the care process;
- enhanced foot screening, care, and referral services;
- enhanced resources to support referrals and links between urban and rural/on-reserve services, thus improving follow-up and continuation of care and treatment;
- establishment of a steering committee (which evolved out of the original working group) that monitors and provides guidance to program activities and consistently seeks input and feedback from community Elders and Healers throughout the program; and
- training for staff members to enhance their cultural awareness and cultural competency, along with weekly talking circles at which the on-site team can debrief and share knowledge.

The care experience for clients accessing services through the Aboriginal Home Care program has changed profoundly. Clients can now access holistic, patient-driven care. When they identify and voice their needs, service providers are ready to listen. Clients have a more active role in the "what" and "how" of the care they receive. For practitioners, the program enables them to bring services to a sector of the population that had previously been underserved. Training activities and resources developed for the program have enhanced practitioners' skills and capacity, and the emphasis on consistency in team members has enhanced cohesiveness, communication, and relationships, improving the scope and quality of care the team members provide.

The impacts of the Aboriginal Home Care program are assessed quantitatively and qualitatively. An increasing proportion of individuals in the region who qualify for home care are accessing the services they need. As a group, clients who access services through the program are demonstrating more positive attitudes, increased participation, and increased compliance compared with what typically occurred before the program was introduced.

To a considerable extent, the success of the Aboriginal Home Care program has come from its many internal and external partnerships and working relationships. RQHR's Eagle Moon Health Office (which works with departments in the health region to make service delivery more effective in meeting the needs of First Nations and Métis people) partnered with Home Care Services in the earliest stages of needs assessment and planning, and has provided knowledge, guidance, and support through development and implementation. The program also collaborates with RQHR's Native Health Services, urban and rural home care managers, and RQHR's research department. The executive director of Home Care Services has consistently championed the program, and having someone in a senior management position committed to the program and empowered to make change has been invaluable. External partners supported the creation of an online directory of services, which has greatly enhanced practitioners' ability to make timely and appropriate service referrals for their clients. Aboriginal community members have also played a key role. By sharing their perspectives and insights on how they experience care, clients have contributed significantly to Home Care Services' ability to adapt services to meet the real-life needs of Aboriginal people and communities.

CONTACT INFORMATION:

Additional information about this program is available online at http://www.rqhealth.ca/programs/comm_hlth_services/homecare/homecare.shtml.

External Source: http://www.healthcouncilcanada.ca/rpt_det.php?id=437

Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA)

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

SNAPSHOT: This innovative practice addresses many of the challenges of delivering comprehensive health care services to an aging population. In 2006, a model of integrated care called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) was launched throughout Quebec.

PRACTICE DESCRIPTION

In 2006, about 14% of Quebec's population was over age 65, and more than three-quarters (77%) of seniors had at least one select chronic condition. A model of integrated care called the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA) was developed to address many of the challenges of delivering comprehensive health care services to an aging population. Seniors who are eligible for services are over age 65, have moderate to severe disabilities, show potential for staying at home, and need two or more services.

The PRISMA model is based on six key elements:

- Coordination of organizations and services: Coordination first occurs at the governance level to bring together health care and social services, then at the management level to coordinate services, and finally at the operational level to bring together an interdisciplinary team.
- A single point of entry: This provides a portal for people to access all the services they need through a single source, rather than expecting them to seek out services from multiple sectors and providers to meet their needs.
- Case management: Case managers provide an initial assessment and are involved with planning and coordination of services with the patient and family. They also act as patient advocates.
- An individualized service plan: This plan is based on the assessment and is developed by the case manager in discussion with the multidisciplinary team, as well as with the client and caregiver.
- A standardized assessment: To evaluate clients' needs and determine the right package of services, a standardized assessment tool (the Functional Autonomy Measurement System, known by its French acronym as SMAF) is used to measure functional independence, communication, and mental functions. This tool is being used in several regions of Quebec to inform financing of long-term care facilities and home care services.
- Electronic records: A computerized clinical chart provides an electronic record that enables communication between the health care team as well as between organizations.

The PRISMA group conducted a four-year study to evaluate the impact of the model on the ability of seniors to remain in their homes. The study found fewer people in the PRISMA program experienced functional decline compared to seniors not in the program, and there were fewer admissions to emergency departments. Satisfaction and empowerment levels were higher among the PRISMA participants compared to seniors not participating in the program.

Since 2005, Quebec's Ministry of Health and Social Services generalized the PRISMA model across the province by merging all public hospitals, long-term care facilities, and home care agencies under single organizations within a region, organized into 95 health and social service centres across the province. The next step in implementation involves functional integration within the merged structures. The PRISMA model has been expanded to other regions in Quebec, and a pilot project has been initiated in France. The PRISMA group is working closely with policy-makers towards a more integrated system in Quebec.

External Source: http://www.prismaquebec.ca/cgi-cs/cs.waframe.index?lang=2

Home First

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

SNAPSHOT: This innovative practice addresses the issue of of Alternate Level of Care (ALC) patients waiting for beds in long-term care facilities. In the last few years, Ontario has developed a Home First program that sends patients back to their communities and homes with intensive case management.

PRACTICE DESCRIPTION:

Canadian provinces and territories are looking for ways to manage the issue of Alternate Level of Care (ALC) patients. In Ontario, the problem has been particularly acute due to large waiting lists—and long waits—for beds in long-term care facilities. In the last few years, Ontario has developed a Home First program that sends patients back to their communities and homes with intensive case management. Clients receive several weeks of enhanced home care support, allowing seniors to see how well they manage at home before they make decisions about where they wish to live long-term. Home First allows seniors to make this potentially life-altering decision over time and in a familiar setting, rather than in a stressful and disorienting hospital environment.

Home First is as much a health care management philosophy as a program. Under Home First, transferring a patient from a hospital to a long-term care home is considered as a last resort only after other community options have been explored. This is better for patients and helps to reduce the demand and wait list for long-term care facilities. Home First was introduced in Ontario by the Mississauga- Halton Local Health Integration Network (LHIN) in 2008. The LHIN has invested significantly in expanding community support services for vulnerable seniors who were referred to long-term care after a hospitalization, but who could be cared for appropriately and safely in their own homes with enhanced home care services.

These types of improvements can lead to cost savings, improved flow through the system, and improved quality of life for many seniors. Over a two-year period, Home First programs for seniors in the Mississauga-Halton region have enabled 2,500 people to go home with support instead of staying longer in the hospital or being moved into long-term care.

All LHINs across Ontario are currently implementing Home First, although each is at a different stage of development. Each LHIN and Community Care Access Centre (CCAC) determines the types of services and hours allotted to Home First clients, based on availability of resources and services within the region. A Home First Implementation Guide and Toolkit was produced in February 2011 by the advisory body for the LHINs (see www.lhincollaborative.ca).

External Source: http://www.lhincollaborative.ca/Page.aspx?id=1902

Patients as Partners

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

SNAPSHOT: This innovative practice addresses the need to help patients constructively share both positive and negative experiences as a voice for improvement to ensure patient experiences can inform system, program, and practice improvements. Patients as Partners is both a policy and philosophy of the British Columbia Ministry of Health. It offers an opportunity for patient engagement in redesign through the partners who deliver Integrated Primary and Community Care.

PRACTICE DESCRIPTION:

The Health Council of Canada's symposium included presentations of a number of approaches to patient and public engagement that could be highlighted as promising practices. One that illustrates three aspects of patient engagement—policy influence, cultural change, and a methodology to improve practice—was the presentation on Patients as Partners.

Patients as Partners is both a policy and philosophy of the British Columbia Ministry of Health. The unofficial motto of Patients as Partners is "nothing about me without me." It offers an opportunity for patient engagement in redesign through the partners who deliver Integrated Primary and Community Care: health authorities, non-governmental organizations (NGOs), and physician collaboration committees (partnerships with the BC Ministry of Health and the BC Medical Association). This includes the General Practice Services Committee, Shared Care Committee, and the Specialist Services Committee.

In 2002, the General Practice Service Committee (GPSC) was formed to enable the BC Government and primary care physicians to work together on strategies "focusing on what is best for patients, not best for physicians or best for government…". Among other things, the GPSC "…is responsible for new initiatives, including clinical incentive payments, maternity care bonuses, training modules to enhance clinical and administrative skills, and the creation of Divisions of Family Practice to coordinate and support family doctors at the regional level." This shift created an environment where physicians were supported to spend more time with their chronically ill and complex care patients. Over time, this has led to a change of culture where patients are more often seen as partners in the management of their care. In fact, according to Kelly McQuillen, Director of Patients as Partners, BC Ministry of Health, "Physicians now ask 'how many patients are on this consultation call today or involved in our redesign approaches?'"

Patients as Partners collaborates with health authorities, NGOs, physician collaborative committees, and other key stakeholders to identify opportunities for patient and public engagement in program and service design, and system and community health care transformation. Patients are engaged through the Patient Voices Network, a mechanism to recruit, train, and support patients, families, and caregivers to participate in health care changes at the individual (patient to provider), program and service design, and community and system levels.

The network helps patients to constructively share both positive and negative experiences as a voice for improvement through support, training, and coaching. Patient voices for improvement are leveraged to ensure patient experiences can inform system, program, and practice improvements. More than 80% of patients report that they find participating in their engagement opportunity is a meaningful and valuable experience.

Patient experience measures are central to the overall Integrated Primary and Community Care evaluation, accountability, research, and quality improvement framework. Patients as Partners will know that patient and public voices in the change process have 'stuck' when they see an improvement in population health, an improved patient and provider experience of care, and lower per capita costs overall. And, patients will be engaged in the design of the provincial evaluation framework. Could patient engagement be the catalyst to move primary health care to the next level?

External Source: http://www.impactbc.ca/patients-as-partners