Health Innovation Portal:
Archive of Innovative Practices

Theme: **Quality Improvement and Patient Safety (Vol. 2)**

January 2014

Health Council of Canada
Conseil canadien de la santé

Selected Search Output Table (December 17, 2013)

SEARCH TERMS:	N/A	LOCATION:	All
HEALTH THEME:	Quality Improvement and Patient Safety	FRAMEWORK CATEGORY:	All
HEALTH SECTOR:	All	SEARCH RESULTS:	29 results out of 52

1. Learning Together with Cases

Implementation Year: Thursday, December 9, 2010 - 16:00	Location: Ontario	Practice Website: https://meds.queensu.ca/central/community/learningwithcases

SNAPSHOT:

This innovative practice facilitates the accessibility of interprofessional education for students and educators of health disciplines at pre-licensure levels. 'Learning Together with Cases' was initiated out of the Office of Interprofessional Education and Practice in the Faculty of Medicine at Queen's University in Kingston, Ontario. Beginning in 2010 as an eighteen-month pilot project, this program has informed the ongoing integration of interprofessional educational learning modules at the University. In the developmental stages of the program, participants included 100 first year medical students enrolled in an introductory musculoskeletal course, paired with 84 second year nursing students and 23 advanced practice nursing students studying geriatrics. Twenty-six second year occupational therapy master's students were involved as virtual consultants for student colleagues.

CONTACT INFORMATION:

Name: Lindsay Davidson Title: Associate Professor Organization: Queen's University, Department of Surgery, Division of Orthopaedics Email address: davdisonol@KGH.KARI.NET Telephone number: 613-544-9626 Information last updated on: November 6, 2013

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

Implementation Year: Friday, December 9, 2011 - 15:00	Location: Manitoba	Practice Website:

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, ManitobaR3B 3M9 Telephone: (204) 788-6436 Email: Jeff.Onyskiw@gov.mb.ca

3. The Caring Together Project

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

4. Express Chemotherapy Clinic

Implementation Year: Wednesday, November 27, 2013 - 09:45	Location: Ontario	Practice Website: http://www.sickkids.ca/Nursing/Nursing-Excellence/2010-Nursing-Excellence-Awards/2010%20Award%20Recipient%20Profiles/NEA2010-HeamONC-clinic.html

SNAPSHOT:

This innovative practice expedites chemotherapy services for children managing acute lymphoblastic leukemia. This Express Clinic was developed as a pilot project in 2004 at the Hospital for Sick Children in Toronto and is still in practice today. Using resource reallocation, this model maximizes health human resources and efficiency of care without increasing costs.

CONTACT INFORMATION:

Name: Eleanor Hendershot Title: Clinical Nurse Specialist-Nurse Practitioner; Lecturer Organization: The Hospital for Sick Children; University of Toronto Email address: eleanor.hendershot@sickkids.ca Telephone number: 416-813-7515 Information last updated on: July 15, 2013

5. Quality Improvement Policy Framework for First Nations

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

6. Patient's View: A Family-Initiated Patient Safety Reporting Program

Implementation Year: Wednesday, November 7, 2012 - 11:15	Location: British Columbia	Practice Website: www.bcpsls.ca

SNAPSHOT:

This innovative practice involves patients and families in reporting adverse events by establishing a family-initiated patient safety reporting program using a face-to-face engagement model and trained volunteers. The original pilot was launched in 2012 on an in-patient unit in a pediatric tertiary care hospital in British Columbia and is currently being spread to other units in the hospital.

CONTACT INFORMATION:

Name: Denise Hudson Title: Quality Leader. Education and Change management Organization: British Columbia Patient Safety and Learning System Email address: dhudson@cw.bc.ca Telephone number: 604-877-6427

7. Managing Obstetrical Risk Efficiently (MOREOB) in British Columbia

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

SNAPSHOT:

This innovative practice aims to build a culture of safety in obstetrics. The practice was launched in British Columbia in Northern Health Authority and involved a team of educators, obstetricians, physicians, midwives, birthing unit staff, nurses, administrators, and auditors.

CONTACT INFORMATION:

Name: Fraser Bell Title: Vice President, Planning, Quality and Information Management Organization: Northern Health Authority Email address: fraser.bell@northernhealth.ca Telephone number: 250-565-2649

8. Physicians Data Collaborative (PDC)

Implementation Year: Thursday, October 7, 2010 - 14:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of improving patient care by enabling sharing of clinical data among divisions of family practice. The practice was launched in British Columbia with 25 divisions of practice, and it involved a development team consisting of a MEDIC consultant, a project manager, and a board of directors with representatives from all health authorities and representatives of academic institutions.

CONTACT INFORMATION:

Name: Claire Doherty Title: Executive Director Organization: Physicians Data Collaborative Email address: physiciansdatacollaborative@yahoo.ca Telephone number: N/A

9. Home Care Business Automation Project: Streamlining home care coordination using cellphones

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

SNAPSHOT:

This innovative practice streamlines home care staff communication and coordination through the use of a cellphone application. It was launched in 2011 by the Saint Elizabeth Health Care home care service and involved health care staff from across Canada.

CONTACT INFORMATION:

Name: Mary Lou Ackerman: Vice President, Business Capabilities Organization: Saint Elizabeth Health Care Email address: mackerman@saintelizabeth.com Telephone number: 905-968-6451

10. Antimicrobial Stewardship Program to Decrease Hospital Infections

Implementation Year: Wednesday, February 3, 2010 - 11:00	Location: Ontario	Practice Website:

SNAPSHOT:

This innovative practice addresses the issue of optimizing antimicrobial use as a means to control hospital-acquired infections and enhance patient safety. In April 2010, Toronto East General Hospital implemented an antimicrobial stewardship program (ASP) as part of the Ontario Antimicrobial Stewardship Project.

CONTACT INFORMATION:

Name: Dr. Jeff Powis, Director, Antimicrobial Stewardship Program Organization: Toronto East General Hospital Email address: jpowi@tegh.on.ca Telephone number: 416-4698-6252

11. Choosing Wisely: Educating patients and physicians to select appropriate tests and treatments

Implementation Year: Tuesday, November 1, 2011 - 00:45	Location: International	Practice Website: http://www.choosingwisely.org/

SNAPSHOT:

This innovative practice aims to better inform and educate patients about medical treatments and tests in order to enable them to contribute to making choices in partnership with their doctor of whether they are necessary. The practice was launched in the United States by the National Physicians Alliance and has since involved the input of more than 500,000 physicians.

CONTACT INFORMATION:

Name: Dr. Christine K. Cassel Title: President and CEO Organization: American Board of Internal Medicine Email address: ccassel@abim.org Telephone number: (215) 446-3528 Information last updated on: July 2013

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

Implementation Year: Thursday, September 8, 2011 - 00:45	Location: British Columbia	Practice Website: http://bcpsqc.ca/clinical-improvement/stroke-and-tia/

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

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

Implementation Year: Thursday, February 3, 2011 - 00:45	Location: Ontario	Practice Website:

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

14. MedRec: Canadian National Medication Reconciliation Strategy

Implementation Year: Thursday, February 3, 2011 - 01:00	Location: National	Practice Website: http://www.ismp-canada.org/medrec/

SNAPSHOT:

This innovative practice aims to create a pan-Canadian approach to mitigating medication safety incidences by increasing reporting capacity and inter-professional networks.

CONTACT INFORMATION:

Name: Margaret Colquhoun, Marie Owen Title: Canadian Co-Leads, Safer Healthcare Now! National Medication Reconciliation Strategy Organization: ISMP Canada; Canadian Patient Safety Institute Email address: mcolquhoun@ismp-canada.org; mowen@cpsi-icsp.ca Telephone number: 416-733-3131 ext. 227

15. Readmission Reduction Program through Payment Systems (USA)

Implementation Year: Friday, February 10, 2012 - 00:00	Location: International	Practice Website: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

SNAPSHOT:

This innovative practice aims to reduce readmission rates in hospitals by changing the in-patient prospective payment system (IPPS).

CONTACT INFORMATION:

Name: Jonathan Blum Title: Deputy Administrator and Director Organization: Center for Medicare Email address: Jonathan.Blum@cms.hhs.gov Telephone number: 202-690-6301 DC | 410-786-4164 Baltimore

16. BC Health Leadership Development Collaborative – Transforming Linx

Implementation Year: Monday, January 2, 2012 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice addresses the need for senior health system levels to lead innovative and change. This 10-month, project-based leadership development experience was launched in British Columbia in 2012.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

17. BC Health Leadership Development Collaborative - Collaboration Practice

Implementation Year: Friday, February 3, 2012 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice is a province-wide collaboration between all Health Authorities in British Columbia to support, develop, engage and advocate for leaders with the ultimate goal of delivering exceptional patient outcomes.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

18. BC Health Leadership Development Collaborative – Mentoring Linx

Implementation Year: Friday, February 3, 2012 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice provides flexible, individualized mentoring opportunities, including long-term mentoring relationships and short-term engagements to discuss specific topics or situations and is available to “people who lead people". Using state-of-the-art software health system leaders create their own mentoring match based on skills, goals, interests and personality and can be matched with leaders across British Columbia.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

19. BC Health Leadership Development Collaborative – Core Linx

Implementation Year: Friday, February 3, 2012 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice is a comprehensive leadership and management development program designed for managers in the first 18 months of their first formal management role in a British Columbia Health Authority.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

20. BC Health Leadership Development Collaborative – Coaching Linx

Implementation Year: Friday, February 3, 2012 - 00:30	Location: British Columbia	Practice Website:

SNAPSHOT:

This innovative practice is designed to help senior leaders (directors and above) within each Health Authority in British Columbia enhance their leadership capacity by focusing on topics such as managing challenging workplace issues, learning from feedback or implementing a new initiative.

CONTACT INFORMATION:

Name: Rachael Roberts Title: Lead Organization: BC Health Leadership Development Collaborative (BCHLDC) Email address: rachael.roberts@phsa.ca Telephone number: 604-875-7234

21. Saskatchewan Lean Management System (LMS)

Implementation Year: Friday, February 3, 2012 - 00:45	Location: Saskatchewan	Practice Website: http://www.health.gov.sk.ca/lean-introduction

SNAPSHOT:

This innovative practice addresses the need for a a patient-focused approach to reducing waste in the health system by identifying and eliminating activities that do not add value. Launched across the entire provincial health system in Saskatchewan in 2012, this program aims to support will support related capacity building and quality improvement initiatives.

CONTACT INFORMATION:

Name: Trish Livingstone Title: Director, Kaizen Promotion Office Organization: Saskatchewan Ministry of Health Email address: tlivingstone@health.gov.sk.ca Telephone number: (306) 787-3146

22. Saskatchewan Surgical Initiative

Implementation Year: Wednesday, February 3, 2010 - 00:45	Location: Saskatchewan	Practice Website: http://www.health.gov.sk.ca/surgical-initiative

SNAPSHOT:

This innovative practices addresses the need to improve surgical care and reduce wait times, from primary care through the acute care system and post-surgical recovery.

CONTACT INFORMATION:

Name: Mark Wyatt Title: Executive Director, SKSI Organization: Saskatchewan Ministry of Health Email address: mark.wyatt@health.gov.sk.ca Telephone number: (306) 787-3153

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

Implementation Year: Wednesday, February 3, 2010 - 13:00	Location: Saskatchewan	Practice Website: http://www.qualityinsight.ca/

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 launced 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

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

Implementation Year: Saturday, February 6, 2010 - 00:30	Location: Ontario	Practice Website: http://health.gov.on.ca/en/pro/programs/ecfa/legislation/quality_improve.aspx

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 Ontarion 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

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

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

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@cpsi-icsp.ca Telephone number: 902-221-4719

26. Manitoba Lean Six Sigma Strategy Training: Green and Black Belt Networks

Implementation Year: Wednesday, February 3, 2010 - 00:30	Location: Manitoba	Practice Website: http://www.gov.mb.ca/health/mpan/pdf/demone.pdf

SNAPSHOT:

This innovative practice addresses the need to support health care stakeholders in applying Lean Management throughout the Manitoba health system. Established in 2010, this program fosters a community of particpants that provide up to a year of mentorship for staff undergoing Lean training and a way for staff to come together to learn about and support each other's diverse improvement projects.

CONTACT INFORMATION:

Name: Dawn Ridd Title: Manager Provincial Lean Strategy, Manitoba Health; Rapid Improvement Lead, Cancer Patient Journey Organization: Manitoba Health Email address: dawn.ridd@gov.mb.ca Telephone number: 204-788-6667

27. Strategic Clinical Networks in Alberta

Implementation Year: Thursday, February 3, 2011 - 00:30	Location: Alberta	Practice Website: http://www.albertahealthservices.ca/6047.asp

SNAPSHOT:

This innovative practice has been developed as part of a provincial quality improvement effort to enhance the patient journey, improve health outcomes, and standardize care delivery. Established throughout Alberta in 2011, the purpose of the Strategic Clinical Networks is to engage clinicians and patients in decision-making about clinical services planning and to support clinical practice improvement by implementing clinical practice guidelines (CPG), developing care 'pathways', improving the patient experience and more.

CONTACT INFORMATION:

Name: Dr. Tom Noseworthy Title: Associate Chief Medical Officer, SCNs and Clinical Care Pathways Organization: Alberta Health Service Email address: Tom.Noseworthy@albertahealthservices.ca Telephone number: (780) 342-2014

28. Deprescription Pilot

Implementation Year: Sunday, February 3, 2013 - 00:00	Location: British Columbia	Practice Website: http://www.vancouversun.com/health/empowered-health/Richmond+hospital+study+aims+reduce+drug+prescriptions+seniors/7089371/story.html

SNAPSHOT:

This innovative practice addresses the idea of "deprescribing", referring to the reduction in the number of prescriptions made for one patient. It has been suggested that over-medicating can result when patients take "pill cocktails" to treat various symptoms. It is a form of improper medication use that can lead to adverse side effects including an increase in morbidity. In response to this concern, pharmaceutical researchers in British Columbia have launched a pilot study at Richmond Hospital that will look at the effects of deprescribing in an elderly population. The pilot is being conducted in an acute-care community setting rather than a large hospital.

CONTACT INFORMATION:

Name: Dr. Scott Garrison Title: Medical Research Director Organization: Vancouver Coastal Health (Richmond) Email address: N/A Telephone number: 604-271-1822

29. National Surgical Quality Improvement Program (NSQIP) in British Columbia through the Surgical Quality Action Network (SQAN)

Implementation Year: Friday, February 3, 2012 - 00:15	Location: British Columbia	Practice Website: http://bcpsqc.ca/clinical-improvement/sqan/

SNAPSHOT:

This innovative practice addresses the need for health care providers to discuss best practices, share local innovations, and network to improve surgical care for patients in British Columbia. Launched in 2012 to facilitate the implementation of NSQIP in hospitals across British Columbia and leverage its use as a data measurement tool in the province, the BCPSQC established the Surgical Quality Action Network (SQAN) to help hospitals "act" on their report card through engagement and shared learning with other comparable hospitals.

CONTACT INFORMATION:

Name: Marlies van Dijk, RN, MSc Title: Director, Clinical Improvement, BC Patient Safety and Quality Council Organization: NSQIP Email address: mvandijk@bcpsqc.ca Telephone number: (604) 668-8228

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Learning Together with Cases

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

SNAPSHOT: This innovative practice facilitates the accessibility of interprofessional education for students and educators of health disciplines at pre-licensure levels. 'Learning Together with Cases' was initiated out of the Office of Interprofessional Education and Practice in the Faculty of Medicine at Queen's University in Kingston, Ontario. Beginning in 2010 as an eighteen-month pilot project, this program has informed the ongoing integration of interprofessional educational learning modules at the University. In the developmental stages of the program, participants included 100 first year medical students enrolled in an introductory musculoskeletal course, paired with 84 second year nursing students and 23 advanced practice nursing students studying geriatrics. Twenty-six second year occupational therapy master's students were involved as virtual consultants for student colleagues.

PRACTICE DESCRIPTION:

The goal for the Learning Together with Cases program is to provide resources for teachers wishing to include interprofessional education in existing courses for pre-licensure health professionals. The areas of focus are guided by the Canadian Interprofessional Health Collaborative's National Framework for Interprofessional Competencies, prioritizing: 1) Role Clarification, 2) Team Functioning, 3) Patient/Client/Family/Community-Centred Care, 4) Collaborative Leadership, 5) Interprofessional Communication, and 6) Interprofessional Conflict Resolution. Initial funding was received from HealthForce Ontario.

The Learning Together with Cases program is facilitated through an open-source, online software, providing a library of interprofessional cases that highlights competencies and requisite knowledge, skills, attitudes, and values. The 'interprofessional toolbox' provides resources for targeted skills development, mechanisms for ensuring patient safety, and involvement of patient perspectives. This space also allows a platform for teachers to discuss challenges and successes, faculty development guidelines, and knowledge translation strategies.

Since the completion of the pilot project phase, the Learning Together with Cases Program is currently being used as a learning tool to inform and provide resources for educators incorporating interprofessional tools into respective health sciences programming, however, no students are currently enrolled in the program.

IMPACT:

At the end of the interprofessional education sessions of the pilot phase (2011), students from each discipline were asked to participate in a focus group. Reports around respectful and engaging interaction were consistent across disciplines. The most beneficial aspects to the program were around increased understanding of respective scopes of practice and how cumulative knowledge bases effectively improved the provision of integrated care for patients.

Faculty members have presented the work of Learning Together with Cases at conferences such as: Interprofessional Education Ontario (2011), the International Conference on Residency Education with the Royal College of Physicians and Surgeons (2010), and the Canadian Conference on Medical Education (2010).

APPLICABILITY/TRANSFERABILITY:

The development of this program was informed by previous efforts from within the Faculty of Health Sciences at Queen's University, which had offered an interprofessional patient safety course through the School of Medicine, School of Nursing and School of Rehabilitation Therapy in 2007 and 2008. The program involved a blended instructional design constructed around a series of virtual patient scenarios, allowing for both individual online learning and collaborative face-to-face interprofessional team-based learning sessions. This program was funded by the Canadian Patient Safety Institute (http://www.patientsafetyinstitute.ca/English/Pages/default.aspx) supported by the Queen's University Office of Health Sciences Education and Practice. It was active for two years, with 200 students involved each year, and survey results indicated that the program was effective in raising student awareness of core patient safety principles and improving understanding of the roles of other health care providers. Despite positive evaluations, the program was discontinued due to obstacles around incongruent

curricula between faculties and through this, the Learning Together with Cases platform.

At this time, the degree to which Learning Together with Cases will continue at Queen's remains unclear. In terms of transferability, questions remain around whether or not these programs should be mandatory and implemented more broadly, and whether interprofessional educational programs should be offered at the earlier stages of health students' educational careers or later, once students have had the opportunity to develop discipline-specific skills and professional identities.

CONTACT INFORMATION:

Name: Lindsay Davidson

Title: Associate Professor

Organization: Queen's University, Department of Surgery, Division of Orthopaedics

Email address: davdisonol@KGH.KARI.NET

Telephone number: 613-544-9626

Information last updated on: November 6, 2013

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

Publications:

Davidson, L., Walz, L. (2013) Virtual Patient Stories as a Facilitator of IPE: A Pilot Study. *The Journal of the International Association of Medical Science Educators*, 23(3S): 419-420. http://www.iamse.org/jiamse/volume23-3s/23-3s_419-420.pdf

Davidson, L., Aiken, A., Donnelly, C. (2008) Learning about Patient Safety through an Interprofessional Lens. Canadian Patient Safety Institute.
http://www.patientsafetyinstitute.ca/english/research/cpsiresearchcompetitions/2006/documents/davidson/reports/davidson%20full%20report.pdf

Personal Communications:

Dr. Lindsay Davidson, Associate Professor, Queens University, School of Medicine, Department of Surgery; October 17, 2013 [email].

External Source: https://meds.queensu.ca/central/community/learningwithcases

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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.

Contact Information:

Jeff Onyskiw,

A/Director

Manitoba Health – Drug Management Policy Unit

3014 - 300 Carlton Street

Winnipeg, ManitobaR3B 3M9

Telephone: (204) 788-6436

Email: Jeff.Onyskiw@gov.mb.ca

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

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

Government of Manitoba. (2011, June 20). Province announces launch of Manitoba Imprxove program. [News Release]. Retrieved from http://news.gov.mb.ca/news/?item=11801

University of Manitoba Faculty of Medicine. (2013). *Upcoming MCHP reports*. Retrieved from http://umanitoba.ca/facultie/medicine/units/mchp/deliverables.html

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The Caring Together Project

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

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

PRACTICE DESCRIPTION:

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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Publications:

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Personal Communications:

Emma Stodel; November 13, 2013 [telephone]

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Express Chemotherapy Clinic

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

SNAPSHOT: This innovative practice expedites chemotherapy services for children managing acute lymphoblastic leukemia. This Express Clinic was developed as a pilot project in 2004 at the Hospital for Sick Children in Toronto and is still in practice today. Using resource reallocation, this model maximizes health human resources and efficiency of care without increasing costs.

PRACTICE DESCRIPTION:

Children receiving chemotherapy, and their families, must make ongoing visits to the hospital, at which time they are subject to long registration processes; lag times associated with obtaining laboratory results, patient assessment, and preparation of chemotherapeutic agents; and the consequences of constrained nursing resources and physical space relative to patient volumes. To reduce the impact of these hospital visits on attending patients, the Express Chemotherapy Clinic was developed to increase overall efficiency of health human resources, timeliness, and quality of care.

To bring the Express Chemotherapy Clinic into practice, a program planning committee comprised primarily of nurses established patient eligibility criteria, determined appropriate protocols and treatment plans, fostered interdepartmental collaboration, developed a plan for communication between staff and families, ensured presence of medical coverage, and negotiated use of physical space. During the introductory phases of the new clinic, physicians and nurses were briefed on patient eligibility criteria and expected protocols. Strategies for fast-tracking the system include having the physician or nurse practitioner write chemotherapy orders ahead of time for the pharmacy to fill by 4:00 pm the day prior to the patient's clinic visit, establishing a rapid registration process, scheduling the physical space when nurses are underutilized (between 8:30 am and 10:00 am daily), and checking patient blood counts ahead of time to ensure appropriateness of scheduled visit.

IMPACT:

This pilot project ran for one year (2004 to 2005) and served a total of 75 patients, with an average of four patients scheduled every day. Evaluation was conducted throughout—each member of the interprofessional team completed a survey, and then families were interviewed separately by a research nurse. There was a 61% response rate among the families, of whom 58% had received care prior to the introduction of the Express Clinic and therefore could thus draw some comparison to changes in care received.

In response to perceptions of efficiency, 89% of families reported receiving chemotherapy in a timely fashion. In response to perceptions of quality of care, the majority of respondents reported that the Express Clinic decreased the sense of burden on the rest of the clinic. In response to perceptions of impact on lifestyle, the feedback on the Express Clinic's ability to reduce the impact of ongoing hospital visits on everyday lifestyle was overwhelmingly positive. From the interprofessional team care providers, 11 registered nurses, five contact nurses, four physicians, two nurse practitioners, five registration clerks, and three pharmacists completed the survey. The majority of staff reported that the redistribution of tasks did not increase their overall workload.

While the program continues to record clinic flow details for internal management purposes, no formal data collection has been conducted or produced for external dissemination since the program's initial implementation in 2004.

APPLICABILITY/TRANSFERABILITY:

This innovative practice has not been adapted from another jurisdiction. While it has not been expanded to other jurisdictions, the express model has expanded to two other areas in the division: the intravenous treatment room and the day hospital. In these settings the streamlined triage system allows direct registration for eligible patients rather than them going through the outpatient clinic. Sustainability for this model is strong given that no additional funding is required based on the reallocation of resources. Its success in improving overall efficiency of care and operational feasibility is demonstrated through the continuity of the pilot project 10 years later and its broader application. Management of the Express Clinic report still receiving informal

inquires about enabling this model of care in other settings in Canada and the United States; however, there is no formal documentation on this external impact factor. An important consideration that affects the transferability of this model is patient volume relative to existing human and physical resources.

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Publications:

Hendeshot, E., Murphy, C., Doyle, S., Van-Clieaf, J., Lowry, J., & Honeyford, L. (2005). Outpatient chemotherapy administration: Decreasing wait times for patients and families. *Journal of Pediatric Oncology Nursing, 22*(1), 31–37. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15574724

Personal Communications:

Hendershot, E. (interviews, August 20, 2013).

External Source:
http://www.sickkids.ca/Nursing/Nursing-Excellence/2010-Nursing-Excellence-Awards/2010%20Award%20Recipient%20Profiles/NEA2010-HeamONC-clinic.html

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Quality Improvement Policy Framework for First Nations

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

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

PRACTICE DESCRIPTION:

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

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

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

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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Other:

Health Canada, FHNIB. (2012, August 20). Response to the Health Council of Canada's Health Care Quality Improvement Survey of Federal/Provincial/Territorial Governments.

Health Canada, FNIHB. (review, August 26, 2013). [Health Canada, FNIHB, Assistant Deputy Minister's Office]

Greene, J. (interview, July 19, 2013). [Health Canada, First Nations & Inuit Health Branch].

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Patient's View: A Family-Initiated Patient Safety Reporting Program

LOCATION:	British Columbia	HEALTH THEME:	Quality Improvement and Patient Safety
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT:

This innovative practice involves patients and families in reporting adverse events by establishing a family-initiated patient safety reporting program using a face-to-face engagement model and trained volunteers. The original pilot was launched in 2012 on an in-patient unit in a pediatric tertiary care hospital in British Columbia and is currently being spread to other units in the hospital.

PRACTICE DESCRIPTION:

Studies in Canada and other countries have estimated that adverse events causing harm affect approximately 10% of patients admitted to hospitals, with nearly half of these events being possibly preventable. In Canadian pediatric hospitals, more than 9% of children experience an adverse event, and the risk is nearly three times higher in academic centres than in community hospitals. To reduce the incidence of adverse events, leaders must have reliable information, learn from this information, and apply the learning to make the health care system safer. Many opportunities for improvement are lost because provider-initiated reports significantly underrepresent true adverse event rates. Thus, reports of events detected by patients and families bring a unique perspective to patient safety.

In 2008/09, a web-based tool called the Bedside Observer was developed and evaluated. Using a version of the BC Patient Safety & Learning System (BC PSLS), a web-based adverse event reporting system, reports of safety concerns from families of children admitted to one unit at BC Children's Hospital (BCCH) were collected. The research validated the tool and process, and demonstrated that families are capable of reliably identifying and reporting legitimate adverse events.

To translate this research into action, a task force from BC PSLS and BCCH launched a pilot project in an in-patient unit in August 2012. An innovative face-to-face patient and family engagement model was trialed. Eight volunteers were selected from an existing pool, orientated to the new role, and deployed with a laptop computer to seek the "patient's view." Staff on the pilot unit were informed and engaged through safety rounds, posters, and emails.

The process is as follows:

- Volunteers obtain a list from the charge nurse identifying families slated for discharge within 48 hours and considered appropriate for the interview.
- Volunteers approach and engage families at the bedside, inviting them to share any safety concerns using the laptop and a validated web-based tool.
- The quality leader reviews the reports, and staff and leaders use the feedback for timely action planning and quality improvement.

Despite the focus on adverse events and safety concerns, families are also asked to describe anything they noticed staff or the hospital doing to help promote safe care.

IMPACT:

The Patient's View is a web-based tool based on a tested, validated tool previously known as Bedside Observer, whose formal evaluation was reported on in the *Canadian Medical Association Journal*.

The current pilot project was evaluated over 10 weeks and found to be successful on numerous indicators. 51% of eligible families participated (*n* = 51), representing 12% of total discharges. Families appreciated being asked about their experiences and were able to provide accurate and legitimate reports of adverse events and safety concerns. Of 76 concerns reported, 70

(92%) were assessed by two independent patient safety experts as valid. Safety reports concerned medications, equipment, complications of care, and miscommunication among staff or between family and staff.

The volunteer model was effective in engaging families and providing them with an outlet to share their stories. Volunteers also felt valued, and reported that they received appropriate training and support. All would recommend the experience to others.

The information gleaned from the Patient's View reports was used by staff and leaders to inform safety and quality improvement initiatives, including new approaches to medication reconciliation and care transfers, standardizing post-operative pain control and flow processes in the emergency department, and improved communication with families.

The volunteer model supports free data collection. However, costs associated with equipment and personnel exist. The program began with a laptop computer, but moving forward will be delivered with iPads donated to the hospital. Personnel includes a 0.4 FTE project lead who trains volunteers, oversees the program rollout, and aggregates data monthly to inform leadership about quality improvement priorities. The time required to review submitted reports is minimal and feasible (e.g., 51 reports × 5 minutes for review = 4.25 hours in the pilot).

APPLICABILITY/TRANSFERABILITY:

The pilot arose as an attempt to put research into practice, and used a web-based tool adapted from an earlier tool that had been formally evaluated and validated.

Patient's View is being spread to other units at BCCH, and is theoretically applicable and transferable to other acute care settings. Already, Great Ormond Street Hospital, London, UK and The Hospital for Sick Children in Toronto are trialing the approach. It is believed that the positive outcomes are replicable in these other settings. This model has only been tested in the pediatric population but will be trialed in the adult population in 2014.

Key factors for success:

- having a committed, interprofessional design and implementation task force;
- having the support of senior leadership;
- seeking input from patients and families, clinical staff, and quality and safety leaders; and
- using volunteers who are interested in future health careers.

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Personal Communications:

Hudson, D. (original submission, July 2013). [BC PSLS].

Publications:

De Fries, E.N., Ramrattan, M.A., Smorenburg, S.M., Gouma, D.J., & Boermeester, M.A. (2008). The incidence and nature of in-hospital adverse events: A systematic review. *Quality & Safety in Health Care, 17*(3), 216–223. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569153/

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External Source: www.bcpsls.ca

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Managing Obstetrical Risk Efficiently (MOREOB) in British Columbia

LOCATION:	British Columbia	HEALTH THEME:	Quality Improvement and Patient Safety
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to build a culture of safety in obstetrics. The practice was launched in British Columbia in Northern Health Authority and involved a team of educators, obstetricians, physicians, midwives, birthing unit staff, nurses, administrators, and auditors.

PRACTICE DESCRIPTION:

The MORE^{OB} program is an interprofessional patient safety program that aims to decrease the number of adverse events and errors in obstetrics. The program is designed to help create a working environment in the birthing unit that eliminates professional autonomous silos, organizational hierarchy, communication gaps, uncoordinated teamwork, and culture of blame.

The program is able to accomplish this goal by bringing together the obstetrical team for regular training, practise, and case review. Activities within the program include environmental scans, patient satisfaction surveys, staying current with new evidence and best practices, participating in workshops, and competency drills.

The structure of MORE^{OB} is based on the high-reliability organizations principles:

1) Patient safety is the priority and everyone's responsibility.

2) Communication is highly valued.

3) Operations are a team effort.

4) Hierarchy disappears in an emergency.

5) Emergencies are rehearsed.

6) Interprofessional reviews are held routinely.

The MORE^{OB} program was initially created by the Patient Safety Division of the Society of Obstetrics and Gynaecology of Canada (SOGC) in 2002. In 2006, Northern Health Authority in British Columbia adopted the MORE^{OB} program in its clinical sites.

IMPACT:

Progress and outcomes from the implementation of MORE^{OB} in British Columbia has been reported in the BC Health Innovation Portal, government websites, and academic journals.

Evaluation of the program in 2009 indicated that 93% of Northern Health obstetrical health care providers, including physicians, midwives, nurses, and administrators, have been participating in the program. Upon evaluating the outcomes, the Patient Safety and Quality Council stated that the health region experienced a growth in leadership capacity towards safer patient care. Surveys have indicated that care providers have an improved sense of work culture, resulting in improved retention and recruitment in all sectors. There is a greater sense of teamwork and, since participants work more cohesively, there is a growing pride in the team in which they are part. There has been steady growth and improvement with self-reported culture change as per the Culture Change Assessment tool. Knowledge enhancement results have improved; specifically, all disciplines demonstrate a common knowledge base. Participants are getting the value of audits and tracking no-harm events on a regular basis as well as participating in routine skills/emergency drills in many sites. Statistical information from the BC Perinatal Health Program database also shows improvements in the number of labour inductions, Caesarean-section deliveries, and newborns

with cord blood gases after delivery.

Because of its success, Northern Health Authority has received the 2009 BC Quality Award by the British Columbia Patient Safety and Quality Council for implementing the MORE^{OB} Program.

APPLICABILITY/TRANSFERABILITY:

Since Northern Health Authority's implementation of MORE^{OB}, the program has been implemented across Canada and the United States with positive results. It has expanded to include more than 260 hospitals and 13,000 participants.

In over 10 years of North American MORE^{OB} activity, participating hospitals indicate that it has:

? improved outcomes and reduced harm to mothers and babies;

? decreased liability incurred costs and average cost per claim;

? improved standardization and consistency of care practices;

? improved and sustained patient safety culture;

? increased core clinical knowledge for participants in all hospital care levels; and

? created an environment in which participants want to stay engaged.

In addition, independent study data found that the MORE^{OB} program had significant and lasting positive effects, such as:

- length of stay greater than two days reduced by 12%;
- infants on ventilators reduced by 31%;
- severe infant morbidity reduced by 24%; and
- infant mortality reduced by 18%.

In British Columbia, MORE^{OB} was implemented in Kamloops and Kelowna in 2012 and 2013, respectively. Evaluation at these sites has not been undertaken to date.

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Publications

Joint Position Paper Working Group. (2012). Joint position paper on rural maternity care. *Can J Rural Med, 17*(4), 135–143. Retrieved from http://srpc.ca/rr2013/thebus/jpponmc.pdf

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http://bcpsqc.ca/bc-quality-awards/2009-bc-quality-awards/northern-health-managing-obstetrical-risk-efficiently/

External Source: http://moreob.com/

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Physicians Data Collaborative (PDC)

LOCATION:	British Columbia	HEALTH THEME:	E-Health
HEALTH SECTOR:	Home and Community Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the issue of improving patient care by enabling sharing of clinical data among divisions of family practice. The practice was launched in British Columbia with 25 divisions of practice, and it involved a development team consisting of a MEDIC consultant, a project manager, and a board of directors with representatives from all health authorities and representatives of academic institutions.

PRACTICE DESCRIPTION:

The Physicians Data Collaborative (PDC) is a not-for-profit organization that enables the collaborative use of clinical data to improve patient care. PDC was formed in 2010 and incorporated in February 2012. Twenty-five Divisions of Family Practice from across British Columbia support PDC financially. In addition to this vital funding, participating divisions provide PDC with the guidance and information it needs to plan its activities and safely share data through a distributed data network. In PDC's distributed data network, patient data always stay in the control of the physician. Instead of sending data to a central repository, this design shares only summary information. Questions are sent out to practices and only answers to the questions are sent back. The hub then summarizes the results across all practices.

PDC aims to create a distributed data network that is driven by front-line physicians and owned and controlled by the divisions. The data network has the potential to achieve the following:

- provide data to drive and evaluate divisional initiatives and support divisional funding applications;
- enable clinical quality improvement activities and continuing medical education (CME) reflective practice;
- answer clinical and research questions of interest to front-line practising physicians; and
- answer population health questions to assist with health system management and improve patient care.

Core principles of PDC's work are transparency of process, a collaborative approach to development, and ensuring data are used in a manner that protects physician and patient privacy.

The PDC Board of Directors includes residents of all five British Columbia health authorities, and users of six electronic medical record systems: Profile (Intrahealth), Jonoke, Med Access, MOIS, OSCAR, and Wolf (TELUS Health Solutions). The board meets once a month, generally via teleconference. Full-day, in-person board meetings take place quarterly.

IMPACT:

PDC, which is still in an emerging phase, has focused on developing its infrastructure and getting started on small quality improvement projects. Milestones are published as updates and annual reports on their website.

In summer 2012, PDC began by hiring Mohawk eHealth Development and Innovation Centre (MEDIC) as their informatics consultant and working on their technical design framework. By November 2012, MEDIC submitted its final report on specifications for the components of the distributed data network, PDC's website was ready to go live, and an EMR Data Query and Assessment project was underway with the University of British Columbia. Through Divisions of Family Practice provincial round tables, the PDC charter was articulated and later approved in winter 2013.

By February 2013, PDC was actively building partnerships and working with stakeholders on small quality projects. For example, the EMR Data Query and Assessment project was completed and an outline for an EMR Adapter component was created to make the distributed data network operable. PDC hired a project manager to spearhead these initiatives. Since then, it has released its first annual report, which highlights a strategic plan, a list of contributing divisions, definition of roles, progress on software development, and successful low-tech projects that are underway. Further outcomes including operability and physicians' satisfaction reports are not yet complete.

APPLICABILITY/TRANSFERABILITY:

PDC was partly adopted from Pegasus Health's approach in using clinical data collaboratively to improve patient care over the past 20 years. Pegasus Health is an independent practitioners' association in Christchurch, New Zealand, that is very similar to a Division of Family Practice in BC.

PRACTICE WEBSITE

https://www.divisionsbc.ca/datacollaborative/home

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Home Care Business Automation Project: Streamlining home care coordination using cellphones

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

SNAPSHOT: This innovative practice streamlines home care staff communication and coordination through the use of a cellphone application. It was launched in 2011 by the Saint Elizabeth Health Care home care service and involved health care staff from across Canada.

PRACTICE DESCRIPTION:

The Saint Elizabeth's Business Automation Project (BAP) involved the deployment of 5,000 BlackBerry devices to Canadian home care frontline staff, service coordinators, supervisors, and regional directors ranging in age from 19 to 73, all having varied levels of comfort with technology. All dispensed BlackBerrys were installed with the CellTrak application. Using CellTrak, the objectives of the project were to:

1. automate the collection of travel mileage and travel time information, achieving financial savings by using optimal route functionality;
2. automate the home care visit verification process using CellTrak as a part of the service delivery process; and
3. redesign and simplify communication and documentation processes.

All Saint Elizabeth home care staff were trained in how to use the CellTrak portal and additional BlackBerry functionality such as email, BlackBerry Messenger, and text messaging. The BAP project closely followed Saint Elizabeth's strategic direction to invest in employees by providing them with the knowledge and tools necessary to deliver exceptional home-based client care. The home care staff were also able to transform their services by automating data collection with CellTrak, which provides information for decision-making and the transfer of knowledge.

IMPACT:

As reported by Saint Elizabeth's, the BAP project has achieved the following as of March 2013:

• a 70% reduction in voice-mail usage—staff are using email to communicate with their regional office, freeing up phone lines for clients calling in;

• automation of the collection of travel mileage and travel time information from staff, resulting in significant financial savings;

• automation of the home care visit verification processes—98% of visits are now verified electronically;

• replacement of pagers with a BlackBerry paging application, resulting in additional costs savings; and

• standardization of communication protocols across the organization.

APPLICABILITY/TRANSFERABILITY:

The BAP is the first national automated program of its kind in Canada. A factor to consider for implementation is that Saint Elizabeth Health Care offers home care services that require communication and coordination of staff working from a distance. Further, although standardized training was given to staff for CellTrak and other Blackberry functions, Saint Elizabeth focused on end-users' capability and customized training to meet individual needs. They have reported that this had a direct effect on compliance results among the diverse staff.

PRACTICE WEBSITE: n/a

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Information last updated on: July 10, 2013

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

Awards:

2012 Canada Award for Excellence: http://www.nqi.ca/en/awards/2012-cae-recipients/2012-cae-profiles/2012-c...

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

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Antimicrobial Stewardship Program to Decrease Hospital Infections

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

SNAPSHOT: This innovative practice addresses the issue of optimizing antimicrobial use as a means to control hospital-acquired infections and enhance patient safety. In April 2010, Toronto East General Hospital implemented an antimicrobial stewardship program (ASP) as part of the Ontario Antimicrobial Stewardship Project.

PRACTICE DESCRIPTION:

Antimicrobial resistance is a known public health issue. Antimicrobial stewardship, the appropriate prescribing of antibiotics, is critical to stemming the continued emergence of antimicrobial-resistant organisms. Antimicrobial overuse in acute care hospitals promotes the emergence of resistant strains such as methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*). Literature has shown that appropriate use of antimicrobials can reduce occurrences of antibiotic-resistant organisms that lead to hospital acquired infections.

The ASP pilot offered at Toronto East General Hospital in 2010 consisted of an interprofessional team led by a pharmacist who met daily with attending physicians in the intensive care unit (ICU) and an infectious disease specialist to consult on the appropriate prescription of antibiotics for patients. The ASP pharmacist then disseminated suggestions for antimicrobial optimization, customizing end-user communication to each attending physician according to their preferences. After the success of the pilot, the ASP practice has extended to include all adult, acute care in-patient areas in the Toronto East General Hospital.

IMPACT:

An infectious diseases team, consisting of a physician and a pharmacist, conducted a prospective audit and provided feedback during the ASP pilot study (April to June 2010). The team met daily with the ICU team to discuss optimization of antimicrobial use. The cost and usage of antimicrobial drugs, as well as rates of *C. difficile* infection during the pilot period were compared to those in the same period during the previous year (April to June 2009). For three months after the pilot phase (i.e. July to September 2010), the strategy was continued three days per week.

After introduction of the ASP, there was significant reduction in the cost of antimicrobial drugs: $27,917 less than during the same period in the previous year, equivalent to a reduction of $15.45 (36.2%) per patient-day ($42.63 versus $27.18). Utilization of broad-spectrum antipseudomonal antimicrobial agents was also significantly lower, declining from 63.16 to 38.59 defined daily doses (DDDs) per 100 patient-days (a reduction of 38.9%). After the pilot period, the rate declined further, to 28.47 DDDs per 100 patient-days. During the pilot period, there were no cases of *C. difficile* infection, and in the post-pilot period, there was one case (overall rate of 0.42 cases per 1,000 patient-days). This rate was lower than (but not significantly different from) the rate for April to September 2009 (1.87 cases per 1,000 patient-days). There were no differences in mortality rate or severity of illness.

Physicians and patients advocate that the ASP team has become integral in changing antimicrobial prescribing patterns and developing a positive culture at Toronto East General Hospital. Results from the program's evaluation are published in the US National Library of Medicine.

APPLICABILITY/TRANSFERABILITY:

ASPs exist across Canada, with a specific concentration in Ontario hospitals as part of the Ontario Antimicrobial Stewardship Strategy, an antimicrobial stewardship project led by ISMP Canada for Ontario as a knowledge translation project comprised of multiple phases. In the first phase, a comprehensive survey was conducted to examine the current state of hospital-based antimicrobial stewardship practices in Ontario. In the second phase, the ISMP ASP project team convened and prioritized interventions that were considered to be appropriate and effective. The following six interventions were identified:

- implement an antimicrobial stewardship program at the hospital level;
- antimicrobial stewardship self-assessment tool;
- prospective audit with intervention and feedback at the individual patient and prescriber levels;
- education/training to build antimicrobial stewardship capacity;
- data collection and feedback at an institutional or program level; and
- tailoring antimicrobial therapy including de-escalation, streamlining, and IV-to-PO switches.

The third phase tested these interventions in a representative sample of pilot hospitals. With initial successes seen in the intensive care unit (ICU) through the pilot study in 2010, Toronto East General Hospital is one of the first ASPs in Canada to expand to include all adult, acute care in-patient areas in the hospital. Knowledge exchange, peer-to-peer communication, and decision support, which were key factors in this success, were applied in implementing the antimicrobial stewardship program throughout the hospital. A hospital-wide ASP is theoretically applicable and transferable to other settings in Canada.

EXTERNAL LINKS: n/a

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

Leung, V., Gill, S., Sauve, J., Walker, K., Stumpo, C., & Powis, J. (2011). Growing a “positive culture” of antimicrobial stewardship in a community hospital. *Canadian Journal of Hospital Pharmacy, 64*(5), 314–320. Abstract retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3203822/

Other:

Institute for Safe Medicine Practices (ISMP) Canada. (n.d.). *Ontario antimicrobial stewardship project: Preserving antibiotics for future generations*. Retrieved from http://www.ismp-canada.org/abx/

Awards:

2013 3M Health Care Quality Team Award: http://www.cchl-ccls.ca/assets/awardsprogram/15,877-3M%20Health%20Awards...

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Choosing Wisely: Educating patients and physicians to select appropriate tests and treatments

LOCATION:	International	HEALTH THEME:	Quality Improvement and Patient Safety
HEALTH SECTOR:	Primary Health Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice aims to better inform and educate patients about medical treatments and tests in order to enable them to contribute to making choices in partnership with their doctor of whether they are necessary. The practice was launched in the United States by the National Physicians Alliance and has since involved the input of more than 500,000 physicians.

PRACTICE DESCRIPTION:

Many experts agree that the current way health care is delivered in the United States contains too much waste—with some stating that as much as 30% of care delivered is duplicative or unnecessary and may not improve people's health. Physicians and patients need to work together and have conversations about wise treatment decisions. That means choosing care that is supported by evidence showing that it works for patients like them, is not duplicative of other tests or procedures already received, won't harm them, and is truly necessary.

Choosing Wisely is an initiative of the American Board of Internal Medicine (ABIM) Foundation to help physicians and patients engage in conversations about the overuse of tests and procedures and support physicians' efforts to help patients make smart and effective care choices. Recognizing the importance of physicians and patients working together, leading specialty societies have joined Choosing Wisely to help improve the quality and safety of health care. As part of Choosing Wisely, each participating specialty society has created lists of "Things Physicians and Patients Should Question" that provide specific, evidence-based recommendations physicians and patients should discuss to help make better decisions given their individual situation.

The resulting lists aim to stimulate discussion about the need—or lack thereof—for many frequently ordered tests or treatments. This concept was originally piloted by the National Physicians Alliance, who created a set of three lists to promote more effective use of health care resources. Consumer Reports, the nation's leading independent, non-profit consumer organization, has also joined the campaign to provide resources for consumers and physicians to engage in these conversations. It is coordinating consumer-oriented organizations to help disseminate information and educate patients on making better decisions.

IMPACT:

This innovative practice was implemented in 2011across the United States, and while it does not have a completed evaluation at this time, several academic centres are making plans to independently report on the impact of the campaign. The practice started with three lists of "Five Things Physicians and Patients Should Question" in family medicine, internal medicine, and pediatrics. Since the pilot project, Choosing Wisely has resulted in nine specialty societies releasing their own lists in April 2012, and another 17 specialty societies releasing lists in February 2013. These 26 lists are currently available on the Choosing Wisely website, accompanied by 34 patient-friendly resources and consumer reports. Further lists are expected to be released by the end of 2013 from 20 additional specialty societies.

This initiative has also been widely publicized in media outlets and journals, including the *New England Journal of Medicine*, *The New York Times*, *Health Affairs*, and the *Associated Press*. In the first 72 hours that the Choosing Wisely website was live, it was accessed by 100,000 physicians and patients.

APPLICABILITY/TRANSFERABILITY:

Choosing Wisely has not been adapted from another jurisdiction. A researcher at St. Michael's hospital in Toronto has plans to

implement a similar model in Ontario under the name Thinking Twice. The campaign has been cited as being part of a broader movement including many comparable campaigns, and the German Network for Evidence-Based Medicine has considered adapting concepts from the program into the German health care system. Thus, the Choosing Wisely initiative is theoretically applicable and transferable to other settings.

The Choosing Wisely campaign identifies the following difficulties in achieving its goals:

- Many recommendations in the campaign require clinical education to understand fully, and many patients tend to follow the recommendations of their physicians without question, even if they have questions.
- The United States medical system is designed so that most doctors get paid when they provide treatment and not paid when they do not recommend treatment. This system creates a pattern of doctors recommending more treatment.
- Critics tend to view efforts to reduce medical services in the United States as "health care rationing." Since doctors do not want to be seen as withholding care, they are hesitant to change established behaviour in any way that lessens the amount of treatment they order. Physicians say that they often feel pressure to engage in defensive medicine by conducting extra testing to avoid lawsuits.

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

Publications:
Volpp, K.G. (2012). Choosing Wisely: Low-value services, utilization, and patient cost sharing. *JAMA: The Journal of the American Medical Association, 308*(16), 1635–1636. doi:10.1001/jama.2012.13616

The JAMA Network. (n.d.). The "Top 5" lists in primary care: Meeting the responsibility of professionalism. *Archives of Internal Medicine, 171*(15),1385–1390. doi:10.1001/archinternmed.2011.231. Retrieved from http://archinte.jamanetwork.com/article.aspx?articleid=1105881

Alternative Profiles:
Wikipedia. (2013, June 7). Choosing Wisely. Retrieved from http://en.wikipedia.org/wiki/Choosing_Wisely

Other:
ABIM Foundation (n.d.). *Choosing Wisely: About the campaign*. Retrieved from http://www.choosingwisely.org/wp-content/uploads/2012/09/031913_Choosing-Wisely-One-Pager.pdf

ABIM Foundation. (2013, February 21). Choosing Wisely news conference. Retrieved from http://www.youtube.com/embed/m6L46QlotOM

Levinson, W. (2013, April). Thinking Twice/Choosing Wisely. *MediNews*. Toronto: University of Toronto Department of Medicine. Retrieved from http://www.deptmedicine.utoronto.ca/Medinews/medi_newsletter/April_2013/Chair_s_Article.htm

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

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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), 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:

BC Patient Safety & Quality Council. (n.d.). *Stroke and TIA collaborative*. Retrieved from http://bcpsqc.ca/blog/events/stroke-tia-collaborative/

Harris, D. (2013) *Improving stroke and TIA care in the emergency department in B.C.: The stroke and TIA collaborative* [Presentation Slides]. Retrieved from http://www.slideshare.net/bcpsqc/e4-devin-harris-17688450

BC Patient Safety & Quality Council. (2012, June 14). *How hospitals in British Columbia are improving stroke care*. Retrieved from http://www.youtube.com/watch?v=TUFAaqKwtVo&feature=plcp

BC Patient Safety & Quality Council. (2012, May 17). *Swallowing screen demonstration for the BC Stroke and TIA collaborative*. Retrieved from http://www.youtube.com/watch?v=HWppunNlhJU

BC Patient Safety & Quality Council. (n.d.). *Stroke and TIA* [Project Website]. http://bcpsqc.ca/clinical-improvement/stroke-and-tia/

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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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

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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MedRec: Canadian National Medication Reconciliation Strategy

LOCATION:	National	HEALTH THEME:	Pharmaceuticals Management
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice aims to create a pan-Canadian approach to mitigating medication safety incidences by increasing reporting capacity and inter-professional networks.

PRACTICE DESCRIPTION:

Medication reconciliation is a formal process in which health care providers work together with patients, families, and caregivers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking (known as a Best Possible Medication History (BPMH)) to ensure that medications being added, changed, or discontinued are carefully evaluated. It is a component of medication management and informs prescribers and enables them to make the most appropriate prescribing decisions for and with the patient.

Medication safety incidents continue to be a significant source of avoidable harm to patients using the Canadian health care system. In 2005, through *Safer Healthcare Now!* (SHN), the Canadian Patient Safety Institute (CPSI), the Institute for Safe Medication Practices Canada (ISMP Canada), and several provincial and national organizations joined to create a pan-Canadian approach to increasing capacity and inter-professional networks to mitigate this harm. Implementation and sharing of interventions and measurement strategies was supported by geographic "nodes" located throughout the country. The Medication Reconciliation (MedRec) intervention supports over 500 teams in acute, long-term, and home care to promote the implementation of processes that ensure accurate and comprehensive medication information is communicated consistently across transitions of care. ISMP Canada in partnership with CPSI supports MedRec provincially, nationally, and internationally. In Canada, SHN teams are supported through live national webinars, face-to-face conferences, virtual series, collaboratives, and an online community. In addition, *Safer Healthcare Now!* Getting Started Kits for implementing MedRec in acute care, long-term care, and home care contexts give practitioners everything they need to begin implementation, including quality improvement methodology.

SHN's national "bottom up approach" has demonstrated that without strong leadership support, reliable system-wide implementation cannot be accomplished. To continue to drive this important practice change, a national leaders' summit, held in February 2011, resulted in the development of a National Medication Reconciliation Strategy. A consensus statement from the summit's 13 participating organizations demonstrates their collective commitment to their role in MedRec.

Also in 2011, 50 health care organizations (across nine provinces) identified as potential practice leaders were surveyed to better understand the current landscape of MedRec in Canada. Among these organizations, 74% had fully implemented MedRec on admission, 43.6% had done so on transfer, and 37.2% had done so on discharge. The use of technology was identified as a key requirement for the successful implementation of MedRec across the continuum of care. The survey also revealed challenges, success factors, and the role of external drivers and supports in the implementation of MedRec, and validated the future directions and priorities for the National Medication Reconciliation Strategy. Such evaluations demonstrate that health care organizations that have successfully implemented MedRec have an overwhelming sense that MedRec benefits patients, is the right thing to do, and makes care safer. Using the survey data, the Cross Country MedRec Check-Up map was developed to highlight the success of MedRec teams, provincial and national supports, Canadian research and published articles, and IT implementation success.

An important part of the National Medication Reconciliation Strategy is supporting public awareness campaigns, using social media, and educating and helping consumers keep track of their medications through an innovative mobile phone app called MyMedRec.

ISMP Canada partnered with several organizations to develop My MedRec, which allows users to track their medications and a number of illness-related parameters, such as blood pressure and cholesterol readings. The mobile phone application also

sends refill and dosage reminders, lets users email their record to their doctors, and provides contact information for prescribers and pharmacies. This app was featured in *Canadian Living* as the app of the month for February 2013 and was rated #1 on the iTunes store as the top free medical app in January 2013.

Canada Health Infoway is providing funding to CPSI, ISMP Canada, and a research team from the University of Victoria for ongoing work. This includes developing tools and resources to help health care organizations across Canada integrate electronic MedRec into their overall efforts to implement a system-wide electronic health record.

IMPACT:

SHN teams are asked to submit data to the SHN Central Measurement Team at the University of Toronto, which helps teams report progress in MedRec and compare themselves to other teams. Core measures were developed to help evaluate the improvement strategy and garner senior management support. The core measures, which are the minimum measures required to evaluate the success of medication reconciliation, include:

- percentage of patients with completed MedRec (measured individually at admission, transfer, and discharge);
- the average number of unintentional discrepancies per patient (at admission); and
- the average number of undocumented intentional discrepancies per patient (at admission).

Using the data submitted voluntarily by participating teams over the course of five years, unintentional discrepancies have been reduced by more than 30% when compared to average baseline unintentional discrepancy rates. Baseline data indicated an average of more than one unintentional discrepancy (potential error) per patient.

In 2012, a need to measure the quality of MedRec was identified and a MedRec Quality Audit Tool was developed. This tool allows organizations to:

1. qualify and quantify how well they are performing the basic aspects of the admission MedRec process; and

2. identify specific MedRec processes or steps that need improvement.

This tool will be launched in 2013 following a final review by end users and incorporation of their feedback.

APPLICABILITY/TRANSFERABILITY:

The Canadian model is currently being implemented in five additional countries enrolled in the World Health Organization's High 5s SOP for Medication Accuracy at Care Transitions (medication reconciliation). Canada leads this MedRec SOP and our experience with the implementation of MedRec through SHN has identified important learning for other countries to consider as they promote MedRec at an international level.

ISMP Canada continues to provide ongoing support to teams around the world. A World MedRec map is being developed to highlight the work of MedRec teams and MedRec research at the global level.

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CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Other:

- Colquhoun, M. (2012). Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care.
- Safer HealthCare Now! (n.d.). *Medication reconciliation*. Retrieved from http://www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/default.aspx

External Source: http://www.ismp-canada.org/medrec/

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Readmission Reduction Program through Payment Systems (USA)

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

SNAPSHOT: This innovative practice aims to reduce readmission rates in hospitals by changing the in-patient prospective payment system (IPPS).

PRACTICE DESCRIPTION:

Hospital readmissions in North America are receiving increasing attention as a largely correctable source of poor quality care and excessive spending. According to a 2009 U.S. study, nearly 20% of Medicare beneficiaries are rehospitalized within 30 days after discharge, at an annual cost of $15 to $25 billion.

In 2012, the Affordable Care Act (ACA) in the U.S. was modified when a new section was added to the Social Security Act establishing the Hospital Readmissions Reduction Program. This change requires the Centers for Medicare & Medicaid Services (CMS) to reduce payments to in-patient prospective payment system (IPPS) hospitals that have excess readmissions. The change was effective for hospital discharges beginning on October 1, 2012.

In the FY 2012 IPPS final rule, CMS finalized the readmission measures for acute myocardial infarction, heart failure , and pneumonia. It also finalized how excess readmission ratios will be calculated. These ratios will be used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a hospital within 30 days of a discharge from the same or another hospital. The readmission ratios represent a hospital's readmission performance compared to the national average for the hospital's patients with AMI, HF, and PN. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum to calculate these excess readmission ratios. The excess readmission ratio adjusts for clinically relevant factors such as patient demographic characteristics, comorbidities, and frailty. Finally, the CMS policy is to use three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For fiscal year 2013, the excess readmission ratio is based on discharges occurring during the three-year period of July 1, 2008 to June 30, 2011.

Although the maximum penalty is set at 1% for 2013, eventually reaching 3% of a hospital's Medicare payments, the CMS implementation reduces the potential penalties in aggregate to only 0.2% of national Medicare payments in 2013. Payments for hospitals with below-average rehospitalization rates for all three conditions will not change. Eventually, CMS plans to expand this program to include other common diagnoses for which readmissions are theoretically preventable, boosting the financial effects.

IMPACT:

CMS has estimated, under the Hospital Readmissions Reduction Program, that for FY 2013 Medicare IPPS operating payments will decrease by approximately $300 million (or 0.3%) of the total Medicare IPPS operating payments.

CMS data show that about 2,200 hospitals face a penalty in FY 2013, and more than 270 of them will get docked the maximum penalty of 1% for FY 2013 (over 12%). CMS stated in the final rule issued in August 2012 that it estimates the program to result in a $280 million decrease in payments to hospitals.

On February 28, 2013, CMS's Jonathan Blum, Acting Principal Deputy Administrator and Director of the Center for Medicare, informed the Senate Finance Committee the 30-day all-cause hospital readmission rate dropped to 17.8% in the last quarter of 2012 after averaging about 19% over the last five years.

APPLICABILITY/TRANSFERABILITY:

The CMS readmissions penalty policy has drawn the attention of hospitals and stimulated similar approaches among other payers, with readmission rates emerging as a quality marker in public reporting programs. Some limitations to this innovative

practice include the inability of hospitals to submit additional corrections related to the underlying claims data, or to add new claims to the data extract used to calculate the ratios during the review and correction process. The practice also fails to reward hospitals that improve.

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Information last updated on: April 8, 2013

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

Publications:

- Berenson, R.A., Paulus, R.A., & Kalman, N.S. (2012). Medicare's readmissions-reduction program—A positive alternative. *New England Journal of Medicine, 366*, 1364–1366. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp1201268

Other:

- Dorland Health. (2013, April 17). Improving medication management, reducing readmissions [Webinar]. http://www.dorlandhealth.com/webinars/Medication_Management_Reducing_Readmissions/#about

External Source:
http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

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BC Health Leadership Development Collaborative – Transforming Linx

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for senior health system levels to lead innovative and change. This 10-month, project-based leadership development experience was launched in British Columbia in 2012.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities (HAs) driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created "Leadership LINX, a Provincial Pathway of Leadership Development" with key areas of: coaching, mentoring, core and transforming.

The Transforming LINX is a comprehensive 10-month, project-based leadership development experience designed specifically for healthcare leaders at the senior level. The program theme is 'complexity in healthcare', which requires new and higher levels of skill, leadership behaviour, innovation, systems awareness and collaborative practice for success in the most senior BC healthcare leadership roles. Transforming LINX aims to accelerate the pipeline of senior leaders prepared to lead innovation and change in the increasing complexity of BC Healthcare and create a community of senior leaders who are connected, committed to change, and who collaborate for the transformation of healthcare system. These leaders are learning together and engaging in learning designed to help them think differently and form networks and partnerships across traditional boundaries. The program consists of 3 Residencies; Online Community; Multi-disciplinary/Cross-Health Authority Action Learning Project Teams; Executive Coaching; 360 Assessments. The program was funded by a grant by the BC Health Education Foundation and each health authority.

IMPACT:

Personal accounts by particpants from Residency #1 and the Guiding Coalition already indicate some changes in thinking desired by the program and the formation of cross-health authority networks. Evaluation of the program will continue throughout and a full report will be available January, 2014. It is too early to determine the impact of the program given the first residency just concluded (February, 2013), but evaluation data from the first residency indicated changes in thinking, which is the first step in healthcare transformation

APPLICABILITY/TRANSFERABILITY:

All Health Authorities are participating so the only replication anticipated is when the next cohort beings in 18-24 months.

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

External submission from the BCHLDC.

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BC Health Leadership Development Collaborative - Collaboration Practice

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice is a province-wide collaboration between all Health Authorities in British Columbia to support, develop, engage and advocate for leaders with the ultimate goal of delivering exceptional patient outcomes.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes.

BCHLDC aims to attract and retain the best leadership in response to an acute shortage in healthcare leadership and the changing demands of the leadership role. As a solution to these problems, 7 BC health authorities formed a collaborative to focus on leadership development. The vision, in part, is to advocate for leaders and leadership practice, improve access to leadership development opportunities, attract and retain the best leaders. The collaboration was funded through Sep, 2013 with a grant from the BCHEF, the CNOs and through Mar 2015 with contribution by all health authorities.

The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created Leadership LINX, a Provincial Pathway of Leadership Development, with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

IMPACT:

Ministry of Health reprentatives remarked one time that the BCHLDC was the most successful collaborative in BC and that most fall by the wayside very early on in their process. Personal accounts by all involved indicate evidence of success, not to mention the physical evidence of the programs' existence. The BCHLDC is contemplating a formal evaluation if its objectives in the next few months.

The program has an impact on system performance because the system's capacity to develop its leaders has grown dramatically because of this collaboration. Since 2010 the following has occurred: a mentoring program previously in one HA is now in 5 and will be in 7 by Spring; an experience leader program in 2 HAs is now in all 7; a coach approach program previously only in 2 HAs is now in 7; the new manager training available across the province has been pulled into 1 comprehensive program thereby improving all programs; a senior leadership program is in delivery. Discounted prices have been negotiated, shared memberships create additional cost savings, and no one has to reinvent the wheel.

APPLICABILITY/TRANSFERABILITY:

The collaborative model of the BCHLDC Steering Committee has been replicated in the working groups its formed, using the same principles, to create the individual program streams. Nationally, a LEADS Collaborative is forming in a similar structure as BCHLDC. They have sought BCHLDC's leadership and coaching as they get started. It's early days to determine if true collaboration will be cultivated.

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

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BC Health Leadership Development Collaborative – Mentoring Linx

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice provides flexible, individualized mentoring opportunities, including long-term mentoring relationships and short-term engagements to discuss specific topics or situations and is available to "people who lead people". Using state-of-the-art software health system leaders create their own mentoring match based on skills, goals, interests and personality and can be matched with leaders across British Columbia.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities (HAs) driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created "Leadership LINX, a Provincial Pathway of Leadership Development" with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

The Mentoring LINX provides flexible, individualized mentoring opportunities, including long-term mentoring relationships and short-term engagements to discuss specific topics or situations and is available to "people who lead people. Using state-of-the-art software leaders create their own mentoring match based on skills, goals, interests and personality and can be matched with leaders across the province. Mentoring LINX is free to eligible participants and there is no work or commitments outside of the contract designed by the mentor or mentee.

According to the vendor used to support the program, Mentoring LINX is the only cross-organization mentoring program in existence in North America. By Fall of 2013, all health authorities will be involved in the program. The program was funded through March, 2013 with a grant from the BC Health Education Foundation and will be supported by HAs starting this fiscal year

IMPACT:

The Mentoring LINX program has been evaluated twice - once while in the pilot stage and once after a Phase I roll-out. The evaluation consisted of an online survey of participants on both occasions. The revised second evaluation linked the questions and subsequent data analysis to the short-term outcomes from the logic model prepared for the overarching project (BC Health Leadership Development Collaborative). Data is available upon request. The data provides both qualitative (program testimonials) and quantitative measures.

Results in both evaluations demonstrated positive impact on health care system performance. Specific results from the second evaluation, for those matched with a mentor/mentee are noted below:

(1) The program is valuable & essential to personal & organizational success & needs to be continued

(2) 68% attributed specific results, mostly learning specific knowledge or skill, directly to their participation in the program.

(3) 74% indicated they would stay with organizations that had this type of development program

One notable qualitative result: "I was going to leave my health authority, but found a mentor who guided me and I stayed" potentially saving thousands of dollars in turnover costs.

APPLICABILITY/TRANSFERABILITY:

This program was originally implemented by Interior Health Authority and now has been adopted by Northern Health Authority, Fraser Health Authority, Vancouver Island Health Authority, and Provincial Health Services Authority. By Fall, 2013, Vancouver Coastal Health and Providence Health Care will have adopted the program meaning 100% of the health authorities will be both contributing and benefiting from Mentoring LINX.

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

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BC Health Leadership Development Collaborative – Core Linx

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice is a comprehensive leadership and management development program designed for managers in the first 18 months of their first formal management role in a British Columbia Health Authority.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities (Has) driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created “Leadership LINX, a Provincial Pathway of Leadership Development” with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

The Core LINX is a comprehensive leadership and management development program designed for managers in the first 18 months of their first formal management role. Due to the large amount of retirements projected in the system, it is necessary to ensure new leaders are preparing in a comprehensive manner and accelerate and deepen their growth. The program serves any new manager regardless of occupation. As a participant of Core LINX, leaders learn essential leadership skills to increase confidence and build a strong foundation for their future as a healthcare leader. Core LINX uses a variety of active learning methodologies and includes courses in leadership and management development, as well as coaching, electives, Hot Topic sessions and manager check-ins.

The Core LINX program just completed a pilot and is expected to be implemented in all HAs by the end of FY2013/2014. The development is funded through Sep, 2013 with a grant from the BCHEF and CNOs. Ongoing delivery will be funded by the HAs.

IMPACT:

Evaluation of the Core Linx pilot program included the following: 1) tracking 4 participants through the program to analyze behavior change using interviews with an external interviewer, 2) end of module evaluation, 3) mid-program manager assessment, and 4) in-module content audits. Also planned are 3 & 6 month follow up assessments with participants and managers.

Mid-program manager assessments indicated new managers had more of a systems lens; less micromanaging, interactions with staff increased; greater clarity; clearer strategies. Participants indicate increased self-responsibility; increased confidence; improved relationships, enhanced team effectiveness; and decrease in stress. Additionally, because all health authorities shared their leading practice content openly, none of the health authorities bore a development cost to increase or improve their leadership development offerings to this important management audience.

APPLICABILITY/TRANSFERABILITY:

This program has been piloted in one health authority and all other HAs have plans to implement the program in FY2013/2014. Results are theoretically replicable across health authorities.

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

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BC Health Leadership Development Collaborative – Coaching Linx

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice is designed to help senior leaders (directors and above) within each Health Authority in British Columbia enhance their leadership capacity by focusing on topics such as managing challenging workplace issues, learning from feedback or implementing a new initiative.

PRACTICE DESCRIPTION:

The BCHLDC is a province-wide collaboration between all Health Authorities driven by a strong and innovative team agreement. BCHLDC supports, develops, engages and advocates for leaders with the ultimate goal of delivering exceptional patient outcomes. The collaboration builds on leading practices already in existence in the province and creates tool kits and professional development opportunities. As an outcome of the collaboration, BCHLDC created "Leadership LINX, a Provincial Pathway of Leadership Development" with 5 key areas: coaching, mentoring, new manager, experienced leader & senior leader.

The 1:1 Coaching Service LINX is designed to help senior leaders (directors and above) within each Health Authority enhance their leadership capacity by focusing on topics such as managing challenging workplace issues, learning from feedback or implementing a new initiative. 1:1 Coaching is client-centered and designed to support a client over time. The 1:1 Coaching service has a centrally-coordinated provincial list of highly quality coaches who are available to senior leaders in BC health organizations. Each coaching contract is customized to the coachee's needs and outlines specific goals, time committed to coaching sessions and timelines. BCHLDC created this program using sophisticated collaboration.

IMPACT:

Personal accounts by those managing coaching services indicate the benefits of the provincial list, the common price, and the assurance of high quality coaches. An evaluation of the program is expected to be undertaken in 2013.

The program has an impact on system performance because of the efficiencies created in the coach only signing one contract, rather than each HA managing its own contract. Additionally, for those who have been using 1:1 external coaching services, there is an expectation that some of the costs will decrease because of the common price. Lastly, it's more efficient for leaders to find an external coach because of the list's existence.

APPLICABILITY/TRANSFERABILITY:

This service has been replicated in all BC health authorities and Providence Health Care.

The same self-reported positive results are being experienced in all health authorities.

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

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Saskatchewan Lean Management System (LMS)

LOCATION:	Saskatchewan	HEALTH THEME:	Quality Improvement and Patient Safety
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

SNAPSHOT: This innovative practice addresses the need for a a patient-focused approach to reducing waste in the health system by identifying and eliminating activities that do not add value. Launched across the entire provincial health system in Saskatchewan in 2012, this program aims to support will support related capacity building and quality improvement initiatives.

PRACTICE DESCRIPTION:

Saskatchewan is the first jurisdiction in Canada to start implementing Lean across the entire provincial health system. Lean is a philosophy or a mindset - a patient-focused approach to reducing waste by identifying and eliminating activities that do not add value. In health care, this may include things like excess inventory, time spent waiting for services, and inefficient processes that reduce time spent on direct patient care.

Saskatchewan has committed to implementing a Lean Management System (LMS) because Lean has proven its value in helping many organizations improve and support quality, cost-effective services that meet the needs of clients, patients and staff. Saskatchewan is focused on major health care reform across its health care system via an aggressive four-year implementation plan and the LMS will support related capacity building and quality improvement initiatives

Quick Facts:

- The adoption of a LMS is one of the health system's 2012-13 strategic priorities.
- During the next four years, over 1,000 focused quality improvement projects will occur across Saskatchewan's health care system, to improve patient experiences and reduce errors.
- Approximately one-quarter of Saskatchewan's 40,000 health sector workforce is being trained in Lean methodology
- In 2012 the Ministry of Health engaged specialized Lean consultant expertise to train health care providers, physicians, leaders and staff and establish necessary infrastructure to ensure that continuous improvement is embedded in Saskatchewan's health system.

The LMS will support the strategic alignment of health system priorities across the province, boost health human resource capacity and capabilities related to quality improvement (skills, dedicated resources, leadership commitment); foster a culture of safety with the goal of zero defects; and establish a cascading measurement and reporting system to support greater system transparency and accountability.

IMPACT:

Eighteen organizations in Saskatchewan are participating in the transformative effort including all Saskatchewan health regions, the Ministry of Health, Shared Services Saskatchewan, e-health Saskatchewan, Saskatchewan Cancer Agency and the Health Quality Council.

While it is still early days in the deployment of the LMS, efforts to date are yielding results.

- Over 1400 safety defects have been removed from the health system.
- The Children's Hospital of Saskatchewan Lean design process helped teams find more efficient ways of providing services, while improving the design and hospital experience for patients and families. The result was a 15.6% reduction of space required at a cost savings of approximately $30M.
- $4M has been saved this year through Lean improvements in inventory management of the provincial blood and plasma supply (a total of $14M since 2008).
- 3S Health provincial laundry services achieved 61% reduction of returned unused linen, 73% reduction of filling cart for

delivery and several thousands in rewash savings.

- Through a staff scheduling improvement event, the Saskatoon Health Region anticipates annual savings of at least $4.4M once fully implemented.
- Operational efficiencies of $85 - $160M over 20 years will be obtained at the Moose Jaw Regional Hospital replacement by using Lean design.

In 2012, the Health Quality Council issued a Request for Proposal for the Evaluation of Saskatchewan's Lean Transformation, Phase 1, to evaluate the early processes and impact of implementation of Lean in the provincial health system. In addition to determining baseline conditions, this first phase evaluation will establish a framework and methods for use in an ongoing evaluation of the multi-year process of implementing the LMS (second phase evaluation).

APPLICABILITY/TRANSFERABILITY:

Lean methodology originated in the manufacturing sector and has now proven to achieve significant improvements and cost reductions in the health care sector. Other jurisdictions have proven that applying Lean methodology in health settings improves patient experiences and health outcomes at a lower cost. For example, the Cleveland Clinic, which employs approximately the same number of people as Saskatchewan's health system, invested $40 million in Lean and achieved $100 million in savings over five years as a result. As well, Canadian provinces such as Manitoba and Prince Edward Island are using a system-oriented Lean strategy to building quality improvement capacity.

In Saskatchewan, the use of a LMS is spreading throughout the health care system and beyond. Its initial focus will be on the Saskatchewan Surgical Initiative and capital development of health care facilities (e.g., Children's Hospital of Saskatchewan and Moose Jaw Regional Hospital). The Lean Management System will also support the achievement of other strategic priorities – such as primary health care redesign, shared services, patient and worker safety, improved access to specialist and diagnostic services and no-wait emergency room care - with over 1,000 quality improvement projects planned.

Additionally, the use of a Lean approach has created lasting change and spread to all government ministries in Saskatchewan. Other jurisdictions have also taken notice of Saskatchewan's system-wide lean efforts, with inquiries to learn more coming from the Government of Canada, Government of Alberta, Cities of Thunder Bay and Oshawa, States of Maine and Minnesota, and health system organizations in British Columbia.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

2012 HCC Survey of the Saskatchewan Government

- http://www.gov.sk.ca/adx/aspx/adxGetMedia.aspx?PN=Shared&mediaId=1769
- http://hqc.sk.ca/Portals/0/documents/RFP%20Lean%20Eval%20Ph1.pdf
- http://www.health.gov.sk.ca/lean-newsletter-summer2012
- http://www.gov.sk.ca/news?newsId=e7eb626a-529a-49c5-8552-09406dceafae
- http://hqc.sk.ca/news-events/whats-new/articletype/articleview/articleid/66/request-for-proposals-evaluation-of-saskatchewans-lean-health-care-transformation-phase-1/

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Information last updated on: February 13 2013

External Source: http://www.health.gov.sk.ca/lean-introduction

Share to: [Facebook] [Twitter] [LinkedIn]

Saskatchewan Surgical Initiative

LOCATION:	Saskatchewan	HEALTH THEME:	Quality Improvement and Patient Safety
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Promising

VIDEO: This Innovative Practice was featured in the Health Council of Canada's video series "Innovations in Reducing Wait Times": www.healthcouncilcanada.ca/waittimes

SNAPSHOT: This innovative practices addresses the need to improve surgical care and reduce wait times, from primary care through the acute care system and post-surgical recovery.

PRACTICE DESCRIPTION:

The Saskatchewan Surgical Initiative was the first major initiative arising from Saskatchewan's 2009 independent Patient First Review. This review identified surgical wait times as a key concern for patients and families, and provided recommendations about improving surgical care and reducing wait times. The Saskatchewan Surgical Initiative is striving to offer "sooner, safer, and smarter" surgical care that improves the patient's experience.

Established in March 2010, the four-year initiative aims to improve surgical care and experience for patients at all stages of the patient journey, from primary care through the acute care system and post-surgical recovery. An ambitious goal was established to provide all patients with the option to have surgery within three months (or sooner for urgent cases). Unlike past programs to address surgical improvement, which primarily emphasized wait time reduction, this initiative also gives priority to quality, safety, patient experience, and sustainability.

The Surgical Initiative strategic plan is innovative in that it was developed through extensive collaboration with former surgical patients, surgeons, family physicians, nurses, therapists, health care administrators, and health sector organizations. Patients, providers, and other health system partners play a key role in guiding the implementation of the plan.

Saskatchewan's Surgical Initiative is accomplished through the following means:

SOONER

- Surgical capacity has been expanded to reduce the backlog of patients on the waiting list. This includes Regina and Saskatoon, where most surgeries are performed, but also smaller surgical centres where there is an opportunity to make better use of health providers and facilities.
- Saskatchewan is using third-party providers to increase surgical and diagnostic capacity in the publicly funded and administered system. Health regions have entered into contracts with third-party providers to provide day surgeries, including orthopedics, ophthalmology, dental, and ear/nose/throat procedures.
- Pooled referrals and other strategies have been introduced to address the uneven distribution of patients among surgeons and maximize the use of all surgeons. This will give patients faster access to the first available surgeon with the required expertise. Patients may still choose any surgeon they prefer, but know they may wait longer. There are currently 15 specialty groups pooling referrals in the province.
- The online Specialist Directory at www.health.gov.sk.ca/specialist-directory helps patients work with their family doctors to understand options and determine which specialists have the shortest wait times.

SAFER

- Surgical safety checklists standardize procedures in all Saskatchewan hospital operating rooms. The checklists promote improved communication among the surgical team and consistent use of practices that are proven effective in increasing patient safety before, during, and after surgery.
- Safer Healthcare Now!, a Canadian Patient Safety Institute initiative, has developed processes to prevent surgical site

infections. Implementation of these prevention protocols is underway.
- Saskatchewan health regions are implementing medication reconciliation at admission to acute care. MedRec prevents errors by ensuring that a patient's medication history is verified, and that medication and doses are appropriate.
- A falls prevention initiative now helps identify risk factors that can contribute to seniors falling, and promotes ways to prevent these injuries.

SMARTER

- New patient pathways are being introduced to streamline the care process and ensure patients receive appropriate, timely care, whether they require surgery or not

i. Hip & Knee Pathway: Family physicians can now refer potential hip or knee surgical patients to multidisciplinary clinics in Regina, Saskatoon, Prince Albert, and Moose Jaw.
ii. Spine Pathway: Saskatchewan is introducing a new way to assess and treat patients with lower back pain. Primary health care providers (family physicians, chiropractors, and physiotherapists) can now take an online continuing education course on handling lower back pain.
iii. New pathways are being introduced for prostate cancer and uro-gynecology. Planning for additional pathway development and implementation is underway.

- Shared decision-making tools are being introduced through all of the pathways to ensure patients are educated, informed participants in their care.
- Groups of clinicians are studying clinical variation and developing standard approaches to help ensure patients receive the most appropriate care.
- The Lean Management System is being introduced across all health regions and is leading to improvements in patient care, more efficient processes, and engagement of health care providers.
- Targeted funding has supported the training of over 100 additional operating room nurses through the perioperative-nurse training program at the Saskatchewan Institute of Applied Science and Technology (SIAST).

IMPACT:

The Surgical Initiative releases monthly progress reports on patient wait times, by region and by regional health authority, at www.sasksurgery.ca. Other performance measures are reported at www.qualityinsight.ca.

Ninety per cent of all patients who had their surgery between July 1 and December 31, 2012, received their procedure within six months, and 78% received their surgery within three months.

From November 2007 to December 2012,

- The number of patients waiting more than 18 months for surgery has dropped by 93%.
- The number of patients waiting more than 12 months for surgery has dropped by 82%.
- The number of patients waiting more than six months for surgery has dropped by 58%.
- The number of patients waiting more than three months for surgery has dropped by 46%.

As of December 31, 2012, all three components of the surgical safety checklist were performed in 96% of audited surgeries throughout the province.

*An outcomes update for the Saskatchewan Surgical Initiative was released on March 18th, 2013 and includes wait times data up and until January 30th, 2013. For more information, please visit the following website:

http://www.gov.sk.ca/adx/aspx/adxGetMedia.aspx?mediaId=0ec0f584-27b5-4f45-803b-6b6941324a26&PN=Shared

APPLICABILITY/TRANSFERABILITY:

A transition plan is being developed to ensure the improvements and momentum achieved during the formal four-year period of the Surgical Initiative are continued into the future and advanced through daily continuous improvement.

An embedded researcher has been located in the Surgical Initiative branch at the ministry of Health and will be publishing a dissertation on the facilitators and barriers to transformational change based on her experience observing the change process. The embedded researcher project is a collaboration between the ministry of Health, CFHI, and the Johnson-Shoyama Graduate School of Public Policy.

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

Saskatchewan Ministry of Health, Year 1 Report (May 2011) http://www.health.gov.sk.ca/sksi-year1-progress

Saskatchewan Ministry of Health, Year 2 Report (May 2012) http://www.health.gov.sk.ca/sksi-year2-progress

Government of Saskatchewan news release (April 23, 2012), Funding for surgical care flows to health regions
http://www.gov.sk.ca/news?newsId=1c06badb-12d7-4905-9c8f-ac905f1bd132

Saskatchewan Surgical Initiative website: http://www.sasksurgery.ca

Wait Times Data Fact Sheet (released March 18, 2013):
http://www.gov.sk.ca/adx/aspx/adxGetMedia.aspx?mediaId=0ec0f584-27b5-4f45-803b-6b6941324a26&PN=Shared

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Information last updated on: January 24, 2012

External Source: http://www.health.gov.sk.ca/surgical-initiative

Share to: Facebook Twitter LinkedIn

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 launced 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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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 (ECAA)

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*,[i] 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

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

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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.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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Manitoba Lean Six Sigma Strategy Training: Green and Black Belt Networks

LOCATION:	Manitoba	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need to support health care stakeholders in applying Lean Management throughout the Manitoba health system. Established in 2010, this program fosters a community of particpants that provide up to a year of mentorship for staff undergoing Lean training and a way for staff to come together to learn about and support each other's diverse improvement projects.

PRACTICE DESCRIPTION:

Since 2010/11, Manitoba Health has been committed to integrating Lean Management into ongoing health system improvement. Lean Management is a quality improvement methodology that has been implemented in various Canadian provinces to improve health care efficiency. The Manitoba-specific Lean Strategy is a province-wide five-year training and mentoring strategy. The aim of this strategy is to deliver training in system efficiency and quality improvement to Manitoba Regional Health Authorities (RHAs) and health system stakeholder agencies. The initial goal for the five-year strategy was to train over 1600 health care staff and implement a minimum of 225 improvement projects resulting in anticipated minimum savings of $4.1 million.

In Year 2, Manitoba Health provided the funding and coordination to establish a Green Belt network to foster a community of practice to support Lean. In Year 3, a Black Belt network was also created to bring together health providers trained at the Black Belt level. The Green Belt and Black Belt networks are unique to Manitoba Health, and are an innovation in implementing Lean Management in health systems.

The Green and Black Belt networks provide up to a year of mentorship for staff undergoing Lean training and a way for staff to come together to learn about and support each other's diverse improvement projects. Furthermore, as the staff involved in the networks develop expertise in diverse areas of improvement, their knowledge and experience can be shared among others looking to address similar issues. The Green and Black Belt networks have also allowed members to leverage additional training sessions, inviting participants from different regions to observe or participate in training taking place across the province.

The networks connect monthly through teleconference meetings (with over 50 participants per call) supported by screen-sharing software that gives all participants access to the same presentation materials. The meetings focus on providing mentorship and assistance to current trainees, but they are also open to past graduates. Additionally, all health staff trained in Lean implementation can access a password-protected website that hosts Lean-related improvement tools and resources for all of the Pursuing Excellence initiatives. Annually, a face-to-face graduation event called "Congress" is organized to celebrate the new trainees and showcase their improvement projects. The incoming cohort of trainees, executive sponsors, and executive leadership involved with the projects are invited to attend.

The Green Belt and Black Belt networks will continue to grow in Years 4 and 5 of the initiative, accommodating all new trainees and Lean staff who have been certified externally into the Lean Community of Practice.

IMPACT (of Green/Black Belt Networks):

The positive impact of the Green Belt and Black Belt networks in supporting the training initiatives mentioned below has not yet been formally evaluated. However, Manitoba Health intends to conduct another evaluation of their training strategy as it continues to roll out over Years 4 and 5. Anecdotal evidence among network participants suggests the networks have been instrumental in bringing trainees together and providing opportunities for effective learning, mentorship, engagement, and collaboration. The teleconferences provide a direct, organized way to ensure participants are progressing towards goals and targets, as well as a safe venue to discuss and address obstacles to improvement and lessons learned. A future evaluation may help determine what resources are required for the continued coordination and long-term sustainability of the Green Belt and Black Belt networks.

Positive impact from Lean Six Sigma initiatives has been formally evaluated, which provides context for the potential role of the Green and Black Belt Networks. In Year 1, approximately 45 small Lean Six Sigma initiatives were implemented as a result of training throughout the province. An evaluation of the first year of the Lean program was completed using the Kirkpatrick Evaluation methodology to examine whether the rollout of the training could be improved. Based on the results of this evaluation, the Green Belt and Black Belt networks were established to increase collaboration and staff-to-staff time. Other modifications were made in Year 2 to increase participation from executive sponsors and to build more capacity within RHAs for long-term sustainability of Lean.

As part of the training initiative, all improvement projects are required to complete an Improvement Report detailing the work undertaken and the amount and types (i.e. space, inventory, staff time, etc.) of savings achieved. Preliminary results for improvement savings for 12 of 23 Rapid Improvement projects resulted in the following:

- staff time available to reinvest = 10,261 hours;
- reduction in the number of pt bed days = 13,683;
- increase in patient throughput (number of patients that can enter the system) = 1,129 patients;
- supplies savings = $8,394;
- 5S space savings = $5,952; and
- financial resources redeployable = $6,398,729

APPLICABILITY/TRANSFERABILITY:

The idea to establish the Green Belt and Black Belt networks in Manitoba to support Lean training originated from prior positive experiences with developing networks or community of practice models that support trainees as they develop their skills and begin work on novel projects. Prior networks coordinated by Manitoba Health that have had a positive impact include the Baby Friendly Breastfeeding network and an Injury Prevention network.

An original goal in establishing the Green Belt and Black Belt networks was to ensure that a comprehensive, provincial-level approach was undertaken, bringing together all of the health regions as well as health care organizations. A benefit of this province-wide approach is that it has accelerated the spread and uptake of improvement projects across regional and institutional boundaries. For example, the Green Belt and Black Belt networks have provided a mechanism through which improvement projects working at one site in the province can be shared and spread to other sites. Successful projects are presented at the Green Belt meetings and may be adapted by others looking to address the same problem, thereby helping to spread the innovation and improvement throughout the province. For example, one site's successful experience with organizing a kanban ordering system has now spread to four additional sites in the province.

The model provided by the Green Belt and Black Belt networks may be readily adopted by other initiatives aiming to develop a Community of Practice to engage and support participants.

Content adapted from the following sources and relevant websites

Manitoba Health. (2011). *Pursuing excellence: A multi-pronged improvement strategy for Manitoba health care.* Retrieved from http://www.gov.mb.ca/health/mpan/pdf/demone.pdf

Manitoba Health. (2012). *Manitoba Health's response to Health Council of Canada's 2012 quality improvement survey.* Winnipeg: Manitoba Health.

Manitoba Health Staff (interviews, February 2013).

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Information last updated on: February 10, 2013

External Source: http://www.gov.mb.ca/health/mpan/pdf/demone.pdf

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Strategic Clinical Networks in Alberta

LOCATION:	Alberta	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Public Health	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice has been developed as part of a provincial quality improvement effort to enhance the patient journey, improve health outcomes, and standardize care delivery. Established throughout Alberta in 2011, the purpose of the Strategic Clinical Networks is to engage clinicians and patients in decision-making about clinical services planning and to support clinical practice improvement by implementing clinical practice guidelines (CPG), developing care 'pathways', improving the patient experience and more.

PRACTICE DESCRIPTION:

Strategic Clinical Networks (SCNs) have been developed in Alberta as part of the province's quality improvement effort to enhance the patient journey, improve health outcomes, and standardize care delivery. Essentially, SCNs are province-wide teams comprised of health care professionals, researchers, community leaders, patients and policy makers, organized around a specific clinical focus. The purpose of each network is to engage clinicians and patients in decision-making about clinical services planning and to support clinical practice improvement by implementing clinical practice guidelines (CPG), developing care 'pathways', improving the patient experience and more.

SCNs were established throughout the province in 2011. Alberta began with six focused networks:

- Addiction and Mental Health
- Bone and Joint Health
- Cancer Care
- Cardiovascular Health and Stroke
- Obesity, Diabetes and Nutrition
- Seniors' Health

One senior leader in Alberta has described a SCN as "… almost like a program-based model of delivery where you get a group of health care professionals, largely physicians - but not exclusively physicians - together to talk about how they can systematically standardize the care for important populations of patients." Another leader stressed that "the networks get diverse groups to start working together on common targets, standardizing care pathways, and then showing that it actually [makes] a difference to the patient's experience and the patient's outcomes."

Each SCN has been asked to align their work with Alberta Health Services' priorities, as well as provincial priorities and take on a major "reassessment" project, with the goal of identifying and potentially eliminating harmful, outdated, ineffective and/or inappropriate processes, procedures, technologies, drugs or care programs. Each SCN has been asked to develop a focussed research and innovation program, in collaboration with academic partners. Since a large part of the work of SCNs is implementing clinical practice guidelines, there is also collaboration with, and learning from, groups doing similar work in other provinces. Finally, the aims of Alberta's SCN initiative align with the Institute for Healthcare Improvement's (IHI) "Triple Aim framework" which is predicated on: improving the health of the population; enhancing the patient experience of care (quality, access and reliability); and reducing/controlling the cost of care, or adding "value for money."

IMPACT:

Scientific literature has shown clinical networks to be a proven model in reducing variation and improving care, by promoting the use/uptake of clinical experience, knowledge and research. As well, clinical networks have been proven to be effective mechanisms to ensure collaboration, joint decision-making and shared learning.

The Strategic Clinical Network's approach—involving a collaborative structure, integrated decision making and physician and patient engagement—is a recent development and has yet to be formally evaluated. Within Alberta Health Services, there are plans for each clinical network to undergo an assessment according to a maturation framework developed from existing

corporate instruments and approaches. The purpose is to make an assessment of a network's 'baseline maturity' and establish appropriate characteristics by which to measure a network's trajectory of maturation. Periodic evaluations will help to ensure that the SCNs are maturing and developing in such a way as to achieve their goals. Additionally, a Collaborative Research in Outcomes (CRIO) grant from Alberta Innovates – Health Solutions will facilitate a future comparative study comparing Alberta's new strategic clinical networks with similar networks in the province of New Brunswick. The research study will evaluate outcomes in four networks (two from each province) in a comparative case study design. Earlier pilot work verified the feasibility of such a study and informed the design of the evaluation plan.

APPLICABILITY/TRANSFERABILITY:

Many high performing health care systems have adopted a system-wide approach to establishing, promoting, and implementing evidence based clinical best practices. In its development, Alberta's Strategic Clinical Network approach reviewed the experiences of clinical networks implemented in other jurisdictions, including Scotland, England and Australia. These models also informed the design of the Operational Clinical Networks (OCNs; ie. Critical care, emergency, and surgery), that have been established in Alberta. "Lessons learned" for effective network design and success factors were also taken from the experience of the Canadian Institutes of Health Research (CIHR) and its 13 partner institutes throughout the country.

Within the province of Alberta, there are plans for the SCN model to be further expanded to other clinical domains. Six more SCNs will be phased into operation over the course of 2013, including:

- Complex Medicine (which will include the current Respiratory Clinical Network)
- Maternal Health
- Neurological Disease, ENT (ear, nose, throat) and Vision
- Newborn, Child and Youth Health
- Population Health and Health Promotion
- Primary Care and Chronic Disease Management

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Alberta Health Services: Strategic Clinical Networks A Primer & Working Document (August 7, 2012 – V5)
http://www.albertahealthservices.ca/hp/if-hp-ce-scn-primer.pdf

Alberta Strategic Clinical Networks Terms of Reference: http://www.albertahealthservices.ca/hp/if-hp-clin-network-tor.pdf

Health Council of Canada Interviews with senior leaders in Alberta, 2012.

Health Council of Canada Interview with Alberta Health Services staff, 2013.

Noseworthy, T. (2012). Innovation, Quality & Accountability in Alberta Health Services, Presentation to the National Health Leadership Conference, Halifax, Nova Scotia: June 4, 2012. http://www.nhlc-cnls.ca/assets/Noseworthy_Final.pdf

Determinants of successful clinical networks: the conceptual framework and study protocol. Haines et al, Implementation Science, 7:16, 2012

A qualitative study of stakeholders' views of the preconditions for and outcomes of successful networks. McInnes et al, BMC Health Serv Res, 2011.

Bringing networks to life- An RCPCH guide to implementing clinical networks. Royal College of Pediatrics & Child Health, UK, 2012.

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External Source: http://www.albertahealthservices.ca/6047.asp

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Deprescription Pilot

LOCATION:	British Columbia	HEALTH THEME:	Pharmaceuticals Management
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the idea of “deprescribing”, referring to the reduction in the number of prescriptions made for one patient. It has been suggested that over-medicating can result when patients take “pill cocktails” to treat various symptoms. It is a form of improper medication use that can lead to adverse side effects including an increase in morbidity. In response to this concern, pharmaceutical researchers in British Columbia have launched a pilot study at Richmond Hospital that will look at the effects of deprescribing in an elderly population. The pilot is being conducted in an acute-care community setting rather than a large hospital.

PRACTICE DESCRIPTION:

Polypharmacy reduction, or “deprescribing”, refers to the reduction in the number of prescriptions made for one patient. It has been suggested that over-medicating can result when patients take “pill cocktails” to treat various symptoms. It is a form of improper medication use that can lead to adverse side effects including an increase in morbidity.

In response to this concern, pharmaceutical researchers in British Columbia have launched a pilot study at Richmond Hospital that will look at the effects of deprescribing in an elderly population. The pilot is being conducted in an acute-care community setting rather than a large hospital. The first phase of the study is currently being implemented which is focused on securing financial support to perform the pilot and recruiting both physicians and patients willing to participate. The second phase of the study takes one year to complete and focuses on optimizing a deprescription plan or formula to be used by physicians. The deprescription plan is going to be designed to reflect both the interests and opinions of the physician and the patient. In doing so, they aim to decrease the dosage of medications such as antidepressents, sedatives and antipsychotics consumed by a patient with the hope of improving their quality of life. The natural progression of this second phase if successful is to disseminate the deprescribing formula to 200 more physicians in order to ensure that the findings can be translated across multiple settings .

IMPACT:

The BC pilot study is still in its initial phase with participating physicians and funding still in the process of being secured so a formal evaluation has not been conducted. Although it has not be evaluated in BC at this time, deprescription has been implemented in various international sites and has been tested in 30 randomized control trials with positive results.

APPLICABILITY/TRANSFERABILITY:

Much research has already been done on deprescribing to evaluate its effects on hospitalization, referral rate and clinical outcomes. A feasibility study was conducted in 2010 by Garfinkel et al. in on drug discontinuation among elderly people in Israel. They observed tremendous improvements in clinical outcomes in 90% of their subjects just by cutting the average number of medications prescribed in half. No adverse effects of discontinuation were reported in this study.

Similarly, a systematic review on deprescribing was presented in February 2013 at the PPC Annual Professional Practice Conference in Toronto. The review analyzed approximately 30 deprescribing trials and found positive effects on clinical outcomes such as improved cognition as well as reduced referral rates and medication costs. These findings are supported by personal testimonies such as an American woman whose mother recovered well just by cutting on medications being taken. This woman went on to advocate deprescribing through her “Is your mum on drugs?” campaign.

Content was developed from the following sources and relevant websites:

Garfinkel D, Mangin D. “Feasibility Study of a Systematic Approach for Discontinuation of Multiple Medications in Older Adults”. Arch Intern Med 2010 (18): 1648-1654.

http://www.vancouversun.com/health/empowered-health/Richmond+hospital+st...

Farrell B. "The Evidence for Deprescribing: Trials and Tribulations". PPC Annual Professional Practice Conference- Final Program (2013): pg 30.

Moynihan R. "Is your mum on drugs? When 'deprescribing' may be the best medicine". BMJ 2011.

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Information last updated on: February 15, 2013

External Source:
http://www.vancouversun.com/health/empowered-health/Richmond+hospital+study+aims+reduce+drug+prescriptions+seniors/7089371/story.html

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National Surgical Quality Improvement Program (NSQIP) in British Columbia through the Surgical Quality Action Network (SQAN)

LOCATION:	British Columbia	HEALTH THEME:	Health Human Resources
HEALTH SECTOR:	Acute Care	FRAMEWORK CATEGORY:	Emerging

SNAPSHOT: This innovative practice addresses the need for health care providers to discuss best practices, share local innovations, and network to improve surgical care for patients in British Columbia. Launched in 2012 to facilitate the implementation of NSQIP in hospitals across British Columbia and leverage its use as a data measurement tool in the province, the BCPSQC established the Surgical Quality Action Network (SQAN) to help hospitals "act" on their report card through engagement and shared learning with other comparable hospitals.

PRACTICE DESCRIPTION:

The National Surgical Quality Improvement Program (NSQIP), which was originally developed by the US Department of Veterans Affairs, is offered through the American College of Surgeons across North America and internationally. NSQIP is the first validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care. The NSQIP initiative is currently being implemented in 24 hospitals in British Columbia as a measurement tool to improve the quality of surgical care in the province. The implementation is being coordinated by the British Columbia Patient Safety and Quality Council (BCPSQC), and the Regional Health Authorities in BC provide the funding for participating hospitals. To facilitate the implementation of NSQIP in hospitals across British Columbia and leverage its use as a data measurement tool in the province, the BCPSQC established the Surgical Quality Action Network (SQAN) to help hospitals "act" on their report card through engagement and shared learning with other comparable hospitals.

The SQAN is a forum for health care providers to discuss best practices, share local innovations, and network to improve surgical care for patients in BC. The SQAN is neither a committee nor a decision-making body; it is an open group of individuals sharing ideas and discussing ways to work together. Representatives from participating sites meet in person and via teleconference to share ideas and successes. Moving forward, a peri-operative efficiency initiative led by a coalition of stakeholders in BC will use the SQAN.

The Network brings together a number of surgical initiatives taking place across BC. The first is the American College of Surgeons' National Quality Improvement Program (NSQIP). The second is the Safety Attitude Questionnaire, which is used to measure teamwork and communication. The third is clinical care management (CCM), which includes implementing the surgical safety checklist and reducing surgical site infections. In addition, 14 hospitals across BC are examining culture at a unit level across the surgical pathway. The sites meet in person and via teleconference to share ideas and successes. The leaders at these sites recognize that culture plays a key part in implementing best practices, and they have created strategies to improve the culture. A second wave of hospitals is joining this group in 2013 to measure culture and enact changes based on these data.

Partnerships are central to the SQAN. The Network is coordinated by the BC Patient Safety & Quality Council (BCPSQC). The Provincial Surgical Advisory Council (PSAC) serves as the Clinical Expert Group for CCM, and the Health Services Purchasing Organization (HSPO) funds the NSQIP.

IMPACT:

The BCPSQC is doing innovative work in using the data collected under NSQIP to inform action and quality improvement for surgery pathways across BC. Through the SQAN, BCPSQC aims to help hospitals "act" on their outcomes report cards through engagement and shared learning with other comparable hospitals. The SQAN facilitates opportunities for all 24 enrolled hospitals to come together and share best practices and ways of implementing new guidelines in order to improve their surgical

outcomes. Additionally, the BCPSQC collates all results from NSQIP's semi-annual reports and can share these findings with the SQAN's members. This analysis gives members an overall sense of whether surgical outcomes have shifted to reflect better quality surgery in the province.

The SQAN provides surgeons and hospitals with improvement resources and education, as well as opportunities to engage with one another (via email, conferences, education opportunities, workshops, etc.) to discuss how to improve performance. At this time, the BCPSQC has received a great deal of positive feedback from surgeons and front-line support staff regarding its efforts to support the implementation of NSQIP and manage the SQAN network. However, no formal evaluation of this network and its impact on surgical care in the province has been conducted.

APPLICABILITY/TRANSFERABILITY:

Initially developed in 2006, the SQAN has grown in parallel with the adoption of NSQIP and other surgical quality improvement initiatives across British Columbia. For example, NSQIP began in 3 hospitals and has now expanded to 24 sites in BC, all of which are members of the SQAN. The Network now also acts as a central coordinator for multiple settings across Canada. The SQAN has welcomed membership from other NSQIP sites in the country, collaborating with stakeholders in Alberta, Newfoundland and Labrador, Ontario, and Quebec. Including non-BC sites, the network has grown to include over 555 members (of whom approximately 50 are surgeons).

Content was adapted from the following sources and relevant websites:

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

http://bcpsqc.ca/clinical-improvement/sqan/

http://bcpsqc.ca/clinical-improvement/nsqip/

http://www.fraserhealth.ca/?section_id=7184§ion_copy_id=4914&tpid=110&

http://bcpsqc.ca/documents/2012/12/NSQIP-BCPSQC-Report-on-Surgical-Measurement-Systems.pdf

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External Source: http://bcpsqc.ca/clinical-improvement/sqan/