

CASEBOOK OF
PRIMARY HEALTHCARE
INNOVATIONS



**PICKING UP
THE PACE**

HOW TO ACCELERATE CHANGE
IN PRIMARY HEALTHCARE

*Sharing success,
learning from challenges*

Acknowledgement

CHSRF would like to acknowledge the work of Ann Silversides, who wrote the casebook summaries for this publication.

This document is available at www.chsrf.ca.

Ce document est aussi disponible en français.

This is a publication of the Canadian Health Services Research Foundation. Funded through an agreement with the Government of Canada, CHSRF is an independent, not-for-profit corporation with a mandate to promote the use of evidence to strengthen the delivery of services that improve the health of Canadians. The views expressed herein are those of the authors and do not necessarily represent the views of CHSRF or the Government of Canada.

ISBN 978-0-9689154-4-8

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INTRODUCTION

After almost three decades in the doldrums, primary healthcare renewal has accelerated dramatically in Canada since 2000. However, progress has been uneven across the country, with some jurisdictions striding boldly forward while others have been more tentative in undertaking reform. Although innovation in primary healthcare is occurring in every province and territory, what sets the past decade apart is the implementation and scaling up of innovations in the organization, funding and delivery of primary healthcare to the *system level* in several provinces. This casebook documents many of the innovations being implemented across Canada.

PICKING UP THE PACE

Countries with strong primary healthcare infrastructure tend to experience better outcomes and efficiency, lower healthcare costs, and higher patient satisfaction than those with weak primary healthcare systems. This evidence, paired with Canada's poor standing in recent international comparisons, should be a strong impetus for Canadian improvements. However, Canada lags in its efforts to spread its successes within and across regions.

At the local level, many improvements have been realized—often thanks to support from the 2000–2006 Health Canada Primary Healthcare Transition Fund. Yet, when it comes to generalizing primary healthcare innovations, Canada has a poor track record. It is our hope that bringing primary healthcare leaders together to discuss the implementation and spread of promising innovations will inspire important health system transformation, to the benefit of all Canadians.

In late 2009, the Canadian Health Service Research Foundation assembled a national and regional steering committee structure composed of policy leaders, decision-makers and senior healthcare providers. The purpose of these committees was to provide advice and identify regional innovations, best practices and challenges associated with advancing primary healthcare in Canada.

In February 2010, each of the five regional steering committees led an assessment intended to uncover both prominent and little-known primary healthcare innovations. The assessment process varied by region, but typically included key informant consultations, environmental scanning and review of recent primary healthcare reports. The results were astounding—more than 120 innovations were identified in just a little over two months.

The national steering committee met in April to present the regional results and again in June to finalize the selection of innovations to be showcased at the conference. Selection criteria were based on the review of primary healthcare literature and feedback from steering committee members, conference co-chairs and CHSRF staff. The selected innovations are:

- **consistent with the conference goal** of advancing system-wide primary healthcare transformation directed toward improved health outcomes, enhanced patient experience and efficient use of resources,
- **relevant to Canadian** policy-makers, clinical and professional leaders, and health system managers,
- expected to or already show **evidence of impact** on population health, patient experience and costs of care,
- successful in or demonstrate clear potential for **scaling up** to the system level,
- **transferable** across provincial/territorial boundaries,
- **sustainable**, and
- **representative of Canada's regions**.

Ultimately, 47 innovations were selected from across Canada. Each demonstrates that change is possible, obstacles can be overcome and that there is much to be gained from the sharing of experience.

WHAT IS INNOVATION?

Fundamentally, innovation consists of new or better ways of doing things that contribute value. Innovation exists in many forms, such as process, product, social and organizational innovation. In the service sector, innovation occurs primarily at the organizational level. It also features interaction with collaborators in the organization's environment, such as universities, research institutions and other partners.

Innovation is an important attribute of high-performance organizations. They excel due to their ability to find better ways of doing things, to take on challenges despite often limited resources. In other words, they are able to adapt, develop a culture of excellence and continuous improvement, achieve quality and reach their goals.

Research shows that primary healthcare productivity is a determining factor of the productivity of the overall healthcare system at the local, regional, provincial/territorial and pan-Canadian levels. As noted earlier, recent studies suggest that Canadian primary healthcare ranks poorly in the international arena. The aim of the casebook and the *Picking Up the Pace* event is to share experience and learning among those with a stake in strengthening primary healthcare in Canada.

WHAT WE FOUND

Essentially, we found two main types of organizational innovation in primary healthcare in Canada:

- 1) innovations arising from the "trenches," that originally emerged in a given organization and gradually spread to other, similar organizations—and in some cases, even won the support of higher authorities who deliberately disseminated them (*a bottom-up approach*), and
- 2) innovations undertaken by decision-makers at the regional or provincial/territorial level that were deployed from the outset on a broad scale (*a top-down approach*).

In both cases, these innovations arise from leaders in their environment. These leaders are agents of change who know how to work with new ideas and how to buckle down and get the job done, despite the many constraints that they inevitably face.

As we reflected on the many innovations that were nominated for inclusion in *Picking Up the Pace*, we were struck by how few system-level innovations emerged from the bottom up. The vast majority of innovations that were implemented broadly were of the top-down variety. This suggests a failure at the system level to identify and harvest well-tested innovations that begin as pilot, demonstration or research projects or local initiatives, even though most of those projects and initiatives were funded directly or indirectly by federal or provincial/territorial health authorities.

During the 1980s and 1990s, primary healthcare innovation in Canada was characterized by numerous small-scale initiatives that remained at the periphery of the healthcare system. However, the 2000s have witnessed significant system-level primary healthcare innovations in several provinces and territories, most notably Alberta, British Columbia, Ontario and Quebec. Why the change?

- Policy-makers in provinces where primary healthcare reform has been most extensive appear to have come to terms with the policy legacy created when Medicare was introduced, which as Carolyn Tuohy has noted, "made no changes to the existing structure of healthcare delivery [and] placed physicians at the heart of the decision-making system at all levels." In the provinces where primary healthcare transformation has been most far-reaching, the government has negotiated major initiatives with the provincial medical association that bargains on behalf of physicians.
- An improved fiscal climate in the early 2000s allowed governments to make significant investments in primary healthcare renewal.

- The 2002 reports of the Commission on the Future of Health Care in Canada (Romanow report) and the Senate Standing Committee on Social Affairs, Science and Technology (Kirby report) galvanized professional and public support for healthcare reform.
- Public concerns about access to care were fuelled by florid media reports on emergency room “overcrowding,” which was often attributed to difficulty accessing family physicians.
- Finally, many family physicians have become willing to embrace non-traditional modes of remuneration and practice organization as a means of improving the quality of their working life and achieving the person-centred, evidence-based care they aspire to deliver.

Genuine progress has been made in the last decade. However, if we are going to make primary healthcare innovation the foundation for improved productivity in the healthcare system, we must learn to “cultivate” it more effectively. We are already making progress, as demonstrated by the many initiatives featured in *Picking Up the Pace*. However, we need to expand our capacity to learn from both success and failure. We need more effective mechanisms for sharing knowledge and for honing the individual and collective skills required to create conditions conducive to the emergence and dissemination of innovation.

The innovations presented at *Picking Up the Pace* are the best examples that we could find to accelerate change that can strengthen primary healthcare in Canada. We hope that the casebook and conference will inspire and enable you to develop strategies for the implementation and spread of some of these innovations within your environment.

Brian Hutchison and Denis A. Roy

Conference Co-chairs

Picking Up the Pace

Lack of timely access to family doctors in the Cape Breton District Health Authority (CBDHA) catchment area meant that one-third of patients reported waiting four or more days to get an appointment and most visits to hospital emergency rooms were for the least urgent needs—levels 4 and 5 on the Canadian Triage Scale. Most doctors in the area are solo practitioners, making holiday and after-hours coverage more difficult than for physicians in group practices. The CBDHA encompasses a population of about 130,000.

IMPLEMENTATION

The goal of the project was to shift physicians to a new way of booking appointments—advanced access, also known as same-day scheduling or open access—in order to improve patient access and reduce non-urgent emergency room visits. Slightly more than 100 family doctors practice in the CBDHA at any given time and most receive 25 to 30 patient requests for appointments each day. To shift to an advanced-access system, physicians have to first clear the backlog of pre-booked appointments. The project provided interested physicians with support to do so. Physicians who made the shift experienced some increase in workload,

“PATIENTS OF PHYSICIANS WITH SAME-DAY BOOKINGS EXPRESSED MORE SATISFACTION THAN THOSE IN MORE TRADITIONAL PRACTICES”

since non-urgent patients were diverted from emergency wards, but also expressed more job satisfaction. As part of the project, all CBDHA family doctors received annual reports on how many of their patients visited local hospital emergency rooms for level 4 and 5 needs, and were also provided with anonymous peer comparisons.

RESULTS

- Four solo practitioners transitioned to a same-day appointment booking system.
- Receptionists in doctors' offices were pleased because patients were happier.
- Patients of physicians with same-day bookings expressed more satisfaction than those in more traditional practices.
- Continuity of care improved as more patients saw family doctors for less urgent conditions, instead of going to emergency wards.

- The practice of one family doctor who shifted to advanced-access booking experienced: a 28% drop in patients' level 4 and 5 visits to emergency wards; a 7% increase in revenue; better continuity of care; early presentation of illness dealt with in office; fewer no-show appointments and improved handling of patient concerns.

CHALLENGES/OBSTACLES

- Uptake was slow by family doctors, most of whom are busy in solo practices and are paid on a fee-for-service basis; many feel they are on a treadmill and changing practice seems too difficult.
- Receptionists and office managers can champion or sabotage a transition; college education for such staff should include familiarity with advanced-access approaches.

SPREAD

One local physician has become an advocate and provides peer counselling to other doctors who express interest in shifting to advanced-access booking. Further spread will require district and provincial strategies, and support for existing and new doctors and office receptionists.

FOR MORE INFORMATION:

www.cbdha.nshealth.ca

In October 2009, in response to Patient First Review recommendations, the government announced the Saskatchewan Surgical Initiative—a province-wide effort aimed at transforming an individual’s surgical experience from entry into the healthcare system to leaving in a healthier state. One of the program’s goals is that by 2014, no patient will wait more than three months for surgery. When healthcare providers, managers and policy makers met to discuss how to achieve this goal, there was a resounding call that improvements to access must be addressed along the entire continuum of care for surgical patients. The Health Quality Council (HQC) was tasked with leading what is believed to be a first-of-its kind approach in Canada to improving access and efficiency across multiple care settings, including primary care.

IMPLEMENTATION

Since the advent of the Saskatchewan Surgical Initiative—launched in April 2010—HQC staff have been meeting with interested groups of primary care doctors, medical specialists and diagnostic services to explore how best to improve access through the chain of healthcare services that surgical patients experience. Learning from its earlier efforts in improving access to primary care via its Chronic Disease Management Collaboratives, HQC is in the early stages of implementing an innovative

“TRUE COLLABORATION IN DESIGN AND IMPLEMENTATION ADDS DEPTH TO THE FINAL PRODUCT BUT ALSO COMPLEXITY AND TIME”

program—known as Clinical Practice Redesign—to support physicians and their office staff to redesign care for better access and efficiency within their own practices, but equally importantly, between practices and across care settings.

RESULTS

- The prototype phase of the Clinical Practice Redesign program was launched in fall 2010. Over the subsequent months, HQC will use a “learn with intent” scale-up method to enable and optimize the spread of the Clinical Practice Redesign program across the province.

CHALLENGES/OBSTACLES

- Medical practices are busy places and the level of quality improvement support currently in the system is inadequate.

- True collaboration in design and implementation adds depth to the final product but also complexity and time.
- Working with practices in different care settings—e.g. specialty care and family practice—requires flexibility in resources and support.

SPREAD

To date, Saskatchewan is the only province embarking on such an integrated and comprehensive approach to improving access to care, the patient experience and efficiency.

FOR MORE INFORMATION:

www.hqc.sk.ca

With a total population of 7,300, the five, mostly rural Cape Breton communities involved in the Tui'kn Initiative had only episodic care from doctors, who might visit for a few hours each week. This approach was not conducive to continuity of care and good chronic disease management, and in some communities there was significant over-prescribing of narcotics. The impetus for change came when the communities joined together: chiefs and councils provided political support to directors from the community health centres who, along with a two-person secretariat, collaborated with the provincial and federal governments and the district health authorities. The project involved a wholesale change in how primary care is delivered in the five communities—ranging in size from 650 to 4,000 residents—from episodic care from physicians to a primary care team approach with care delivered by full-time health professionals.

IMPLEMENTATION

The change involved complex negotiations because responsibility for First Nations healthcare is shared by the federal and provincial governments and district health authorities. Doctors who had served the communities part time and were paid on a fee-for-service basis declined an offer to shift to delivering care full time in a collaborative team and to be remunerated on an alternate payment system. Health Canada's First Nations and Inuit Health

“THE COMMUNITIES NOW HAVE ACCESS TO PRIMARY CARE 37.5 HOURS A WEEK”

Branch pays for staff at each community's health centre, but only for upstream care (immunizations, etc.), not for primary care. Some of the communities have control over how they allocate federal health dollars, while others are tied to specific spending envelopes. New physicians were hired under contracts between the band and the local district health authority. Nurse practitioners joined primary care teams in two of the communities.

RESULTS

- Access to local primary care services increased.
- Coordination, integration and continuity of care have improved.
- There is more emphasis on health promotion, including prenatal care, disease prevention and chronic disease management.
- The communities now have access to primary care 37.5 hours a week.

CHALLENGES/OBSTACLES

- There were concerns related to the departure of long-serving physicians to whom many community members were very loyal.
- It was difficult to recruit and retain family doctors interested in working in a primary care team.
- Aboriginal healthcare is highly complex because it involves so many jurisdictions and programs that are not well integrated.
- Compiling health indicator reports for the population is difficult because provincial healthcare databases (billing, etc.) do not differentiate recipients by First Nations status.
- The gains made in the transition to the new model of primary healthcare are extremely fragile. A shift in policy could quickly undo what has taken years to build.

SPREAD

It is expected that the model will spread to the other eight First Nations communities in mainland Nova Scotia. Health directors from the 13 communities meet regularly and representatives from other First Nations communities have toured the project.

FOR MORE INFORMATION:

www.tuikn.ca

The 1991 Royal Commission on Health for the province of British Columbia underscored the stark health disparities between Aboriginal Canadians and the general population. In the wake of the creation of the Royal Commission, a group of First Nations leaders in Prince George, British Columbia, established the Central Interior Native Health Society primary healthcare clinic. It is a family practice clinic, not a drop-in clinic, and was created to be a welcoming and non-judgmental environment for urban Aboriginals marginalized by systemic inequalities.

IMPLEMENTATION

The clinic aims to serve homeless and Aboriginal people; the latter account for about 80% of the clinic's total patient population, which ranges from 900 to 1,200 (the population is fairly transient). The clinic is governed by a six-member Aboriginal board of directors, which sets policy along with the executive team and service providers. A First Nation Elder is on the clinical team and works to reconnect Aboriginal people with their culture, and especially their spirituality. When learning collaboratives were introduced in B.C., there was an assumption that managing diabetes would be the most pressing need for clinic patients. However, the clinic's advanced electronic medical record (EMR) system

“CLIENTS ARE BEING DIVERTED FROM SEEKING CARE AT EMERGENCY DEPARTMENTS; MANY HAD BEEN TOLD THEY WERE NO LONGER WELCOME AT REGULAR FAMILY PRACTICES IN THE CITY”

revealed that hepatitis C and HIV/AIDS were the top chronic health issues. When the clinic first opened in 1993, staff included a part-time physician, social worker, nurse, bookkeeper/office manager, medical office assistant and executive director. The clinic received an infusion of resources in 2003, when the province initiated primary healthcare reform. It now has a staff of 19, including part-timers. Social workers on staff do outreach, often to seek out patients to ensure follow-up and, when clients return to reserves, to forge links with on-reserve healthcare workers. The clinic works on a harm reduction model and offers a Methadone maintenance program.

RESULTS

- A four-year CIHR-funded study of the clinic is underway to better understand how primary healthcare services are provided to meet the needs of people who have been marginalized by systemic inequities, and to use that knowledge to develop a preliminary set of indicators that reflect the most relevant dimensions of service delivery in the context of people's lives and well-being.
- Clients are being diverted from seeking care at emergency departments; many had been told they were no longer welcome at regular family practices in the city and had relied on emergency wards for care.

CHALLENGES/OBSTACLES

- It is necessary to recruit physicians who can work in a harm reduction environment in a non-judgmental way. This is especially challenging in the context of an overall doctor shortage.

SPREAD

The clinic has had numerous requests to help set up Aboriginal health clinics in other northern B.C. communities. Clinic leaders insist that any similar clinics must be desired and “owned” by the local Aboriginal population.

FOR MORE INFORMATION:

phc@cinhs.org

Many women from two First Nations communities west of Rocky Mountain House lacked consistent prenatal care. As a result, once in labour, many were routinely triaged as high risk and routinely transferred from the local hospital to a higher level of care. The experience was isolating and stressful. The women, many of whom were young, were then discharged with little follow up. Members of the community, along with local healthcare providers, recognized they were under-served for pre- and postnatal care.

IMPLEMENTATION

The midwifery program was developed with the support of band councils and federal, provincial and primary care health representatives. Women are made aware of the program and self-refer. The midwife spends every Tuesday at one of the reserves. She conducts full prenatal visits, including referrals and lab work. During that day, parenting support, cooking and sewing circles are available, with elders in attendance. The midwife has access to patients' electronic medical records at the health centres and evaluation plans are in place. The midwife attends deliveries at Rocky Mountain House

“AS A RESULT OF THE TRUST DEVELOPED WITH THE MIDWIFERY PROGRAM, THE PRIMARY CARE NETWORK WAS INVITED BY THE COMMUNITIES TO INTRODUCE A CHRONIC DISEASE MANAGEMENT PROGRAM”

Hospital because these First Nations patients do not meet the criteria for home birth. Initially, half of the program's expenses were covered by the federal government, with the balance being covered by the Primary Care Network and the health authority. In 2010, the program began to receive public funding from Alberta.

RESULTS

- The number of prenatal care visits increased, from zero to up to 10 (the average number is six or seven).
- The majority of pregnant women now see the midwife.
- The incidence of premature and low-weight births has decreased.
- There are more spontaneous vaginal deliveries at Rocky Mountain House.
- Breastfeeding has increased.

CHALLENGES/OBSTACLES

- Obtaining appropriate funding for the program.
- Overcoming a culture of distrust for non-Aboriginal medicine and a history of poor recognition of the community's cultural needs.

SPREAD

As a result of the trust developed with the midwifery program, the primary care network was invited by the communities to introduce a chronic disease management program on the reserves, where there is a high prevalence of diabetes.

FOR MORE INFORMATION:
www.rockymedical.com

Over 40% of patients in a local cardiac rehabilitation program did not have access to a family doctor and most had not seen one for many years. Their average age was 44, and a high proportion of them smoked and suffered from obesity and chronic diseases. This initiative puts health professionals directly in the workplace in order to connect with this difficult-to-reach population and provide “upstream” health education. The goal is to promote a healthy lifestyle, screen for cardiovascular and respiratory health issues, and prevent and manage chronic diseases.

IMPLEMENTATION

An interdisciplinary health team provides services in the workplace. Worker participation is voluntary. Initially, the local *Centre de santé and des services sociaux* (CSSS) agreed to fund a nurse for seven hours a week and two drug companies provided additional project funding to the end of March 2008. (Quebec created CSSSs in mid-2000, merging long-term care, *Centres locaux des services communautaires* (CLSCs) and, in most cases, hospitals.) The project is now a partnership with 18 private-sector companies, ranging in size from seven to 120 employees, with close collaboration among the interdisciplinary team, company executives, employees and union

“CASES OF CANCER, DIABETES/GLYCEMIC ANOMALIES, HEART DISEASE AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE ARE BEING DETECTED EARLIER”

representatives. Currently, 503 workers participate and companies sign on to the project for a three-year period. Currently, two-thirds of the project’s budget is contributed by employers and employees.

RESULTS

- There has been a positive impact on workers’ health; some went from a high to a low risk of heart disease.
- Cases of cancer, diabetes/glycemic anomalies, heart disease and chronic obstructive pulmonary disease are being detected earlier.
- There are positive changes of lifestyle for the workers (e.g. change in the contents of lunch bags, quitting smoking and participation in sports).

- Wait times for access to a professional have been reduced; all registered workers have quick access to the Jocoeur team.

CHALLENGES/OBSTACLES

- Workers were initially concerned about the confidentiality of the data collected.
- Family doctors of some of the workers participating were reluctant; ongoing communications were necessary until they began to see positive results in their patients.
- The companies’ leaders were looking for a quick and visible return on prevention efforts.
- Initially there was lack of appreciation for health professionals other than physicians.
- There was no long-term funding for the project.

SPREAD

Fourteen companies are awaiting services (2,300 workers) and a similar project is being implemented at the CSSS du Lac Témiscamingue. The project has received 17 requests for information from cities, health centres and small and medium-sized enterprises in Quebec that are interested in implementing a similar project.

FOR MORE INFORMATION:

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CHSRF produced an accompanying video for this innovation, available through www.chsrf.ca or www.youtube.com/user/CHSRF.

In 1999, in Sherbrooke, Quebec, there was a high occupancy rate in long-term care institutions, high rates of older patients in acute care hospital beds awaiting placements, a lack of coordination among service providers and unnecessary repetition of clinical assessments. Sherbrooke has a population of about 150,000, approximately 20% of whom are over 65 years of age. Many functionally dependent seniors wanted the option of receiving care at home, and this type of service delivery was supported by the institutional and medical communities and private sector service partners. The reorganization of services was managed by the *Centre de santé et des services sociaux—institut universitaire de gériatrie de Sherbrooke* and the PRISMA research team (*Programme de recherche sur l'intégration des services de maintien de l'autonomie*) of the Research Centre on Aging in Sherbrooke. When it was introduced to the city in 1999, the integrated service model was unique in Quebec.

IMPLEMENTATION

The model called for the adoption of a shared access mechanism for services, a common tool for evaluating needs and shareable, computerized clinical records. In 2002, electronic medical records (EMRs) were introduced to allow record sharing, and a single access point was created for obtaining services for dependent seniors. In

“SHERBROOKE EXPERIENCED A 14% REDUCTION IN THE LOSS OF AUTONOMY OF THE SENIORS, THE STABILIZATION OF HOSPITALIZATIONS AND RELATED TRENDS, AND A POSITIVE EFFECT ON THE SATISFACTION AND EMPOWERMENT OF AFFECTED SENIORS”

2004 and 2005, the number of long-term beds in the city was significantly reduced and numerous residents had to be relocated. Home-care services were increased and new private residential care facilities were opened.

RESULTS

- Better control over wait times for beds in homes and stabilization of the number of long-term care beds.
- A control group comparison with three communities where services were not integrated demonstrated that Sherbrooke experienced a 14% reduction in the loss of autonomy of the seniors, the stabilization of hospitalizations and related trends, and a positive effect on the satisfaction and empowerment of affected seniors.

- The model has spread in Quebec, but using a monitoring tool, the province gave Sherbrooke a score of 67% for having instituted most of the components of service integration, compared to a provincial average of 37% at the other integrated service models.

CHALLENGES/OBSTACLES

- Home support services had to be increased during a period of great anxiety because of the cuts to long-term care beds and the immediate need to relocate residents.
- The nature and scope of the work done by individuals—such as case managers, nurses and physiotherapists—had to be redefined as a result of the shift from institutional to more home-care services.
- There is a labour shortage for health and home-care workers.

SPREAD

This model of integrated services for seniors has spread through the province, although fewer components of the model have been implemented at the other sites.

FOR MORE INFORMATION:

Céline Bureau

cbureau.csss-iugs@ssss.gouv.qc.ca

The creation of *Centres de santé et des services sociaux* (CSSSs), which integrate hospitals with community health services, opened the door to new ways to improve health delivery. Défi Santé grew out of the recognition that a small percentage of patients consume a disproportionate amount of total healthcare resources (hospital, primary care and community). The founding principle was that identifying these people and helping them to take charge of their health would improve their level of health while making better use of resources.

IMPLEMENTATION

The CSSS des Sommets, located in the Laurentians, uses an integrated clinical database which stratifies healthcare consumers based on use and enables the CSSS to identify the highest consumers. The initial cohort consisted of 200 patients with an average age of 66 (93% of whom had a family physician). Most patients suffered from more than one chronic condition, including mental disorders, substance abuse and physical ailments. Every family doctor in the territory covered by the CSSS des Sommets received a personalized letter confirming their role in the initiative. They were informed that these patients were clinically complex and high consumers of care. A nursing manager

“FROM 2006 TO 2008, THE COHORT’S ANNUAL EMERGENCY VISITS DROPPED FROM 760 TO 212 AND HOSPITAL ADMISSIONS DECLINED FROM 514 TO 88”

for complex cases completed clinical assessments and coordinated the resources needed for intervention plans with the family physician and community resources, in order to prevent acute episodes of chronic conditions and work with the patient to help him or her become chronically well. Clients were followed intensively in the community for months, and proactive work was done to prevent avoidable emergency visits and repeated hospitalizations.

RESULTS

- From 2006 to 2008, the cohort’s annual emergency visits dropped from 760 to 212 and hospital admissions declined from 514 to 88.
- Well-being and quality of life improved, based on responses to questionnaire SF-36.
- Interprofessional collaboration between family doctors, CSSS nurse case managers and community pharmacies was renewed and proactive clinical follow-up of complex cases increased.

- The creation of new alliances led to more effective use of community resources.

CHALLENGES/OBSTACLES

- One of the challenges was to have common understanding of the organizational goals among the CSSS professional staff, physicians and managers.
- There was a need to create new alliances with new partners in the community, including the patient, the patient’s family and the family physician.

SPREAD

In Quebec, Défi Santé is spreading to more than 25 health organizations. This approach is being introduced in organizations that have expressed interest in making these changes. Conference presentations have generated interest throughout Quebec and more recently, in Ontario.

FOR MORE INFORMATION:

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Individuals with mild to moderate dementia in the Corner Brook area of Newfoundland and Labrador were sometimes admitted to a locked ward in the local residential long-term care facility only because of an absence of alternative accommodation. These often inappropriate and premature placements meant individuals who were medically stable were living in a institutional environment, became more dependent and lost some of their ability to function independently. Research in one part of the province demonstrated that for 15.3% of residents in one long-term care facility, mild to moderate cognitive impairment was the sole reason given for admission. The province introduced a plan to improve long-term care in Corner Brook and reduce reliance on protective care (locked ward) beds. Four 10-bed bungalows were constructed as a demonstration project to provide more home-like care for individuals with mild to moderate dementia.

IMPLEMENTATION

In 2008, three of the four bungalows, all located in mixed residential neighbourhoods, began accepting individuals with mild to moderate dementia. (The fourth bungalow will be used to house individuals with more advanced dementia; staffing and care arrangements are still being finalized.) Family members were given the choice of whether to move their relatives from the long-term care

“‘I NEVER THOUGHT I WOULD TASTE MUM’S COOKIES AGAIN,’ SAID ONE ADULT CHILD”

facility to the new one-storey secure houses with fenced backyards. Bungalow residents take part in the activities of daily living—they dress themselves and help to cook meals, garden, do the laundry and perform other household activities—and thus maintain their independence. The bungalows are staffed during the day by two personal care workers; a third worker covers the night shift. The personal care workers administer medications in a pouch system, and a licensed practical nurse and recreational therapist also work at the houses.

RESULTS

- The level of family satisfaction is high: “*I never thought I would taste mum’s cookies again,*” said one adult child.
- Residents who were transferred from institutional care showed clinically improved function and behaviour.
- The cost per resident is lower compared to a locked unit in long-term institutional care.

CHALLENGES/OBSTACLES

- Long-term care and other professional staff were initially apprehensive and sceptical about the bungalow model and to having personal care workers, members of an unregulated profession, provide most of the care and assistance with medications.
- Although the model is showing success, anticipated enhancements to home care services in the province could enable more people with mild to moderate dementia to remain longer in their own homes, leading to a change in the staffing model, and perhaps the sustainability, of this bungalow model.

SPREAD

Additional bungalows are being constructed in the province; two other health authorities have received capital investment to build the bungalow model.

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Individuals coping with depression and anxiety, whether related to a chronic illness or not, often first visit their family doctor, who may lack training or experience in dealing with mild to moderate depression and anxiety. Doctors can refer patients suffering from serious mental illnesses, such as schizophrenia and bipolar disorder, to mental health centres, but there are few referral resources for depression and anxiety. The British Columbia division of the Canadian Mental Health Association (BC CMHA) developed interventions to help: a DVD called *Living Life to the Full*, which doctors can give to patients, and guided self-help materials supplemented with telephone coach support from BC CMHA counsellors.

IMPLEMENTATION

Referral to the program is primarily through family physicians. Patients and caregivers of patients with chronic disease are eligible. Mental health and addictions clinicians, and home and community care personnel can also make referrals with the knowledge of the patient's family doctor. Referrals increased after primary care doctors began taking mental health modules through B.C.'s Practice Support Program (see page 13). Telephone coaches (19 full-time-equivalents) are available at times convenient for the client/patient. Patients are offered three to five sessions over a one- to two-month period,

“PHYSICIANS REPORT THEY NOW HAVE TOOLS OTHER THAN MEDICATION TO OFFER PATIENTS AND ARE MORE LIKELY TO DO MENTAL HEALTH ASSESSMENTS”

and several follow-up check-ins are scheduled. Patients also have access to a 16-section workbook. Program materials are available in English and, because of the large Chinese population in B.C., materials were culturally adapted and translated, and telephone coaching is available in Cantonese. A participant advisory committee provides feedback on the program, which rolled out in three phases from June 2008 to February 2009. Initially funded for three years, starting in 2007, the contract has been extended to 2011. Program costs have averaged \$2.5 million a year.

RESULTS

- As of late August 2010, more than 38,000 DVDs have been distributed and about 6,700 referrals have been made for telephone coaching, which is offered within five business days of referral. More than 650 doctors have made referrals.

- Patient health questionnaires and assessment scores show a significant post- intervention decrease in depression and anxiety measures, and a significant increase in quality of life and physical health rating.
- Physicians report they now have tools other than medication to offer patients and are more likely to do mental health assessments.

CHALLENGES/OBSTACLES

- Initially it was difficult to gain access to busy family doctors to introduce and explain the intervention. (This was eased when doctors began participating in the Practice Support Program.)
- Keeping up with demand is a challenge.

SPREAD

The intervention has already spread throughout the province with new referrals averaging 580 a month. There has been interest from other provincial governments and mental health associations.

FOR MORE INFORMATION:

www.cmha.bc.ca/bounceback

This program originated when mental health service providers in Hamilton identified various problems they were experiencing in their relationship with primary care providers, who were delivering significant amounts of mental healthcare, often without necessary support. Both primary care and mental health service providers saw an opportunity to improve the relationship between the two groups, and improve detection and treatment rates.

IMPLEMENTATION

The program is in its 17th year and has grown over time. Mental health counsellors and psychiatrists are now integrated into the offices of 150 family doctors in Hamilton, providing about 70% of the city's population with access to a mental health team in the office of their family doctor (the ratio is one counsellor per 7,200 patients). The program is located in 81 different practice sites, and many are solo practices. A central management team helps establish efficient placement of mental health counsellors, reducing travel time between offices. There are close to 50 full-time-equivalent (FTE) positions

“PATIENTS HAVE STATISTICALLY SIGNIFICANT OUTCOMES RELATED TO IMPROVED MENTAL AND PHYSICAL HEALTH AND WELL-BEING”

for mental health counsellors, including addiction and children's mental health counsellors, and most have backgrounds in social work or nursing. Psychiatrists visit family doctors about half a day per month to provide both direct care and supervision.

RESULTS

- The program has improved access to mental health services, with family doctors referring 11 times as many cases for a mental health assessment as before the program started.
- Patients have statistically significant outcomes related to improved mental and physical health and well-being.
- There has been a significant reduction in referrals to outpatient clinics, inpatient admissions of patients and length of stays in hospital.
- Patients and providers of primary and mental healthcare report a high level of satisfaction with the program.

CHALLENGES/OBSTACLES

- Some family doctors were initially reluctant to move to a new model of care.
- The new model of care had not been tested on a large scale.
- There were logistical challenges with integrating almost 50 FTE counsellors into 81 different sites and finding space in many of the practices.
- There was a need to prepare mental health counsellors and psychiatrists to work in primary care.

SPREAD

The mental health shared-care program has been adopted and adapted by many places across the country, and has become a prototype for policy development for Ontario's family health teams, over 100 of which now have mental health teams in place. As well, the Hamilton program has added new components: a child and youth mental health program, an addictions program, a one-to-one peer support program, and a depression disease management program.

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Mental health disorders affect about 20% of the rural population in Canada and these rates can increase in communities that experience significant job loss. The closure of a pulp and paper mill near Dalhousie, New Brunswick, led to the massive loss of high-income jobs. With this catastrophic socio-economic event came the potential for higher than usual rates of conditions such as depression and anxiety disorders. The stigma associated with seeking mental health services meant disorders were going untreated. Patients who accepted referrals to mental health services faced lengthy wait times. Because family doctors are the front-line service for patients suffering from mental disorders, this pilot program (January 2009 to September 2011) aims to integrate usual mental healthcare into general healthcare delivery. Primary healthcare providers are trained to appropriately identify, diagnose, treat and monitor individuals suffering from common mental disorders and to refer more serious cases. The enhanced capacity at the primary care level should support more effective use of speciality mental health services.

IMPLEMENTATION

Psychiatrist Dr. Stan Kutcher from Dalhousie University in Halifax developed a train-the-trainer program adapted to the needs of the community. Three primary care staff at the St. Joseph's Community Health Centre (CHC) in Dalhousie have completed leader training, along with a local addictions counsellor, a psychologist and a consulting psychiatrist. The CHC has 10,000 patients and

“THE STIGMA ASSOCIATED WITH SEEKING MENTAL HEALTH SERVICES MEANT DISORDERS WERE GOING UNTREATED. PATIENTS WHO ACCEPTED REFERRALS TO MENTAL HEALTH SERVICES FACED LENGTHY WAIT TIMES”

also serves people without a family doctor at a walk-in clinic. In the pilot project, the CHC's five full-time-equivalent (FTE) doctors, eight FTE nurses, two FTE nurse practitioners and one FTE social worker are trained using a “needs-driven, competencies-based mental health delivery framework.”

RESULTS

- It is too early in the project for results, but those who have undergone training report a boost in their confidence to handle mental health issues.
- The pilot will undergo a formal evaluation.

CHALLENGES/OBSTACLES

- There was a need to gain the buy-in and engagement of local mental health professionals.
- The primary consultant had to be available.

SPREAD

It is expected that when this pilot is evaluated, the approach can be implemented in other communities in the province.

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This program is part of a multi-pronged effort to revitalize family-practice medicine in British Columbia. The Practice Support Program (PSP) followed a watershed 2006 funding agreement between the B.C. Medical Association (BCMA) and the Ministry of Health Services that largely replaced across-the-board fee increases with targeted incentive payments. The PSP is sponsored by the General Practice Services Committee (a joint BCMA/ministry body) and was introduced in recognition that financial incentives alone would not be sufficient and doctors would need practical tools and support to redesign their clinical and office practice to better serve patients.

IMPLEMENTATION

The PSP is a voluntary program that focuses on office efficiency and clinical redesign. It is available to all B.C. family doctors. The PSP was launched with four modules; advanced access scheduling, chronic disease management, adult mental health and medical visits with groups of patients (focusing on self-management and health literacy). The modules are introduced in learning sessions and action periods, and doctors are remunerated for participating. A provincial coordinating

“AFTER PARTICIPATING IN THE MENTAL HEALTH MODULE, DOCTORS REPORTED INCREASED CONFIDENCE IN DIAGNOSING, TREATING AND MANAGING PATIENTS WITH MENTAL HEALTH CONDITIONS. THEY ALSO REPORTED PRESCRIBING FEWER MEDICATIONS”

office develops program content and provides orientation training that includes a review of change concepts and quality improvement methodology. Peer physicians act as champions and help regional support teams deliver the program. The PSP is building templates so that physicians can use their electronic medical records (EMRs) to create recall lists and patient registries. The mental health module has been particularly popular; physicians are given a manual and tools for diagnosing mental health conditions and helping patients manage.

RESULTS

- 83% of family doctors reported improved professional satisfaction.
- Access to family physicians improved, with appointment delays reduced from 4.7 to 1.8 days.
- More than 50% of actively practising family doctors have participated in the program and practices have, on average, participated in two program modules.

- Of participating doctors: 83% created patient registries, 91% reported they used a team-based approach to care and 95% reported patients becoming partners in care.
- After participating in the mental health module, doctors reported increased confidence in diagnosing, treating and managing patients with mental health conditions. They also reported prescribing fewer medications.

CHALLENGES/OBSTACLES

- Senior healthcare managers did not initially buy into the concept of quality improvement (QI) or see its potential benefits.
- Some family doctors resisted QI language and methodology.
- The high volume of demand was not anticipated. Program details and materials were not all finalized at the time of introduction and this led to local variation in program delivery.

SPREAD

Demand continues to be high among B.C. family doctors. More clinical modules are being developed and the PSP has been expanded to offer medical specialists assistance with office efficiencies. The program could easily be replicated in other jurisdictions.

FOR MORE INFORMATION:

www.pspbc.ca

Concern about poor access to healthcare services led to the launch of the access improvement measures (AIM) initiative in southern Alberta in 2005. Inspired by the Breakthrough Series of the U.S. Institute for Healthcare Improvement, AIM's goal is to help physicians reduce or eliminate patient wait times, and improve practice efficiency and clinical care. Partners included Alberta Health and Wellness, Alberta Health Services, Toward Optimized Practice, Primary Care Initiative and the Alberta Medical Association.

IMPLEMENTATION

Groups of five to 25 clinics are established as learning collaboratives. Each group is assigned a facilitator and meets six times a year to learn about measures and strategies to improve access, with individual clinics adopting the strategies most relevant to their specific needs. However, most work toward at least two common goals: 1) to eliminate the use of different wait lists and appointment "types" (replacing these with appointments of varied duration); and 2) to facilitate same-day access for appointments. To help physicians better understand the needs of their patient population, the province generates reports based on demographics and the most

"DOCTORS REPORT THEY HAVE UNDERGONE A CULTURE CHANGE AND THINK DIFFERENTLY AS A RESULT OF THE PROGRAM"

common billing and diagnostic codes. Physicians can also compare the data with information in their electronic medical records, to decide which clinical areas to target for improvement (e.g. rates of mammography or blood-pressure checks). Participation in AIM is not tied to a financial incentive, but AIM gives doctors the skills to take advantage of existing incentives. Doctors in primary care networks were the initial target audience, but speciality and regional program teams were later included.

RESULTS

- Since 2005, 135 primary care teams and 57 specialty and regional program teams representing more than 1,000 primary care and specialty physicians have participated in AIM.
- In surveys, doctors report they have undergone a culture change and think differently as a result of the program.
- Surveys also show doctors see improvements in the following areas: office efficiency and patient access (96%); teamwork (92%); work satisfaction (91%); clarity of roles (89%); clinical care (88%); and continuity of care (85%).
- Overall, 51% of doctors reported they were very satisfied with their clinic's improvement and 42% reported they were somewhat satisfied.
- Clinic-level improvements in access (measured by "time to third next available appointment") suggest that substantial progress has been made by the clinics/teams that focused on access.

CHALLENGES/OBSTACLES

- Doctors and their staff who embark on office improvement strategies initially face an additional workload.
- Converts can face challenges selling the approach to sceptical colleagues.
- It can be challenging to sustain the improvements.
- Issues related to measurement for improvement vs. measurement for reporting create difficulties in aggregating information to demonstrate program impact at geographic and provincial levels.

SPREAD

AIM has reached about 695 of the approximately 2,000 family doctors in the province. Alberta Health and Wellness and the Healthy Workforce Action Plan continue to fund the program. The goal is to engage more primary care and speciality physicians and the interprofessional teams within primary care networks.

FOR MORE INFORMATION:

www.albertaaim.ca

Quality Improvement and Innovation Partnership (QIIP) is a provincial organization sponsored by the Ministry of Health and Long Term Care with the mandate to improve and sustain clinical, functional and population health outcomes in Ontario. QIIP uses three main strategies to achieve its objectives: networking and partnerships; resources and supports; improvement and innovation methods. Under its first initiative, *Learning Collaboratives*, teams applied improvement methodologies in specific areas: chronic disease management (diabetes), health prevention (colorectal cancer screening) and office practice redesign (access and efficiency). QIIP's second initiative is *The Learning Community*.

IMPLEMENTATION

Launched in June 2010, The Learning Community is a group of improvement-minded providers who leverage and deepen their knowledge and expertise. By working together on an ongoing basis, communities support the exploration of innovative approaches resulting in

“THE SMITHVILLE FHT REPORTED DECREASING THE AVERAGE TIME TO THE NEXT APPOINTMENT FROM 31 TO ZERO DAYS”

sustainable improvement. As of September 2010, the initiative has 179 teams representing 73 organizations joining the Learning Community and participating in up to six action groups, including asthma, COPD, hypertension, diabetes, integrated cancer screening and office practice redesign. The Learning Community Model is adapted from the Institute for Health Innovation's Breakthrough Series. The Learning Community comprises the following three elements:

1. Active Learning Cycles
2. The GATEWAY (a virtual place for primary healthcare teams to learn, share and innovate with one another)
3. Quality Improvement Coach, which offers regional support and improvement expertise.

RESULTS

- A series of Learning Collaboratives were conducted over a two-year period with 121 primary healthcare teams composed of Family Health Teams (FHTs), Community Health Centres (CHCs) and Shared Care Pilot Initiatives (SCPIs).

- With the implementation of advanced access, teams were able to adopt the principles of office practice redesign and reduce wait times so patients could see their provider on the day of their choosing. Change was demonstrated by measuring the third next available appointment. The Smithville FHT reported decreasing the average time to the next appointment from 31 to zero days.
- At the Bancroft FHT, the number of eligible patients screened for colorectal cancer with FOBT (fecal occult blood test) or colonoscopy rose from 26% in to 65%.
- Documented self-management goals for patients with diabetes increased by 74% at City of Lakes FHT.

CHALLENGES/OBSTACLES

- The ability to sustain improvements and spread to other areas of focus and models of care will require providers and in particular leaders to embrace a culture of improvement and support the development of a coordinated strategic approach by all stakeholders to quality improvement for primary healthcare across the entire province.

SPREAD

QIIP is leading the advancement of quality improvement initiatives in primary healthcare with the continuous engagement and adoption by Family Health Teams and Community Health Centres in Ontario.

FOR MORE INFORMATION:

www.qiip.ca

In the mid-20th century, traditional birthing practices were displaced in many northern communities. During the 1960s and early 1970s, maternity care outside the larger centres, including birth, was provided primarily in nurse stations by nurse midwives, many of them trained in the United Kingdom. In the mid-1970s, maternity care policy changed due to difficulties in hiring internationally educated nurse midwives in northern remote communities and changing attitudes about acceptable risk levels. New obstetrical policy dictated that all expectant mothers in smaller communities be sent to larger regional centres to give birth.

At 36 to 37 weeks, women are transferred to larger centres to await childbirth, creating stress and financial burdens for the women and their families. Recently, childbirth has become available in some communities, where primary services are delivered by midwives as part of an interdisciplinary team. The shift has been facilitated by community demand, midwifery legislation and new service-delivery models. Many northern centres don't have the population to support a midwife, but even larger centres like Fort Simpson and Hay River still lack birthing services.

IMPLEMENTATION

In Northern Quebec, Rankin Inlet, Fort Smith and Cambridge Bay, midwives provide pre- and postnatal services and attend deliveries. Pregnant women deemed at high risk or with complications in Fort Smith and Cambridge Bay are sent to the hospital in Yellowknife.

“RATES OF PRE-TERM BIRTH AND CAESAREAN SECTION ARE LOWER THAN TERRITORIAL OR NATIONAL AVERAGES”

(Rankin transfers are to Winnipeg.) Fort Smith has no resident doctors (physicians come on short-term locums), but two resident midwives provide pre- and postnatal services to 40 or 50 women each year. In consultation with a physician, all pregnant women in Fort Smith are reviewed at 34 weeks to determine suitability for birthing at the local cottage hospital, or if they have to be transferred. The majority of births now take place in the community, attended by midwives. In Cambridge Bay, midwives are “imported” from the south on a rotating basis to provide care to about 24 pregnant women each year. Students from university midwifery programs are placed with practising midwives in the north and a goal is eventually to have community members train to become resident midwives.

RESULTS

- Birthing services are available in the community.
- Rates of pre-term birth and caesarean section are lower than territorial or national averages.
- Emergency transfers for childbirth have decreased.

- A client satisfaction survey found the midwifery services and community birthing are accepted and appreciated.
- Breastfeeding rates have increased.

CHALLENGES/OBSTACLES

- Historical challenges included a lack of legislation allowing the integration of midwifery services and the effort required to gain community acceptance of a new model for birthing services.
- There is still a belief that the capacity to do local caesarean sections is needed to provide community birthing services.

SPREAD

Small to mid-sized communities that have lost or may lose local birthing services could use the Fort Smith model as a template to establish or preserve local birth.

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CHSRF produced an accompanying video for this innovation, available through www.chsrf.ca or www.youtube.com/user/CHSRF.

Before this initiative, the 1,200 residents of Long and Brier islands of southwest Nova Scotia were lobbying for a resident doctor. For many years, people in these communities had only episodic medical attention. Residents typically travelled off-island to access care at emergency departments at the Digby General and Yarmouth Regional hospitals and the Annapolis community health centre.

IMPLEMENTATION

The inability to recruit a physician because of financial restraints, long travel times and isolation, led provincial officials and community leaders to develop an innovative primary healthcare model. The approach entails using paramedics to deliver primary healthcare in their “down time.” An ambulance base was established on Long Island to accommodate the paramedics and services were

“EMERGENCY DEPARTMENT VISITS DECREASED BY 40% AND PHARMACEUTICAL PRESCRIPTION COSTS DECLINED SIGNIFICANTLY”

phased in. Oversight is provided by a nurse practitioner, while a consulting off-site physician, who is part of the collaborative team, visits the community at least once a month. In addition to providing acute care, the paramedics’ expanded scope allows them to make home visits for continuing care follow-up, including diabetic checks, oxygen saturation tests, dressing changes, fall assessments and provision of intravenous antibiotics. As well, they take blood, administer flu shots, hold clinics and check blood pressure.

RESULTS

- Residents’ satisfaction rose due to increased access to a range of services.
- Emergency department visits decreased by 40%.
- Pharmaceutical prescription costs declined significantly (nurse practitioners spend more time with patients, emphasizing education and self-management).
- There was successful collaboration among non-traditional health providers.
- Paramedics consider community paramedicine training a badge of honour.

CHALLENGES/OBSTACLES

- Recruiting doctors to collaborative teams with nurse practitioners and paramedics.
- Sustainability is contingent on the ongoing support of emergency health services, the district health authority and the paramedic contractor.

SPREAD

The term “community paramedicine” was coined in Nova Scotia. The relevant training is becoming a standard part of paramedic education in Canada, as well as in the United Kingdom and in Australia, where access to care in remote regions is an issue. Community paramedics are being introduced in Cape Breton and there are initiatives to bring paramedics with this training into emergency wards and long-term care settings, in a bid to reduce emergency ward visits.

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Morbidity and mortality are higher the further one lives away from the city, and the highest death rates are in the most remote communities—the most isolated Canadians live three years less than their urban counterparts. Labrador has many remote communities that are served by nursing stations and rely on transport to a hospital for care for more serious illnesses and accidents. Remote video consultation provides access to a broad range of health services and cuts down on the requirement for travel. Recently, remote video consultation has been used for direct resuscitation of patients in the most northern communities and lives have been saved.

IMPLEMENTATION

Twenty remote communities in Labrador have remote video consultation capability with equipment located in nursing stations. The connection was at first facilitated by Telesat, but has evolved so that connections are now through the local telephone providers. The main centre in Labrador is Happy Valley-Goose Bay, where physicians at the health centre do video consultations every day for primary and secondary care. Tertiary care consults—for example for cancer care—are available. In addition to clinical applications, the video equipment is sometimes used for meetings and professional development. Recently,

“THERE ARE INITIAL CONCERNS ABOUT SECURITY AND PATIENT CONFIDENTIALITY, BUT THESE DISSIPATE WITH USE”

Dr. Michael Jong in Happy Valley has been using the equipment to facilitate remote resuscitation of patients in the most northern communities who are suffering from conditions such as heart attacks, hypothermia and gunshot wounds. Such help was not possible when telephones were the main tool for contact, because a person doing CPR cannot effectively communicate over the phone.

RESULTS

- Video consultations save money and provide better access to care for patients.
- Technology is improving rapidly, the capacity for video consultation is growing and new applications are constantly being discovered.

CHALLENGES/OBSTACLES

- Health professionals do not receive training in remote video consultation during their education and well-established professionals are the hardest to train. Physicians proficient with the equipment may have little time to train colleagues.
- There are initial concerns about security and patient confidentiality, but these dissipate with use. Security of transmission is maintained by a secure pipeline, used only by the health authority, from the phone company.
- Storms can disrupt microwave transmission and lead to intermittent loss of connectivity.

SPREAD

Publication of evidence of the benefits of the system, in particular how it can improve health outcomes and save money, helps to facilitate spread. Adding training in remote video consultation to the curriculum of undergraduate and post-graduate training of healthcare professionals would also help encourage use.

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Access to primary care is a particular problem in Quebec, where about 30% of the population does not have a family doctor. One reason for this is the high proportion of time that Quebec family doctors, compared to peers in other provinces, spend working in hospitals. This project began with recognition of the need for some type of medical coordination at the community level to facilitate the triaging of unattached patients (also called orphan patients), so that the most vulnerable can have access to a family doctor.

IMPLEMENTATION

The medical coordinator at the local *Centre de santé et des services sociaux* (CSSS) canvasses family doctors for volunteers to participate in the program, which means they are willing to accept new patients. Participation rates vary throughout the province from a low of 20% to a high of 80% of doctors in CSSS catchment areas. Patients in

**“AS OF SEPTEMBER 2010, 30,000
PREVIOUSLY UNATTACHED PATIENTS HAD
FOUND FAMILY DOCTORS”**

need of a family doctor can self-refer or be referred by clinics or hospital emergency department and discharge staff. A CSSS nurse administers a questionnaire based on clinical criteria and then prioritizes patients according to a standardized system that is used throughout the province. Older patients with chronic conditions are generally given a higher priority. Physicians who accept new patients receive financial incentives. An information system—the *Système intégré du guichet d'accès pour la clientèle sans omnipraticien* (SIGACO)—has been developed to track the patients who have registered through the CSSSs. The program was developed as a partnership between local committees of general practitioners (regional departments of general medicine—see page 40), the provincial health ministry and the CSSS.

RESULTS

- Of the province's 95 CSSSs, 91 participate in the program.
- As of September 2010, 30,000 previously unattached patients had found family doctors.
- Much better information is available about the unattached patient population in Quebec.
- Physicians now have good information about the new patients they accept.

- Physicians can refer unattached patients to the CSSS nurse, instead of having to tell patients they can't accept them or being obliged to choose one patient over another.
- Retiring physicians now have a mechanism for referring their patients.

CHALLENGES/OBSTACLES

- There is a lack of awareness in CSSSs about the importance of a strong front line and of the benefits of being in contact with physicians working in a private office.
- This initiative is not deemed a priority by all CSSSs.
- There are disparities among CSSSs in the resources dedicated (nurses, clerical support) to the mechanism in support of the medical coordinator.

SPREAD

This initiative can spread throughout the province. The medical coordinator for the local committee of general practitioners plays an important role in explaining the benefits of the initiative.

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This project aimed to address the health consequences of lack of access to family doctors. It was expected that a significant proportion of unattached patients (also known as orphan patients) suffer from asymptomatic or undiagnosed disease and risk. Conditions such as diabetes, cardiovascular disease, COPD and colorectal and cervical cancer are highly treatable in early stages but less so when advanced.

IMPLEMENTATION

The project was funded by the Central East Local Health Integrated Network (LHIN), which serves 1.4 million people in rural and urban settings. The Ministry of Health and Long-Term Care estimated that there were 86,000 unattached patients in the LHIN. The project had two interdisciplinary teams of health professionals. The service was advertised locally and referrals came from emergency departments, walk-in clinics, shelters, health units, etc. Patients had an intake interview where personal health history was obtained and were given requisitions for screening blood work and investigations. A general physical assessment followed. At the last of two or three visits, the patients received a copy of their chart, referrals

“A SAMPLE OF 600 PATIENTS (349 MEN AND 251 WOMEN) WAS EVALUATED ... 48% HAD UNMANAGED PRE-EXISTING MEDICAL CONCERNS; 255 PATIENTS (42%) WERE GIVEN A NEW DIAGNOSIS”

to specialists or programs and sometimes started on medication. One team (a part-time doctor, two nurse practitioners and one or two registered nurses) rotated through health facilities in the Kawartha catchment area. A second team operated out of fixed sites in Scarborough, where the issue is not a shortage of doctors, but too much episodic care and reliance on walk-in clinics.

RESULTS

- Approximately 1,400 people were assessed during the life of the project.
- A sample of 600 patients (349 men and 251 women) was evaluated. Only 8% did not complete the screening. 48% had unmanaged pre-existing medical concerns. 255 patients (42%) were given a new diagnosis as a result of the screening and 251 were found to have significant risk factors.

- New diagnoses included cardiovascular disease, HTN, dyslipidemia, metabolic syndrome, chronic obstructive lung disease, diabetes, sexually transmitted infections and cancer. Patients were linked with treatment programs and specialists. Many but not all were linked with primary care.
- Fifteen unstable patients required immediate care.

CHALLENGES/OBSTACLES

- It required two years of mostly volunteer time to get the model approved and funded.
- There were concerns that the project would scoop up existing healthcare resources.
- High-needs geographic areas had not been accurately identified by officials.
- Sharing chart information was an issue in the absence of electronic health records.
- Information technology issues and privacy concerns exist about sharing patient information with bodies such as Health Care Connect (see next page).

SPREAD

The province is assisting in the evaluation of this pilot, which could be expanded to other LHINs. Funding ended in May 2010 and continued funding is sought.

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About 780,000 people in Ontario lack access to a family healthcare provider, according to the June 2010 Primary Care Access Survey. Health Care Connect (HCC), launched by the province in 2009, refers unattached patients to physicians and nurse practitioners who are accepting new patients. The goal is to divert patients from emergency rooms, support chronic disease prevention and promote more efficient use of Ontario's healthcare system.

IMPLEMENTATION

Two full-time nurses (called Care Connectors) are funded in each of the province's 14 Local Health Integrated Networks (LHINs) to liaise with patients and healthcare providers. Ontario residents with valid health cards can register for Health Care Connect. Patients are referred on a priority basis, determined by their answers to a health needs questionnaire. The program is promoted through

"75% OF REFERRED PATIENTS (INCLUDING THOSE IN NORTHERN AND RURAL COMMUNITIES) HAVE BEEN REFERRED TO A PROVIDER WITHIN 10KM OF THEIR HOME"

targeted marketing, in hospital emergency departments, physicians' offices and other community organizations. Care Connectors liaise with Health Force Ontario physician recruitment staff and are alerted when a new physician plans to move to a community.

RESULTS

- As of September 24, 2010, 76,000 patients have registered, 5,600 of whom are deemed high needs by the health questionnaire.
- 51% of registered patients have referred to a family physician.
- 75% of high-needs patients have been referred.
- 75% of referred patients (including those in northern and rural communities) have been referred to a provider within 10km of their home.

CHALLENGES/OBSTACLES

- Addressing unique local circumstances that affect the availability of providers to accept new patients.

- Increasing family physicians' awareness of the program.
- Creating awareness of the program among unattached patients.
- Creating an intake health needs questionnaire that effectively balances the need for detailed information with ease of use.

SPREAD

To date, one other province has expressed interest. Other provinces should be able to implement a similar program for unattached patients.

FOR MORE INFORMATION:

www.health.gov.on.ca/en/ms/healthcareconnect/public/

A 2006 Saskatoon study of health disparity by neighbourhood income identified the need to improve access to healthcare in low-income neighbourhoods. It found that these neighbourhoods, with a combined population of about 18,000, are associated with high rates of unemployment, increased healthcare utilization and a greater burden of illness compared to the general city population. Rates were higher, among others, for suicide attempts, mental disorders, diabetes, chronic obstructive pulmonary disease, coronary heart disease, chlamydia, gonorrhoea, hepatitis C, teen birth and low birth weight. There are limited medical clinics in the low-income neighbourhoods.

IMPLEMENTATION

The health bus, a converted recreational vehicle with a fully equipped examination room, is staffed by nurse practitioners and paramedics who perform services such as health checks, blood pressure and blood sugar checks, chronic disease management, disease prevention, health

“THERE WAS A NEED TO LEARN HOW TO MERGE AN EMERGENCY-BASED SYSTEM WITH CHRONIC-CARE MANAGEMENT”

education, wound care, advocacy and follow-up care. Referrals are made to other services. The bus operates seven days a week from noon to 7:45 p.m. and parks in various locations that are convenient for residents. The service is publicized by community organizations, hospital emergency department staff, social service agencies and, importantly, word of mouth. A community advisory committee helps oversee operations.

RESULTS

- More than 5,000 people have visited the health bus for care and there is a 43% return rate.
- The Aboriginal community is about 60% of the target population and they told organizers the bus would be successful only if people felt “welcome, safe and not judged”. There have been no complaints.
- No formal evaluation has been done but “health bus stories” reveal successes, including endorsements from over-capacity emergency rooms.

CHALLENGES/OBSTACLES

- Weather: the bus doesn’t operate when it is minus 40 Celsius with the wind chill because it is dangerous for people to be outdoors.
- There was a need to learn how to merge an emergency-based system with chronic-care management.

SPREAD

Many different Saskatchewan communities—rural, urban and reserves—have expressed interest in having their own health bus.

FOR MORE INFORMATION:

www.saskatoonhealthregion.ca/your_health/ps_primary_health.htm



CHSRF produced an accompanying video for this innovation, available through www.chsrf.ca or www.youtube.com/user/CHSRF.

Montreal pediatrician Dr. Gilles Julien recognized, through his work in the community, in hospitals and with youth protection services, that vulnerable and special needs children were being poorly served by different systems that didn't work well together. As a result, children were falling through the cracks and being disadvantaged from a very young age. Julien saw the need for a community-based approach to counter the effects of poverty and social inequities on childhood development and to defend children's rights. In 1997, he opened the Assistance d'enfants en difficulté in Hochelaga-Maisonneuve—the first social pediatric centre—to help meet the needs of young children in a poor neighbourhood in Montreal.

IMPLEMENTATION

Social pediatric centres are primary healthcare clinics established in underprivileged neighbourhoods that provide psychosocial follow-up care to at-risk families reluctant to use known institutional services. A social pediatrician,

“THE DISADVANTAGE EXPERIENCED BY CHILDREN FROM POORER MONTREAL NEIGHBOURHOODS IS GETTING WORSE, NOT BETTER”

assisted by a multidisciplinary team, assesses the health, language and social skills of children and determines an action plan. A clinical coordinator then monitors the child's progress with partners who are committed to the child and his or her family. Although these clinics can take various forms, some elements are essential, such as integrated healthcare adapted to children's needs; the capacity to accommodate a child and his or her family in all circumstances; an expanded local network to support children; and the capacity to defend children's rights. For the last three years, the centres have supported a special project at Montreal-area schools in which staff work with three-year-olds during the summer, to help prepare them for school.

RESULTS

- An evaluation by the University of Quebec at Montreal will be completed in fall 2010. Hundreds of children are served at each centre every week.
- In accordance with the concept that “It takes a village to raise a child,” the centres have paved the way and supported communities in their involvement with their children.
- The development model for each centre is directly linked with the community's involvement, in terms of the contribution of offices, funds, and volunteers.

CHALLENGES/OBSTACLES

- Almost half (46%) of the children in the most disadvantaged areas of Montreal are not ready for school, compared to an average of 35% of children for the city, according to a 2008 report by the Montreal Public Health Department.
- The disadvantage experienced by children from poorer Montreal neighbourhoods is getting worse, not better, according to Dr. Julien.
- Financing the activities of the social pediatric centres and linking with various public systems (health, youth protection, education, justice) have been challenges.

SPREAD

There are now eight social pediatric centres in Quebec and affiliated centres in Saskatoon and Vancouver. First Nations and Inuit groups have expressed interest in applying the model to some of their communities.

FOR MORE INFORMATION:

fondation@pediatriesociale.org

www.fondationdrjulien.org

More than 5,000 people are homeless on any given night in Toronto, about 70% of them in the downtown area. These people have a high prevalence of physical and mental illness and experience difficulty accessing healthcare despite their high needs. A group of 11 physicians began to volunteer their services since the fee-for-service payment model does not apply well to this population. Much of the healthcare they need is not billable and many do not have health cards. In 2005, the province introduced an alternate payment plan to remunerate medical care for this population. In 2006, the doctors formed an association, the Inner City Health Associates (ICHA), and in 2010 the ICHA was incorporated.

IMPLEMENTATION

The program's goal is to improve access to and coordination of health services for the chronically homeless. It is a transitional service, designed to fill a gap in healthcare until individuals can connect to mainstream services, which can be a challenging process.

“PATIENT RECEPTIVITY HAS BEEN EXCELLENT AND THERE HAVE BEEN NUMEROUS REQUESTS TO EXPAND TO MORE CLINIC SITES”

The ICHA includes 65 physicians with backgrounds in family medicine, psychiatry, and internal and community medicine, who work in 40 agencies, including homeless shelters, drop-in centres and street outreach teams. Most work part time, but a few physicians work almost exclusively for the ICHA. In addition to providing direct care, the associates consult to outreach and intensive case management teams. The program provides opportunities for elective rotations for medical students and residents. Some specific projects include a partnership with Toronto Community Care Access Centre and Toronto North Support Services to deliver coordinated access to healthcare for homeless people; a partnership with Toronto Social Services to facilitate access to disability form completion; and the evaluation of two care models in a study funded by the Canadian Institutes for Health Research.

RESULTS

- In the first quarter of 2010, the ICHA provided 1,290 hours of family physician time and 1,792 hours of specialist time in shelters and drop-ins for homeless people.
- In 2009, the ICHA saw over 1,700 homeless clients in need of medical care.

- Care from mental health specialists helped more than a third of 73 homeless clients with severe, persistent mental illness and substance abuse problems to achieve clinical improvements. Almost half of the clients were housed after the six-month period.
- Patient receptivity has been excellent and there have been numerous requests to expand to more clinic sites.

CHALLENGES/OBSTACLES

- It can be difficult to make linkages and integrate with mainstream sources of care.
- Discharge planning from hospital and social services agencies can be poor.
- There is a lack of funding for administrative and infrastructure support such as scheduling and coordinating care and record keeping.

SPREAD

The program has continued to expand. In 2008, seven psychiatrists and eight family physicians were recruited. There are ongoing requests for help from agencies that work with the homeless.

FOR MORE INFORMATION:

www.icha-toronto.ca

Nova Scotians have rates above the national average for smoking, high blood pressure, obesity and diabetes—modifiable factors that put them at elevated risk for cardiovascular disease (CVD), which accounts for nearly 36% of annual deaths in the province. Circulatory diseases (particularly heart disease, stroke and hypertension) cost the Nova Scotia healthcare system an estimated \$961 million per year. This project aimed to improve management of patients' cardiovascular risk, thereby improving their overall cardiac health.

IMPLEMENTATION

ANCHOR is an acronym for “a novel approach to cardiovascular health by optimizing risk management.” Supported by a \$2-million grant from a pharmaceutical company, ANCHOR is based on applying behavioural change counselling techniques, long used in the addictions and health psychology fields, to a general

“THE ANCHOR INTERVENTION SIGNIFICANTLY REDUCED THE 10-YEAR RISK OF HAVING A CORONARY EVENT”

health intervention in primary care. The intervention, which lasted almost two years, took place at two locations—a community health centre in Halifax and a group practice in Sydney—that serve populations with similar demographics. There was also a comparison group. About 1,100 patients over the age of 30 (roughly 60% with moderate to high risk factors), completed the intervention. “Patients received services including one-on-one counselling, telephone support, group education sessions and referrals to allied health professionals. A cardiac nurse was the lead at each site. All health professionals who delivered the intervention received training from a health psychologist. A health risk assessment was conducted when patients began the intervention and was followed up to measure any reduction in their risk for heart disease. After the initial intervention ended in 2008, other studies were launched, such as one to determine how many patients maintain their health status over time.

RESULTS

- The ANCHOR intervention significantly reduced the 10-year risk of having a coronary event (as measured by the Framingham scale). Twenty-five percent of those who were at moderate or high risk for a coronary event at the start were low risk at the post health risk assessment.
- The clinical results were a result of lifestyle behavioural change; not an increase in pharmaceutical intervention.

- In both sexes, there was a significant reduction in metabolic syndrome.
- Successful public/private collaboration involved a drug company, the health ministry, two district health authorities and a health charity.

CHALLENGES/OBSTACLES

- Some family doctors resisted participation in collaborative models of care.
- There was a lack of expertise and resources to assist in change management strategies for primary care practices.
- Some patients lacked confidence in having their care managed by non-physician health professionals.
- A cost-benefit analysis of the model should be completed before applying it more widely.
- There was a lack of free or low-cost community resources to support patients.

SPREAD

Key lessons include the fact that this skill-based intervention is portable and healthcare professionals can improve their ability to counsel their patients on behavioural change.

FOR MORE INFORMATION:
www.anchorproject.ca

More than 80% of Alberta's French-speaking population has little or no access to primary care in French (about 66,000 Albertans have French as their mother tongue). When the generic version of the Stanford chronic disease self-management program was introduced in Alberta in 2005, it was only available in English. Close to 9% of the population in Alberta has diabetes, but when the Stanford diabetes self-management program (DSMP) was introduced in the province, it too was available only in English. Alberta supported three people to become high-level "T-trainers" for the DSMP in 2008. Subsequent rollout of the DSMP across the province was affected by transitions in the province's healthcare system. In the interim, an opportunity for a mutually beneficial collaboration arose between the Réseau de santé albertain and Alberta Health Services.

IMPLEMENTATION

In 2008, the Réseau santé albertain (RSA) received funding from the Public Health Agency of Canada (PHAC) to have the Stanford generic disease self-management program

"MEMBERS OF THE TREATY 8 NATIONS IN NORTHERN ALBERTA HAVE EXPRESSED INTEREST IN RECEIVING TRAINING FOR THE DIABETES SELF-MANAGEMENT PROGRAM"

translated into French. In 2009, the province collaborated with the RSA to train Francophone master trainers who could deliver the program in French. (Under the Stanford system, the top level trainers are "T-Trainers," who train master trainers who can, in turn, train leaders to hold community-level workshops.) In January 2010, the PHAC funded the RSA to translate the DSMP, train leaders and pilot the new diabetes program. In March 2010, Alberta Health Services collaborated with the RSA to train Francophone and English-speaking master trainers and leaders from Alberta Health Services and the province's Primary Care Networks.

RESULTS

- Francophone Albertans can receive DSMP support in their own language and the number of English-speaking trainers for the program has also increased.
- Stanford has made the French version of the chronic disease self-management and the DSMP workshop materials, created in Alberta, available worldwide.
- As of August 2010 there are seven master trainers in Alberta for the DSMP.

CHALLENGES/OBSTACLES

- There are challenges obtaining referrals and recruiting patients for the program primarily because the DSMP has not yet been integrated into the established care map for diabetes in Alberta.

SPREAD

Albertans are now available to do DSMP training and another session is planned for fall 2010. French and English workshops can be delivered anywhere in the province. Members of the Treaty 8 Nations in northern Alberta have expressed interest in receiving training for the DSMP.

FOR MORE INFORMATION:

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The average in-hospital length of stay for heart failure in Alberta's Chinook zone was among the longest in the province. (The Lethbridge-area Chinook zone covers a population of about 150,000.) Emergency department and readmission rates were also a concern and higher per-population rates of heart failure were predicted for the future. This program aims to build capacity for heart function management among patients and primary care providers—initiatives that ensure appropriate referrals to cardiologists and hence improve the utilization of the speciality Heart Function Clinic (HFC) in the Chinook Regional Hospital.

IMPLEMENTATION

Patients with a diagnosis of heart failure who visit the Chinook Regional Hospital emergency department for management of their condition are contacted by an HFC advanced practice nurse within two weeks of their visit. Patients admitted to hospital with a diagnosis

“ADMISSIONS AND RE-ADMISSIONS FOR HEART FAILURE HAVE DECREASED AND 95% OF HEART-FAILURE PATIENTS ADMITTED TO HOSPITAL RECEIVE DISCHARGE EDUCATION”

of congestive heart failure, or whose hospital stay is complicated by heart failure, are also contacted by a nurse within two weeks of discharge. Patients receive a series of three visits by the nurse for assessment and self-management coaching. They are also encouraged to attend, with their families, a focused heart-failure education class offered within the Building Healthy Lifestyles Program. The nurses regularly communicate with the patient's primary care provider and, as appropriate, offer care recommendations, such as a referral request if the patient could benefit from the more specialized services of the existing heart function network. Educational sessions are conducted with healthcare providers across the continuum, with a focus on getting the most current, evidence-informed tools and resources into as many hands as possible. The program has been financed through the Alberta Cardiac Access Collaborative (ACAC) and the Alberta wait-times initiative. Funding, initially scheduled to end in spring 2010, was extended for one year.

RESULTS

- Emergency room visits for heart-failure-related issues have decreased.
- Admissions and re-admissions for heart failure have decreased.

- 95% of heart-failure patients admitted to hospital receive discharge education.
- Lengths of stay in hospital related to heart failure are shorter.
- Community-based healthcare providers are navigating the system more appropriately for their heart-failure patients.

CHALLENGES/OBSTACLES

- Family doctors needed to feel comfortable dealing with patients whom they might previously have referred to specialists.
- Clients had to buy into self-management and accept that they have an active role to play in their own care.
- The program has not yet secured ongoing funding.

SPREAD

Rural primary care teams in the Lethbridge area are now being educated about the resources available for heart-failure patients, and how current evidence can be incorporated into interdisciplinary primary care. Organizers hope to see this project's approach spread through the province.

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Older adults with complex health needs run a high risk of being re-admitted to hospital because of the lack of coordination between primary care, home care and hospital care. There are few places where discharged patients can access urgent (but not emergency) care, so they often end up in emergency departments. This project aims to maximize the health and independence of such older adults, facilitate "aging at home" and reduce the likelihood of emergency department visits and hospital readmissions. This project focuses on the one-third of discharges in the Toronto Central Local Health Integrated Network (LHIN) that have a predicted 90-day readmission rate of 32%.

IMPLEMENTATION

The Virtual Ward (VW) is not a location but rather a team of healthcare professionals that coordinates short-term transitional care for the highest-risk patients. It is coordinated out of Women's College Hospital and incorporates the U.S. Institute for Healthcare Improvement's five approaches to reducing readmission:

"THERE IS POOR LINKAGE BETWEEN ELECTRONIC HEALTH RECORDS (EHRs), WHICH ARE DIFFERENT IN EACH HOSPITAL AND CANNOT BE ACCESSED BY ALL TEAM MEMBERS"

comprehensive discharge planning with timely communication; post-discharge support; multidisciplinary team-based management; patient education and self-management support; and remote monitoring. The VW provides transitional care for two to eight weeks, after which patients are discharged to the care of their family physician (if they have one) and the Toronto Community Care Access Centre (CCAC). The team consists of a (rotating) doctor with significant inpatient experience (because patients are often quite ill), case managers, a nurse practitioner/physician assistant, pharmacist and unit facilitator/ward clerk. Care includes social support, addictions counselling and end-of-life counselling and planning. The VW has a single shared set of notes and a single point of contact for patients.

RESULTS

- The VW has succeeded in getting four organizations (St. Michael's and Women's College hospitals, the University Health Network and the CCAC), to collaborate at the point of care.

- More than 100 patients have been admitted since March 16, 2010, with an average length of stay of about 35 days.
- Anecdotally, patient and staff satisfaction is very high.

CHALLENGES/OBSTACLES

- Because healthcare is fragmented, funding for this project had to be obtained from a variety of sources.
- There is poor linkage between electronic health records (EHRs), which are different in each hospital and cannot be accessed by all team members; CCACs have their own system of tracking patient encounters.
- It was difficult to set up a 24/7 call system for patients.
- Despite intensive case management, it is difficult to keep patients with severe medical illness and alcohol or other substance abuse problems out of hospital.

SPREAD

The initiative, supported by the province, was developed so that it could be broadly disseminated. Results from an evaluation will permit the Toronto Central LHIN to decide whether this VW model, which can be applied in a community hospital context, should be rolled out across the LHIN.

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Many older adults with complex health needs in the East York area of Toronto are regularly re-admitted to the Toronto East General Hospital (TEGH) at a higher rate than average for Toronto. To better serve the needs of this complex patient population, a virtual ward (VW) was embedded in the South East Toronto Family Health Team (SETFHT), an academic FHT located across the road from the community hospital. The goal is to improve continuity of care and reduce rates of emergency department visits and hospital readmissions for patients over 65 who, at the time of discharge, are deemed high risk for readmission. The SETFHT includes physicians who can accept new patients, so the VW service is available for unattached/orphan patients as well as for its established patients. The SETFHT aims to enroll 100 unattached patients a year.

IMPLEMENTATION

A physician assistant (PA) identifies older patients at high risk of readmission using the LACE score (length of stay, acuity of admission, comorbidities and emergency room

“THE HOSPITAL AND THE CCACS ARE FUNDED BY THE LOCAL HEALTH INTEGRATED NETWORK (LHIN) BUT PRIMARY CARE IS NOT AT THE TABLE, WHICH LEADS TO LACK OF COMMUNICATION AND COORDINATION”

visits). The PA meets with the patient while still in hospital, follows up by telephone within 24 hours of discharge, and arranges a clinic visit a few days afterward. The VW team includes doctors, a pharmacist, a dietician, and a nurse to help navigate the patient’s transition from hospital to home. The team offers individualized medical care, referrals to appropriate community support services such as Meals on Wheels, addictions counselling and patient education to improve self-management. Intensive VW follow up with daily telephone calls lasts about eight weeks. Previously unattached patients are rostered into the FHT. The FHT is part of a telehomecare project and VW patients with chronic obstructive lung disease, diabetes and congestive heart failure receive telehomecare equipment for up to six months. Patients submit vital signs every morning, allowing staff to monitor chronic conditions virtually. Home visits are arranged if necessary and self-management is incorporated into daily care.

RESULTS

- No measurable results yet: admissions to the VW began in mid-June 2010 and 10 patients had been admitted by early August 2010.

CHALLENGES/OBSTACLES

- Information sharing: there is no integrated electronic health record link with the hospital or the Community Care Access Centres (CCAC), which provide home care. Currently the hospital faxes information so the SETFHT can undertake discharge planning for its own patients. A VW category was created in September 2010 within the TEGH patient electronic record and the SETFHT can now communicate weekly progress notes into the record. Efforts are underway to enable electronic record sharing among the CCAC, SETFHT and TEGH.
- Patients admitted to hospital are often put on different medications and discharged without communication to the primary care provider; the SETFHT’s care navigator and pharmacist find out what care was provided in hospital to ensure appropriate follow up after discharge.
- The hospital and the CCACs are funded by the local health integrated network (LHIN) but primary care is not at the table, which leads to lack of communication and coordination. Home care is provided by different regional CCACs and negotiations to collaborate with one do not necessarily include the others.

SPREAD

If the results are positive, other primary care practice groups will be encouraged to link with their local hospitals and develop their own VWs.

FOR MORE INFORMATION:

www.setfht.on.ca

The Ontario Ministry of Health and Long-Term Care began implementing Family Health Teams (FHTs) to improve access to family healthcare. While Ontario has taken steps to improve primary healthcare, it is not inherently team based. The key characteristic of FHTs is the provision of comprehensive care through interdisciplinary teams—“primary care on steroids,” as one provincial official put it. FHTs are locally driven organizations that include family physicians, nurse practitioners and a range of other interdisciplinary healthcare providers, as determined by local needs. Healthcare is delivered to a defined population that includes patients who lacked a family doctor before the FHT was introduced. The FHTs emphasize health promotion and improved management of chronic diseases. As well, team members coordinate care, linking patients to, and helping them navigate through, other parts of the healthcare system.

IMPLEMENTATION

Physicians who are part of various approved payment models, under which they are paid primarily on a capitation basis, are eligible to apply to become a FHT. When an

“FHTS DELIVER CARE TO CLOSE APPROXIMATELY 2.5 MILLION ONTARIANS, INCLUDING ABOUT 411,000 WHO PREVIOUSLY DID NOT HAVE A FAMILY DOCTOR”

application is approved, the new team must form a non-profit corporation and work together out of one or more sites. The province has created 200 FHTs in the province; as of September 2010, 151 are already operating, 19 are in various stages of development and the remaining 30 are expected to be operational by fall 2011. New FHTs receive resources to support their development, including a grant to hire a consultant experienced at working with FHTs, mentorship through the province’s Quality Improvement and Innovation Partnership (see page 15), and a team of trained implementation specialists from the health ministry. The province also provides FHTs with information technology support for creation and use of electronic medical records. Successful interdisciplinary work requires clear definitions of the roles of the various healthcare providers; this clarity reduces the possibility of “ambiguity and misunderstanding regarding protocols, procedures, responsibility and authority.” The province provides a series of online guides for FHTs, one of which outlines possible roles and responsibilities for a range of healthcare providers (registered nurses, registered practical nurses, dieticians, pharmacists, chiropractors, etc.) based on their regulated scopes of practice.

RESULTS

- FHTs deliver care to approximately 2.5 million Ontarians, including about 411,000 who previously did not have a family doctor, according to ministry numbers.
- FHTs deliver diverse programs and services, ranging from smoking cessation to chronic disease management.
- A formal evaluation of the model is being conducted.

CHALLENGES/OBSTACLES

- Challenges are different in every community, but include finding qualified personnel to join the team and relocating to larger premises in order to house a multidisciplinary team.

SPREAD

There has been a strong interest among physicians to form FHTs.

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A 1972 federal task force report, *The Community Health Centre in Canada*, recommended the development of Community Health Centres (CHCs) that would integrate health and social services, and emphasize prevention, health promotion and provision of other personal services (such as occupational health). The first Ontario CHCs were introduced in Toronto and Ottawa in the mid-1970s as pilots and served predominantly poor, ethnically diverse, urban communities. Because CHCs focus on the social determinants of health as well as primary care, team members include clinical staff (physicians, nurse practitioners, nurses, etc.) and health promotion and community development staff. CHCs are now located in rural and urban areas, serving isolated communities and those with populations that, compared to the general population, are at a higher risk of developing health problems.

IMPLEMENTATION

In 1982, CHCs became an official part of the primary healthcare delivery system in Ontario. Today, 73 CHCs and 28 CHC satellite centres (fully functional centres

“COMPARING CHCS TO OTHER HEALTH DELIVERY MODELS IN ONTARIO ... CHCS PROVIDED BETTER CARE FOR DIABETES AND CORONARY ARTERY DISEASE”

operated by the main CHCs) serve about 3% of the population. The Association of Ontario Health Centres has developed three major documents on interprofessional collaboration and team building: *Building Better Teams: Learning from Ontario CHCs—A Report of Research Findings*; *Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres—Resources, Tips, and Activities You Can Use to Enhance Collaboration*; *Supporting New Leaders in Developing a Collaborative Team*. This third toolkit is a resource for new administrative leads and executive directors, and for community-based healthcare organizations that are still in the process of hiring leaders and staff, as well as satellite organizations and teams going through high employee and management turnover.

RESULTS

- A study published in the July 2010 edition of *Canadian Family Physician* found that compared to other healthcare delivery models in Ontario, CHCs are twice as likely to: (1) assess and/or determine what programs and services are needed by the communities they serve; (2) reach out to the populations in the communities they serve; and (3) monitor and evaluate the effectiveness of the services and programs they offer.

- A 2007 research report that compared CHCs to other health delivery models in Ontario found that CHCs provided better care for diabetes and coronary artery disease.

CHALLENGES/OBSTACLES

- Healthcare providers are educated in silos and are unfamiliar with working in interdisciplinary teams before joining a CHC.
- It takes time to build strong teams and the workload is heavy.
- Insufficient administrative support means providers do work that could be done by others.
- The physical layout of older CHCs does not allow for natural team interaction and many centres have too few treatment rooms to allow full scope of practice to be implemented.

SPREAD

Further expansion of the model will be a political decision.

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Ontario was the first Canadian jurisdiction to introduce nurse practitioner-led clinics, which offer a team-based approach to comprehensive primary care. Such clinics have a long history in the United States. The clinics are a key part of the province's plan to improve access to healthcare services for those without a primary healthcare provider and to improve "quality and accountability for patients." Nurse practitioners (NPs) are registered nurses with advanced education and expertise and an expanded scope of practice. They can treat common illnesses, order diagnostic tests such as labs and X-rays, as well as prescribe medications and refer patients to specialists. Nurse practitioner-led clinics also provide a strong emphasis on health promotion and disease prevention, chronic disease management and assistance with navigating the healthcare system.

IMPLEMENTATION

In 2007 the first nurse practitioner-led clinic opened in Sudbury and the provincial government committed to open 25 additional clinics. NPs, registered non-profit organizations and local community-based organizations

“SUDBURY DISTRICT NURSE PRACTITIONER CLINICS SERVE 3,000 CLIENTS WHO DID NOT HAVE A PRIMARY HEALTHCARE PROVIDER BEFORE THE CLINIC OPENED”

were invited to apply. Two additional clinics opened in August 2010 and two more will open in fall 2010. The government also announced the locations of 14 more clinics that will open by the end of 2012. To facilitate the expansion of the model, the province has increased the number of education places for primary healthcare nurse practitioners from 75 to 176. In addition to NPs, other team members may include registered nurses, social workers, pharmacists, registered dietitians, mental health workers and collaborating physicians (the latter mostly on a part-time consulting basis). Patients are registered with the clinic and not to a specific healthcare provider. NPs are represented on each clinic's board of directors.

RESULTS

- Sudbury District Nurse Practitioner Clinics serve 3,000 clients who did not have a primary healthcare provider before the clinic opened.

CHALLENGES/OBSTACLES

- The Ontario Medical Association opposes the creation of nurse practitioner-led clinics.

SPREAD

Locations for all 25 nurse practitioner-led clinics have been announced and are expected to be open by the end of 2012.

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Before rostering was introduced, family doctors did not necessarily keep track of patients who had moved away, joined another doctor's practice or died. Rostering formalizes the family doctor/patient relationship and makes explicit the obligations of both parties. It also facilitates a shift from fee-for-service payment to other types of payment for doctors, such as capitation or a blended fee-for-service/capitation model. Rostering encourages family doctors to collaborate and provide better after-hours and holiday coverage for patients.

IMPLEMENTATION

Patient rostering was first introduced in Ontario on a small scale at Health Service Organizations in the 1970s. Since then, the Ministry of Health and Long-Term Care (MOHLTC) has required rostering in a series of evolving primary care delivery models. In rostering agreements, patients agree to seek care from their family doctor or

“THERE IS CONTINUED INAPPROPRIATE USE OF WALK-IN CLINICS AND EMERGENCY DEPARTMENTS FOR CONDITIONS THAT COULD BE DEALT WITH BY FAMILY DOCTORS”

associated colleagues, unless away from home or in need of emergency care. Doctors' obligations are also made explicit and include the provision of some after-hours and on-call care. Doctors miss out on bonus payments if their patients go to walk-in clinics or seek care from other family doctors. Rostering is a requirement for doctors in Family Health Organizations (FHOs, which are replacing Family Health Networks) who are paid on a blended capitation basis. Doctors in Family Health Groups (FHGs) are primarily paid on a fee-for-service, but are eligible for bonus payments when patients are rostered. The more recently established Family Health Teams (FHTs) also have rostering as a requirement for blended capitation funding or other eligible alternative payment plans. Rostering has not been applied to Ontario's Community Health Centres.

RESULTS

- More than 75% of Ontario residents (9.2 million out of 12 million) are rostered to more than 7,278 family doctors in primary care reform models.

CHALLENGES/OBSTACLES

- Physicians take a cautious approach to practice change.

- There are some administrative challenges (e.g. at outset, a doctor must cull files to create a list of active patients).
- There is continued inappropriate use of walk-in clinics and emergency departments for conditions that could be dealt with by family doctors.

SPREAD

The majority of the Ontario population is now rostered.

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This initiative was launched out of recognition that fee-for-service payment has limitations when it comes to compensating doctors for meeting the needs of patients with complex care requirements. The Performance and Diligence Indicator (PDI) program provides payments to individual family physicians who take steps toward meeting specific indicators that deliver substantive clinical value. The PDI is one part of a master agreement governing doctors' services in Alberta and has been funded as a demonstration program until March 2011. The goal is to provide incentives that will promote the implementation of evidence-based practices among all family physicians (those practising both in and outside of primary care networks), improve outcomes for patients and promote sustainability of the health system.

IMPLEMENTATION

This voluntary program is being implemented in three phases. In Phase 1, family doctors establish a validated list of patients (the set of patients for whom the physician is actively serving as the most responsible primary care

**“ONLY ABOUT 10% OF FAMILY DOCTORS
WITH ELECTRONIC MEDICAL RECORDS (EMRS)
CAN EASILY GENERATE INFORMATION FOR
THE PDI PROGRAM”**

physician). Doctors must document the most recent date that patients confirmed that relationship. In Phase 2, doctors will be asked to establish baselines for clinical indicators. Phase 3 will focus on improvement from baselines and excellence in clinical care. Phase 2 is now in development, as specialists and family doctors are being brought together to achieve consensus on the type of indicators that should be required. The PDI program will begin with indicators that are easier to implement, such as screening for hypertension. Indicators will reflect several aspects of quality, including screening, diagnosis, patient management, health promotion, access, continuity of care and patient experience. Funding for the period 2009 to 2011 totals just over \$37 million.

RESULTS

- More than 1,000 family doctors (out of about 2,500 doctors who practise family medicine in Alberta) have successfully participated in Phase 1 of the PDI program and have created validated patient lists. Phase 2 is currently being implemented.

CHALLENGES/OBSTACLES

- Only about 10% of family doctors with electronic medical records (EMRs) can easily generate information for the PDI program, due to the high variability in the functionality of EMRs and the degree to which doctors use them. As a result of this technological challenge the rate of implementation varies among physicians.
- Future funding is subject to completion of a new master agreement between Alberta Health and Wellness, the Alberta Medical Association and Alberta Health Services.

SPREAD

Family doctors who have completed Phase 1 are moving onto Phase 2. Subject to available funding, the program will spread to potentially include all family physicians in the province.

FOR MORE INFORMATION:

www.albertapci.ca/AboutPCI/pdi/

When Quebec began encouraging patient registration in 2002, family doctors lacked information about their patient population and the province didn't know which segments of the population had or didn't have access to a family doctor. (In 2002, family doctors did not have electronic medical records (EMRs) from which to draw patient information—even today only about 10% of family doctors have EMRs.) The province wanted doctors to have more information about their patients so they could develop and tailor services to support them. In addition, the province wanted to link more people to their doctors—without registration, patients had a less formal tie to their doctor and were less likely to benefit from continuity of care. The province considered rostering a prerequisite to quality improvement in family medicine.

IMPLEMENTATION

The first step was to roster all patients of family medicine groups. By the end of 2004, about 20 groups had registered their patients and by 2010, 200 family practice groups had done so. The second step (2004–2008) was

“HAVING DATA FOR EACH AGE GROUP AND REGION HELPS THE PROVINCE REORGANIZE SERVICES AT ALL LEVELS”

to roster vulnerable patients, primarily older patients with complex care needs, both inside and outside of family medicine groups. At the beginning of 2009, the province began to roster the patients of all family doctors, whether in group or solo practices. The province pays an annual fee to family doctors for each of their rostered, active patients. Additional resources are available to doctors who accept previously unattached patients (those who lacked a family doctor) and patients with complex healthcare needs. Solo practitioners are encouraged to link with family medicine group clinics where their patients can go for after-hour care.

RESULTS

- 58% of the population of Quebec has been rostered, including 88% of all patients aged 70 and over; more than half of those rostered are patients of family medicine groups.
- Continuity of care has improved.
- Having data for each age group and region helps the province reorganize services at all levels.

CHALLENGES/OBSTACLES

- Early on, there was strong resistance to rostering from doctors who were concerned that it was the first step toward a shift from fee-for-service to capitation payment.
- Doctors perceived that the intent was more government control over the practice of medicine.
- There was resistance to centralized establishment of standards, such as minimum number of patients to be rostered, by the provincial ministry of health and social services.

SPREAD

The province hopes to have 90% of patients over 70 years old rostered by 2015. Doctors have come to accept patient rostering.

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Since the 1970s, Ontario has introduced a variety of alternatives to the fee-for-service payment model for primary care physicians. Changes have been introduced to address concerns such as: citizens were having difficulty finding a family doctor, medical students were not choosing the speciality (in part because of pay rates), and the province was seeking to encourage group practices and multidisciplinary teams. Various payment models were introduced in order to encourage physicians to accept different ways of being paid and of practising. In August 2010, payment options were standardized. The 3,221 physicians who belong to Family Health Organizations (FHOs) are paid on a capitation basis. The 3,189 doctors who belong to Family Health Groups (FHGs), physician groups that range in size from three to 100 or more, are paid on a fee-for-service basis. There are also incentive payments for measures such as reaching screening targets and accepting patients who lack a family doctor. The province estimates that only about 1,000 doctors practising family medicine are not enrolled in any program. (Another 4,000 to 5,000 doctors trained in family medicine work in speciality areas such as palliative care, HIV/AIDS and travel medicine.) Meanwhile, the province also introduced reforms to help recruit and retain doctors to work in emergency departments and signed an agreement with some rural and northern physician groups to provide benefits that include guaranteed remuneration and maternity benefits. (Fewer than 100 doctors are part of the Rural and Northern Physician Group Agreement.)

IMPLEMENTATION

Some limited payment reform began in the 1970s with physicians at Community Health Centres being paid by salary and doctors at Health Service Organizations (which have since transformed into FHOs) being paid on a capitation basis under which they receive a certain sum per patient per year. In 1996, the province introduced Primary Care Networks (PCNs) in 13 locations. PCN physicians,

“INCREASING NUMBERS OF FAMILY DOCTORS ARE WORKING IN GROUP PRACTICES AND IN MULTIDISCIPLINARY TEAMS”

who provided care to enrolled patients, were paid on a predominantly capitation model. All PCNs also had access to incentives for preventive interventions and funding for information technology. The next stage saw the creation of FHGs and Family Health Networks (FHNs), which absorbed the PCNs and operated on a capitation model. Almost all FHNs have now shifted into FHOs.

RESULTS

- Increasing numbers of Ontario family doctors are accepting alternatives to fee-for-service payment.
- Increasing numbers of family doctors are working in group practices and in multidisciplinary teams.

CHALLENGES/OBSTACLES

- There was initial resistance from individual physicians and organized medicine.
- Change management and team building have been challenges.
- Despite the expansion of after-hours care under FHGs and FHOs, there has been no significant reduction in patients' use of emergency wards for non-urgent concerns.

SPREAD

Payment reform has proceeded well in Ontario. The issue now is how to mature the model to improve the delivery of healthcare.

FOR MORE INFORMATION:

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Family doctors practising in the Northwest Territories on a fee-for-service basis were reportedly struggling financially as that model of payment did not suit the comparatively remote and sparsely populated environment in which they practised. In Yellowknife, the largest centre, there were a number of independently run medical clinics and each had its own relationship with the tertiary care hospital where doctors also provided services. After lengthy and difficult negotiations, the territorial government shifted the method of payment to a salary basis. New doctors were hired and doctors who had been paid on a fee-for-service basis had the option to transition to a salary. The process took several years; by 2009, 95% of family doctors (54 doctors) were on salary; most practiced in Yellowknife in collaborative practices. Salaries are accompanied by benefits, including group health insurance, sick leave, maternity leave, and recruitment and retention bonuses.

IMPLEMENTATION

The transition from self-employed family physicians operating in independent clinics to physicians becoming government employees began in 2001 and necessitated prompt administrative changes. The medical director took on more administrative tasks, policy development was required, standards of practice were set and human resources were modified. Additional contract negotiations were required and a new relationship was forged with the medical association. As part of the shift, new roles—such as those of nurse practitioners and midwives—were added to the primary healthcare system, leading to changes in scope of practice and additional team development. There is a single electronic medical record (EMR) system in the

“THE PAYMENT SHIFT IMPROVED PHYSICIAN RETENTION AND INTRODUCED MORE PREDICTABILITY INTO THE TERRITORIAL HEALTHCARE BUDGET”

NWT, compared to provinces where multiple brands of EMRs are in use. For example, the 30 family doctors who are based in Yellowknife and also travel to more remote communities, share the same EMR, making all patient information available in all locations. Home care, public health and mental health services also share the same digitized database of patients.

RESULTS

- Family doctors in the NWT have become leaders in the use of EMRs.
- The payment shift improved physician retention and introduced more predictability into the territorial healthcare budget.

- Recruitment of healthcare professionals has not been a problem; residents of the NWT have ready access to family physicians.

CHALLENGES/OBSTACLES

- Change management: the NWT is the only jurisdiction in Canada in which all family doctors are employed by the government and work under a standard physician contract—there was no roadmap for the transition.
- It has been a challenge to change the culture of the healthcare providers and introduce multidisciplinary teams and collaborative work.

SPREAD

To date, the NWT is the only jurisdiction in Canada that has placed all family physicians on a salary.

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This initiative, with a goal of system-wide change, originated with Manitoba's Ministry of Health. It aims to improve access to primary healthcare and address physician isolation by supporting inter-professional, collaborative care. Other goals are to increase the capacity of primary care family doctors and other primary care professionals to deliver integrated, high-quality health promotion and healthcare, and to respond to the demand for better chronic disease management. The initiative also strives to improve primary care providers' access to, and use of, information systems, and to improve the work life of providers. To be eligible to participate at this stage of the roll-out, physicians must be paid on a fee-for-service basis and practise in groups of at least five full-time-equivalent doctors with a minimum of 6,500 patients.

IMPLEMENTATION

The Physician Integrated Network (PIN) is in its second phase. Some 130 family doctors at 13 group practice sites participate, caring for a total of about 150,000 patients (Manitoba's population is 1.2 million). Change-management funding was provided to each group to support the creation of a plan to meet the PIN objectives. Phase 1 required intensive work related to electronic medical records (EMRs) to ensure quality indicator data are tracked, so that changes and quality targets can be measured. Using EMRs is a requirement for participation and the initiative has received some funding from Canada Health Infoway. The ability to link EMR information with provincial data sets was limited by the absence of a formal patient-enrolment process in the province—something that is being explored. Physician

“THE CONSISTENCY AND COMPREHENSIVENESS OF PATIENT CARE IMPROVED, PARTICULARLY FOR PATIENTS WITH CHRONIC DISEASE”

group practices were asked what they needed to meet the PIN's objectives and all chose to add allied healthcare professionals to their team. The physicians were provided with a toolkit outlining the scope of practice, roles, average costs and liability issues associated with a range of allied health professionals. Funding for non-physician care team members came from quality-based incentive funding (not from physician fee-for-service compensation).

RESULTS

A 2009 evaluation found:

- Access to physicians remained relatively unchanged, but patients' access to alternate healthcare providers improved.

- The use of EMRs improved physician awareness of and adherence to standards and guidelines for patient care.
- The consistency and comprehensiveness of patient care improved, particularly for patients with chronic disease.
- Relationships and understanding were strengthened among primary healthcare team members.

CHALLENGES/OBSTACLES

- Time and effort were required to implement PIN changes.
- Initially there was no process for identifying qualified EMR vendors.
- Fiscal restraint limited resources.

SPREAD

The province is exploring the application of the PIN approach for physicians who are or can be networked together, but are not necessarily in group practices, as well as to alternatively funded physicians, such as those working in community health centres.

FOR MORE INFORMATION:

www.gov.mb.ca/health/phc/pin/

A decade ago, family practice in British Columbia was in decline—medical students were choosing other specialties and doctors were leaving their practices. In a bid to renew family practice, the General Practice Service Committee (GPSC), a partnership between the health ministry and the B.C. Medical Association (BCMA), created the Divisions of Family Practice initiative in 2002. Under this program, doctors voluntarily link up at a local level to improve primary care in their community, working with other health and social service organizations to better coordinate services and resources. Goals include a more sustainable healthcare system, improved population health and improved experiences for doctors and patients.

IMPLEMENTATION

Divisions of Family Practice are member-driven, non-profit societies. When groups of doctors express interest in becoming a Division, a committee comprising executives from the local health authority, the health ministry and the GPSC meets with them to explain the initiative and describe how Divisions have evolved elsewhere. Divisions receive

“THE PROGRAM RELIEVES PRESSURE ON DOCTORS LOOKING AFTER THEIR CLINICAL PRACTICE WHILE TRYING TO MANAGE IN-HOSPITAL PATIENTS AND ALSO PROVIDES CARE TO UNATTACHED IN-HOSPITAL PATIENTS”

financial support to hire a coordinator and to support individual doctors who participate in community meetings, program planning and other activities not covered under fee-for-service payment schedules. Each Division may address priority issues such as hospital and residential care facility medical coverage, mental health and addiction concerns, and finding family doctors for unattached or orphan patients.

RESULTS

- Sixteen Divisions have been created in the province, encompassing 60 communities, and the pace of development increased rapidly in 2010.
- More than 2,300 family doctors (over 60% of family doctors in the province) are eligible to participate in a local Division.
- Four Divisions have created hospital care programs, where family physicians sign up to take shifts to cover in-hospital patients. The program relieves pressure on doctors looking after their clinical practice while trying to manage in-hospital patients and also provides care to unattached in-hospital patients.

- Three Divisions are striving to find ways to provide access to a family physician for each citizen who wants one.
- One Division is launching a multidisciplinary primary care access clinic, and two are close to signing residential care service agreements.
- One Division has recruited seven new family physicians to an area that was previously designated by the provincial government as badly needing additional practitioners. A key factor in recruitment was the Division itself: doctors appreciated the opportunity to join a supportive, organized community of physicians.

CHALLENGES/OBSTACLES

- Facilitating face-to-face meetings among rural and remote physicians, and developing videoconferencing capability for those who want it.
- Encouraging new Divisions to address a limited number of issues (“They want to do everything all at once.”)

SPREAD

Divisions of Family Practice are spreading across B.C. and it is anticipated that every community or region in B.C. will have one by 2012.

FOR MORE INFORMATION:

www.divisionsbc.ca

During the 1990s, many practising family doctors in Quebec distrusted the provincial government and viewed health ministry officials as technocrats trying to rule the way doctors practise medicine. The government and the Quebec Federation of General Practitioners decided to create regional departments of general medicine (RDGM) to bring together all the general practitioners who provide primary healthcare services in a given region and give them a role in the governance of primary care. This initiative had the goals of improving the organization of primary care to better meet the needs of the population, helping distribute medical personnel more equitably among the regions, and raising the standing and job satisfaction of those who practise primary care family medicine.

IMPLEMENTATION

The *Act respecting health services and social services* empowers the RDGM to make recommendations about the staffing of general practitioners and to propose plans for organizing medical services in the region. There are 16 RDGMs in Quebec, each headed by a practising physician who is chosen by peers and works part time in the role of RDGM chief. Each RDGM works with the regional health and social services agency. Because suggestions come from peers, the RDGMs have been successful in bringing doctors together to make changes. For example, in one small city different clinics agreed to share the task, on a rotating basis, of providing same-day care to patients with non-urgent needs, hence reducing demand on the local emergency department.

“THE SYSTEM IS BETTER ABLE TO DEPLOY LARGE-SCALE INTERVENTIONS (SUCH AS DURING THE H1N1 PANDEMIC)”

Family doctors in one region agreed to accept into their practice, on a rotating basis, vulnerable patients without a family doctor who are being discharged from hospital. The RDGM also concerns itself with distributing its doctors in an equitable manner between primary care and institutional care. The 16 RDGM chiefs meet three to four times a year to learn from one another.

RESULTS

- Many innovative service organization models have been developed at both the regional and local levels (family medicine groups, after-hours clinics, etc.)
- The correlation between the supply of primary care services and the needs of the population has improved.
- Medical personnel have been distributed better, which has an impact on the services provided to certain patients.
- The system is better able to deploy large-scale interventions (such as during the H1N1 pandemic).

CHALLENGES/OBSTACLES

- It was a major challenge for the heads of the RDGMs to meet with all the primary care physicians in their region to inform them about the new body and to learn about their concerns.
- Not all the health and social service agencies had the same understanding of the RDGMs' role. Some adjustments were necessary.

SPREAD

This governance model applies throughout the province and has been accepted by physicians.

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REACH Community Health Centre was a joint project of residents of the Grandview-Woodlands area in east downtown Vancouver and the department of pediatrics at the University of British Columbia. When REACH was established, public medical insurance was in its infancy and residents frequently attended hospital outpatient departments, where care was free. The United Way identified the area as having the second-highest poverty rate in Vancouver. Local residents wanted a health centre and the department of pediatrics wanted a neighbourhood teaching site. REACH was first staffed by volunteer family physicians and dentists. Since its inception it has been training new healthcare providers.

IMPLEMENTATION

The university's early contribution included providing administrative support, such as legal counsel, accounting, purchasing and personnel assistance. A start-up grant from the Vancouver Foundation helped defray development costs. In 1970, REACH became a registered non-profit charitable organization, which gave the community a

“QUALITY MEASURES INCLUDE REVIEWING RATES FOR SCREENING (SUCH AS PAP SMEARS, MAMMOGRAMS AND DENTAL CHECKUPS) FROM EMRS”

formal voice in setting policy and priorities for programs. The services offered have evolved over the years. REACH at first responded to the need to provide youth with free, confidential reproductive healthcare. Today, the centre serves a diverse ethnic population. In addition to the primary care health team of physicians and nurses, it offers a wide range of services including counselling, fee-for-service and subsidized dental care, nutrition counselling, a pharmacy and a multicultural, community-based health promotion program. There are almost 50 staff members who speak, in addition to English, about 15 different languages. REACH provides 24-hour medical and dental care and physicians maintain hospital privileges and provide obstetrical care. Electronic records are in use for both health and dental care. A contract with Vancouver Coastal Health to provide medical and allied care service provides about half the centre's funding, 35% comes from cost recovery from the dental and pharmacy program, and the balance comes from grants, donations and other third-party billings.

RESULTS

- REACH is seen as a leader in primary medical and community dental care.

- Staff and client retention is noteworthy. REACH has no trouble hiring staff.
- REACH was an early B.C. site for OSCAR, an open source electronic medical record (EMR) and an electronic dental record.
- Quality measures include reviewing rates for screening (such as pap smears, mammograms and dental checkups) from EMRs. Quality committees and client feedback are also used.

CHALLENGES/OBSTACLES

- There are tensions involved in providing care to the existing client base, being open to those seeking care and addressing emerging needs, especially for individuals with complex psycho-social concerns.
- Fee-based systems are not aligned with goals of addressing social inequalities.
- Although care is provided by an interdisciplinary team, clients may be attached to “their” doctor and that therapeutic relationship.
- Funding constraints limit capacity for growth.

SPREAD

There has been little replication in the rest of B.C. of a community health centre governed by a local board, within a reasonably sized catchment area or population, with community input and providing care to a mixed-income community.

FOR MORE INFORMATION CONTACT:
www.reachcentre.bc.ca

The Sault Ste. Marie Health Centre was the first group health centre in Canada, established before the 1969 introduction of medicare in Ontario. It was founded under the stewardship of the United Steelworkers of America, whose members worked at the Algoma Steel Corporation. It was initially funded by unionized workers' monthly premiums and staffed by 13 doctors. It differs from other Community Health Centres (CHCs) in Ontario in its governance, payment model (physicians are not salaried) and range of services offered.

IMPLEMENTATION

The centre is operated jointly by a community board and the Algoma District Medical Group. It is staffed by 60 doctors, 300 other allied health professionals and employees. About 80% of the population of Sault Ste. Marie is served by the health centre, which provides primary healthcare through interdisciplinary teams, family and specialist physician services, diagnostic imaging and a day-surgery unit, as well as other services. Until Ontario required a shift to private labs, it had its own laboratory. Active programs for conditions such as diabetes, congestive heart failure and asthma have led to improved patient outcomes. Patients receiving primary care at the centre are enrolled, but patients can see specialists without being enrolled. The centre has employed nurse practitioners since 1972. Electronic medical records (EMRs) were introduced in 1997. Twenty-nine of the centre's healthcare providers

“WAIT TIMES FROM BREAST CANCER DIAGNOSIS TO SURGICAL INTERVENTION HAVE BEEN REDUCED FROM 108 DAYS TO LESS THAN A MONTH”

now participate in a Canada Health Infoway e-prescribing project, which allows them to fill out prescriptions electronically and have the patients' prescriptions and full drug histories available at local pharmacies, thus improving medication management.

RESULTS

The centre has been considered a national leader in healthcare innovation for decades.

- A community program to improve health outcomes for patients with congestive heart failure achieved a 43% reduction in hospital readmission rates, a level that has been sustained over five years.

- Wait times from breast cancer diagnosis to surgical intervention have been reduced from 108 days to less than a month; 70.6% of female patients receive mammography screening compared to a national average of 53.6%.
- The centre has a diabetes registry. A template in patients' EMRs enables primary care providers to monitor patients and ensure timely, proactive treatment. The centre also offers patients a diabetes education and care program, and patients who access the program have had impressive improvements in their average blood sugar levels.

CHALLENGES/OBSTACLES

- 35% of centre physicians are over age 50 and there is a waiting list of patients who would like to receive care at the centre.
- Funding contracts with the province and the Ontario Medical Association are unique and complicated to negotiate.

SPREAD

Although this group health centre is unique in its origins and governance, Ontario's family health teams have been modelled on its operations.

FOR MORE INFORMATION:

www.ghc.on.ca

Local residents, frustrated with the lack of medical services in the north end of Halifax, launched the centre as a part-time storefront operation with one examination room and volunteer health professionals. Until then, people needing care were directed to hospital outpatient clinics. Health needs in the area are significant. The north end is home to a large, multi-generational African-Nova Scotian population, is often a landing place for refugees and new immigrants, and is the site of missions, shelters, and services such as methadone maintenance and needle exchange clinics. A 2006 patient survey revealed that 59% of respondents have annual incomes below \$20,000 and 80% received some kind of income support. The often complex needs of the 15,000 residents in the centre's catchment area reflect these social determinants of health.

IMPLEMENTATION

The centre's unique status (affiliated with, but independent of the local health authority) has allowed it to survive changes in health funding structures and governments. The centre has evolved through its 39 years. In 1997, the

“FACTORS THAT HAVE CONTRIBUTED TO THE CENTRE'S SUCCESS MAY ALSO BE BARRIERS TO THE SPREAD OF THIS MODEL”

clinic began offering psychiatric services and in 2000, an electronic health record system was implemented. Today, the multidisciplinary health team, with about 23 full-time members, includes nurses, nurse practitioners, physicians, a social worker, a dietician and mental health workers. The team offers a wide range of services, with an emphasis on community development, collaboration and harm reduction. One nurse practitioner works in outreach, making home visits to clients. A 24-hour on-call service is available to all registered clients. Only 7% of the centre's funding is spent on administration, with the balance on medical programs. All residents in the catchment are eligible to register if they do not have a family doctor. In 2009–2010 the centre enrolled 423 new clients and had 14,452 client encounters (representing more than 5,000 registered clients). Most recently, the centre implemented a Mobile Outreach Street Health (MOSH) program that provides accessible primary healthcare services to people who are homeless or insecurely housed, street involved and underserved in the community.

RESULTS

- There is significant anecdotal evidence of improved health among residents, fewer emergency ward visits, etc. However, there are no nationally accepted standards for the evaluation of primary healthcare outcomes and the centre does not have the resources for a rigorous evaluation.

CHALLENGES/OBSTACLES

- There is a lack of support for evaluation (although the MOSH program has a built-in evaluation component).
- There is a heavy reliance on government funding.
- Services increase without any increase in staff or funding.

SPREAD

Factors that have contributed to the centre's success may also be barriers to the spread of this model: the centre is closely aligned to the community it serves; it is fully autonomous; service provision is rooted in collaboration, which can make it difficult to recruit healthcare workers; and services are provided consistent with harm reduction principles, which remain controversial.

FOR MORE INFORMATION:

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CHSRF produced an accompanying video for this innovation, available through www.chsrf.ca or www.youtube.com/user/CHSRF.

The Saskatoon Community Clinic opened its doors in 1963, and is sponsored by the Community Health Services (Saskatoon) Association, which was founded in 1962 by pro-medicare doctors and citizens. Today the clinic is a member-owned and operated primary healthcare cooperative with 30,000 clients and 10,000 members. It has 160 full- and part-time staff and operates at two sites. A downtown clinic serves a general population of all incomes including a high percentage (23%) of elderly people with multiple health needs, and an inner city site serves an impoverished, primarily First Nations population with high rates of diabetes, Hepatitis C, HIV/AIDS, cardiovascular disease, addictions and mental health problems. A multidisciplinary team delivers care at both clinic sites. Services include primary healthcare, lab and X-ray services, foot care, nutrition and mental health counselling, community development, a pharmacy, and chronic disease outreach.

IMPLEMENTATION

Over the last few years, the clinic has been implementing a diabetes and cardiovascular chronic disease management initiative. It had been assumed that the multidisciplinary team approach meant that the clinic was managing chronic diseases as well or better than other primary care providers in the province. However, the clinic found that its performance was “not bad, but also not stellar” and set out to establish best-practice protocols for the prevention and management of diabetes and cardiovascular disease. The clinic does not have electronic medical records (EMRs), so in order to track progress with patients, flow charts were created and populated with information pulled from patient

“IMPROVEMENT ON KEY MEASURES (SUCH AS BLOOD PRESSURE OR OVERALL BLOOD SUGAR CONTROL AT TARGET) RANGED FROM 10% TO 300% OVER BASELINE”

charts and supplied by the Ministry of Health. When the clinic was implementing its initiative, the Saskatchewan Health Quality Council (HQC) had begun offering chronic disease management collaborative learning workshops. The Saskatoon health region provided some consulting services. The clinic identified 790 patients as being at risk or suffering from diabetes and cardiovascular disease. Clients had one-on-one contact with doctors and/or nurse practitioners, flow sheets were used to ensure key factors were considered, goals were established and progress measured. Small group education and support groups were convened, and clients were connected with appropriate community resources.

RESULTS

- Improvement on key measures (such as blood pressure or overall blood sugar control at target) ranged from 10% to 300% over baseline and the clinic scored above the provincial average for a high number of indicators.

CHALLENGES/OBSTACLES

- Explaining the process to physicians posed an initial obstacle, but they stayed involved and motivated as they began to see improvements in patients' key measures, such as blood pressure.
- Nurses saw the creation of flow charts as an extra task added to their already busy jobs.

SPREAD

With the support of the HQC, the clinic's chronic disease management methodology has been replicated at other group and individual primary care practices in the province.

FOR MORE INFORMATION:

www.saskatooncommunityclinic.ca

It sometimes took three days to adjust medications for patients on anticoagulants who attended one of the five family medicine clinics in Chaudière-Appalaches, a semi-rural area southeast of Quebec City. The clinics, which serve about 22,000 patients, received upwards of 200,000 paper files a year. During doctors' vacations, patients sometimes went without appointments.

IMPLEMENTATION

With the province's support, the 20 doctors at the five clinics joined to form the Montmagny Family Medicine Group in 2003. (The smallest clinics have one doctor each, the largest has 14 doctors.) By 2006, the group had full electronic medical record (EMR) capacity, with links for lab and imaging results, hospital records and e-prescribing, and computerized appointment booking. All documents, clinical notes and prescriptions are digitized. Physicians can access patient records remotely, enabling

“INNOVATION HAS SAVED ABOUT 10% OF THE PHYSICIANS' TIME EACH DAY—THE EQUIVALENT OF ADDING TWO FULL-TIME DOCTORS TO THE GROUP”

them to work in multiple locations, including hospital and emergency wards, the walk-in clinic and patients' homes. The group hired three nurses who work on chronic disease management (e.g. diabetes and hypertension). Nurses assumed care for the 450 patients taking anticoagulants. They get to know the patients better and medication adjustments now take only minutes after lab results are received electronically.

RESULTS

- The staff is more efficient, information is more easily accessible, decisions can be made more quickly and there are fewer drug interactions.
- Innovation has saved about 10% of the physicians' time each day—the equivalent of adding two full-time doctors to the group.
- Nurses provide more education, care and timely follow up to patients with chronic illnesses.

CHALLENGES/OBSTACLES

- Solving information technology problems: it would be helpful to have a mobile team of provincial experts who could consult with physicians and help tailor EMRs to the needs of individual practices.

- A local peer champion helps pave the way for transforming physician work environments.
- Making the best use of nurses' capabilities and overcoming some reticence in delegating clinical follow-up to nurses.
- Addressing security and privacy issues involved in linking medical records from different organizations.
- Getting past the difficult middle transition period and moving to full EMR capacity: many family medicine groups still have mixed (half paper, half electronic) environments; more problem-solving support with EMR capability would help the groups become more efficient.

SPREAD

In addition to viewing videos and other tools on the internet, interested parties are touring the Montmagny Family Medicine Group clinics to see how the integrated system works.

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Many family doctors in Alberta lacked the resources to deal with some of the care issues being downloaded from the hospital system. Patients were waiting longer for hospital beds and being discharged earlier and there was a sense of lack of support for community-based care. Long waits for family doctor appointments and delays arranging diagnostic tests and specialist consultations also created problems. Overall, family doctors worried that the quality of care they were delivering was suffering.

IMPLEMENTATION

Primary care networks (PCNs) were formed in 2005 in the wake of the federal government's primary care transfer funding. PCNs are voluntary groupings of family physicians who continue to own and operate their own practices. A joint venture agreement is created between Alberta Health Services and the physician group, which is responsible to

“AVERAGE WAIT TIMES HAVE DROPPED FROM 10 TO 5 DAYS TO THE NEXT AVAILABLE APPOINTMENT”

form a non-profit corporation. The partnership creates a governance committee that provides oversight for PCN strategic direction as well as a structure to handle daily operations. In addition to fee-for-service payments, PCNs receive payments of up to \$50 per patient, and use these resources to improve care delivery through initiatives such as hiring allied professionals to create multidisciplinary teams, stepping up chronic disease management, offering extended clinic hours, and better coordinating with home care, mental and public health services. PCNs range in size from a group of three doctors to more than 200, with an average of 60.

RESULTS

- A large provincial evaluation was completed in summer 2010.
- Over 90% of PCNs have identified diabetes as a key health issue and have developed programs to improve care delivery.
- Several clinical indicators including blood pressure, mammogram and colorectal screening have increased significantly at the Chinook PCN (100 doctors caring for 200,000 patients in 17 different clinics). Over all participating physicians, average wait times have dropped from 10 to 5 days to the next available appointment.

- Family physicians' work satisfaction has risen. At one rural clinic of 10 doctors there's been a statistically significant improvement in sense of job autonomy, the ability to influence patient behaviour and communications between provider and community programs.

CHALLENGES/OBSTACLES

- Governance: PCNs at first struggled with structuring the non-profit joint ventures and identifying who is responsible and accountable. Legal costs were significant. Now two legal templates for two different governance models have been developed.
- Physicians found it challenging to identify how best to use nurses and other health professionals in medical practice and determine what roles to relinquish but their understanding and practice of true team-based care is growing.

SPREAD

As of August 1, 2010, 35 PCNs involving over 2,000 family doctors (or about 70% of those eligible) were providing care to 2.4 million Albertans—about 64% of the target to have 80% of Albertans receiving care from PCNs by 2011. Eight more PCNs are in development. Negotiations are underway to secure funding.

FOR MORE INFORMATION CONTACT:
www.albertapci.ca/AboutPCNs/

This community health centre in Saint John, New Brunswick, serves a roster of about 8,500 primary care patients and offers community-based programming. The centre is staffed by a large multidisciplinary team, but despite the large role of medications in patients' care, there was no pharmacist. Care for individuals taking anticoagulants was not standardized and after writing out a requisition for blood work, doctors did not necessarily routinely follow up with patients. In 2007, a part-time pharmacist was added to the team with the goals of improving medication management and increasing the team's access to drug information.

IMPLEMENTATION

To help team members appreciate how his contributions could be useful, the pharmacist met with selected patients (for example, those taking multiple medications) before their scheduled doctor's appointment, reviewed their medications, and then made suggestions to the doctor. In this way, he demonstrated how his expertise was useful. Evidence from the scientific literature was

"HAVING THE PHARMACIST TAKE ON CHRONIC DISEASE MANAGEMENT HAS FREED UP TIME FOR OTHER TEAM MEMBERS"

used to decide what services the pharmacist should offer. The pharmacist took on managing about 80 patients on anticoagulants, based on evidence showing that when pharmacists manage their care, patients have fewer strokes, clots or bleed episodes. The pharmacist also consults about medications with community groups and runs, with a nurse practitioner, a smoking cessation clinic. As part of a collaborative practice agreement, the centre's pharmacist can also initiate, modify and discontinue pharmacotherapy for patients.

RESULTS

- Annual quality assurance has proved that the anticoagulation management is of high quality.
- The smoking cessation clinic has a 14% cessation rate.
- Having the pharmacist take on chronic disease management has freed up time for other team members.

CHALLENGES/OBSTACLES

- It was necessary to educate multidisciplinary team members about a pharmacist's scope of practice and what pharmacists are capable of contributing.

- The position is funded on a part-time basis (as a result, the pharmacist works half the time in the hospital, half the time at the centre). The centre could benefit from a full-time pharmacist.

SPREAD

Incorporating pharmacists into multidisciplinary primary healthcare teams has proved successful in other jurisdictions, such as Saskatchewan. Innovative partnerships could be sought with community pharmacies, if a method could be introduced to provide financial support to those pharmacists so they could offer services similar those offered at the St. Joseph's centre.

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