



# Health Innovation Portal: Archive of Innovative Practices

## Theme: Pharmaceuticals Management

January 2014



Health Council of Canada  
Conseil canadien de la santé



**Selected Search Output Table (December 17, 2013)**

<b>SEARCH TERMS:</b>	<b>N/A</b>	<b>LOCATION:</b>	<b>All</b>
<b>HEALTH THEME:</b>	<b>Performance Measurement and Reporting</b>	<b>FRAMEWORK CATEGORY:</b>	<b>All</b>
<b>HEALTH SECTOR:</b>	<b>All</b>	<b>SEARCH RESULTS:</b>	<b>22 results out of 25</b>

**1. Quality Improvement Training and Support**

<b>Implementation Year:</b> Sunday, December 9, 2007 - 15:45	<b>Location:</b> Ontario	<b>Practice Website:</b> <a href="http://www.hqontario.ca/quality-improvement/primary-care">http://www.hqontario.ca/quality-improvement/primary-care</a>
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**SNAPSHOT:**

This innovative practice provides quality improvement (QI) training and support to primary care practices. The practice was launched Ontario and has involved 750 interprofessional practice-based teams supported by QI coaches.

**CONTACT INFORMATION:**

Susan Taylor Program Manager Health Quality Ontario Telephone: 416-323-6868 ext. 245 Email: Susan.Taylor@hqontario.ca

**2. Patient Enrolment with a Primary Care Provider**

<b>Implementation Year:</b> Tuesday, December 9, 2003 - 15:45	<b>Location:</b> Ontario	<b>Practice Website:</b>
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**SNAPSHOT:**

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

**CONTACT INFORMATION:**

Phil Graham Manager, Family Health Teams and Related Programs Primary Care Branch Negotiations and Accountability Management Division Ontario Ministry of Health and Long-Term Care Telephone: 416-212-0832 Email: Phil.Graham@ontario.ca

**3. Physicians Data Collaborative**

<b>Implementation Year:</b> Sunday, December 9, 2012 - 15:30	<b>Location:</b> British Columbia	<b>Practice Website:</b>
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**SNAPSHOT:**

This innovative practice involves the creation of a network of physicians' offices that enables the collaborative use of clinical data generated by an electronic medical record (EMR) to improve patient care. The practice was launched in British Columbia and currently involves 23 of BC's 33 geographically based divisions of family practice.

**CONTACT INFORMATION:**

Claire Doherty Executive Director Physicians Data Collaborative physiciansdatacollaborative@yahoo.ca

**4. Patients as Partners—Patient Voices Network**



<b>Implementation Year:</b> Wednesday, December 9, 2009 - 15:30	<b>Location:</b>	<b>Practice Website:</b>
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**SNAPSHOT:**

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

**CONTACT INFORMATION:**

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

**5. Improving Medication Prescribing and Outcomes Via Medical Education (Manitoba IMPRxOVE™)**

<b>Implementation Year:</b> Friday, December 9, 2011 - 15:00	<b>Location:</b> Manitoba	<b>Practice Website:</b>
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**SNAPSHOT:**

This innovative practice improves safety and health outcomes for patients receiving medications for mental health conditions and involves family physicians, psychiatrists, and a private sector information technology and clinical analytics firm. The practice was launched in Manitoba in June 2011 to approximately half of the physicians eligible for the program. It was rolled out to remaining physicians in January 2013.

**CONTACT INFORMATION:**

**Jeff Onyskiw, A/Director Manitoba Health – Drug Management Policy Unit 3014 - 300 Carlton Street Winnipeg, Manitoba R3B 3M9 Telephone: (204) 788-6436 Email: Jeff.Onyskiw@gov.mb.ca**

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

<b>Implementation Year:</b> Thursday, December 9, 1999 - 14:15	<b>Location:</b> International	<b>Practice Website:</b> <a href="http://www.dfdrussell.org/">http://www.dfdrussell.org/</a>
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**SNAPSHOT:**

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

**CONTACT INFORMATION:**

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

**7. Better Outcomes Registry & Network (BORN)**

<b>Implementation Year:</b> Wednesday, December 9, 2009 - 14:00	<b>Location:</b> Ontario	<b>Practice Website:</b> <a href="http://www.bornontario.ca/en/about-born/">http://www.bornontario.ca/en/about-born/</a>
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**SNAPSHOT:**

This innovative program collects, shares and protects data around each child born in Ontario to inform subsequent programming for maternal and child health care and services, and broader quality improvement in the province. The Better Outcomes Registry & Network (BORN) was established in 2009 through the Children's Hospital of Eastern Ontario in Ottawa. In the 2011 to 2012 fiscal year, BORN collected data on 142,376 babies across the province, and now connects more than 5000 users to data that span all levels of care from pre-pregnancy to early childhood.



**CONTACT INFORMATION:**

**Name:** Mari Teitelbaum **Title:** Director **Organization:** BORN **Email address:** info@BORNOntario.ca **Telephone number:** 613.737.7600 x 6022  
**Information last updated on:** November 12, 2013

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

<b>Implementation Year:</b> Friday, October 7, 2011 - 13:00	<b>Location:</b> British Columbia	<b>Practice Website:</b>
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**SNAPSHOT:**

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

**CONTACT INFORMATION:**

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

**9. Lowering Cardiovascular Risk in Primary Care: Primary Care Connect, the Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI)**

<b>Implementation Year:</b> Thursday, October 7, 2010 - 13:00	<b>Location:</b> Ontario	<b>Practice Website:</b>
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**SNAPSHOT:**

This innovative practice addresses the issue of health outcomes and treatment experiences among patients with vascular disease. The practice was launched in six Ontario family practices and involved a collaborative network of registered nurses, family physicians, specialists, pharmacists, and other allied health care professionals.

**CONTACT INFORMATION:**

**Name:** Maribeth Casey **Title:** Director, Medical Group, Chronic Disease Prevention and Management **Organization:** Diversified Health **Email address:** mbcasey@divcomevents.com **Telephone number:** (905) 464-5548

**10. The Stroke/TIA Collaborative: Enhancing stroke management and the use of indicators**

<b>Implementation Year:</b> Thursday, September 8, 2011 - 00:45	<b>Location:</b> British Columbia	<b>Practice Website:</b> <a href="http://bcpsqc.ca/clinical-improvement/stroke-and-tia/">http://bcpsqc.ca/clinical-improvement/stroke-and-tia/</a>
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**SNAPSHOT:**

This innovative practice addresses the issue of enhancing stroke management and the use of indicators. The practice was launched in British Columbia in 29 sites and involved a faculty of four stroke neurologists, a clinical nurse educator, an emergency department physician, a stroke coordinator, a stroke rapid assessment unit, a stroke survivor, and 17 teams of health care professionals who were engaged in the collaborative.

**CONTACT INFORMATION:**

**Name:** Dr. Devin Harris **Title:** Clinical Lead **Organization:** Stroke and TIA Initiative **Email address:** devinh@shaw.ca; dharris@bcpsqc.ca **Telephone number:** N/A **Information last updated on:** June 26, 2013

**11. Performance Huddles: Bringing Interprofessional Teams Together to Improve Quality and Safety**

<b>Implementation Year:</b> Thursday, February 3, 2011 - 00:45	<b>Location:</b> Ontario	<b>Practice Website:</b>
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**SNAPSHOT:**

This innovative practice addresses how interprofessional teams communicate, collaborate, and monitor their progress on quality improvement at the point of care. This interactive practice was launched in Ontario in November 2011, taking place in numerous patient care units at three sites of a multi-site hospital system.

**CONTACT INFORMATION:**

**Name:** Kiki Ferrari **Title:** Executive Director, Clinical Services Organization: William Osler Health System **Email address:** kiki.ferrari@williamoslerhs.ca **Telephone number:** 905 494 2120 ext. 50167 **Information last updated on:** May 6, 2013

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

<b>Implementation Year:</b> Saturday, February 3, 2007 - 00:15	<b>Location:</b> National	<b>Practice Website:</b> <a href="http://www.nccmt.ca/registry/index-eng.html">http://www.nccmt.ca/registry/index-eng.html</a>
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**SNAPSHOT:**

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

**CONTACT INFORMATION:**

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

**13. Path to Care: Referral and Wait Time Measurement and Management**

<b>Implementation Year:</b> Wednesday, February 3, 2010 - 00:45	<b>Location:</b> Alberta	<b>Practice Website:</b> <a href="http://www.albertahealthservices.ca/">http://www.albertahealthservices.ca/</a>
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**SNAPSHOT:**

This innovative practice aims to improve access and reduce health care service and referral wait times through a province wide program. This practice was launched in Alberta in 2010 and aims to develop and implement provincially adjudicated referral standards.

**CONTACT INFORMATION:**

**Name:** Allison Bichel, MPH MBA **Title:** Executive Director Access Organization: Alberta Health Services **Email address:** allison.bichel@albertahealthservices.ca **Telephone number:** 403-617-6642

**14. Nova Scotia Breast Screening Program – Wait Time Reporting**

<b>Implementation Year:</b> Wednesday, February 3, 2010 - 00:15	<b>Location:</b> Nova Scotia	<b>Practice Website:</b> <a href="http://breastscreening.nshealth.ca/">http://breastscreening.nshealth.ca/</a>
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**SNAPSHOT:**

This innovative practice addresses the issue of performance measurement by reporting on nine indicators related to wait times and breast screening. Launched in Nova Scotia in 2010, results are provided to the public via the provincial wait times website.

**CONTACT INFORMATION:**

**Name:** Ryan Duggan **Title:** Data Analyst/Project Co-ordinator Organization: Nova Scotia Breast Screening Program **Email address:** Ryan.Duggan@cdha.nshealth.ca **Telephone number:** 902-488-0839

**15. Health Quality Council of Saskatchewan's QualityInsight.ca Website**

<b>Implementation Year:</b> Wednesday, February 3, 2010 - 13:00	<b>Location:</b> Saskatchewan	<b>Practice Website:</b> <a href="http://www.qualityinsight.ca/">http://www.qualityinsight.ca/</a>
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**SNAPSHOT:**

This innovative practice is designed to give the public, providers, managers, and leaders access to information about how the health system is performing. Developed by Saskatchewan's Health Quality Council and launched in March 2010, this website contains 100 measures of how Saskatchewan's health care system is performing, from wait times for surgery to patients' rating of their hospital care.

**CONTACT INFORMATION:**

**Name:** Rosemary Gray **Title:** Program Director **Organization:** Saskatchewan Health Quality Council **Email address:** rgray@hqc.sk.ca **Telephone number:** 306-668-8810 ext 116

**16. Annual Quality Improvement Plans (QIPs) as part of Ontario's Excellent Care for All Act (ECAA)**

<b>Implementation Year:</b> Saturday, February 6, 2010 - 00:30	<b>Location:</b> Ontario	<b>Practice Website:</b> <a href="http://health.gov.on.ca/en/pro/programs/ecfa/legislation/quality_improve.aspx">http://health.gov.on.ca/en/pro/programs/ecfa/legislation/quality_improve.aspx</a>
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**SNAPSHOT:**

This innovative practice addresses the need for effective quality improvement plans for accountability and transparency purposes. Launched as part of the Excellent Care for All Act in Ontario in June 2010, this is a tool that enables hospitals to identify, report, and achieve quality improvement objectives in a structured way.

**CONTACT INFORMATION:**

**Nom :** Jillian Paul **Titre :** Gestionnaire **Organisme :** Ministère de la Santé et des Soins de longue durée **Courriel :** jillian.paul@ontario.ca **Téléphone :** (416) 325-5600

**17. Atlantic Health Quality and Patient Safety Collaborative (AHQPSC): Atlantic Sustainability and Spread Facilitated Learning Series**

<b>Implementation Year:</b> Wednesday, February 3, 2010 - 00:30	<b>Location:</b> New Brunswick, Newfoundland & Labrador, Nova Scotia, Prince Edward Island	<b>Practice Website:</b> <a href="http://www.saferhealthcarenow.ca/EN/events/VirtualPrograms/Pages/default.aspx">http://www.saferhealthcarenow.ca/EN/events/VirtualPrograms/Pages/default.aspx</a>
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**SNAPSHOT:**

This innovative practice has a three-year mandate to develop common strategies and recommendations to inform Atlantic Deputy Ministers of Health on health care quality and patient safety trends, issues, policy directions, and opportunities. Launched in the participating provinces in 2010, this collaborative is the only one of its kind in Canada that brings together representatives from multiple provincial ministries, regional authorities, and health system authorities to provide ground-level training and capacity building.

**CONTACT INFORMATION:**

**Name:** Theresa Fillatre, MHSA, RN, BSW, CHE **Title:** Chair of Atlantic Health Quality & Patient Safety Collaborative, and Senior Director at CPSI **Organization:** Canadian Patient Safety Institute **Email address:** tfillatre@cps-i-csp.ca **Telephone number:** 902-221-4719

**18. Transformation by Design in Ontario**

<b>Implementation Year:</b> Tuesday, February 3, 2009 - 00:30	<b>Location:</b> Ontario	<b>Practice Website:</b> <a href="http://www.providence.on.ca">http://www.providence.on.ca</a>
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**SNAPSHOT:**

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

**CONTACT INFORMATION:**



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

### 19. Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative

<b>Implementation Year:</b> Saturday, February 3, 2007 - 00:30	<b>Location:</b> British Columbia	<b>Practice Website:</b> <a href="http://www.bcchildrens.ca/Services/SpecializedPediatrics/RICHERInitiative/default.htm">http://www.bcchildrens.ca/Services/SpecializedPediatrics/RICHERInitiative/default.htm</a>
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**SNAPSHOT:**

This innovative practice addresses child health inequities through a publicly funded, community-based primary health care and specialist pediatrics service designed to meet the needs of children, youth, and families living in Vancouver's inner-city neighbourhoods. BC Children's Hospital developed the Responsive Intersectoral Children's Health, Education, & Research (RICHER) Initiative in 2007 as a means to promote access to health care for all.

**CONTACT INFORMATION:**

**Name:** Dr. Judith Lynam **Title:** Professor and RICHER Research Lead **Organization:** University of British Columbia School of Nursing **Email address:** judith.lynam@nursing.ubc.ca **Telephone number:** 604-822-7476

### 20. Health Quality Ontario's Home Care Indicator Reporting

<b>Implementation Year:</b> Friday, February 12, 2010 - 00:15	<b>Location:</b> Ontario	<b>Practice Website:</b> <a href="http://www.hqontario.ca/">http://www.hqontario.ca/</a>
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**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

### 21. The Client Health Related Information System (CHRIS)

<b>Implementation Year:</b> Thursday, February 3, 2011 - 00:00	<b>Location:</b> Ontario	<b>Practice Website:</b> <a href="http://www.ccac-ont.ca/Upload/oaccac/General/MA03.pdf">www.ccac-ont.ca/Upload/oaccac/General/MA03.pdf</a>
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**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:**

### 22. Patient Safety in the Netherlands

<b>Implementation Year:</b> Saturday, February 3, 2007 - 00:15	<b>Location:</b> International	<b>Practice Website:</b> <a href="http://www.biomedcentral.com/content/pdf/1748-5908-5-50.pdf">http://www.biomedcentral.com/content/pdf/1748-5908-5-50.pdf</a>
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**SNAPSHOT:**

This innovative practice requires health care providers in the Netherlands are to document the quality of care they provide, with reference to evidence-based guidelines and performance indicators.



**CONTACT INFORMATION:**

**Name:** Mirjam Harmsen **Title:** Author and PI **Organization:** Scientific Institute for Quality of Healthcare, Radboud University Nijmegen Medical Centre, Nijmegen, The Netherlands **Email address:** M.Harmsen@iq.umcn.nl





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# Quality Improvement Training and Support

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

**Snapshot:** This innovative practice provides quality improvement (QI) training and support to primary care practices. The practice was launched Ontario and has involved 750 interprofessional practice-based teams supported by QI coaches.

## Practice Description:

In 2007, the Ministry of Health and Long-Term Care established the Quality Management Collaborative, with an initial mandate to assist family health teams (FHTs) to navigate the transition to a new team-based model of primary health care. In 2009, the organization became an independent not-for-profit entity and was renamed the Quality Improvement and Innovation Partnership (QIIP). Its expanded mandate is to support quality improvement across the primary care sector. During 2008 and 2009, QIIP ran a series of three learning collaboratives for interprofessional, practice-based QI teams from FHTs and community health centres (CHCs), modelled on the Institute for Healthcare Improvement's Breakthrough series. Participants received coaching support and focused their quality improvement efforts on chronic disease management (diabetes), prevention (colorectal cancer screening), and office practice redesign (access and efficiency).

In 2010, QIIP launched the Learning Community, which combines virtual and face-to-face learning on the application of QI methods and tools, and support from QI coaches. In Wave 1, interprofessional teams from FHTs and CHCs participated in one or more of six action groups focused on improving chronic disease management (asthma, chronic obstructive pulmonary disease, diabetes, hypertension), preventive care (integrated cancer screening) and access and efficiency (office practice redesign). Waves 2 through 5 focused on advanced access and efficiency; they were open to practice-based teams from any primary care model. Wave 6 addressed chronic disease management in addition to advanced access and efficiency.

In April 2011, QIIP merged with three other quality-related organizations funded by the ministry to form Health Quality Ontario (HQO). The Learning Community has continued under the new organization.

HQO is about to pilot a CME/e-Learning model that adopts a hybrid approach for delivering QI training and support for advanced access in primary care organizations. Compared to the traditional learning collaborative model, the hybrid model combines fewer learning sessions and less HQO coaching with a series of four online learning modules and peer-champion support. The revised program will allow interprofessional primary care teams to access the program continuously rather than in discrete waves. In partnership with McMaster University, HQO is mounting a demonstration of the hybrid approach with approximately 20 primary care practices.

## Impact:

A research team from the Centre for Studies in Family Medicine at Western University and the Centre for Studies in Primary Care at Queen's University conducted a multi-component, mixed method, external evaluation of the three QIIP learning collaboratives that were mounted during the period from 2008 to 2010 (Harris et al., 2013). The evaluation examined the impact of the program on type 2 diabetes management, colorectal cancer screening, access to care, and team functioning. The performance of the practices before and after participation was compared with the performance of randomly selected non-participating practices from the same geographic location and model of care (FHT or CHC) during the same time periods.

Key findings included the following:

- Participants' knowledge of QI methods (the Model for Improvement) and the Chronic Disease Prevention and Management framework increased.
- Participants improved interprofessional capacity in their practice through better understanding of each other's roles and working together to improve patient care.
- The learning collaboratives facilitated improved team interactions, sharing of information and resources, and collaboration among team members.



- QI coaches were instrumental in helping teams implement QI activities.
- The performance of both participating and control practices improved over time.
- Among patients with diabetes, participating practices showed greater improvement in lipid profile monitoring (chart audit), eye examinations (chart audit and administrative data), peripheral neuropathy examinations (chart audit), and documentation of body mass index (chart audit).
- Participating practices showed greater improvement in HbA1c testing of patients with diabetes (administrative data).
- Among patients with HbA1c above the study target (? 7.3%) at baseline, patients in participating practices were more likely than patients in control practices to be at the Canadian practice guidelines target of ? 7.0% post-collaborative (chart audit).
- Participating practices had greater improvement than control practices in the proportion of patients with diabetes whose LDL cholesterol was at target (? 2.0 mmol/L) (chart audit).
- Among patients with diabetes, participating practices had small but statistically significantly greater increases than control practices in prescribing statin and angiotensin converting enzyme inhibitor (ACE) or angiotensin receptor blocker (ARB) (administrative data).
- Participating practices had greater improvement than control practices in the proportion of eligible patients screened for colorectal cancer (administrative data).
- Participating practices were more likely than control practices to adopt an advanced access model (48% versus 29%). However, the study was not adequately powered for this outcome to detect a difference of this magnitude, and therefore the difference was not statistically significant.
- The median time to third-next available appointment post-learning collaborative was 2.0 days among participating practices and 4.0 days in the control practices. However, the study was not adequately powered for this outcome to detect a difference of this magnitude, and therefore the difference was not statistically significant.

Zorzi et al. (2013) conducted a multi-component formative and summative evaluation of the HQO Advanced Access and Efficiency initiative (Learning Community Waves 3 and 4) in 2011/12. The evaluators urged caution in the interpretation of the summative findings because of the absence of a comparison group and because the patient perspective was not captured. Among their findings:

- Most (91%) of the participating practices reported the time to third-next available appointment measure on a regular basis.
- Almost all of the practices surveyed (80%) were satisfied with their experience in the initiative. Practices in the structured learning stream (six hours/month of face-to-face or virtual coaching support, access to the virtual workspace, monthly calls with participating practices, and two face-to-face learning sessions) tended to be more satisfied (82% satisfied) than those in the self-directed stream (one hour/month of virtual coaching support, access to the virtual workspace, and monthly calls with participating practices) (71% satisfied).
- Two third of practices indicated that the initiative met their expectations completely. Some practices indicated that the program did not meet their expectations, either because it was more time consuming than they expected, or because they didn't perceive the resources and measures to be relevant to the way their practice was set up.
- Key Learning Community strengths identified by participating practices were coaching, QI method/approach, and resources (roadmap and workbook). Key concerns were the time commitment required, the virtual workspace, and measures and specific tools not being applicable to some types of practices.
- QI coaches were considered to be essential by 75% of the practices.
- As of October 2012, 18% of Wave 3 practices and 17% of Wave 4 practices had withdrawn after the first learning session. All withdrawn practices interviewed indicated they left the initiative because there was a lack of interest and buy-in among the team members. In addition, many had difficulty juggling competing priorities with limited time, and some hadn't understood the time commitment that was needed.
- Over half of the participating practices said they were applying the QI principles (plan-do-study-act cycles) from the Learning Community to other aspects of their work. A number of practices mentioned that they have spread their advanced access knowledge and data collection practices across and beyond their organization.
- Eighteen of the 24 practices interviewed found the data reporting aspects of the initiative to be very useful. The data reporting piece was only valuable if the practices were using the measures to identify areas of concern, inform changes, and monitor progress.



- Decreases in time to third-next available appointment (TNA) and cycle time (total length of office visit) were statistically significant, averaging one day per month and one minute per month, respectively.
- Red zone time (percent of the visit spent with a care team member) increased significantly by an average of 1% per month.
- Average improvement in TNA between month one and month six was 2.7 days in the self-directed stream and 5.5 days in the structured stream.
- 52% of teams in the self-directed stream and 66% of teams in the structured stream had moderate (20–49%) or high (> 50%) improvement in TNA.

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

### **Applicability/Transferability**

The success of the program is dependent on:

- building relationships with key partners (e.g., medical associations, nursing associations);
- willingness of primary care providers to participate in the initiative;
- targeting participation by all providers on the team rather than individual providers;
- providing information to teams on how the initiative can assist their practice;
- engaging champions to demonstrate the benefits of QI work;
- establishing requirements for QI (e.g., QI plans, alignment of quality indicators with strategic priorities);
- dedicating resources to the coaching of teams;
- the ability of teams to retrieve data from information systems; and
- continuous assessment of the QI training and support program in order to revise practices, methods, and processes based on lessons learned.

Training and support for primary care QI have been implemented in many other jurisdictions internationally and in Canada, including in British Columbia, Alberta, and Saskatchewan.

### **Contact Information:**

Susan Taylor

Program Manager

Health Quality Ontario

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Email: [Susan.Taylor@hqontario.ca](mailto:Susan.Taylor@hqontario.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.

#### *Personal Communication*

Dobell, G. (August 25, 2013). [Director, Evaluation and Research, Health Quality Ontario].

#### *Publications*



Harris, S., Birtwhistle, R., Brown, J.B., Green, M., Kotecha, J., Reichert, S., ... Webster-Bogart, S. (June 28, 2013). *Evaluation of the Health Quality Ontario quality improvement & innovation partnership learning collaboratives: Final report*. Toronto, ON.

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

Zorzi, R., Frank, C., Christian, S., McGuire, M., Bakker, P., & Hauseman, C. (January 15, 2013). *Evaluation of Health Quality Ontario's learning community AA&E initiative*. Toronto, ON.

**External Source:** <http://www.hqontario.ca/quality-improvement/primary-care>



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# Patient Enrolment with a Primary Care Provider

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

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

## Practice Description:

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

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

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

## Impact:

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

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

## Applicability/Transferability

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

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

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

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# Physicians Data Collaborative

LOCATION:	British Columbia	HEALTH THEME:	E-Health
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

**Snapshot:** This innovative practice involves the creation of a network of physicians' offices that enables the collaborative use of clinical data generated by an electronic medical record (EMR) to improve patient care. The practice was launched in British Columbia and currently involves 23 of BC's 33 geographically based divisions of family practice.

## Practice Description:

The Physicians Data Collaborative (PDC) is developing a distributed data network that is driven by front-line physicians and owned by BC's divisions of family practice. The PDC's mission is to operate a trusted physician network that enables doctors to collaboratively use data for improving primary care through:

- local health care initiatives;
- continuous learning; and
- clinical research.

The PDC values 1) ownership and operation by physicians, 2) protection of privacy and safety for providers and patients, and 3) results that are meaningful for physicians in daily practice. The PDC's distributed data network will not collect patient-level data into a centralized hub. Rather, questions (e.g., prevalence of diabetes) will be sent out to participating practices and only answers (e.g., 200/1500 patients have a diagnosis of diabetes) will be input. The hub will summarize the results across practices and present the end-user with reports that would allow for comparisons among practices within a trusted community or region. An iterative approach to system development is being used, with the first releases scheduled for late 2013. These early releases will be deployed with a limited number of EMR systems and a fixed set of primary health care questions of interest. The PDC is funded by membership fees paid by the participating divisions of family practice, set at 3.5% of the division's infrastructure funding (provided by the Ministry of Health through the General Practice Services Committee, a joint committee of the BC Medical Association and the Ministry of Health).

## Impact:

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

This innovative practice is under development. However, international evidence and experiences suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

## Applicability/Transferability

The PDC has been inspired by Pegasus Health, an independent practitioner association in Christchurch, New Zealand, which has used clinical data collaboratively over the past 20 years to improve patient care. The practice informant did not identify other practices that PDC had adapted from and was unaware if the practice was used as a model elsewhere in Canada. The success of this specific practice is dependent on timely engagement of stakeholders (including EMR vendors), building consensus among stakeholders, and adoption by physicians.

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

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

Physicians Data Collaborative. (2013). *2013 Annual Report*. Retrieved from  
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# Patients as Partners—Patient Voices Network

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

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

## Practice Description:

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

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

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

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

## Impact:

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

## Applicability/Transferability

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

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



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

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# Improving Medication Prescribing and Outcomes Via Medical Education (Manitoba IMPRxOVE™)

LOCATION:	Manitoba	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

## Snapshot:

This innovative practice improves safety and health outcomes for patients receiving medications for mental health conditions and involves family physicians, psychiatrists, and a private sector information technology and clinical analytics firm. The practice was launched in Manitoba in June 2011 to approximately half of the physicians eligible for the program. It was rolled out to remaining physicians in January 2013.

## Practice Description:

In June 2011, Manitoba Health launched the Manitoba IMPRxOVE™ program. Manitoba contracted with Comprehensive NeuroSciences of Canada (CNSC), a wholly owned subsidiary of U.S.-based Care Management Technologies, to develop the program. Manitoba IMPRxOVE™ delivers an audit and feedback intervention based on CNSC's proprietary clinical algorithms to improve safety and health outcomes for Manitobans who are receiving medications for mental health conditions. CNSC conducts monthly reviews of the pharmacy claims data in the Ministry of Health's Drug Program Information Network (DPIN). The purpose of these reviews is to evaluate the quality and appropriateness of the prescription of behavioural medications, and to identify patients at risk due to inappropriate use. If a prescribing pattern that places a patient at risk of a negative health outcome is identified, feedback in the form of evidence-based, patient-specific information—including prescribing alternatives—is mailed to the physician for consideration. Prescribing and treatment decisions remain with the treating physician, based on assessment of patient needs. Before the program was launched, advisory panels of family physicians and psychiatrists, led by the heads of the University of Manitoba Departments of Psychiatry and Family Medicine-Primary Care, identified clinical scenarios in which medication management could be optimized. Physician participation in the IMPRxOVE™ program is voluntary.

## Impact:

This innovative practice has been in operation since June 2011. An evaluation of the program is currently underway. Prior to launch of the program, the Provincial Drug Program obtained input from the head of the University of Manitoba Department of Psychiatry, the Manitoba Centre for Health Policy, and Care Management Technologies to identify preliminary research objectives/hypotheses, criteria for evaluation, and data requirements for evaluating program effects. To facilitate evaluation, a researcher from the Manitoba Centre for Health Policy randomized the 1,417 physicians eligible for the program into a control and an active mailing group, with a plan to maintain the randomization for 12 months, at which time data analysis would begin. Early evidence suggests that physicians who receive the mailing tend to reduce the frequency with which they engage in the behaviour identified in the indicator.

## Applicability/Transferability

The practice informant did not indicate other practices that Manitoba IMPRxOVE™ adapted and was unaware if the program itself was used as a model elsewhere. However, research indicates that the program has been implemented with different indicators in HMOs in the United States.

The success of this specific program is dependent upon government commitment, the support of clinical leaders (department heads of family medicine and psychiatry), establishing an evaluation framework, ensuring compliance with provincial health information regulations, and the willingness of physicians to participate.

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

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

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

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

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

## PRACTICE DESCRIPTION:

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

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

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

## IMPACT:

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

## APPLICABILITY/TRANSFERABILITY:

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



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

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

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Information last updated on: September 20, 2013

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

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Blash, L., Chapman, S., Dower, C. (2011). *DFD Russell medical centers—Engaging medical assistants in quality improvement efforts*. Retrieved from

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**External Source:** <http://www.dfdrussell.org/>



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## Better Outcomes Registry & Network (BORN)

LOCATION:	Ontario	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

**SNAPSHOT:** This innovative program collects, shares and protects data around each child born in Ontario to inform subsequent programming for maternal and child health care and services, and broader quality improvement in the province. The Better Outcomes Registry & Network (BORN) was established in 2009 through the Children’s Hospital of Eastern Ontario in Ottawa. In the 2011 to 2012 fiscal year, BORN collected data on 142,376 babies across the province, and now connects more than 5000 users to data that span all levels of care from pre-pregnancy to early childhood.

### PROGRAM DESCRIPTION:

BORN gathers, aggregates and interprets data on every birth and young child in the province. Clinical data is gathered and used by professions in every health-sector setting including hospitals, midwifery practices, prenatal and newborn screening labs, fertility clinics, public health, follow-up clinics and some primary care offices and clinics.

A central component of BORN is its web-based information system (BIS – BORN Information System), which was formally launched in 2012. BORN has registry status under Ontario’s Personal Health Information Protection Act (2004) and this allows the organization to collect, use and disclose personal health information to facilitate and improve health care. Consequently, this system allows for real-time data entry and reporting, which can be accessed by every user at the contributing sites. Through this method of data collection, BORN is able to conduct regular performance measurement and direct subsequent research. An example of a more targeted reporting mechanism includes the Maternal Newborn Dashboard—a pilot project for the Ontario Antenatal Record, which uses key performance indicators to compare against population benchmark rates to improve the determination of data around congenital anomalies.

BORN is funded through the Ontario Ministry of Health and Long-Term Care and is administered by the Children’s Hospital of Eastern Ontario. Other collaborators include: E-Health Ontario, Health Quality Ontario; Newborn Screening Ontario; the Ontario Midwifery Program; the Ontario Hospital Association; Public Health Ontario; TARGetKids! Applied Research Group; the Provincial Council for Maternal and Child Health; Champlain Maternal Newborn Regional Program; the CHEO Research Institute; the Society of Obstetricians and Gynecologists of Canada; the Institute for Clinical Evaluative Sciences; the Canadian Neonatal Network; and the Southwestern Ontario Maternal, Newborn, Child and Youth Network; as well as fourteen Local Health Integration Networks.

### IMPACT:

BORN’s data collection has been reported as integral to the success of partnered initiatives such as at Markham-Stouffville Hospital, where regular monitoring enabled a reduction in cesarean section rates. Another successful pilot program used BORN data to evaluate the efficacy of keeping mothers and newborns together right after birth rather than separating the newborn into a neonatal intensive care unit. Also, the ability to cross-reference births with Newborn Screening Ontario has helped to identify nearly 500 potentially missed screens, reducing unsatisfactory newborn screens for rare genetic diseases from 16% to 7% in one hospital during 2011-2012. Regular tracking of false positive and false negative rates enables screening laboratories to accurately assess and refine their performance.

### APPLICABILITY/TRANSFERABILITY:

BORN grew out of efforts beginning in the 1980s with the then Perinatal Education Program of Eastern Ontario (now the Champlain Maternal Newborn Regional Program) which led to the aggregation of data across the province.

For knowledge translation purposes, BORN has a committee structure that is responsible for ensuring consistency of practice across Ontario. It uses communication technologies such as webinars to provide regular education, information and training sessions in more remote settings; and conducts regular clinical data reporting which can be accessed across affiliated institutions. BORN also works with maternal child groups in other provinces to provide comparative perspectives on such things as antenatal care pathways and C-section trends.



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

***Publications:***

2011-2012. BORN: Better Outcomes Registry & Network

<http://www.bornontario.ca/assets/documents/BORN%202011-2012%20Program%20Report.pdf>

***Other:***

<http://www.bornontario.ca/assets/documents/webinars/BORN%20Partnership%20-%20eHealth%20Ontario%20&%20PCMH.pdf>

**External Source:** <http://www.bornontario.ca/en/about-born/>





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

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

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

## PRACTICE DESCRIPTION:

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

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

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

## IMPACT:

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

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

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

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



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

#### **APPLICABILITY/TRANSFERABILITY:**

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

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

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

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

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

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

#### **PRACTICE**

##### **WEBSITE:**

[http://physicians.fraserhealth.ca/resources/mental\\_health\\_and\\_substance\\_use/psychosis\\_treatment\\_optimization\\_program/psychosis\\_treatment\\_optimization\\_program](http://physicians.fraserhealth.ca/resources/mental_health_and_substance_use/psychosis_treatment_optimization_program/psychosis_treatment_optimization_program)

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Information last updated on: May 1, 2013

##### **CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:**

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Isomura, T. (feedback and review, May 1 2013). [Fraser Health Authority]

###### ***Publications***

###### ***Alternative Profiles***



***Other***

Isomura, T. Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care (2012).



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# Lowering Cardiovascular Risk in Primary Care: Primary Care Connect, the Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI)

LOCATION:	Ontario	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Promising

**SNAPSHOT:** This innovative practice addresses the issue of health outcomes and treatment experiences among patients with vascular disease. The practice was launched in six Ontario family practices and involved a collaborative network of registered nurses, family physicians, specialists, pharmacists, and other allied health care professionals.

## PRACTICE DESCRIPTION:

Vascular disease is the number one preventable cause of death in Canada and it places a large burden on patients and the health care system in general. The Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI) was launched in May 2010. Based on its success, program founders partnered with Diversified Health Canada, a leader in Continuing Medical Education, to transfer and reproduce results in other communities and with other chronic diseases, such as Diabetes and Cardiovascular Obstructive Pulmonary Disease (COPD). This model is known as Primary Care Connect (PCC). In Peterborough, nine family practices in five family health teams have implemented PCC.

PCC is focused on prevention, early detection, and disease management, with a key priority being educating and informing the public. CVDPMI targets individuals who are at risk of vascular disease yet do not display symptoms and are not currently seeking medical help. Patients identified during electronic medical record screening are asked to visit their family practice or other clinical setting for a health assessment and vascular workup. If there is evidence of vascular disease, the patient is given the option to enrol in an individualized treatment program that consists of five follow-up appointments over nine months, and whatever clinical interventions are required.

This proactive approach is an innovation in preventing and managing chronic disease that is expected to improve health outcomes, improve patients' treatment experience, and reduce downstream costs. The broader goal of the PCC is to enable collaboration among interprofessional health care providers and community partners. For example, CVDPMI is managed by registered nurses who collaborate with family physicians, specialists, pharmacists, and dietitians in the identification and treatment of at-risk patients. CVDPMI was launched by the Primary Health Care Services of Peterborough and supported by local and provincial health organizations, including the Peterborough Regional Nephrology Associates, AstraZeneca, the Heart and Stroke Foundation of Ontario, the Peterborough Regional Vascular Health Network, and the Greater Peterborough Health Services Foundation.

## IMPACT:

Results indicate that the CVDPMI's systematic, guidelines-based approach significantly improved cardiovascular risk in a real-world primary care setting. Data were captured for 1,329 patients, and over an average of 3.4 clinic visits, risk factor profiles improved significantly, patients showed a 20% reduction in cardiovascular risk for the next 10 years, and there was a decrease in the use of acute care services. Personal accounts suggest that participants are impressed with the level of care they receive and are more aware of their own health. The results of this evaluation have been published in the *Canadian Journal of Cardiology*.

A preliminary evaluation of the cost-effectiveness of CVDPMI found that a 65% probability that CVDPMI is cost effective compared to no program. Findings from this cost-effectiveness evaluation are planned for publication, and the results will be presented at the Canadian Association of Population Therapeutics in November 2013. The CVDPMI has received a number of accolades, including international recognition at an Innovations in Health Care Policy Conference in New York City in March 2010. In September 2011, the Health Council of Canada featured the innovative program in a podcast called "[Engaging Patients](#)".



[in Primary Care.”](#)

#### **APPLICABILITY/TRANSFERABILITY:**

The Peterborough CVDPMI initiative builds on the success of several national and regional strategies that support health care providers who treat patients for cardiovascular disease. The CVDPMI acts as an implementation arm for the Canadian Cardiovascular Harmonized National Guidelines Endeavour (C-Change), the Canadian Heart Health Strategy and Action Plan (CHHS-AP), the Council of the Federation of Premiers Health Innovation Recommendations, Toward Optimized Practice (Alberta), the Ontario Vascular Blueprint, and Ontario's Action Plan for Healthcare.

Program developers believe the positive results demonstrated by CVDPMI in patient health outcomes, risk reduction and health economics are highly transferable to other communities and other chronic diseases, such as Diabetes and COPD. An accredited knowledge transfer framework, Primary Care Connect, was developed through collaboration with Diversified Health Canada and will facilitate the application of this practice in other settings. To facilitate the spread of this practice, implementation should be supported by coaching and mentoring. It should also include proactive assessment, learning opportunities, evaluation and outcomes reporting.

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Information last updated on: July, 2013

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

##### ***Personal Communications:***

Casey, M. (feedback and review, July 22, 2013). [Diversified Health]

##### ***Publications:***

Kammila, S., Casey, B., Harterre, D.J., and Oh, P. (2012). Improving cardiovascular risk in primary care: the Peterborough Comprehensive Vascular Disease Prevention and Management Initiative (CVDPMI). *Canadian Journal of Cardiology*. 28(5) S181-S182.

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# The Stroke/TIA Collaborative: Enhancing stroke management and the use of indicators

LOCATION:	British Columbia	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

**SNAPSHOT:** This innovative practice addresses the issue of enhancing stroke management and the use of indicators. The practice was launched in British Columbia in 29 sites and involved a faculty of four stroke neurologists, a clinical nurse educator, an emergency department physician, a stroke coordinator, a stroke rapid assessment unit, a stroke survivor, and 17 teams of health care professionals who were engaged in the collaborative.

## PRACTICE DESCRIPTION:

In BC, stroke is the leading cause of acquired long-term disability in adults and third leading cause of death. There are stroke best practices presented by the Canadian Stroke Strategy and stroke-specialized working groups that focus on stroke prevention, acute stroke management, and chronic stroke rehabilitation. However, these stroke guidelines are often not put into practice. In order to decrease the morbidity and mortality of ischemic stroke, the British Columbia Patient Safety and Quality Council (BCPSQC) launched the Stroke and TIA Collaborative Initiative through funding from the BCPSQC, the provincial health service authority, St Paul's Hospital, and ESD Stroke Rehabilitation Inc.

The initiative brought together an interdisciplinary group of health care professionals to discuss how best to deliver stroke care in order to decrease stroke morbidity and mortality. The group decided on several process goals, such as preventing the development of stroke from transient ischemic attacks (TIAs), enhancing acute pharmacological intervention (tPA), ensuring better adherence to best practices, and promoting more transitions from the emergency department to secondary prevention services. The collaborative used a structured improvement methodology that included four face-to-face learning sessions, access to expert faculty, coaching from improvement advisors, and bi-weekly webinars. Following each discussion and learning session was a plan-do-stop-assess (PDSA) cycle to test-out the efficiency of the proposed practices.

## IMPACT:

Throughout the intervention, the BCPSQC documented data pertaining to participation, primary outcome measures, and process measures. The findings were presented publicly at the BC Quality Forum, the 2012 Canadian Stroke Congress, the International Stroke Congress, health authority and provincial news releases, the BCPSQC website, and academic publications. Several practices, such as triage and swallowing tests, were also published as instructional videos on the BCPSQC website and YouTube. Also, several success stories highlighting hospital-specific accomplishments were published on the BCPSQC website.

The collaborative gained the participation of 17 teams representing 29 sites. These teams consists mostly of managers and nurses, with nurses making the greatest contribution (about 45%). In terms of improvement progress, by May 2012, 90% of the members reported attaining sustainable improvement in stroke management, four out of five health authorities observed small decreases in 30-day mortality, and three out of five health authorities achieved an increase in tPA administration. Other collaborative measures were outcome measures from 11 chosen best practices. For example, there was a 25% drop in wait time for medication administration, a decrease in wait time for imaging services such as CT by almost 50 minutes, an increase in 24-hour mobilization to 90%, and an increase to 100% of patients checked for glucose levels upon admission.

There was also enhanced cross-site collaboration and knowledge translation, as well as an increase in momentum to implement best practices at the health authorities.

## APPLICABILITY/TRANSFERABILITY:

This initiative was launched as part of the Clinical Care Management (CCM) initiative ([http://innovation.healthcouncilcanada.ca/ip/1226?keys=CCM&tid=All&tid\\_1=All&term\\_node\\_tid\\_depth=All&tid\\_2=All&field\\_ip\\_publication\\_date\\_value%5Bmin%5D%5Byear%5D=&field\\_ip\\_publication\\_date\\_value%5Bmax%5D%5Byear%5D](http://innovation.healthcouncilcanada.ca/ip/1226?keys=CCM&tid=All&tid_1=All&term_node_tid_depth=All&tid_2=All&field_ip_publication_date_value%5Bmin%5D%5Byear%5D=&field_ip_publication_date_value%5Bmax%5D%5Byear%5D)), specifically the CCM Stroke Initiative. The initiative gained national



recognition through presentations and publications, thereby engaging Calgary and Saskatchewan in the next collaborative. The next collaborative will continue the efforts of the 2011/2012 collaborative.

This practice is theoretically transferable to other various sites if health professionals at all levels participate, there is an understanding of culture and context in which care is provided, and the strengths of health care professionals are recognized and used in the process.

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

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BC Patient Safety & Quality Council. (n.d.). *Stroke collaborative—Success stories*. Retrieved from <http://bcpsqc.ca/blog/newsandinsights/stroke-collaborative-success-stories/>

**External Source:** <http://bcpsqc.ca/clinical-improvement/stroke-and-tia/>



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# Performance Huddles: Bringing Interprofessional Teams Together to Improve Quality and Safety

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

## SNAPSHOT:

This innovative practice addresses how interprofessional teams communicate, collaborate, and monitor their progress on quality improvement at the point of care. This interactive practice was launched in Ontario in November 2011, taking place in numerous patient care units at three sites of a multi-site hospital system.

## PRACTICE DESCRIPTION:

Creating a culture of participation and collaboration across any organization can be a challenge. To harness the ingenuity of interprofessional teams at the front line, William Osler Health System has implemented performance huddles, which enable corporate priorities to be lived, evaluated, and improved continuously at the point of care. Born out of an organization-wide access and flow initiative, performance huddles are short (five to 10 minutes), focused daily staff meetings dedicated to quality improvement. Huddles provide an opportunity for health care providers and support staff to discuss the previous day's performance based on real-time data, and to collaboratively identify barriers, develop solutions, and celebrate joint successes.

Led by each unit's Patient Care Manager (PCM), huddles involve everyone on the unit—physicians, nurses, allied health professionals, and administrative and support staff—and occasionally even patients and visitors. Huddles use visual management techniques to help interprofessional teams communicate in the same language, through a standardized display called the Vital Signs board. Every day, the PCM obtains the previous day's data from an online performance data portal and posts them on their board. These daily data are linked to the corporate scorecard. Data also include direct feedback from patients collected through the Osler call centre. Nurses at the call centre phone the majority of in-patients within 48 hours of discharge to learn about their experiences. Through huddles, staff bring forward improvement ideas and are empowered with resources and support to implement solutions. This creates accountability at an individual level and allows each person to play a role in the organization's success.

The performance huddle boards are located in public areas on the units for patients, families, and visitors to see and ask questions about. Patients and families have also been involved in the huddle.

The initiative was introduced in November 2011 at all three sites of the William Osler Health System and then quickly spread to all the other patient care units and some non-clinical service areas. In order to roll out performance huddles, a senior leadership champion was established, as dedicated leadership is required to implement the initiative and to monitor its progress. It is also important to have "standardized work"—clear, written, standardized steps on how to perform a huddle and a standardized approach across the organization.

## IMPACT:

Performance huddles are evaluated in three key ways. First, unit participation is assessed through monthly audits of Vital Signs boards across the organization, and followed up with coaching for units with less consistent participation. Second, huddle effectiveness is gauged through progress against corporate performance metrics, which are assessed monthly at executive, clinical, and program leadership levels. If targets are not met, program and unit leaders work with front-line staff to develop plans for improvement. Third, leadership support is provided in the form of peer-to-peer mentorship for huddle leaders. Patient care leaders also attend huddles on a weekly basis and provide coaching to huddle leaders.





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

Huddles have been instrumental in building interprofessional teams, enhancing communication, and creating a culture of open communication, trust, and belonging. Examples of success through huddles include an improvement in “time to in-patient bed,” which has decreased by over 50%, and reductions in rates of falls and urinary tract infections. In non-clinical service areas, such as Health Information Management, huddles have enabled reductions in records distribution processing time and chart preparation turnaround time. Key success factors include a multidisciplinary approach with physician involvement, weekly attendance by program directors to provide coaching and guidance, and regular attendance by the Senior Leadership Team. Members from the Board of Directors have also attended the huddles, which has helped increase their awareness of the direct impact of huddles on quality and safety initiatives.

#### **APPLICABILITY/TRANSFERABILITY:**

This practice was implemented through the Ontario emergency room (ER) and alternative level of care (ALC) Performance Improvement Process (PIP) strategy. Adapted for use at William Osler Health System, the concept of a performance huddle is not new, but has been enhanced by the inclusion of real-time patient satisfaction data.

Due to its effectiveness in integrating interprofessional teams, the practice of performance huddles has quickly spread from pilot clinical units to all clinical areas and most non-clinical and administrative areas across two hospital sites and the administrative site. Key to the broader adoption of the practice have been champions at the senior leadership level who provide guidance and monitor progress, decision support services related to the collection and reporting of metrics, a standardized guide for huddle leaders, and change management and project management resources to help teams to implement solutions.

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##### ***Personal Communication:***

Ferrari, K. (feedback and review, May 6, 2013). [William Osler Health System].

##### ***Publications:***

##### ***Alternate Profiles:***

##### ***Other:***

Ferrari, K. Content developed from an abstract submission to the Health Council of Canada’s National Symposium on Integrated Care (2012).



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# Registry of Methods and Tools for Knowledge Translation in Public Health

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

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

## PRACTICE DESCRIPTION:

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

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

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

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

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

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

## IMPACT:

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

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



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

#### APPLICABILITY/TRANSFERABILITY:

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

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

##### **Publications:**

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

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



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# Path to Care: Referral and Wait Time Measurement and Management

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

**SNAPSHOT:** This innovative practice aims to improve access and reduce health care service and referral wait times through a province wide program. This practice was launched in Alberta in 2010 and aims to develop and implement provincially adjudicated referral standards.

## PRACTICE DESCRIPTION:

Path to Care: Referral and Wait Time Measurement and Management is a province-wide initiative to improve access and reduce health care service and referral wait times in Alberta. The initiative evolved partly from Alberta's Wait Time Management Initiatives, which supported the province's research and development on access improvement from 2007 to 2010. It also has roots in Alberta's work on the Transformational Improvement Program (TIPs)—Improving Access, Reducing Wait Times, which is part of *Alberta's 5-Year Health Action Plan* (2010 to 2015).

Path to Care is in year 2 of a five-year program. The specific objectives of the program are to improve access and reduce wait times; implement service redesign across common processes that affect access across primary care, the five zones, and Strategic Clinical Networks within Alberta; standardize the elements of referral and triage criteria across program areas; establish consistent operational policies regarding service response times, and patient and provider communication; increase transparency of service delivery and wait times; and improve request tracking and status reporting.

The specific program related to referral management includes redesigning services; developing provincially adjudicated referral standards and access targets by population or care pathway; and automating the referral process through e-referral. This work addresses current challenges with respect to variable referral and communication processes (i.e., lack of standardized referral processes and lack of transparency about the status of referrals); capacity management issues related to matching service supply and demand; and lack of automation of the referral process.

Alberta Health Services (AHS) is beginning a clinical engagement and design phase to define Alberta's e-referral experience. A web portal will be used to automate the referral process. In the short term, Alberta Netcare Portal (ANP) users will be able to create and manage referrals within Netcare; long-term plans include integrating ANP with clinical applications such as EMR, scheduling systems, and the patient portal. AHS will do a limited production roll out of e-referral provincially for hip and knee surgery, breast cancer, and lung cancer starting in November 2013. These clinical pathways were chosen because provincially adjudicated guidelines for them already exist, they have already done business process re-engineering, and they have clinical champions. A business case and implementation plan for provincial deployment of the e-referral and wait time platform beyond the limited production toll out is currently being developed.

## IMPACT:

The evidence for the effectiveness and efficiency of electronic referrals comes primarily from international case studies, since no systematic reviews or randomized controlled trials have been published to definitively quantify the impact of electronic referral systems. It suggest that electronic referrals have helped eliminate the risks associated with manual workflow processes and have significantly reduced inefficiencies in the health care system, duplication, and transcription errors. Almost all e-referral initiatives have resulted in improved access to services, increased capacity of the health care system, and reduced wait times for patients.

A formal program evaluation of Alberta's Path to Care, including a benefits realization/return on investment analysis is being developed. The evaluation will look at the impact of Path to Care across the quality dimensions (access, appropriateness, acceptability, efficiency, safety, and effectiveness).

## APPLICABILITY/TRANSFERABILITY:



AHS is building on work done to reduce variability in the referral process and automate it in, for example, the United States (San Francisco General Hospital, Cook County Health and Hospital System, Boston Medical Centre, Harvard University/Partners Health System), Denmark (MedCom-Projects), Australia (Australia Capital Health), and New Zealand (Hutt Valley District Health Board).

The AHS's referral management process has not been implemented elsewhere. The initiative is theoretically applicable and transferable elsewhere.

**Content adapted from the following sources and relevant websites:**

- Alberta Health Services. (2012). *Closed loop referral management in Alberta: Draft white paper*. Edmonton, AB. (Internal Document).
- Alberta Health Services. (2012). *Path to Care: Opportunity assessment* [Internal Document].
- Bichel, A. (personal communication: interview and feedback, December 11, 2012). [Alberta Health Services]

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**External Source:** <http://www.albertahealthservices.ca/>



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# Nova Scotia Breast Screening Program – Wait Time Reporting

LOCATION:	Nova Scotia	HEALTH THEME:	Access and Wait Times
HEALTH SECTOR:		FRAMEWORK CATEGORY:	Emerging

**SNAPSHOT:** This innovative practice addresses the issue of performance measurement by reporting on nine indicators related to wait times and breast screening. Launched in Nova Scotia in 2010, results are provided to the public via the provincial wait times website

## PRACTICE DESCRIPTION:

The Canadian Breast Cancer Screening Initiative (CBCSI) has a national wait time performance indicator for diagnostic interval. The Nova Scotia Breast Screening Program (NSBSP) has extended its wait time reporting beyond diagnostic interval. It reports on nine indicators that monitor a patients' real wait time experience along the entire breast health continuum, from screening to surgery. The indicators include: (1) date from when a first-time client calls central booking to the date of screening appointment; (2) date from screening mammogram to the date of work-up mammogram; (3) date from screening mammogram to the date of finalized report; (4) date from finalized report to date of work-up mammogram; (5) date from when a requisition is received to date of an urgent or semi-urgent diagnostic mammogram; (6) date from most recent breast-related diagnostic imaging procedure to date of needle core biopsy; (7) date from screening mammogram to date of needle core biopsy; (8) date from work-up mammogram to date of needle core biopsy; and (9) date from needle core biopsy to breast cancer surgery. Results are provided to the public via the provincial wait times website and directly to managers and staff within breast imaging departments. Sites are shown their performance relative to the national target, the provincial average, and all other sites. The NSBSP captures data at a level where it is able to break the national indicator into specific waits and identify where bottlenecks may exist along the clinical trajectory.

## IMPACT:

The NSBSP adopted the use of retrospective analysis to improve the dissemination of wait time information. Typically the 50th (median) and 90th percentiles are calculated for each indicator over a 3-month calendar quarter. Often wait time reporting is seen as a measure for public transparency. The NSBSP took the opportunity to share wait times information directly with health care personnel. This level of engagement has proven successful, as personnel are more conscientious of the targets they are being measured against. Also, poor performing sites are more apt to approach the NSBSP, seeking ways to improve performance.

Breaking wait time indicators into smaller component waits has also helped to improve wait times. Specific personnel (e.g. radiologists) "own" certain wait times (e.g. reporting time), meaning their performance is the key factor of that component wait. As a result, a sense of ownership and responsibility to the wait times has developed in personnel across the province. Since the introduction of regular wait time reporting to all breast imaging departments in Nova Scotia, there has been a noted improvement in wait times and a decrease in the variability across sites.

In the 4<sup>th</sup> quarter of 2010, just as this practice began, it took 41 days for 90% of patients in Nova Scotia to have a work-up mammogram after an abnormal screen. As of the 4<sup>th</sup> quarter of 2012 this wait has been reduced to 26 days for 90% of patients in Nova Scotia.

## APPLICABILITY/TRANSFERABILITY:

To date, the NSBSP is not aware of this approach being formally implemented in any other setting.

This practice has brought awareness of patient wait times and wait time targets to front line health care providers delivering the services being measured. Regardless if presenting wait time information alone doesn't improve performance, having the information readily available is the first step to invoking positive change and creating an environment that fosters new ideas from all levels of the organization.



Although the reporting of median and 90<sup>th</sup> percentiles was not novel, the dissemination of breast imaging wait time information directly to health care providers was an approach piloted in Nova Scotia.

**Content was adapted from the following sources and relevant websites:**

- <http://waittimes.novascotia.ca>
- Duggan, R. Content developed from an abstract submission for the Health Council's National Symposium on Integrated Care (2012).

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Information last updated on: April 12, 2013

**External Source:** <http://breastscreening.nshealth.ca/>



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# Health Quality Council of Saskatchewan's QualityInsight.ca Website

LOCATION:	Saskatchewan	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

**SNAPSHOT:** This innovative practice is designed to give the public, providers, managers, and leaders access to information about how the health system is performing. Developed by Saskatchewan's Health Quality Council and launched in March 2010, this website contains 100 measures of how Saskatchewan's health care system is performing, from wait times for surgery to patients' rating of their hospital care.

## PRACTICE DESCRIPTION:

Beginning in March 2010, Quality Insight was developed by [Saskatchewan's Health Quality Council](#) in collaboration with the [Quality Insight Working Group](#) and two Saskatchewan Surgical Initiative advisory groups: the Executive Sponsorship Group and the Guiding Coalition.

Quality Insight, the first website of its kind in Canada, is an easy-to-use resource that contains more than 100 measures of how Saskatchewan's health care system is performing, from wait times for surgery to patients' rating of their hospital care. Quality Insight was designed to give everyone—the public, providers, managers, and leaders—unprecedented access to information about how the health system is performing.

This level of transparency in informing and supporting quality improvement work in a health system is a first in Canada, and perhaps the world. Quality Insight is a definitive resource for all health system partners. By pulling together many sources of data, it provides meaningful, frequently updated data that can provide a “real-time” snapshot of the Saskatchewan health system and its progress towards measureable targets, including progress towards targets for improving surgical care for patients in Saskatchewan.

Indicators featured on the Quality Insight website cover a broad spectrum across the diverse dimensions of quality, such as access, safety, and patient experience. The website aims to highlight progress in global benchmarks for overall health system strategic priorities as well as more representative indicators at the regional and local levels. Data charts are updated monthly, quarterly, or annually depending on the indicator. Information is gathered from a variety of data sources, including provincial administrative databases, acute care and emergency department patient experience surveys (with plans to add primary health care survey results), and health care partner organization databases. A standardized data-submission process is also in place between the Health Quality Council and certain health regions for the gathering of local data from non-standardized data sets. Building on the collaborative work of the Saskatchewan Surgical Initiative, initial indicators were selected by the Quality Insight Working Group in consultation with the provincial health regions and other partner and stakeholder organizations. New indicators are added based on the strategic and operational needs identified by these partner organizations.

A major aim of the Quality Insight website is to shift the culture of data reporting and increase understanding about the usability of data for learning and improvement. Graphic presentations of data—including run charts and statistical control charts—place an emphasis on monitoring trends over time instead of reacting to single-point measures. The website also provides resources on how to interpret the data presented in this way to facilitate real-time decision-making among health system leaders. Additionally, a News and Resources section on the Quality Insight homepage features current articles about measuring for improvement.

## IMPACT:

Quality Insight's primary users include the Saskatchewan public, as well as quality improvement managers and policy analysts in the health regions and ministry of Health. While no formal evaluation has been conducted on the impact and use of the website to date, there is much anecdotal evidence to suggest Quality Insight has added value for these users. Importantly, the province and health regions look to Quality Insight as the definitive resource on health system performance—provincially, regionally, and locally—and depend on the data available through this site to inform their improvement efforts and track the effect of those efforts.





The Health Quality Council also has a routine process of soliciting feedback from key users across the health system, inquiring about what could be added or improved to ensure the website meets end users' needs. This process combined with Informal consultation and requests for improvement sent by users play a key role in guiding development decisions. In fact, they are the key determinants for prioritizing enhancements to the system.

#### **APPLICABILITY/TRANSFERABILITY:**

Since going live in February 2011, Quality Insight has continued to improve and expand. A major milestone was the introduction of the first regional strategic dashboard (developed in consultation with Cypress Health Region to meet more local needs) in December 2011. Other regions across the province have also developed similar regional dashboards highlighting local strategic priorities. With the adoption of a Lean Management System across Saskatchewan's health care system, there is growing interest in using the Quality Insight website as a platform for a provincial e-Visibility Wall, to be launched in early 2013. As part of the Lean approach, this would enable the provincial leadership team and the public to monitor the impact of quality improvement initiatives in the province as they are put into action.

Although other examples of aggregate data websites exist in Canada and abroad, Quality Insight is unique in its dedication to public accessibility and the capture of real-time, dynamic measures. Other jurisdictions in Canada have expressed interest in learning more about the Health Quality Council's website design. Likewise, there is potential for other ministries and sectors in Saskatchewan to follow Quality Insight's example of sharing publically available information in a transparent and meaningful way.

#### **CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:**

<http://hqc.sk.ca/saskatchewan/health-system-performance/>

<http://www.qualityinsight.ca/about/>

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Information last updated on: February 21 2013

**External Source:** <http://www.qualityinsight.ca/>



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## Annual Quality Improvement Plans (QIPs) as part of Ontario's Excellent Care for All Act (ECFAA)

LOCATION:	Ontario	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

**SNAPSHOT:** This innovative practice addresses the need for effective quality improvement plans for accountability and transparency purposes. Launched as part of the Excellent Care for All Act in Ontario in June 2010, this is a tool that enables hospitals to identify, report, and achieve quality improvement objectives in a structured way.

### PRACTICE DESCRIPTION:

The *Excellent Care for All Act* (ECFAA) came into law in June of 2010. The *Act* puts Ontario patients first by strengthening the health care sector's organizational focus and accountability to deliver high-quality patient care. Quality improvement plans (QIPs), one of the components of ECFAA, are often referred to as the cornerstone of the legislation.

The ECFAA calls for the following:

- quality committees that are responsible for monitoring and reporting on quality issues;
- annual quality improvement plans (QIPs), which each health care organization must develop and make public;
- executive compensation to be linked to achieving performance improvement targets set out in the annual quality improvement plan;
- patient/client/caregiver surveys to assess satisfaction with services;
- staff (employee and service provider) surveys to assess satisfaction with employment experience and views about the quality of care provided by the health care organization;
- a patient declaration of values developed after public consultation by health care organizations that are currently without one; and
- a patient relations process to address patient experience issues and reflect the organization's declaration of values.

Annual quality improvement plans are developed by the health care organization and include quality indicators, measurable performance improvement targets, and planned improvement activities that align with the organization's quality improvement goals and priorities. The ministry provides guidance, common templates, and other supports to health care organizations to assist in the development of a QIP that aligns with system priorities. QIPs are developed annually, posted publicly, and submitted to Health Quality Ontario. Posting publicly is meant to promote the principles of the ECFAA, including accountability and transparency. Further accountability is found in the legislative provision that ties each hospital CEO's compensation with the achievement of a hospital's quality improvement goals.

The QIP is a tool that enables hospitals to identify, report, and achieve QI objectives in a structured way. Every hospital has a Quality Committee with oversight for the development of the QIP, which must be certified by the chair of the hospital board and the chief executive officer.

Excellent QIPs and well-executed implementation will strengthen the hospital sector's ability to deliver high-quality patient care. Quality improvement plans are used in a variety of health care practices across the world to ensure an evidence base for public accountability. As Ross Baker outlined in his seminal report *Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations*,<sup>[1]</sup> quality improvement plans are used at Virginia Mason Medical Center by the board and senior managers as part of a broader strategic agenda. Further, at the Vancouver Island Health Authority the board works with VIHA staff to set quality and patient safety priorities in a quality plan, taking into account the ministry of Health's direction.

QIPs submitted to Health Quality Ontario are reviewed and used to inform feedback to the field. For the 2012/13 hospital QIPs, this resulted in development of the *QIP: An Analysis for Improvement* report. The report describes overall progress from one year to the next and identifies hospitals that have exemplar plans and practices. As well, the report includes the provincial



average and comparative performance information for a series of indicators. These indicators include *Clostridium difficile* infection, ventilator-associated pneumonia, hand hygiene, central line–associated bloodstream infection, pressure ulcers, falls, surgical safety checklist, physical restraints, hospital standardized mortality ratio, total margins, emergency department length of stay for admitted patients, patient satisfaction, 30-day readmission rate, and percentage of alternate level of care (ALC) days.

QIPs were also introduced for interprofessional team-based primary care models (including Family Health Teams, Community Health Centres, Nurse Practitioner–Led Clinics, and Aboriginal Health Access Centres) in 2013 as an essential focus of Ontario’s health care transformation agenda.

#### IMPACT:

According to Health Quality Ontario’s 2012/2013 *QIP: An Analysis for Improvement*, there has been progress made since the initial QIPs were submitted under the ECFAA in 2011/2012. HQO highlights three key areas of progress, including:

- perfect QIP submission compliance (i.e. all hospitals submitted plans);
- QIPs captured clear aims that were aligned with hospitals’ strategic priorities, and included appropriate measures and targets; and
- QIPs gave rise to innovative and thought-provoking change ideas.

The inclusion of specific indicators and targets in QIPs facilitates analysis of their impact on health outcomes and health care performance. The 2012/2013 *Analysis for Improvement* does illustrate improved performance related to central line bloodstream infection, ventilator-associated pneumonia, hand hygiene, and patient satisfaction. However, analysis indicates that there is still improvement to be made, since many hospitals did not reach their targets for ALC days and emergency department wait times.

A 2012 study was undertaken to understand how the ECFAA, including its quality improvement plan requirements, had influenced some Ontario organizations’ governance practices for quality and patient safety. Results indicated that, in the near term, the requirements may hinder the effectiveness of high-performing organizations with an existing focus in these areas. As well, there were some concerns about the measures, e.g., in some cases their focus on provincial priorities caused distraction from efforts to address local priorities. However, this same study notes that the ECFAA has helped “raise the bar” on quality of care and patient safety, and supports alignment between governance and the delivery of quality care.

#### APPLICABILITY/TRANSFERABILITY:

Senior leaders in Ontario have indicated that QIPs drive transparency by holding organizations accountable. As of March 2013, QIPs are required in hospitals and interprofessional primary care organizations. There are plans to support health care organizations across the care continuum with adopting the principles of the ECFAA; development and implementation of quality improvement plans is part of this vision.

#### Content has been adapted from the following website:

Ontario Ministry of Health and Long-Term Care. (2012). *About the Excellent Care for All Act*. Retrieved on November 28, 2012 from <http://health.gov.on.ca/en/pro/programs/ecfa/legislation/act.aspx>

Baker, G.R., Denis, J.-L., Pomey, M.-P., and MacIntosh-Murray, Anu. (2010). *Effective governance for quality and patient safety in Canadian healthcare organizations*. Ottawa, ON: Canadian Health Services Research Foundation & the Canadian Patient Safety Institute, p. 15. Retrieved from [http://www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/11505\\_Baker\\_rpt\\_FINAL.pdf](http://www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/11505_Baker_rpt_FINAL.pdf)

Baker, G.R., & MacIntosh-Murray, A. (2012). Governance for quality and patient safety: The impact of the Ontario Excellent Care for All Act, 2010. *Healthcare Quarterly*, 15, 44–50. Retrieved from <http://www.longwoods.com/content/23161>

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**External Source:** [http://health.gov.on.ca/en/pro/programs/ecfa/legislation/quality\\_improve.aspx](http://health.gov.on.ca/en/pro/programs/ecfa/legislation/quality_improve.aspx)



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# Atlantic Health Quality and Patient Safety Collaborative (AHQPSC): Atlantic Sustainability and Spread Facilitated Learning Series

LOCATION:	New Brunswick, Newfoundland & Labrador, Nova Scotia, Prince Edward Island	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

**SNAPSHOT:** This innovative practice has a three-year mandate to develop common strategies and recommendations to inform Atlantic Deputy Ministers of Health on health care quality and patient safety trends, issues, policy directions, and opportunities. Launched in the participating provinces in 2010, this collaborative is the only one of its kind in Canada that brings together representatives from multiple provincial ministries, regional authorities, and health system authorities to provide ground-level training and capacity building.

## PRACTICE DESCRIPTION:

In 2010, the Atlantic Health Quality and Patient Safety Collaborative (AHQPSC) was created out of the *Safer Healthcare Now!* Atlantic Node Steering Committee. The Collaborative has a voluntary membership including provincial health ministry representatives from the four Atlantic provinces, regional and health system representatives, provincial quality and patient safety committee chairs, and the Canadian Patient Safety Institute (CPSI) Director of Atlantic Canada. Secretariat support is provided by the Canadian Patient Safety Institute (CPSI). The AHQPSC is the first trans-provincial collaborative of its kind in Canada, and marks the beginning of a new era of partnership among the Atlantic provinces as they move forward in their joint effort to maximize patient safety and quality care.

The main purpose of the AHQPSC, which has a three-year mandate, is to develop common strategies and recommendations to inform Atlantic Deputy Ministers of Health on health care quality and patient safety trends, issues, policy directions, and opportunities. The AHQPSC was initially funded by CPSI through a one-time start-up grant, and it has gone on to generate modest revenues through the Atlantic Learning Exchange, one of its initiatives. This is not a high-cost or high-tech practice. The majority of meetings are virtual and held quarterly, with one full-day face-to-face meeting annually. Discussions involve facilitation, capacity and relationship building, knowledge exchange, and the provision of evidence-based recommendations to address system-level quality and patient safety issues across the Atlantic region.

The main objectives of the AHQPSC are to

- address common quality and patient safety learning needs;
- identify and recommend initial common health care quality and patient safety performance indicators to populate a standard Atlantic Balanced Scorecard using indicators developed by each provincial Quality Patient Safety structure;
- facilitate the engagement of a broader range of regional and national stakeholders to action the quality and patient safety agenda and strengthen the culture of quality and patient safety in the Atlantic health system;
- increase capacity to apply quality and patient safety research in strategies to address common quality and patient safety issues at the system level;
- leverage information management and information technology solutions to improve the measurement of quality and patient safety outcomes;
- facilitate recognition of quality and patient safety excellence, including showcasing and celebrating collaborative strategies and results; and
- demonstrate cost avoidance and/or savings through implementing quality and patient safety initiatives.

## IMPACT:



The AHQPSC has successfully launched several initiatives, including the first Atlantic Health Quality and Patient Safety Learning Exchange which took place in Charlottetown, PEI, in May, 2011. The next Atlantic Learning Exchange will be held in Moncton, New Brunswick, on May 14–15, 2013.

In November 2011, the AHQPSC supported the development and implementation of a 24-month Atlantic Sustainability and Spread Facilitated Learning Series (SS-FLS) made up of 16 teams from 14 health authorities. The purpose of this improvement initiative is to build capacity in the Atlantic health service delivery organizations for implementing and spreading sustainable change, while addressing explicit priorities in the participating organizations' quality and patient safety plans. Most are focusing on surgical care safety, medication reconciliation, or both.

Additionally, an educational Effective Governance for Quality and Patient Safety Program has been delivered in three of the four Atlantic provinces in 2012/2013 as a result of recommendations to the Deputy Ministers. Work is also underway to develop a critical mass of peer governance facilitators for the Atlantic provinces in partnership with the Canadian Healthcare Association, CPSI, the four provinces, and the Health Association of Nova Scotia.

Personal accounts from AHQPSC members demonstrate that this practice is having a positive effect by allowing different stakeholders to move forward and strengthen the health quality and patient safety agenda in Atlantic Canada. This has been achieved through regional and district health authorities, which now have better access to evidence-informed resources and tools, and have adopted them into their quality and patient safety plans, and provincial patient safety frameworks. Collaborative members have observed that this practice has allowed for better facilitation and relationship building between organizations including CPSI, the Canadian Institute for Health Information (CIHI), the Canadian Foundation for Healthcare Improvement, Accreditation Canada, and others. The AHQPSC is also beginning to examine system performance through the lens of common CIHI quality and patient safety indicators in order to implement standardized measures in the future.

#### **APPLICABILITY/TRANSFERABILITY:**

Although there are some international bodies responsible for providing the public and policy-makers with health quality and patient safety recommendations in their respective countries (e.g., The Australian Commission on Safety and Quality in Health Care), the AHQPSC is the only collaboration of its kind in Canada that brings together representatives from multiple provincial ministries, regional authorities, and health system authorities to provide ground-level training and capacity building. However, this practice should translate well to other provinces and territories.

#### **Content was adapted from the following sources and relevant websites:**

Fillatre, T., Chair AHQPSC (personal communication, February 25, 2013). [www.patientsafetyinstitute.ca](http://www.patientsafetyinstitute.ca)  
<http://www.saferhealthcarenow.ca/EN/events/VirtualPrograms/Pages/default.aspx>

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Information last updated on: February 19, 2013

**External Source:** <http://www.saferhealthcarenow.ca/EN/events/VirtualPrograms/Pages/default.aspx>



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# Transformation by Design in Ontario

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

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

## PRACTICE DESCRIPTION:

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

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

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

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

## IMPACT:



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

#### **APPLICABILITY/TRANSFERABILITY:**

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

#### **Content adapted from the following sources and relevant websites:**

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

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Information last updated on: November 26, 2012

**External Source:** <http://www.providence.on.ca>





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# Responsive Intersectoral Children’s Health, Education, & Research (RICHER) Initiative

<b>LOCATION:</b>	<b>British Columbia</b>	<b>HEALTH THEME:</b>	<b>Access and Wait Times</b>
<b>HEALTH SECTOR:</b>	<b>Acute Care</b>	<b>FRAMEWORK CATEGORY:</b>	<b>Emerging</b>

**SNAPSHOT:** This innovative practice addresses child health inequities through a publicly funded, community-based primary health care and specialist pediatrics service designed to meet the needs of children, youth, and families living in Vancouver’s inner-city neighbourhoods. BC Children’s Hospital developed the Responsive Intersectoral Children’s Health, Education, & Research (RICHER) Initiative in 2007 as a means to promote access to health care for all.

## PRACTICE DESCRIPTION:

In recent years, understanding and addressing child health inequities has become a priority for research and practice. As pathways of influence on children’s health and development extend beyond the biomedical domain, the emergent literature recognizes that new approaches to integrated care are needed to promote access to health care.

BC Children’s Hospital developed the Responsive Intersectoral Children’s Health, Education, & Research (RICHER) Initiative in 2007. The RICHER initiative is a publicly funded, community-based primary health care and specialist pediatrics service designed to meet the needs of children, youth, and families living in Vancouver’s inner-city neighbourhoods. The family’s particular needs are taken into consideration when providing health care services, which are linked to specialized health care services and their community-based support networks. The primary focus of the initiative is on at-risk children, since their material and social circumstances often make them more likely to suffer the consequences of delayed development and poor health. Lack of access to appropriate health care further compounds their vulnerabilities, as it compromises continuity of care and interferes with timely referrals for assessment and treatment.

The goal of RICHER is to reduce child health inequities while improving children’s access to primary, secondary, and tertiary health care. The RICHER initiative provides regularly scheduled and easily accessible primary health care outreach clinics and specialized pediatric health services. RICHER is integrated with community infrastructure, and services are delivered in community spaces (e.g., daycares, schools, community centres). Through intersectoral partnerships, typical health services are complemented by services and community-based resources, many of which assist clinicians to address social determinants of health. Nurse practitioners are the point of care primary health care providers who work with clinical support from pediatricians and other specialists who provide pediatric outreach consultation. Services include assessment, treatment, and follow-up of common, predictable health conditions; episodic illness care; mental health screening and referral to appropriate resources; and developmental screening and referral for assessment at Sunny Hill Health Centre for Children. The initiative complements existing tertiary and health promotion programs. It incorporates elements of social and community pediatric approaches to care delivery. The initiative works in collaboration with Vancouver Coastal Health Authority, established community and tertiary health care services, and existing community-based organizations. The intersectoral model of service delivery is unique in its collaborations among primary health care, community organizations, and public health, and its link to specialty and tertiary services.

The nurse practitioners are employed by BC Children’s Hospital, and the specialist services are administered through BC Children’s Hospital with funding from the BC Medical Services Plan. BC Children’s Hospital provides the administrative infrastructure (clinical bookings, records) and community partners provide the venues for the clinical programs.

## IMPACT:

Funding has been obtained for ongoing research to evaluate the RICHER initiative. Funding support has been provided by the Canadian Institute of Health Research—Partnerships for Health Services Innovation, the Michael Smith Foundation for Health Research, the BC Medical Services Foundation, and the Canadian Nurses Foundation. Research results demonstrate that the RICHER model of engagement not only effectively fosters access for families with multiple forms of disadvantage but also improves outcomes by empowering parents to become more active participants in care.



In 2010, a structured questionnaire was administered to families receiving clinical services from RICHER. The purpose of the survey was to examine whether the program was reaching the target population and to consider patients' experiences of primary health care. The survey incorporated standardized measures that reflected the key components of primary health care: access, continuity (informational, relationship, and management continuity), interprofessional communication, patient activation, and patient empowerment. Analyses of the survey data show that the RICHER approach does foster access to primary care for children and families facing significant poverty and multiple forms of social and material vulnerability, including family instability, housing challenges, and food insecurity. Moreover, the children accessing RICHER clinical programs have considerably higher rates of complex health conditions and developmental challenges than would be expected in a typical population. Parents also reported that, through engagement with RICHER clinicians, they acquired knowledge of their child's health condition, and felt well prepared to manage their child's condition, navigate the health care system, and mobilize needed supports and information. A major cornerstone of RICHER's success hinges on access and continuities of care and the formation and maintenance of relationships with individuals, community partners, and secondary and tertiary providers.

#### **APPLICABILITY/TRANSFERABILITY:**

The RICHER initiative builds on the insights of the social pediatrics approach developed by Dr. Gilles Julien to remove barriers to access, and thereby improve health and educational outcomes for inner-city children and youth. It also builds on research that has (1) demonstrated the impact of marginalization and exclusion on child and family health over the life course, (2) identified conditions that mitigate the impact of adversity on child health and development, and (3) identified the processes of care that are associated with improved health outcomes for populations vulnerable because of their social and material circumstances.

Content was adapted from the following sources and relevant websites:

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

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**External Source:** <http://www.bcchildrens.ca/Services/SpecializedPediatrics/RICHERInitiative/default.htm>



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# 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/>



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# 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](http://www.ccac-ont.ca/Upload/oaccac/General/MA03.pdf)



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## Patient Safety in the Netherlands

LOCATION:	International	HEALTH THEME:	Performance Measurement and Reporting
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Not Categorized (Archived)

**SNAPSHOT:** This innovative practice requires health care providers in the Netherlands are to document the quality of care they provide, with reference to evidence-based guidelines and performance indicators.

### PRACTICE DESCRIPTION:

In this survey, respondents in the Netherlands reported consistently low levels of medical mistakes, including diagnostic and lab errors and medication errors. On the other hand, among those people who experienced an error in their health care, those in the Netherlands were the most likely to say the errors had “very serious” consequences. What can Canada learn from the Netherlands? Health care providers in the Netherlands are required to document the quality of care they provide, with reference to evidence-based guidelines and performance indicators. In addition, the medical community highly values evidence-based guidelines for medication prescribing and largely adheres to such guidelines. Many hospitals in the Netherlands have, at least to some extent, implemented the country’s Safety Management System. Some key elements of the system include: a risk inventory; a blame-free incident reporting; an evidence-based method for analyzing risks, errors, incidents; and a method for implementing changes and improvements based on incident analyses. The Netherlands achieves this while spending a lower percentage of their GDP on health care compared to many countries, with particularly low spending on drugs.

**External Source:** <http://www.biomedcentral.com/content/pdf/1748-5908-5-50.pdf>