Health Innovation Portal:
Archive of Innovative Practices

Theme: **Patient Centered Care (Vol. 2)**

January 2014

Health Council of Canada
Conseil canadien de la santé

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:**	**36 results out of 79**

1. Patients as Partners—Patient Voices Network

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

2. The Caring Together Project

Implementation Year: Monday, December 9, 2013 - 14:00	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice facilitates interprofessional practice for palliative care givers. The Caring Together Project was initiated in 2007 as on online learning resource and piloted in two not-for-profit long term care homes in Ontario involving a total of 55 staff members. Since the project continued from its pilot phase, the e-learning resource has been integrated into interprofessional course work for health science students at the University of Ottawa (2013).

CONTACT INFORMATION:

Name: Emma Stodel Title: Consultant Organization: Learning 4 Excellence Email address: estodel@learning4excellence.com Telephone number: 613-822-7060 Information last updated on: November 14, 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

4. Including patients and families on hospital Unit Action Councils to promote patient-centered Integrated Interprofessional Care

Implementation Year: Saturday, November 26, 2011 - 14:30	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice portrays an interprofessional, patient-centred, collaborative practice model of care delivery through engaging patients and their families as members of Unit Action Councils (UACs). This project was launched in 2011 in Ontario across an alliance of four rural community hospitals.

CONTACT INFORMATION:

Name: Dianne Gaffney Title: Corporate Lead, Professional Practice Organization: Huron Perth Healthcare Alliance Email address: dianne.gaffney@hpha.ca Telephone number: 519-272-8210 ext. 2316 Information last updated on: July 31, 2013

5. Supporting Aboriginal Seniors at Home (SASH), Southwest Ontario Aboriginal Health Access Centre

Implementation Year: Friday, November 26, 2010 - 10:15	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice provides culturally safe care to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. In doing so, the practice addresses disparities between the life expectancy and the incidence of chronic disease for Aboriginal and non-Aboriginal seniors. It was launched in Ontario at an Aboriginal Health Access Centre, and involved a nurse practitioner, a senior's health advocate, and a patient navigator.

CONTACT INFORMATION:

Name: Barb Chrysler Title: Manager, Primary Care Organization: Southwest Ontario Aboriginal Health Access Centre Email address: bchrysler@soahac.on.ca Telephone number: (519) 289 0352 Information last updated on: September 23, 2013

6. Culturally Competent Collaborative Practice Model for Chronic Disease Management

Implementation Year: Friday, November 26, 2010 - 09:45	Location: Saskatchewan	Practice Website:

SNAPSHOT:

This innovative practice aims to improve quality of life and health care delivery for First Nations people with chronic disease, through better linkages between provincial and on-reserve services and enhanced service delivery on-reserve. Launched in 2010, this practice included collaboration among Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program) and three First Nations communities including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation.

CONTACT INFORMATION:

Name: Sandy Hassler Title: Collaborative Practice Coordinator (retired) Organization: n/a Email address: s.hassler@sasktel.net Telephone number: 306 736-9099 Information last updated on: October 10, 2013

7. Promoting paternal involvement through the Fathers Friendly Initiative within Families (FFIF)

Implementation Year: Monday, November 5, 2012 - 14:30	Location: Quebec	Practice Website: http://iap.uqo.ca/en/

SNAPSHOT:

This innovative practice helps make existing health care and services to make them more inclusive, accessible, and useful for fathers. Fathers Friendly Initiative within the Families (FFIF) is being implemented in five regions of Quebec throughout 2012–2017, and aims to train health care managers and workers who interact with parents in the perinatal period.

CONTACT INFORMATION:

Name: Francine de Montigny Title: Canadian Research Chair in Psychosocial Family Health Organization: Université du Québec en Outaouais Email address: francine.demontigny@uqo.ca Telephone number: 819-595-3900-2257 Information last updated on: July 15, 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

9. Intensive Outpatient Rehabilitation Program for Stroke Survivors and Limb Amputees

Implementation Year: Friday, October 7, 2011 - 14:00	**Location: British Columbia**	**Practice Website: http://www.viha.ca/adult_rehab_services/outpatient_programs/iorp.htm**

SNAPSHOT:

This innovative practice addresses the need to increase access to rehabilitation services for stroke or limb amputees through an interprofessional team supporting patients to reintegrate in their community. This practice was initiated in October 2011 in two communities in the Vancouver Island Health Authority (VIHA).

CONTACT INFORMATION:

Name: Marci Ekland, Manager Rehab, Services and Regional OP Program Organization: Vancouver Island Health Authority Email address: marci.ekland@viha.ca Telephone number: (250) 755-7681 ex 52333

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

11. Quinte Pediatrics and Adolescent Medicine's Social Media Platform

Implementation Year: Sunday, February 3, 2008 - 01:00	**Location: Ontario**	**Practice Website: http://quintepediatrics.com/**

SNAPSHOT:

This innovative practice aims to streamlines the provision of care to pediatric patients through the use of social media—Facebook, Twitter, and smartphone apps. This practice started in a clinical setting in Belleville, and involves a physician and a social media specialist.

CONTACT INFORMATION:

Name: Sara Hamil Title: Director, Social Media and Communications Organization: Quinte Pediatrics and Adolescent Medicine Email address: sara@quintepediatrics.com Telephone number: 613.966.1999 Information last updated on: July 2013

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

13. All-Access Dentistry: Specialized Geriatric Dental Services

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

14. Young Carers Program of Hospice Toronto

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

17. Prevention Olympics

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

18. MedicAlert Access En-Route: Medic Alert Interchange Project

Implementation Year: Friday, February 3, 2012 - 01:00	Location: Nova Scotia	Practice Website: http://www.gov.ns.ca/health/ehs/medicAlert.asp

SNAPSHOT:

This innovative practice gives paramedics access to the MedicAlert emergency health record from ambulances and includes it in electronic patient care records.

CONTACT INFORMATION:

Name: Robert Ridge Title: President and CEO Organization: Canadian MedicAlert Foundation Email address: rridge@medicalert.ca Telephone number: 416-490-3522

19. Residents First

Implementation Year: Friday, January 1, 2010 - 00:15	Location: Ontario	Practice Website: http://www.quality-improvement/long-term-care

SNAPSHOT:

This innovative practice aims to supports long-term care homes in providing an environment for their residents that enhances their quality of life. Launched in Ontario in 2010, this five year initiative aims to strengthen the long-term care sector's capacity for quality improvement.

CONTACT INFORMATION:

Name: Gayle Stuart Title: Program Manager, Residents First Organization: Health Quality Ontario Email address: gayle.stuart@hqontario.ca Telephone number: 416-323-6868

20. Self-Advocacy For Everyone (SAFE) Toolkit

Implementation Year: Tuesday, February 8, 2011 - 00:30	**Location: Manitoba**	**Practice Website: http://www.safetoask.ca/safetoolkit/index.html**

SNAPSHOT:

This innovative practice focuses on engaging patients and encouraging individuals to take ownership of their health care by educating them on a number of tops through a patient safety toolkit. Launched in Manitoba in 2011, the program offers information, tips and resources that can help people learn to be more involved in their health care.

CONTACT INFORMATION:

Name:Dawn White Title: Consultant Organization: Manitoba Institute for Patient Safety Email address: dwhite@mbips.ca Telephone number: (204) 927-6471

21. Health Upwardly Mobile (HUM) Inc.

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

22. Integrated Client Care Program (ICCP) for Older Adults with Complex Needs

Implementation Year: Thursday, February 3, 2011 - 01:00	**Location: Ontario**	**Practice Website: http://www.ccac-ont.ca/Upload/on/General/ICCP_Older_Adults_with_Complex_Needs.pdf**

SNAPSHOT:

This innovative practice aims to implement and evaluate practical models of integrated care for specific complex needs populations: older adults with complex needs, medically fragile children, and palliative clients. Launched since early 2011, the Toronto Central Community Care Access Centre (TC-CCAC) in partnership with the Toronto Central Local Health Integration Network (TC-LHIN) has been leading this collaborative, LHIN-wide, multi-year strategy and change initiative.

CONTACT INFORMATION:

Name: Jodeme Goldhar Title: Lead, Health System Integration for Complex Populations and Primary Care Organization: Toronto Central Community Care Access Centre Email address: jodeme.goldhar@toronto.ccac-ont.ca

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

Implementation Year:	**Location: Ontario**	**Practice Website: http://www.pccchealth.org/cms/sitem.cfm/our_sit**

Tuesday, February 1, 2011 - 00:30		**es/mental_health_services/**

SNAPSHOT:

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

CONTACT INFORMATION:

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

24. Virtual Ward, South East Toronto Family Health Team

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

25. Integrated Discharge Planning

Implementation Year: Wednesday, February 2, 2011 - 00:45	**Location: Ontario**	**Practice Website: http://www.headwatershealth.ca/**

SNAPSHOT:

This innovative practice is a framework for discharge planning to streamline processes and improve system navigation for clients and their families. Beginning as a one-year pilot project in 2011 between the Headwaters Health Care Centre (HHCC) and the Central West Community Care Access Centre (CCAC) in Ontario, the programs success has led to the recent adoption of this role and partnership into standard practice.

CONTACT INFORMATION:

Name: Mary Wheelwright Title: Program Director, Rehabilitation, Medicine and Complex Continuing Care Organization: Headwaters Health Care Centre Email address: mwheelwright@headwatershealth.ca

26. Integrated Comprehensive Care at St. Joseph's

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

SNAPSHOT:

This innovative practice is a collaborative model of care that integrates the transition of patients from the hospital to the community. Launched in St. Joseph's Healthcare, Hamilton and St. Joseph's Home Care, Hamilton, in March 2012, the objectives of the project are to explore the benefits of integrated case management and to evolve the existing case management model into a patient-centred model that follows the patient across the continuum of care.

CONTACT INFORMATION:

Name: Carolyn Gosse Organization: St. Joseph's Healthcare, Hamilton Email address: cgosse@stjosham.on.ca

27. Seniors Managing Independent Living Easily (SMILE)

Implementation Year: Sunday, February 3, 2008 - 00:45	**Location: Ontario**	**Practice Website: http://www.von.ca**

SNAPSHOT:

This innovative practice is designed to provide functional supports to frail seniors. The program aims to make it possible for seniors who are at risk of premature dependency to receive help with instrumental activities of daily living in order for them to remain in their homes and out of hospital and long-term care homes. SMILE was implemented in 2008, funded by the South East Ontario Regional LHIN as part of the Aging at Home strategy of the Ontario Ministry of Health and Long-Term Care.

CONTACT INFORMATION:

Name: Lori Cooper Title: District Executive Director; Community Support Services Organization: VON Canada, Southeast District Email address: lori.cooper@von.ca

28. Cudworth Health Council in Saskatchewan

Implementation Year: Wednesday, February 2, 2011 - 01:00	**Location: Saskatchewan**	**Practice Website: http://www.townofcudworth.com/Community%20Newsletter%20may%202012%20(2).pdf**

SNAPSHOT:

This innovative practice addresses the need to promote active engagement of individuals and communities in planning, reviewing, and implementing strategies that both maintain and improve the health and well-being of citizens. The Saskatoon Health Region (SHR) developed a community engagement process to enable community members living in the Town of Cudworth and surrounding area to influence, design, implement, and evaluate health services in their community.

CONTACT INFORMATION:

Name: Pat Stuart Title: Manager Primary Health Organization: Saskatoon Health Region Email address: pat.stuart@saskatoonhealthregion.ca Telephone number: 306-655-5364

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

30. Community Agency Notification Program

Implementation Year: Thursday, February 3, 2011 - 00:45	**Location: Ontario**	**Practice Website: http://torontoems.ca/community-paramedicine/can**

SNAPSHOT:

This innovative practice addresses the fact that many patients living at home receive various levels of support from community agencies. In an acute medical situation, these support agencies often lose contact with their patients. In March 2011, Toronto Emergency Medical Services (EMS) launched a pilot program called Community Agency Notification (CAN). CAN is a communication protocol initiated by paramedics that notifies community agencies when their client comes into contact with EMS. The alert enables the community agency to follow up with the hospital and/or resident.

CONTACT INFORMATION:

Name: John Klich Title: Superintendent, Community Paramedicine Program Organization: Toronto Emergency Medical Services Email address: jklich@toronto.ca Telephone number: 416-392-3881

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

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

32. Health Quality Ontario's Home Care Indicator Reporting

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

33. The Client Health Related Information System (CHRIS)

Implementation Year: Thursday, February 3, 2011 - 00:00	Location: Ontario	Practice Website: www.ccac-ont.ca/Upload/oaccac/General/MA03.pdf

SNAPSHOT:

This innovative practice addresses home care planning and management, alleviating the previous challenges of multiple data entries, the need to fax important client information, and multiple referrals. In Ontario, the Association of Community Care Access Centres (CCACs) has been spreading the use of the Client Health Related Information System (or CHRIS, as it is more commonly known). CHRIS is a web-based client management system with four key components: case management, service provisioning, reporting.

CONTACT INFORMATION:

34. Transitional Restorative Care Program

Implementation Year:	Location: Ontario	Practice Website:

Thursday, February 3, 2011 - 00:30		**http://www.rougevalley.ca/transitional-restorative-care-program**

SNAPSHOT:

This innovative practice addresses the need for rehabilitation services, such as physiotherapy and occupational therapy, to play a key role in helping patients regain enough strength and mobility to return home. At the Rouge Valley Health System – Ajax and Pickering hospital campus (Ontario), a new transitional restorative care program helps prepare patients to return home from the hospital and resume their daily activities.

CONTACT INFORMATION:

Name: N/A Title: N/A Organization: Rouge Valley Health System Email address: N/A Phone number: (905) 683-2320 ext. 1390

35. Partnering for Patients

Implementation Year: Thursday, February 3, 2011 - 00:30	**Location: Alberta**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses the issue of coordinating home care. In Red Deer, Alberta, home care case managers work in hospital emergency departments to assess patients to determine the best care path for the patient, whether it is hospital admission, home care, or a long-term care facility.

CONTACT INFORMATION:

36. Alberta's Caregiver Support

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

Patients as Partners—Patient Voices Network

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

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

Practice Description:

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

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

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

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

Impact:

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

Applicability/Transferability

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

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

Contact Information:

Caryl Harper

Ministry of Health

Patients as Partners: Patient Voices Network

3-2, 1515 Blanshard St.

Victoria, BC V8W 3C8

Telephone: 604-742-1772

Email: connect@patientvoices.ca

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

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

Government of British Columbia. (n.d.). *Patient voices network*. Retrieved from http://www2.gov.bc.ca/govtogetherbc/consultations/patients_as_partners.page

Impact BC. (n.d.). *The patient voice*. Retrieved from http://www.impactbc.ca/what-we-do/the-patient-voice

The Caring Together Project

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

SNAPSHOT: This innovative practicefacilitates interprofessional practice for palliative care givers.The Caring Together Project was initiated in 2007 as on online learning resource and piloted in two not-for-profit long term care homes in Ontario involving a total of 55 staff members. Since the project continued from its pilot phase, the e-learning resource has been integrated into interprofessional course work for health science students at the University of Ottawa (2013).

PRACTICE DESCRIPTION:

Elderly individuals receiving care at the end of their lives require care from a variety of caregivers. Recognizing gaps in interprofessional education particularly for the delivery of palliative care services, the Caring Together Project was designed to increase patient-centred care skills within a collaborative care model. Using case-based learning activities to allow participants to apply clinical theory in the practice setting, the project targets frontline caregivers including physicians, pharmacists, and nurses. The electronic format enables the interactive modality of drawing upon the knowledge and experience of health care professionals, educators, academics, and industry while integrating the patient perspective. This project was originally funded in part by an Inukshuk Wireless Grant. After the initial pilot phase, the core components of the Caring Together Project have been integrated into health sciences interprofessional programming at the University of Ottawa, most recently as an elective for third year Health Sciences students (2013).

IMPACT:

The latest data available regarding the impact of the Caring Together Project are derived from the evaluation conducted alongside the pilot implementation (2008-2009). The assessment examined the effectiveness of using the online learning resource to increase palliative care and interprofessional care skills as well as the stimulation of respective knowledge translation in the workplace. An experimental group (128 residents and 189 staff) was compared to a controlled replication group (100 residents and 88 staff) drawn from two long-term care homes in Ontario. From these two settings, a total of 55 caregivers from 19 disciplines volunteered to participate in the project, of which 94% completed the learning resource and evaluation.

Overall, the online learning resource met the learners' needs for accessing relevant education materials that could be applied to their practice settings to effectively care for residents at the end of life. Participants reported that these resources enabled them to learn with, from, and about one another in an engaging and convenient way. Perceptions of knowledge transfer and effectiveness of the resources were positive, however, associated evidence was weak. There was no distinctive change in attitudes toward interprofessional care, however, this was attributed to relatively high baseline attitudes.

While the Caring Together resources are still being used intermittently for interprofessional health sciences education at the University of Ottawa, current data are not publically available as the projects are intended for registered staff and students.

APPLICABILITY/TRANSFERABILITY:

The development of the Caring Together Project has been informed by previous work conducted by related innovators with similar intentions to improve quality of collaborative care through e-learning initiatives. A variation of Caring Together that focused on dementia care was initiated as a pilot project from 2003 to 2004. Later, 'the Working Together Project' was piloted in the spring of 2006 through collaboration of experts from: the Elisabeth Bruyere Research Institute; Bruyere Continuing Care; and the University of Ottawa's Faculty of Education, Centre for e-Learning, Department of Family Medicine, and the Primary Health Care Nurse Practitioner Program in the School of Nursing (funded by the Ministry of Health and Long Term Care). 'E-Physician Health' was then launched in October 2009, branded as 'the world's first comprehensive online physician health and wellness resource' (http://ephysicianhealth.com/). It has been used by over 27,000 individuals from over 130 countries. The most recent related initiative is the 'Caring for Persons with Spinal Cord Injury' project (http://eprimarycare.onf.org/), which went live in March 2013 and has yet to be evaluated.

Together, these initiatives are indicative of an educational shift towards more flexible and accessible resources for continuing education for health care professionals. Significant barriers have been experienced as a result of the general 'pilot nature' of the projects and difficulty ensuring continuity of funding, communication, and technical support.

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Publications:

MacDonald, C., Stodel, E., Hall, P., Weaver, L. (2009) The Impact of an Online Learning Resource Designed to Enhance Interprofessional Collaborative Practice in Palliative Care: Findings from the Caring Together Pilot Project. *Journal of Research in Interprofessional Practice and Education,* 1(1): 42-66. http://www.jripe.org/index.php/journal/article/view/6/17

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Emma Stodel; November 13, 2013 [telephone]

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

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

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

PRACTICE DESCRIPTION:

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

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

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

Buddies for Seniors

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

Technology Training

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

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

IMPACT:

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

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

Considerations and suggestions for implementing this program:

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

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Personal Communications:

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

Other:

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

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

Including patients and families on hospital Unit Action Councils to promote patient-centered Integrated Interprofessional Care

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

SNAPSHOT: This innovative practice portrays an interprofessional, patient-centred, collaborative practice model of care delivery through engaging patients and their families as members of Unit Action Councils (UACs). This project was launched in 2011 in Ontario across an alliance of four rural community hospitals.

PRACTICE DESCRIPTION:

There is growing recognition of the need for health care professionals across all sectors to work in interprofessional teams in order to improve the quality, safety, continuity, and cost-effectiveness of health care delivery. To ensure success, patients and their families need to be meaningfully engaged on interprofessional teams as full partners in the design, delivery, and evaluation of health care services.

The Huron Perth Healthcare Alliance (HPHA) of four rural community hospitals began implementing an interprofessional practice model in 2010. The creation of Unit Action Councils (UACs) on patient care units is one of the key initiatives to advance interprofessional care (IPC) and enhance patient and family-centred care (PFCC); however, traditionally these councils have only included health care professionals. In partnership with the Canadian Foundation for Healthcare Improvement (CFHI), the University of Western Ontario, and Fanshawe College, the HPHA launched a patient engagement project that would see the inclusion of patients and family members on the UACs, to create a unique model of interprofessional, patient-centred, collaborative practice.

The two-year project launched in 2011 and began with a collection of narratives written by patients and families that were validated through open community forums. These narratives shared both positive and negative experiences and established the core values of care recipients. These data were then used by UACs to guide project work that would enhance IPC, PFCC, and the quality of care delivered.

The pilot consists of 15 UACs, eight of which include a patient and a family member on the council (intervention). The remaining seven UACs include only health care professionals (control). All leaders and care providers at each hospital attended an educational workshop on IPC and PFCC prior to the formation of the UACs. The patient and family members recruited also participated in an educational workshop prior to the first meetings of their UACs.

All 15 UACs have now developed patient-centred models to revise care delivery based on the values determined through narratives and forums. As council members, patients and family members are involved in setting up new processes and structures to reflect the PFCC model, collecting data to monitor output, and evaluating the intervention's effect on outcomes. Following the two-year study, the UACs will remain as part of the hospitals' organizational structure.

IMPACT:

Qualitative data to guide the projects were obtained from the patient narratives, community forums, and focus groups that were held with the intervention and control units. Common themes emerged, including timeliness, communication, caring, respect, and continuity of care.

An evaluation plan is in place. The effectiveness and impact of the UACs will be evaluated through a variety of measures. UAC members will be assessed using validated tools that measure collaboration, quality of life, and empowerment. Patients and families will be surveyed using validated tools that measure quality and safety of care and self-care management. Additionally, clinical data related to quality of care and safety outcomes will be collected. Summative and formative evaluations will be

completed at five points during the study. These evaluations will compare intervention and control outcomes to determine the impact of including patients and families as UAC members. A final report is expected in November 2013.

The project was funded in part by the CFHI's patient engagement initiative (2011). Each of seven projects received support, mentoring, and an investment of $700,000 that was matched through co-sponsorship support. After November 2013, costs will be covered by operating budgets in each hospital.

APPLICABILITY/TRANSFERABILITY:

The UAC patient engagement project has not been adapted from another jurisdiction or implemented elsewhere; it is the first to engage patients and families on UACs. However, this initiative is theoretically transferable to other settings. Already, this model of patient engagement is being used to enhance the involvement of patients and families in other patient care committees throughout the HPHA organizations. Results from this pilot are theoretically applicable in other health care organizations.

Lessons learned for applicability/transferability:

- Educational sessions for staff, leadership, and patient and family members were critical in enabling and sustaining the culture shift to a new model of care.
- Patients and family members contribute more than simply perspectives on care; they bring diverse skills that complement those of staff. However, recruitment may take longer than expected.
- Mentoring is useful for the staff who fulfill the facilitator role for the UACs.
- Alignment with organizational strategies and priorities, as well as support from the Senior Leadership Team, Clinical Program Directors, and Board is essential.
- Meaningful engagement of physicians early in the process is necessary.

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Gaffney, D. (review, July 2013). [Huron Perth Healthcare Alliance].

Other:

Gaffney, D. Abstract submission to the Health Council of Canada's National Symposium of Integrated Care (2012).

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Supporting Aboriginal Seniors at Home (SASH), Southwest Ontario Aboriginal Health Access Centre

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

SNAPSHOT: This innovative practice provides culturally safe care to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. In doing so, the practice addresses disparities between the life expectancy and the incidence of chronic disease for Aboriginal and non-Aboriginal seniors. It was launched in Ontario at an Aboriginal Health Access Centre, and involved a nurse practitioner, a senior's health advocate, and a patient navigator.

PRACTICE DESCRIPTION:

The Supporting Aboriginal Seniors at Home (SASH) program offers culturally based services designed to reduce the incidence of chronic disease and increase the life expectancy of Aboriginal seniors. The program targets First Nations, Inuit, and Métis seniors and their family members. It was established in 2010 and is supported by Aging at Home funding. It was developed in consultation with Aboriginal community members, drawing on models of care that support the delivery of culturally appropriate and culturally safe care.

Staff assigned to the SASH program includes a nurse practitioner, a seniors health advocate, and a patient navigator, as well as a cultural safety trainer and management staff. The nurse practitioner provides primary care and chronic disease management services to seniors at the clinic, in community centres, or in seniors' homes. The seniors health advocate assists seniors to access community and social services. The patient navigator helps clients find their way through the complex hospital system. The SASH team works with the health care team to develop a client-centred care plan that incorporates traditional healing and culturally safe practices. The cultural safety trainer educates organizations in the region on the provision of culturally safe care, and builds their capacity to work well with Aboriginal patients. Chronic disease management services focus on helping people stabilize, improve, develop better self-management skills, and, in some cases, recover. The team supports clients, caregivers, and families in their interactions with health practitioners, and arranges interpretation and translation services as needed. They connect clients and their families with traditional Aboriginal healers, and counsel clients and their families to ensure that they understand their care plan while in hospital. Team members participate in discharge planning for their clients, helping them transition from hospital settings to home, arranging follow-up care, and connecting them with a comprehensive and holistic range of resources and supports. The team works closely with local organizations and hospitals, and the patient navigators have taken on a community development role, meeting with organizations and bands to better understand service pathways in the region.

The SASH program provides care that is different than what is typically available to Aboriginal seniors. It incorporates a spiritual component in its approach to treatment and wellness, and patients are able to access traditional services. It uses a patient-centred model, and staff members go above and beyond to provide exceptional programming and ensure that patients' comprehensive needs are taken into account.

IMPACT:

The SASH program was implemented in 2010 and has not completed an evaluation at this time. However, the program is now implementing results-based accountability processes. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. These include increased use of primary care services and reduced use of emergency department services, increased access to appointments with specialists, improved identification and management of chronic disease, and increased movement of people into recovery from addiction. The program is also building the capacity of organizations and practitioners to work well with Aboriginal seniors and provide culturally appropriate and safe care. Linkages between the program and other organizations (in particular, non-Aboriginal organizations) are strengthening.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that SASH had adapted from and were unaware if the practice was used as a model elsewhere. Components of the model have been adopted by a local CancerCare program. Lessons learned that might affect the applicability or transferability of the practice include the importance of community development and partnership, and the importance of attending to human resources issues. Staff members must be comfortable working in community settings; comfortable working with networking and promotion activities; and capable of working well with people with mental health issues, addiction issues, and other complicated medical conditions. Staff must also understand the ways of the communities they are working in, and be resourceful about how to address basic needs in areas such as food, housing, and economic security.

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Personal Communications:

Chrysler, B. (interview and feedback, August 7, 2013). [Southwestern Ontario Aboriginal Health Access Centre].

Culturally Competent Collaborative Practice Model for Chronic Disease Management

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

SNAPSHOT: This innovative practice aims to improve quality of life and health care delivery for First Nations people with chronic disease, through better linkages between provincial and on-reserve services and enhanced service delivery on-reserve. Launched in 2010, this practice included collaboration among Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program) and three First Nations communities including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation.

PRACTICE DESCRIPTION:

In 2010, three partners came together to begin the first ever Kidney Health Education and Targeted Screening Program. The partners were Health Canada (First Nations and Inuit Health), The Kidney Foundation of Canada (Saskatchewan Branch), and the Regina Qu'Appelle Health Region (Chronic Kidney Disease Program). Three First Nations community partners were asked to participate including Cowessess First Nation, Gordon First Nation and Muskowekwan First Nation. This pilot project had the following goals: improved coordination of care of individuals with chronic disease, improved client outcomes, increased access to chronic disease management, increased community capacity and improved self-care management.

Each community had two days of screening where approximately twenty-five people were screened per day. In total, 150 people were screened for chronic disease and educated about ways to keep themselves healthy. Each participant signed a consent form that explained the purpose of the program and what would occur that day and a pre-survey was completed to assess prior knowledge. A health data form was filled out to collect information and record test results, and a copy was also given to the participant in the form of a "kidney report card." Tests were administered including blood pressure, random glucose, A1c, estimated glomerular filtration rate, urinalysis, weight, body mass index, percentage of body fat and waist circumference.

After the tests were completed the participants met with a nurse from the Chronic Kidney Disease program to discuss their results and ask any questions. The nurse provided health advice for optimal kidney function and well-being. Follow-up screening was done in 2011 following the same process.

IMPACT:

There was evidence in the follow-up surveys of the health changes that people were making. They were exercising more, losing weight and decreasing fat and salt consumption, quitting smoking and regularly monitoring their blood glucose and blood pressure and taking their medications. There was also improved coordination and increased access to chronic disease management. Further evaluations are forthcoming.

APPLICABILITY/TRANSFERABILITY:

The practice informant did not identify other practices that the Collaborative Practice Model had adapted from and were unaware if the practice was used as a model elsewhere. However, specific lessons learned from this practice include: repeat screening of clients; regular meetings and foundation for collaboration established to improve coordination of care; client education sessions and engagement of local leadership increased community capacities, and client input contributed to improved self-care management. Challenges that impacted the program included: staff turnover and shortages, heavy workloads prevented staff from dedicating time to the project; and, it was difficult at times to coordinate activities with the Regional Health Authority due to their staff shortages and constraints.

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Personal Communications:

Hassler, Sandra (interview and feedback, June 2013). [Collaborative Practice Project].

Other

Petruka, P. and Bassendowski, S. (April 2013). Innovative Collaborative Practice Models to Managing Home Care Clients. Saskatchewan Region.

Lytle, K. (no date). Strengthening the Bridge: Continuing Prevention of Chronic Disease in Saskatchewan First Nations. The Kidney Foundation of Canada, Saskatchewan Branch.

Promoting paternal involvement through the Fathers Friendly Initiative within Families (FFIF)

LOCATION:	Quebec	**HEALTH THEME:**	Patient Centered Care
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice helps make existing health care and services to make them more inclusive, accessible, and useful for fathers. Fathers Friendly Initiative within the Families (FFIF) is being implemented in five regions of Quebec throughout 2012–2017, and aims to train health care managers and workers who interact with parents in the perinatal period.

PRACTICE DESCRIPTION:

The period surrounding birth and infancy is a crucial family transition. It is essential that both parents be involved with their children. Research has shown the positive effects that paternal involvement has on children's development, the quality of the marital relationship, and fathers' mental health. The FFIF is a program that aims to make existing health care and services more inclusive, accessible, and useful for fathers. The purpose of the FFIF is to promote fathers' involvement in their families and communities, in particular by developing and integrating clinical practices that include fathers.

The Government of Quebec's 2008–2018 perinatal policy included recommendations to actively recognize, favour, and support fathers' involvement throughout the perinatal period. The FFIF initiative is consistent with these priorities.

FFIF is a multisystemic program to promote father involvement within the family, the health care system, and society. The FFIF guides workers and managers in health care, social services, and community services to better support paternal involvement through innovative, effective actions targeting fathers and their families. The program offers workshops for health care practitioners working with families in various areas of practice. These meetings give participants an opportunity to reflect on their beliefs and practices regarding fathers. FFIF workshops are not theoretical courses, but rather places for exchange, where professional practices can be analyzed and new approaches can be developed. The goals of changing approaches to paternal involvement are to:

- promote healthy development of children and their families, and a successful school integration;
- prevent early marital separation and divorce; and
- promote parents' mental health.

The FFIF program was piloted in 2010/2011 in the Southern Laurentians. Following positive results, the program has expanded and is now being implemented in five regions of Quebec (from 2012 to 2017), with funding support by Avenir d'Enfants.

IMPACT:

The FFIF pilot project involved 30 primary care workers and 10 managers. The foundation of the approach was workshops linking reflexive discussions with more theoretical exchanges. These discussions make it possible to raise front-line workers' awareness of fathers' needs while simultaneously encouraging them to develop their skills, adapt their approach to the real working context, and change their beliefs.

The pilot project evaluation showed significant evidence of changes in beliefs, attitudes, and practices towards fathers and their families, as well as diverse adaptations of the health care establishments' environment to men's needs. Additionally, the assessment showed that FFIF:

1) supports health care, social services, and community institutions and organizations in establishing and adapting father-friendly services, activities, and practices; and

2) promotes interprofessional collaboration in providing services that are more complementary and more consistent.

The FFIF research project will continue to undergo evaluation as it expands. Evaluation is structured into three theme: evaluation of the implementation context; the implementation process; and intervention effects, results, and consequences. The latter evaluation will include analysis of the content of front-line workers' and physicians' reflexive workshops, fathers' focus groups, and questionnaires administered to workers and fathers before and after the implementation.

To date, the initiative has had a positive impact in raising awareness about paternal involvement. Political decision-makers, health care and social services agencies, health care and social services centres, community organizations, and the general public are being informed about the importance of supporting paternal involvement and are motivated to take action to make fathers more visible in the community.

An assessment of the costs of this program has not been completed at this time.

APPLICABILITY/TRANSFERABILITY:

The FFIF program has not been implemented outside of Quebec but is theoretically applicable and transferable to other settings. The FFIF team has designed promotional materials, teaching guides, and participant booklets; these tools have been developed to support the adaption and application of this initiative to other settings.

Within Quebec, FFIF has expanded from a pilot to five regions: Outaouais, Laurentians, Montérégie, Mauricie, and Centre du Québec. There has also been interest in the program abroad, with a team investigating the application of FFIF in Australia.

The five regions participating in the expansion have identified different organizational and planning needs for implementing FFIF. Relevant factors include: openness to changes in practices, giving paternal involvement priority in action plans, availability of health care and social services workers to participate in reflective workshops, and budgets for releasing staff members and the clients targeted by the services and activities.

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Personal Communications:

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Publications:

de Montigny, F. & Gervais, C. (2013). The Fathers Friendly Initiative within the Families. *Impact, 3*(1). Retrieved from http://cerif.uqo.ca/sites/cerif.uqo.ca/files/impact_vol3-no1eng_final.pdf

External Source: http://iap.uqo.ca/en/

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

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

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

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

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

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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

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Personal Communications:

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

Other:

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

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

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

Intensive Outpatient Rehabilitation Program for Stroke Survivors and Limb Amputees

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

SNAPSHOT: This innovative practice addresses the need to increase access to rehabilitation services for stroke or limb amputees through an interprofessional team supporting patients to reintegrate in their community. This practice was initiated in October 2011 in two communities in the Vancouver Island Health Authority (VIHA).

PRACTICE DESCRIPTION:

The Intensive Outpatient Rehabilitation Program (IORP) has clinics in Victoria and Nanaimo for patients with moderate levels of impairment following a stroke and for patients with limb amputation. The six- to eight-week outpatient rehabilitation program offers an alternative to traditional hospital-based in-patient rehabilitation by allowing patients to live at home and access community facilities for services. The interprofressional team offering the program includes physiotherapy, registered nursing, occupational therapy, social work, rehabilitation assistants, unit clerks, speech and language pathology, prosthetics, and physiatry.

The IORP team screens patients (referred by general practitioners) for admission to the program and then works with the in-patient care team to transition patients to outpatient care, where they can access the rehabilitation services at community facilities.

IMPACT:

The VIHA collected outcomes data at the end of one year and reported that:

- 129 patients were enrolled in the IORP;
- in-patient rehabilitation length of stay for those patients enrolled in IORP decreased by
    - 11 days for patients with stroke in Nanaimo;
    - 8 days for patients with amputation in Nanaimo; and
    - 8 days for patients with amputation in Victoria.
    - roughly 2,490 in-patient days were saved, resulting in over $2.5 million in cost avoidance; and
    - functional independence measures at discharge, for both patient groups, exceeded the 2009/2010 national average for patients leaving high-intensity in-patient rehabilitation units.

The outcome data indicate that an intensive, interprofessional outpatient rehabilitation program can effectively meet the needs of these patient groups in a cost-effective manner. Ongoing evaluations will continue during the implementation of this care model as it spreads across the Vancouver Island Health Authority.

APPLICABILITY/TRANSFERABILITY:

VIHA has chosen to continue the IORP and expand the criteria to include other complex patient groups across the health authority. Expansion of this type of program is an integral component of IORP's strategic plan. Similar programs are offered in the United States. An IORP program also exists at the Woodstock Hospital in Woodstock, Ontario. The Woodstock Hospital IORP reports positive outcomes for patients enrolled, with a formal evaluation being planned for the future.

PRACTICE WEBSITE: http://www.viha.ca/adult_rehab_services/outpatient_programs/iorp.htm

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Other:

3M Health Care Quality Team Award (2013):

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

Woodstock Hospital. (n.d.). *Intensive Rehabilitation Outpatient Program (IROP)*. Retrieved from http://www.wgh.on.ca/wgh/index.php?option=com_content&view=article&id=53...

External Source: http://www.viha.ca/adult_rehab_services/outpatient_programs/iorp.htm

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

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

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

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

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

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

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

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

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

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

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

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

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

Cranley, L.A., Norton, P., Cummings, G., Barnard, D., & Estabrooks, C. (2011). SCOPE: Safer care for older persons (in residential) environments: A study protocol. *Implementation Science, 6*, 71. Retrieved from http://www.implementationscience.com/content/6/1/71

Canadian Patient Safety Institute. (n.d.). *Safer healthcare now!* [Website]. http://www.saferhealthcarenow.ca/EN/Pages/default.aspx

External Source: N/a

Quinte Pediatrics and Adolescent Medicine's Social Media Platform

LOCATION:	**Ontario**	**HEALTH THEME:**	**Patient Centered Care**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice aims to streamlines the provision of care to pediatric patients through the use of social media—Facebook, Twitter, and smartphone apps. This practice started in a clinical setting in Belleville, and involves a physician and a social media specialist.

PRACTICE DESCRIPTION:

Quinte Pediatrics and Adolescent Medicine (QP) is a community pediatric practice in Belleville, Ontario, that provides medical care to infants, children, and adolescents. The QP team wanted to "take down the walls of their practice," build community among their patient families, share credible and useful resources, and connect with other health care professionals.

QP hired a social media and communications director, Sara Hamil, who is a key component of achieving these goals. The director manages QP's online community profile, which involves engaging with patients, initiating conversations, overseeing online resources, and generating overall content for a blog, YouTube channel, and other platforms.

Dr. Dempsey, the lead pediatrician at QP, started with his own Twitter account. With the help of the social media specialist, this was expanded to a QP Twitter account, Facebook, and, more recently, LinkedIn, YouTube, and FourSquare. The QP team now provides patient resources that they have vetted and found to be credible on their website.

IMPACT:

This innovative practice was implemented in 2008 but a formal evaluation has not been completed at this time. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. The response to this initiative has been positive because it aims to take down the barriers that people have in their mind about coming to a health care provider. Online, the QP social media platform has 1,051 followers on Twitter, 460 likes on Facebook, and 98 check-ins on FourSquare. One unexpected benefit of this innovative practice is that the QP team realized their community extends beyond Belleville and have connected with partners across Canada and internationally. Patients have also become engaged in this social media conversation and have become partners with QP and with one another.

APPLICABILITY/TRANSFERABILITY:

The QP social media platform has not been adapted from another jurisdiction or implemented elsewhere in this way. However, this initiative is theoretically applicable and transferable to other settings, and many other physicians, hospitals, and practices are starting to use some configuration of social media platforms in their professional work.

For those interested in implementing this practice, the QP team suggests starting out with simple tasks to open the channels of communication, such as online postings of hours of operation, which staff members are away, and who is filling in. QP started with a website and has been looking at who uses what type of social media platform. They have found that young families like to use Facebook, adolescents like texting, and Twitter is used by health care partners in the community and some parents. This provides insights on where to post certain messages depending on the targeted audience and what you want to get across.

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Other:

Quinte Pediatrics & Adolescent Medicine. (2013, April 15). *Guest post: Quinte Pediatrics' social media voice reaches far beyond Quinte region*. Retrieved from http://quintepediatrics.com/2013/04/guest-post-quinte-pediatrics-social-media-voice-reaches-far-beyond-quinte-region/

Queen's University. (2013, April 16). *Doctor and social media specialist: The new front line of health care*. Retrieved from http://connellyonline.ca/SoMe/GR-April-16-2013.pdf

External Source: http://quintepediatrics.com/

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

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

Goar, C. (2013, April 25). Sherbourne Health Centre improves cancer care for Toronto's homeless. *Toronto Star*. Retrieved from http://www.thestar.com/opinion/commentary/2013/04/25/sherbourne_health_centre_improves_cancer_care_for_torontos_homeless_goar.html

Cancer Quality Council of Ontario. (n.d.). *Award recipients 2012*. Retrieved from http://www.cqco.ca/cms/One.aspx?portalId=89613&pageId=253500

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

All-Access Dentistry: Specialized Geriatric Dental Services

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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Personal Communications:
Archer, N. (interview, review, and feedback, May 1, 2013). [Runnymede Dental Centre].

Alternative Profiles:

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

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

Young Carers Program of Hospice Toronto

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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

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

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Integrated Care for Individuals with Severe and Persistent Mental Illness

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

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

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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

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

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Prevention Olympics

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

SNAPSHOT:

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

PRACTICE DESCRIPTION:

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

The prevention initiative involved the following steps:

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

2) Identified patients requiring preventive practices

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

4) Communicated outreach to patients

5) Created four clinical teams for friendly competition

6) Data tracked and reconciled with EMR

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Personal Communications:

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

Publications

Alternative Profiles:

Other:

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

MedicAlert Access En-Route: Medic Alert Interchange Project

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

SNAPSHOT: This innovative practice gives paramedics access to the MedicAlert emergency health record from ambulances and includes it in electronic patient care records.

PRACTICE DESCRIPTION:

The MedicAlert Access En Route program gives paramedics instant access to MedicAlert health records by linking patient-provided emergency medical information directly with first responders through a wireless connection. The program is the first such system in Canada and has been implemented throughout Nova Scotia. Its purpose is to ensure responders have access to high-quality health information before they arrive on the scene of an incident to ensure the best possible patient treatment. The three partners involved in the program are the Nova Scotia Department of Health, Canada Health Infoway, and Canadian MedicAlert Foundation.

With the new system, paramedics can access the MedicAlert emergency health record from ambulances and include it as part of the electronic patient care record. Upon receiving a 911 call, emergency dispatch operators ask the caller if the individual needing care is a MedicAlert member. If so, the unique MedicAlert ID number is captured and sent to the responding ambulance. Paramedics use the number to call up a patient's information from the MedicAlert database into their tablet PC through a wireless connection. They then use the Siren ePCR software, developed by Medusa Medical Technologies, to chart the care they provide to patients in the field. Paramedics can also consult the patient's chart to obtain critical data such as allergy, medication, and physician information. Accessing a patient's record also triggers MedicAlert's 24/7 hotline service to then notify listed family members of the incident.

The program targets the more than 43,500 Nova Scotians enrolled as members with MedicAlert, a national charity. They are people of all ages with chronic medical conditions such as diabetes, hypertension, asthma, and severe allergies, as well as those with medical implants and special needs.

The system will help create more comprehensive and integrated information sharing between ambulatory care, emergency departments, primary care physicians, and other sources of patient service. The model can also be used to provide other health care professionals, such as emergency department staff, with timely and secure access to MedicAlert information.

IMPACT:

The program is currently undergoing evaluation.

Initial feedback from paramedics has been very positive. The system has allowed them to better prepare for an incident and to provide treatment in a more confident manner given the robustness of the MedicAlert record. A challenge is that since only 3% of Nova Scotians are MedicAlert members, the system is accessed infrequently, making ongoing paramedic awareness and skill in using the system an issue.

Preliminary research in 2010 showed that 42% of the province's ambulances had used the MedicAlert link. It is now part of the standard emergency health services in the province.

A preliminary investigation on usage was conducted by Dr. Alix Carter, Medical Director, Research, and Medical Oversight Physician for Emergency Health Services Nova Scotia. A follow-up study going into more detail was planned but was put on hold due to other priorities. MedicAlert is still working with the EMS department in Nova Scotia to complete an impact assessment.

APPLICABILITY/TRANSFERABILITY:

Phase 2 of the program in Nova Scotia will involve completing a wireless link from the ambulance to the hospital emergency department receiving the patient.

There is great potential to expand this program or similar services to other jurisdictions across Canada. MedicAlert is currently in discussions with several jurisdictions to widen availability of the service. Notably, MedicAlert has offered the service to municipalities that have the Medusa system, including the Regional Municipality of York in the Greater Toronto Area. The module is being integrated into the Medusa system so that any jurisdiction that upgrades its system will also be able to take advantage of the Access En Route link.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

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- Canadian MedicAlert Foundation. (2009, April 23). *Enhanced emergency care for Nova Scotians*. Retrieved from http://www.medicalert.ca/en/about/releases/2009-04-23.asp

External Source: http://www.gov.ns.ca/health/ehs/medicAlert.asp

Residents First

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

SNAPSHOT: This innovative practice aims to supports long-term care homes in providing an environment for their residents that enhances their quality of life. Launched in Ontario in 2010, this five year initiative aims to strengthen the long-term care sector's capacity for quality improvement.

PRACTICE DESCRIPTION:

Long-term care has become an integral part of Canadian health care and further efforts to provide appropriate care in the appropriate place for seniors are needed. Residents First is a comprehensive and innovative quality improvement (QI) initiative in Ontario that supports long-term care homes in providing an environment for their residents that enhances their quality of life. Residents First also facilitates comprehensive and lasting change by strengthening the long-term care sector's capacity for QI.

Residents First, a five-year initiative of Health Quality Ontario (HQO), launched in 2009 with funding from the Ontario Ministry of Health and Long-Term Care. HQO experts in quality improvement delivered training. This partnership-driven initiative was developed with the input of a broad range of stakeholders, including organizations representing Long Term Care (LTC) homes, residents and their families. These groups continue to have input as members of the provincial steering committee that guides implementation.

Residents First participating homes receive training to support their QI efforts in topics areas that are known to have a big impact on quality of life for residents, such as: preventing falls and pressure ulcers, behavioural supports, emergency department utilization, continence care, and continuity of care for residents. The Residents First initiative provided different streams for customized training, facilitating and coaching in QI for long-term care leaders and staff. These streams are:

1. Leading Quality Program

This stream aims to strengthen the ability of leaders in the long-term care sectors in Ontario to lead and realize QI as a key strategy to achieve their mission and the goals of the sector as a whole. The program acknowledges the key influence of leaders on the QI journey in their regions, and is based on the best practice to support their achievements of QI. The shared commitment of all participants is to further the Residents First mandate of growing the Ontario LTC capacity for QI, so that the quality of each long-term care resident's care is the best in Canada and is comparable to leading jurisdictions the world over.

2. Collaborative Learning

Each participating home assembles a five-member quality improvement team to join a Residents First Learning Collaborative. Through this Learning Collaborative model, teams work on the same topic, and develop shared aims, measures, and change concepts. Learning workshops teach participants to apply QI tools and methods in their own practice and encourage the sharing of their experiences. Quality improvement teams are supported throughout this process by improvement facilitators, web-based tools, and communications. Teams provide monthly reports on their progress and challenges, and share information through monthly teleconferences and seven face-to-face meetings over a nine month period.

3. Improvement Facilitation

Residents First offered seven-day, intensive in-person training concentrating on the Model for Improvement and Lean methodologies. In the last year, Residents First partnered with Behavioural Supports Ontario (BSO) to offer a condensed version of the seven day training. This three day improvement facilitator (IF) training focused on how BSO clients interact with care across the health system. The third day was designed to assist the IF in applying the newly acquired knowledge and skills to responsive behaviours.

4. LEAN Process Improvement

LEAN is a QI methodology that uses many of the same tools and methods used in general QI systems. LEAN techniques are used by front-line teams, who are the experts on their processes, to redesign those processes. LEAN is an opportunity for quality improvement teams to focus exclusively on analyzing and redesigning a specific key process that is critical to quality. Teams examine workflow processes in their homes, search for ways to reduce duplication, standardize inconsistent steps, and eliminate any work that does not add value to residents.

The Residents First program is unique to Canada in that it provides QI training specifically to the LTC homes across the province and measures and tracks progress on an individual home basis. This substantiates the effort of staff and administrators in improving quality and allows for better accountability. All tools are available online. As of October 2012, Residents First has trained 1,966 long-term care staff and leaders from across the province and 90% of Ontario's long-term care homes have voluntarily taken part in one of the initiative's learning streams. Further, 575 leaders have completed Leading Quality, 433 homes have completed team-based training, and 877 improvement facilitators have been trained. The initiative will conclude in 2014.

IMPACT:

At the time of writing, Residents First is still underway and a formal evaluation has yet to be completed. However, individual participating homes have reported that residents and staff have observed significant positive impact to their home care environments due to the program. One QI project at Leisureworld Etobicoke achieved a reduction in falls from 5.3 to 1.9 per week, with a significant drop in urinary tract infections which were among the main causes of resident being transferred to the Emergency Department. Data indicated an avoided cost of $162,000 due to reduced transfers.

In addition to observed success stories, HQO reports on quality results for LTC homes on their website on a quarterly basis (http://www.hqontario.ca/public-reporting/long-term-care) and is searchable by postal code or by Local Health Integration Networks (LHIN). QO reports on 12 provincial quality indicators including falls, pressure ulcers, incontinence, and restraints at the home level. These indicators can serve to track the progress of this initiative; however at the time of writing, the data have not been aggregated for a formal evaluation of the program.

APPLICABILITY/TRANSFERABILITY:

Similar capacity building initiatives have been implemented in the United States and the United Kingdom (with a focus on palliative care) in the early 2000s and have led to positive results with an increased interest in QI techniques by those working in LTC homes. In the United States, a program called Advancing Excellence in America's Nursing Homes was consulted to develop Residents First in Ontario. Residents First is also based on lessons learned from another Ontario capacity building strategy, Behavioral Supports Ontario. Residents First has grown throughout the Ontario long term care sector and is likely to be transferable to other jurisdictions.

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

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External Source: http://www.quality-improvement/long-term-care

Self-Advocacy For Everyone (SAFE) Toolkit

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

SNAPSHOT: This innovative practice focuses on engaging patients and encouraging individuals to take ownership of their health care by educating them on a number of tops through a patient safety toolkit. Launched in Manitoba in 2011, the program offers information, tips and resources that can help people learn to be more involved in their health care.

PRACTICE DESCRIPTION:

In 2011, the Manitoba Institute for Patient Safety (MIPS) launched the Self-Advocacy For Everyone (SAFE) patient safety toolkit. The SAFE toolkit has information, tips, and resources that can help people learn to be more involved in their health care. The toolkit aims to:

- promote clear, common messages to the public and health care providers on patient safety topics
- provide a patient safety resource for Manitobans
- promote an approach to health care delivery that involves patients and families as key members of their health care team

The SAFE toolkit includes information on 13 key patient safety topics in summary and full-version formats, and a Leader's Guide. The 13 topics are: Know Your Patient Rights, Prepare for Surgery, Choose Your Patient Advocate, Prevent Falls, Know Your Healthcare Plan, Know the Process When Harm Happens, Access Your Medical Records, Know the Patient Safety Contacts, Talk with Your Doctor, Know the Steps in Stating Your Concerns, Work with Your Pharmacist, Know Some Patient Safety Definitions, and Prepare Your Stay in Hospital.

The SAFE toolkit is unique in that it focuses specifically on patients and encourages individuals to take ownership of their health care by educating them on the above 13 topics. The toolkit was developed as part of Phase 3 of the 'It's Safe to Ask' initiative in collaboration with the MIPS's Patient Advisory Committee and many others who provided feedback on this public awareness/education tool. Further, a group of representatives of the Seniors Advisory Council attended a focus group to review and enhance the toolkit's Leader's Guide, which is used to inform potential leaders about the toolkit's content and resources, and how to implement public information sessions. The Leader's Guide also increases the number of leaders offering structured sessions and discussions to Manitobans about patient safety topics. MIPS continues to promote the SAFE toolkit and work with community groups interested in promoting patient safety awareness at grassroots levels in Manitoba.

Funding assistance for the It's ' Safe to Ask' initiative, from which the toolkit originated, was provided by AstraZeneca, the Winnipeg Foundation, the Canadian Patient Safety Institute, the College of Physicians and Surgeons of Manitoba, and the Manitoba Medical Services Foundation.

IMPACT:

The toolkit was presented at conferences for provincial senior resource coordinators and at the Alzheimer Society conference. Staff also made presentations to community support groups, such as the Canadian National Institute for the Blind's (CNIB) Steinbach support group. Health care staff in the regions engaged communities in patient safety activities related to the toolkit such as at community booths in shopping malls and pharmacies, lunch and learn sessions, health fairs, mobile patient safety sessions, and newspaper articles.

Given the fairly recent implementation of this tool, no formal evaluation has been conducted to date. However, the SAFE Patients Blog contains several personal accounts and informal observations on the usefulness of certain topics (including "Talk with Your Doctor and Choose Your Patient Advocate"). Patients report that they are taking components of the SAFE toolkit and bringing them to their physician visits, which helps them keep track of future appointments, and also gives them a sense of control and encourages them to ask questions. Clinicians who have come across patients using the SAFE toolkit information

(such as the medication history card) find this tool helpful, especially when meeting with first-time or out-of-province patients.

APPLICABILITY/TRANSFERABILITY:

Somewhat similar tools are in place across Canada with respect to reconciling medications. However, these tools are targeted to clinicians, whereas the SAFE toolkit is patient-centred. The SAFE toolkit has not been implemented elsewhere, but is likely transferable to other jurisdictions given its well-developed topic information and Leader's Guide. Successful implementation of this innovation requires strong patient and family engagement as well as clinician leadership in providing education.

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

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External Source: http://www.safetoask.ca/safetoolkit/index.html

Health Upwardly Mobile (HUM) Inc.

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

Content was adapted from the following sources and relevant websites:

http://www.healthupwardlymobile.net/

External Submission from Paige Abbott, HUM

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Information last updated on: March 26, 2013

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

Integrated Client Care Program (ICCP) for Older Adults with Complex Needs

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

SNAPSHOT: This innovative practice aims to implement and evaluate practical models of integrated care for specific complex needs populations: older adults with complex needs, medically fragile children, and palliative clients. Launched since early 2011, the Toronto Central Community Care Access Centre (TC-CCAC) in partnership with the Toronto Central Local Health Integration Network (TC-LHIN) has been leading this collaborative, LHIN-wide, multi-year strategy and change initiative.

PRACTICE DESCRIPTION:

Since early 2011, the Toronto Central Community Care Access Centre (TC-CCAC) in partnership with the Toronto Central Local Health Integration Network (TC-LHIN) has been leading a collaborative, LHIN-wide, multi-year strategy and change initiative. This initiative is to implement and evaluate practical models of integrated care for specific complex needs populations: older adults with complex needs, medically fragile children, and palliative clients. The strategy for older adults is a Toronto-based initiative that ensures that all older adults with complex needs are a part of an integrated community model of care by aligning and leveraging existing resources, bringing together sectors from across the health system, and building capacity to be more responsive to clients and their caregivers. The approach is focused on functional integration at the point of care and is designed to improve quality while ultimately bending the cost curve for some of the system's most complex and costly clients. Through a quality improvement approach to evaluation, key lessons have been identified in relation to the critical success factors for health system integration and the key components for successful integration at the point of care.

IMPACT:

Integration at the point of care involves wrapping care around clients and their families and creating interprofessional teams. At the heart of this work is understanding the players involved in a client's care and bringing them together at the point of care for shared assessments and planning that is centred on the goals of clients and their families. Since its inception, a number of key innovations have demonstrated significant value and are driving sustainable solutions across the TC LHIN. Noteworthy innovations include:

• care coordinators providing intensive case management focused on system navigation, bringing together interorganizational and interprofessional care teams to ensure wrap-around care and smooth transitions;
• primary care engagement with CCAC care coordinators working hand in hand with primary care providers in family health teams, Community Health Centres, and large neighbourhood communities with solo-primary care physicians;
• the EMS-CCAC partnership to support smooth transitions by creating the ED Transfer Package and team communication flagging systems and acute care repatriation;
• acute care with new flagging systems for high-risk clients and virtual case conferences between the community and acute-care providers; and
• engagement with community pharmacists to move to a single pharmacy for each client, and dedicated training to support caregivers based on experience-based problem-solving techniques.

APPLICABILITY/TRANSFERABILITY:

The first generation of ICCP has successfully transitioned the local health system into a level of readiness for transformative change and has embarked on a large-scale expansion. As Ontario continues to face significant challenges in achieving value and sustainability through system-wide integration, this Toronto-based model is moving the local health system towards a scalable model for integration while also delivering grassroots impact.

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Content adapted from the following sources and relevant website:

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

External Source: http://www.ccac-ont.ca/Upload/on/General/ICCP_Older_Adults_with_Complex_Needs.pdf

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

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

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

Content was adapted from the following sources and relevant websites:

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

http://www.fcmhas.ca/

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Information last updated on: December 18, 2012

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

Virtual Ward, South East Toronto Family Health Team

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

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

Content was adapted from the following sources and relevant websites:

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

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

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Information last updated on: December 6, 2012

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

Integrated Discharge Planning

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

SNAPSHOT: This innovative practice is a framework for discharge planning to streamline processes and improve system navigation for clients and their families. Beginning as a one-year pilot project in 2011 between the Headwaters Health Care Centre (HHCC) and the Central West Community Care Access Centre (CCAC) in Ontario, the programs success has led to the recent adoption of this role and partnership into standard practice.

PRACTICE DESCRIPTION:

The Transitional Case Manager role is the result of an innovative partnership between Headwaters Health Care Centre (HHCC) and the Central West Community Care Access Centre (CCAC) in Ontario. It began as a one-year pilot project in 2011, but its success has led to the recent adoption of this role and partnership into standard practice. Together the organizations have developed a new framework for discharge planning to streamline processes and improve system navigation for clients and their families. Historically, discharge planning at the hospital did not begin until late in the client's stay, and only involved the CCAC at time of discharge. This did not allow for optimal planning and resourcing to occur, which led to unidentified needs and gaps in service for clients once they returned to the community.

The new model supports the Home First philosophy and discharge planning by beginning discharge coordination at the time of hospital admission. It acknowledges that both organizations are accountable for discharge planning and transition, and uses the skills and expertise of both partners to ensure optimal transition from acute care to the community. The Transitional Case Manager role combines both discharge coordination and case management. The focus is on patient navigation and smooth hospital transitions, which include supporting the client flow in and out of the hospital through ambulatory care services, surgery, and repatriation of clients to and from HHCC. The role supports linking clients to other community agencies through increased awareness of CCAC services and information sharing at the time of discharge. The project encompassed the full age spectrum and continues to address multiple populations, from pediatrics through geriatrics. The complex chronic care population consumes the majority of the attention of the Transitional Case Manager and interprofessional team.

IMPACT:

The pilot project was evaluated. From 2010/11 to 2011/12, outcome measures that demonstrated improvement included an increase in the percentage of clients discharged home from hospital (72% to 76%), a decrease in the length of hospital stay (16.3 to 13.4 days for complex continuing care patients in Assess and Restore beds), and an increase in the number of clients discharged home with CCAC support (22% to 31%). The client and family benefits of this model included reduced duplication in sharing of information, a common language and approach across hospital and CCAC, and consistency in coordination and seamless handoffs leading to smooth transition back into the home. This initiative also resulted in an increased appreciation of the partners' roles and expertise in discharge and transition planning.

APPLICABILITY/TRANSFERABILITY:

Although interest has been expressed and the success of the concept has been demonstrated, there have been no replications of this practice to date.

Content was adapted from the following sources and relevant websites:

http://www.ccac-ont.ca/Content.aspx?EnterpriseID=5&LanguageID=1&MenuID=1

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

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Information last updated on: December 5, 2012

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

Integrated Comprehensive Care at St. Joseph's

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

SNAPSHOT: This innovative practice is a collaborative model of care that integrates the transition of patients from the hospital to the community. Launched in St. Joseph's Healthcare, Hamilton and St. Joseph's Home Care, Hamilton, in March 2012, the objectives of the project are to explore the benefits of integrated case management and to evolve the existing case management model into a patient-centred model that follows the patient across the continuum of care.

PRACTICE DESCRIPTON:

St. Joseph's Health System (SJHS) is engaged in a pilot project on the feasibility of an innovative model of care that directly integrates the transition of patients from the hospital to the community. St. Joseph's Healthcare, Hamilton and St. Joseph's Home Care, Hamilton, both members of SJHS, are collaborating on this initiative, and patient enrolment began in March 2012. Patients from the following clinical domains are included in the project: elective total hip and knee replacement, thoracic surgery, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The objectives of the project are to explore the benefits of integrated case management and to evolve the existing case management model into a patient-centred model that follows the patient across the continuum of care.

Integral to the success of this project is the role of the Integrated Care Coordinator (ICC). The ICC coordinates transitions of care throughout the patients' journey, and is responsible for exchanging knowledge related to their respective health conditions and the continuum of services and resources to enhance client self-management and quality of care. The ICC follows patients through the various care settings to ensure continuity of care, working collaboratively with all existing providers of care in the hospital and the community. The ICC coordinates the process with the selected patients at their point of entry to St. Joseph's Heathcare Hamilton, i.e. prior to their elective surgery (total joint replacements and thoracic surgery), or upon presentation to the emergency department at St. Joseph's Healthcare, Hamilton (chronic diseases). A process mapping exercise was used to ensure the team understood the entire journey from the patient's perspective, and could best design an improved, integrated transition process. An integrated electronic health record was developed and has been implemented. This provides the entire team with real-time remote access to the integrated patient record. The team members can securely access the patient record remotely via tablets, laptops, or desktop computers. Patients also have access to a member of the team 24 hours a day, 7 days a week. Patient concerns can then be directed to the most appropriate member of the health care team. Timely access to a knowledgeable team member who can view their home care history from their time of discharge has prevented a number of emergency department visits.

IMPACT:

An independent program evaluation is being conducted by the Program for Assessment of Technology in Health (PATH). The evaluation includes an assessment of clinical outcomes for patients; system concerns such as quality, throughput, and efficiency (length of stay, readmissions, emergency room visits); patient concerns (accessibility, satisfaction, and continuity of care); and comparison with the existing model of care, including their respective costs. A patient satisfaction questionnaire is administered to patients at the time of discharge and 60 days post-discharge from hospital. The questionnaire at time of discharge is focused on pre-hospital and in-patient care, while the latter questionnaire is focused on transitions home and home care.

To date, the project has demonstrated success with respect to integrated team collaboration in the care of each patient. The project has also resulted in more efficient home visits, with a 50% reduction in the time it takes to complete a home visit. The integrated electronic health record has been a key enabler for delivering care in a timely and efficient way in the community. An integrated care plan has been developed for each patient group, with engagement and feedback from hospital and home care providers. Patient satisfaction with the process is very high, and they note in particular the collaboration of team members and access to a central point of contact.

APPLICABILITY/TRANSFERABILITY:

If successful, this model of Integrated Comprehensive Care will create the conditions for bundled funding and care. The bundled

care model encourages health care providers to maximize quality and efficiency, because the provider absorbs the cost of unnecessary hospital days, complications, and readmissions. This offers the potential of a faster, better, cheaper model of care. SJHS believes that implementation on a greater scale could free up valuable resources to allow Community Care Access Centres in Ontario to offer case management to the more chronic and complex patients in the health care system.

Content was developed based on the following sources and relevant websites:

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

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Seniors Managing Independent Living Easily (SMILE)

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

SNAPSHOT: This innovative practice is designed to provide functional supports to frail seniors. The program aims to make it possible for seniors who are at risk of premature dependency to receive help with instrumental activities of daily living in order for them to remain in their homes and out of hospital and long-term care homes. SMILE was implemented in 2008, funded by the South East Ontario Regional LHIN as part of the Aging at Home strategy of the Ontario Ministry of Health and Long-Term Care.

PRACTICE DESCRIPTION:

SMILE, Seniors Managing Independent Living Easily, is a South East Ontario Regional Program administered by VON Canada. The program is designed to provide functional supports to frail seniors within the SE LHIN region. The program makes it possible for seniors who are at risk of premature dependency to receive help with instrumental activities of daily living in order for them to remain in their homes and out of hospital and long-term care homes. SMILE was implemented in 2008, funded by the LHIN as part of the Aging at Home strategy of the Ontario Ministry of Health and Long-Term Care.

SMILE is a proven approach to client-centred care that is based on client choice. It offers seniors options for managing their care and selecting the desired services and service providers. Clients and caregivers create and have control over their care plan, which reflects both assessed needs and personal choice. SMILE clients may use either traditional service providers (agencies funded by the LHIN) or non-traditional services providers (neighbours, businesses, or other community organizations).

IMPACT:

SMILE affects long-term care utilization, and keeping clients at home longer and delaying or avoiding long-term care placement is an overall goal for SMILE. In order to demonstrate a measure of success, the program tracked 170 clients who were on a waiting list for LTC when admitted to SMILE 18 months ago. SMILE demonstrated success in having successfully supported seniors to remain at home. This success represented a savings in the system of $4,597,575, or 52%.

The SMILE program was designed based on input form seniors; therefore, ongoing feedback from seniors and caregivers being served by the program is essential. Ten percent of the clients are surveyed annually. The most recent survey, completed in February 2012, had a 66.6% return rate. The majority of clients continue to express satisfaction with the program service, and 49% stated they felt their physical health had improved as a result of the SMILE program.

Below are examples of comments that reinforce the fact that SMILE helps to assist seniors to stay at home, stay out of hospitals, and remain independent.

- “Since I have had the help from SMILE for cleaning and outdoor chores, it has allowed me to breathe and has kept me out of hospital. Before your help, I was in hospital weekly or bi-weekly.”
- “My sister Marg recently passed away on Nov 10, 2012. She received many of your wonderful services over the last few years, and I want you to know we really appreciated every single one of them. As I understand it, the SMILE Program provided the funds for Marg to attend the day program two days a week, which included her transportation. SMILE also arranged and paid for her in-home cleaning and grocery shopping.

“On behalf of my family I would like to sincerely thank you for all the services you provided for her. Without your help, Marg could not have stayed in her own apartment this long. It was very helpful to me and her extended family knowing that she was safe and well provided for. She always said she wanted to stay in her own apartment as long as she could, and with your help, she achieved that goal. May God bless you all in the jobs you do every day to make life for seniors so much better.”

In 2010, VON Canada engaged Hollander Analytical Services Ltd. to carry out an external evaluation of the SMILE program. The final evaluation reports from Hollanger were received in April 2011. While able to document findings that indicate a positive impact on clients, their families, and the overall health care system, the study was unable to conclusively or quantitatively demonstrate the impact of SMILE in the time frame provided for the evaluation.

APPLICABILITY/TRANSFERABILITY:

SMILE is theoretically applicable to other contexts, and the program's positive results could be replicated elsewhere.

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Cudworth Health Council in Saskatchewan

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

SNAPSHOT: This innovative practice addresses the need to promote active engagement of individuals and communities in planning, reviewing, and implementing strategies that both maintain and improve the health and well-being of citizens. The Saskatoon Health Region (SHR) developed a community engagement process to enable community members living in the Town of Cudworth and surrounding area to influence, design, implement, and evaluate health services in their community.

PRACTICE DESCRIPTION:

Saskatoon Health Region (SHR) developed a community engagement process to enable community members living in the Town of Cudworth and surrounding area to influence, design, implement, and evaluate health services in their community. SHR was having numerous community discussions regarding threats to funding of local laboratory services, so they invited community members to participate in talking about how the community and health region could work together when talking about health services and healthy communities. The Health Region funded the initiative to get the Council going. No honorariums were given for participation. Out of these discussions, the Cudworth Health Council was established.

The Council members were selected by and from the community. The purpose of the Council is to promote active engagement of individuals and communities in planning, reviewing, and implementing strategies that both maintain and improve the health and well-being of SHR citizens. The key objectives are (1) to develop processes that support communities as active partners in their health and health care services; (2) to partner with communities and key stakeholders to share information and promote understanding of perspectives that might not otherwise be understood; (3) to build capacity through informing and empowering individuals and communities to take more responsibility for and control over their health; (4) to build mutual trust and credibility through the process of engagement; and (5) to promote effective, efficient, and sustainable services that appropriately meet the needs of communities. The core components of the design implementation were assessment, building relationships, community engagement, and communication. Some of the guiding principles used to create the design are paraphrased as follows:

1. Communities will be actively and meaningfully engaged in identifying community needs and participating in key strategic initiatives.
2. Except in circumstances beyond the control of the Saskatoon Regional Health Authority,no decisions shall be made to eliminate, significantly change, or add to existing services without the knowledge of, active input from, and discussion of options with the local Community Health Council. It is understood the Saskatoon Regional Health Authority has the ultimate decision-making authority.
3. SHR and the local communities will openly share information that affects the health and well-being of residents.
4. SHR and the local communities will support healthy living by working together to address priority health promotion and disease prevention strategies.
5. The engagement process must be transparent, legitimate, and official. Community input is valued and the region is committed to providing feedback about its decisions.
6. Participants should be involved in the process as early as possible.
7. The potential for communities to influence decisions must be real.
8. Information must be timely such that sufficient time is allowed to understand and deliberate. Information must be clear, transparent, and easy to understand.
9. SHR resources must be available to support engagement processes.
10. SHR and the Council shall strive to achieve mutually acceptable outcomes.

IMPACT:

This practice has not been formally evaluated. However, a qualitative evaluation has been done with the community through a storytelling format. These are some of the key lessons learned: involve the community in decisions that affect them or their

health; do not make decisions about health planning without involving the community; involve the community as early as possible in conversations about health planning; and use a facilitator to support the process.

Factors affecting success included

- The community and the health region were committed to a dialogue process, and all parties "stayed at the table" to talk through difficult issues.
- The "right" people were present—they had decision-making authority and could commit to a plan of action without having to seek approval elsewhere.
- The senior leadership of the Health Region were kept informed about the process and progress.

APPLICABILITY/TRANSFERABILITY:

Currently, the process and practice have been adapted by two other communities. Each community determines its own Terms of Engagement or Reference. Primary Health has just published a Community Engagement Framework, which provides a detailed explanation of how to engage with communities. There is much provincial interest in adapting the process and practice in other community settings. In fact, community engagement is happening in Wadena, Wynyard, Watrous, Wakaw, and Delisle.

Content developed from the following sources and relevant websites:

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

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External Source: http://www.townofcudworth.com/Community%20Newsletter%20may%202012%20(2).pdf

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

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

Community Agency Notification Program

LOCATION:	Ontario	**HEALTH THEME:**	E-Health
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the fact that many patients living at home receive various levels of support from community agencies. In an acute medical situation, these support agencies often lose contact with their patients. In March 2011, Toronto Emergency Medical Services (EMS) launched a pilot program called Community Agency Notification (CAN). CAN is a communication protocol initiated by paramedics that notifies community agencies when their client comes into contact with EMS. The alert enables the community agency to follow up with the hospital and/or resident.

PRACTICE DESCRIPTION:

In March 2011, Toronto Emergency Medical Services (EMS) launched a pilot program called Community Agency Notification (CAN). The CAN pilot program involved a collaboration between the Toronto EMS Community Paramedicine Program and St. Clair West Services for Seniors. Since that time, the program has been rolled out in partnership with several other community agencies that provide supportive housing services in the Toronto Community Housing buildings and with the Integrated Client Care Program at the Toronto Central Community Care Access Centre. Many patients living at home receive various levels of support from community agencies. In an acute medical situation, these support agencies often lose contact with their patients. The CAN program leverages paramedic patient contact to keep community supports updated on patient disposition. CAN is a communication protocol initiated by paramedics that notifies community agencies when their client comes into contact with EMS. The alert enables the community agency to follow up with the hospital and/or resident.

Phase 1 (March 2011–November 2012) of the CAN pilot has been funded individually by each of the participating community agencies. Phase 2 (December 2012) of the pilot will be funded by Toronto EMS and will feature a client-specific notification platform. This will dramatically increase the capacity and specificity of the program, allowing for more organizations and clients to participate. Phase 2 is anticipated to run for 12 to 18 months with the intent that it will demonstrate this proof of concept and thus become the basis for applying for funding for a more sustainable and comprehensive notification platform.

The CAN program is structured as a service of the community agency. Toronto EMS and community agencies work together in Toronto Housing Corporation seniors' buildings to enrol residents in the program. Each resident receives a completed patient information sheet that includes a summary of the patient's medical history, medications, and emergency contact information, along with simple instructions on how to make a notification. The patient information sheet is placed in a highly visible envelope marked with the Toronto EMS logo and "Important Information for Paramedics." The resident is asked to put the envelope in a prominent place so paramedics can find it.

When an EMS call is dispatched, the premise information will remind responding paramedics that the CAN program is in place at the building. Upon patient contact, the paramedics will know to check the apartment for the envelope. Paramedics are expected to keep the patient information sheet with the patient, especially if they are transported to hospital. The information may help with the assessment and care of the patient, especially if he or she is unable to communicate due to a language barrier or their medical condition. Paramedics and hospital staff are encouraged to call a central telephone number to provide real-time notification to community agencies of their client's situation. Whenever a notification is made, the patient information sheet is updated on discharge from hospital or on follow-up by the community agency if there was no transport to hospital. The information sheet is also reviewed and updated on a yearly basis.

IMPACT:

Evaluation methods are being established for Toronto EMS and each participating community agency. The evaluations include tracking agency responses and patient outcomes to EMS notifications. Between June 2011 and November 2012, there were a total of 41 community agency notifications. There has been anecdotal evidence supporting the benefits of both notification and the patient information sheet. The CAN pilot program was useful for community agencies. Qualitative results from informal observations and patient accounts indicate increased communication and follow-up between patients, community agencies, and hospitals.

APPLICABILITY/TRANSFERABILITY:

The CAN program is unique to Toronto and has not been implemented elsewhere. To date, there is no evidence of any other programs that are leveraging the paramedic–patient experience to initiate case management and advance integration of health care supports. It is proposed that the CAN program will create “seamless transitions” through the health care system for enrolled patients.

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Relevant websites:

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

External Source: http://torontoems.ca/community-paramedicine/can

Cancer Care Ontario's Provincial Patient and Family Advisory Council

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

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

PRACTICE DESCRIPTION:

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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Relevant websites:

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

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

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

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

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

Health Quality Ontario's Home Care Indicator Reporting

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

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

PRACTICE DESCRIPTION

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

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

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

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

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

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

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

The Client Health Related Information System (CHRIS)

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

SNAPSHOT: This innovative practice addresses home care planning and management, alleviating the previous challenges of multiple data entries, the need to fax important client information, and multiple referrals. In Ontario, the Association of Community Care Access Centres (CCACs) has been spreading the use of the Client Health Related Information System (or CHRIS, as it is more commonly known). CHRIS is a web-based client management system with four key components: case management, service provisioning, reporting.

PRACTICE DESCRIPTION

In Ontario, the Association of Community Care Access Centres (CCACs) has been spreading the use of the Client Health Related Information System (or CHRIS, as it is more commonly known). CHRIS is a web-based client management system with four key components: case management, service provisioning, reporting, and financial management. It combines both resource planning and client management, alleviating the previous challenges of multiple data entries, the need to fax important client information, and multiple referrals.

The Association developed its own electronic system because software providers were not able to meet all their needs. Some key features of CHRIS include:

- direct link to assessments, where CHRIS and the RAI-HC function as one seamless application, allowing automated entry of information and availability of a quick summary of results
- automated file transfer for providers and agencies, allowing important information to flow between case managers, agencies, and providers
- geographic coding and mapping for referrals to case managers and providers
- seamless integration within the CCACs' Document Management System, setting the foundation for better automation of document workflow within and outside of CCACs

Nearly all (96%) of CCACs' staff are supported by CHRIS, with plans for continued integration with other agencies and providers. Challenges included some issues with integrity of the data, interfaces with existing client data systems, and culture changes associated with balancing human care and electronic care to best meet the needs of clients. These challenges were overcome through building trust, communicating, planning, and working collaboratively.

External Source: www.ccac-ont.ca/Upload/oaccac/General/MA03.pdf

Transitional Restorative Care Program

LOCATION:	**Ontario**	**HEALTH THEME:**	**Patient Centered Care**
HEALTH SECTOR:	**Rehabilitation**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice addresses the need for rehabilitation services, such as physiotherapy and occupational therapy, to play a key role in helping patients regain enough strength and mobility to return home. At the Rouge Valley Health System – Ajax and Pickering hospital campus (Ontario), a new transitional restorative care program helps prepare patients to return home from the hospital and resume their daily activities.

PRACTICE DESCRIPTION:

Rehabilitation services, such as physiotherapy and occupational therapy, play a key role in helping patients regain enough strength and mobility to return home. At the Rouge Valley Health System – Ajax and Pickering hospital campus (Ontario), a new transitional restorative care program helps prepare patients to return home from the hospital and resume their daily activities. Patients receive physiotherapy and/or occupational therapy to increase their strength, stamina, and independence, helping them to return to routine activities such as getting out of bed, dressing, and walking. The program helps to recondition patients who often become more frail and immobile due to being in hospital for long periods of time. The restorative bed unit is equipped to help older patients regain their strength and confidence so that they may safely return home, rather than continue to wait in hospital for long-term care facility placement. Patients stay an average of 45–90 days in the restorative bed unit.

Restorative beds are also being added to hospitals in the Ottawa region in an effort to enable more seniors to return home from hospital, leading to fewer placements in long-term care homes.

Similar programs in hospitals would help to alleviate the pressure of the Alternate Level of Care (ALC) issue. In the absence of such programs, even providing ALC patients with some form of physiotherapy and exercise to counteract the effects of immobility could be helpful.

External Source: http://www.rougevalley.ca/transitional-restorative-care-program

Partnering for Patients

LOCATION:	**Alberta**	**HEALTH THEME:**	**Patient Centered Care**
HEALTH SECTOR:	**Acute Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice addresses the issue of coordinating home care. In Red Deer, Alberta, home care case managers work in hospital emergency departments to assess patients to determine the best care path for the patient, whether it is hospital admission, home care, or a long-term care facility.

PRACTICE DESCRIPTION:

In Red Deer, Alberta, home care case managers work in hospital emergency departments to assess patients to determine the best care path for the patient, whether it is hospital admission, home care, or a long-term care facility. The case manager works with the emergency department staff and patients to do this planning and to ensure that it is safe to discharge the patient home with home care supports and referrals to community-based services, including the transfer of pertinent health information. This Partnering for Patients home care program is also aligned with primary care, allowing appropriate transitions and follow up. In addition, the case manager visits with general patients in the emergency department to educate them about home care options. This pilot project allowed nearly half (46%) of the patients to avoid hospital admission by being directed to home care.

Alberta's Caregiver Support

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

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

PRACTICE DESCRIPTION:

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

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

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