Portail de l'innovation en santé : Archive des pratiques novatrices

Thème : **Ressources humaines de la santé (vol. 1)**

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TERMES DE RECHERCHE:	**N/A**	**LOCATION:**	**Tout**
THÈME DE LA SANTÉ:	**Ressources humaines de la santé**	**CADRE CATÉGORIE:**	**Tout**
HEALTH SECTOR:	**Tout**	**RÉSULTATS DE LA RECHERCHE:**	**30 résultats sur 92**

1. QuickCare Clinics

Implementation Year: Jeudi, janvier 9, 2014 - 13:00	**Location: Manitoba**	**Practice Website: http://www.gov.mb.ca/health/primarycare/quickcare.html**

SNAPSHOT:

This innovative practice is designed to meet low-complexity, primary health care needs, thereby addressing unnecessary visits to the emergency room, duplicated diagnostics, testing, and imaging, and shortages around availability of family physicians. The first QuickCare Clinic opened in Winnipeg, Manitoba in 2012, followed by three more QuickCare Clinics in the same year. Collectively the four QuickCare clinics had over 45,000 patient visits by the fall of 2013.

CONTACT INFORMATION:

Name: Marta Crawford Title: Consultant Organization: Primary Care Network Implementation, Manitoba Health Email address: marta.crawford@gov.mb.ca Telephone number: 204-786-7342

2. Winnipeg Regional Health Authority Palliative Care Program (WRHA-PCP)

Implementation Year: Jeudi, janvier 6, 2011 - 14:45	**Location: Manitoba**	**Practice Website: http://www.wrha.mb.ca/prog/palliative/**

SNAPSHOT:

This innovative practice aims to improve the quality of life for patients receiving palliative care through the development of interprofessional health care teams delivering services across the continuum of care. The WRHA-PCP was initiated in the Winnipeg region in 2011, receives ongoing support and funding from the Regional Health Authority, and continues to expand its health human resource capacities.

CONTACT INFORMATION:

Name: Lori Embleton Title: Program Director Organization: St. Boniface General Hospital, Winnipeg Regional Health Authority- Palliative Care Email address: lembleton@wrha.mb.ca Telephone number: 204-237-2371

3. The Taber Clinic

Implementation Year: Mercredi, janvier 6, 1999 - 14:45	**Location: Alberta**	**Practice Website: http://www.chinookprimarycarenetwork.ab.ca/clinics/clinic.php?view=19**

SNAPSHOT:

This innovative practice addresses the issue of accessibility and quality of care to primary care services in the context of an aging demographic. The practice has existed in Taber, Alberta since 1947, and in 2000, implemented the 'Taber Project', a demonstration project including new payment and service delivery system. The Clinic has operated within the Chinook Primary Care Network since 2005, and currently serves over 16,000 patients in the community. Functioning with a team-based model of care, this practice involves 12 physicians, 4 licensed practical nurses, 2 nurse practitioners as well as 6 registered nurses, a registered psychiatric nurse, behaviorist, Respiratory Therapist, dietitians, Diabetes Educator (RN), medical office assistants and health coaches.

CONTACT INFORMATION:

Name: Rob Wedel Title: Family Physician Organization: Taber, Alberta Chinook Primary Care Network Email address: robwedel@me.com

Information last updated on: January 3, 2013

4. Physician-Pharmacist Collaborative Care Management

Implementation Year: Samedi, janvier 6, 2007 - 14:45	**Location: Québec**	**Practice Website: http://www.opq.org/fr-CA/grand-public/nouvelles-activites-des-pharmaciens/**

SNAPSHOT:

This innovative practice aims to address issues around access to primary health care services and improving the quality of drug-related chronic care management. Collaboration between pharmacists and physicians is becoming increasingly common across Canada. The practice highlighted here describes a high-impact study that has contributed to the broader provincial shift to expand scopes of practice of pharmacists in Quebec. This study was part of a larger study launched in Montreal from 2007 to 2010. It involved eight physician-pharmacists collaborative care management locations, twenty-seven physicians, twenty-eight pharmacists, and 108 patients. This study, among others, is linked to the most recent bill passed in Quebec in May, 2013 which allows pharmacists to extend prescriptions for one year, adjust medications, order and interpret laboratory tests that monitor drug use.

CONTACT INFORMATION:

Name: Lyne Lalonde Title: Professor Organization: Centre Hospitalier de l'Université de Montréal, Hôtel-Dieu Email address: lyne.lalonde@umontreal.ca Telephone number: 514-890-8000 ext 15491

5. Interprofessional Communications Skills Development Workshops

Implementation Year: Jeudi, janvier 6, 2005 - 14:45	**Location: Nouvelle-Écosse**	**Practice Website: http://www.cancercare.ns.ca/en/home/healthprofessionals/education/excellence/default.aspx**

SNAPSHOT:

This innovative practice aims to improve community cancer care for patients and families by enhancing the communication skills of health care professionals across disciplines. The pilot series of interprofessional communications skills development workshops were initially implemented in 2005 and formally commenced in 2006 through Cancer Care Nova Scotia and Dalhousie University's Continuing Medical Education. Since the pilot year, these workshops have been informally integrated into the Health Professional Education workshops.

CONTACT INFORMATION:

Name: Meg McCallum Title: Provincial Manager, Education and Patient Navigation Organization: Cancer Care Nova Scotia Email address: meg.mccallum@ccns.nshealth.ca Telephone number: 902-473-3781

6. Hospital Home Team (Virtual Ward)

Implementation Year: Jeudi, janvier 6, 2011 - 14:45	**Location: Manitoba**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to reduce frequencies of emergency department visits, hospital admissions, re-admissions and duration of stay through the provision of accessible, comprehensive health care services. Established in 2011 out of Access River East, a Health and Social Services Centre in North East (NE) Winnipeg, this team managed an original caseload of ten select patients with complex health care needs and has since continued to expand patient intake.

CONTACT INFORMATION:

Name: Debra Vanance Title: Community Area Director, River East & Transcona Organization: Winnipeg Regional Health Authority and Government of Manitoba Family Services Email address: dvanance@wrha.mb.ca Telephone number: 204 938 5011

7. Communities of Practice

Implementation Year: Vendredi, janvier 6, 2006 - 14:45	**Location: Alberta**	**Practice Website:**

SNAPSHOT:

This innovative practice facilitates the implementation of interprofessional learning and care environments for students and providers. Through the support of Alberta Health Services, 'Communities of Practice' were initially piloted at seven practice sites across the province in 2006-2007. This model has continued to develop and now, there are over fifty Communities of Practice integrated within Alberta Health Services.

CONTACT INFORMATION:

Name: Esther Suter Title: Director, Workforce Research and Evaluation Organization: Alberta Health Services Email address: esther.suter@albertahealthservices.a Telephone number: 403-943-0183

8. Collaborative Practice & Learning Environments

Implementation Year: Mercredi, janvier 6, 2010 - 14:45	**Location: Alberta**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to develop, implement and evaluate innovative interprofessional (IP) approaches to health care delivery across selected health care practice sites in Alberta, British Columbia, Manitoba and Saskatchewan.
The multi-jurisdictional initiative began in 2010 and has been carried out by The Northern and Western Health Human Resource Forum in partnership with the Western Canadian Interprofessional Health Collaborative (WCIHC). The selected sites will constitute Collaborative Practice & Learning Environments (CP&LEs), providing a model for exemplary collaborative practice and hosting IP clinical student placements.

CONTACT INFORMATION:

Name: Esther Suter Title: Director, Workforce Research and Evaluation Organization: Alberta Health Services Email address: esther.suter@albertahealthservices.a Telephone number: 403-943-0183

9. Adopting Research to Improve Care Project (ARTIC)

Implementation Year: Mercredi, janvier 6, 2010 - 14:30	**Location: Ontario**	**Practice Website: http://caho-hospitals.com/partnerships/adopting-research-to-improve-care-artic/**

SNAPSHOT:

This innovative practice aims to integrate evidence-based research into the systematic improvement of health care service quality. The 'Adopting Research to Improve Care' Project (ARTIC) was launched through the network of the Council of Academic Hospitals of Ontario (CAHO) in 2010 and has initiated six evidence implementation projects to date.

CONTACT INFORMATION:

Name: Chris Paterson Title: Director, Stakeholder Relations Organization Council of Academic Hospitals in Ontario Email address: cpaterson@caho-hospitals.com Telephone number: 416-402-4461

10. Longitudinal Elderly Person Shadowing Project

Implementation Year: Dimanche, décembre 9, 2007 - 16:00	**Location: Saskatchewan**	**Practice Website:**

SNAPSHOT:

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

CONTACT INFORMATION:

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

11. Learning Together with Cases

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

SNAPSHOT:

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

CONTACT INFORMATION:

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

12. Interfaculty Course Development for Interprofessional Collaboration

Implementation Year: Dimanche, décembre 9, 2007 - 16:00	Location: Québec	Practice Website: http://www.cihc.ca/regional/overview/atlanticlist/ficcp

SNAPSHOT:

This innovative practice improves the quality of health care services by providing an interprofessional program for health sciences students at pre-licensure levels. The program was introduced in Laval University in Quebec in 2007, and it continues to involve faculty and students from 10 health science disciplines.

CONTACT INFORMATION:

Name: Serge Dumont Title: Full Professor Organization: University of Laval, School of Social Work Email address: serge.dumont@svs.ulaval.ca Telephone number: 418-525-4444 ext. 20976 Information last updated on: October 17, 2013

13. Regional Departments of General Medicine (Départements régional de medicine générale; DRMGs)

Implementation Year: Lundi, décembre 9, 1991 - 15:45	Location: Québec	Practice Website:

SNAPSHOT:

This innovative practice coordinates the supply and planning of primary care services at the regional level. The practice was launched in each of Quebec's 18 health regions and involves all family physicians practicing in the region.

CONTACT INFORMATION:

Johanne Caseault Conseillère en affaires intergouvernementales Direction des affaires intergouvernementales et de la coopération internationale Ministère de la Santé et des Services sociaux 1005, chemin Ste-Foy, 1er étage Québec (Québec) G1S 4N4 Téléphone: (418) 266-5838 Télécopieur: (418) 266-8755 Courriel: johanne.caseault@msss.gouv.qc.ca

14. Primary Care Networks

Implementation Year: Vendredi, décembre 9, 2005 - 15:45	Location: Alberta	Practice Website:

SNAPSHOT:

This innovative practice involves the establishment of a new model of primary care that increases access to and the effectiveness of primary care. The practice was launched throughout Alberta and currently includes 41 primary care networks (PCNs) and involves more than 2,700 family physicians and about 900 other health professionals.

CONTACT INFORMATION:

Tricia Smith Director – Primary Care Networks Primary Health Care Branch Alberta Health Telephone: (780) 643-1435 Email: tricia.smith@gov.ab.ca

15. Physician Assistants in Manitoba

Implementation Year: Jeudi, décembre 9, 1999 - 15:30	**Location: Manitoba**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to “ensure more timely access to team-based care for Manitoba families” (Government of Manitoba, 2012) through the use of physician assistants. The integration of physician assistants (PAs) into practice was launched in a variety of acute and primary care settings and involves government funding of PA clinical positions in these settings.

CONTACT INFORMATION:

Dr. Sheldon Permack, MD FCFP Medical Director Family Medicine/Primary Care Winnipeg Regional Health Authority Telephone: 204-940-8734

16. Integration of Pharmacists in Family Health Teams

Implementation Year: Samedi, décembre 9, 2006 - 15:15	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice improves the appropriateness and outcomes of medication management by including pharmacists in primary health care practices. The practice was launched in Ontario in family health teams (as well as community health centres and nurse practitioner–led clinics) and involves pharmacists and primary care clinicians.

CONTACT INFORMATION:

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

17. Integration of Primary Health Care Nurse Practitioners (PHC NPs)

Implementation Year: Mercredi, décembre 9, 1998 - 15:00	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice improves accessibility and quality of primary care through the use of nurse practitioners The practice has been implemented in Ontario in more than 300 primary care settings and involves provincial government funding of nurse practitioner (NP) education and clinical positions in family health teams, community health centres, nurse practitioner–led clinics, and other primary care practices and organizations.

CONTACT INFORMATION:

Ministry of Health and Long-Term Care Email: nursingsecretariat.moh@ontario.ca)

18. Full Service Family Practice Incentive Program

Implementation Year: Mardi, décembre 9, 2003 - 15:00	**Location: Colombie-Britannique**	**Practice Website: http://www.primaryheathcarebc,ca/gpsc_incentives.html**

SNAPSHOT:

This innovative practice improves patient care by supporting and compensating the delivery of guideline-based care by general practitioners (GPs). The practice was launched province-wide in British Columbia and is available to all GPs.

CONTACT INFORMATION:

Kelly McQuillen Executive Director Primary Health Care and Specialist Services, Health Services and Quality Assurance Divisions Ministry of Health 3-2, 1515 Blanshard Street Victoria BC V8W 3C8 Phone: 250 952-1204 Email: Kelly.McQuillen@gov.bc.ca

19. Family Medicine Groups

Implementation Year: Mardi, décembre 9, 2003 - 15:00	**Location: Québec**	**Practice Website: http://sante.gouv.qc.ca/systeme-sante-en-bref/groupe-de-medecine-de-famille-gmf/**

SNAPSHOT:

This innovative practice provides access to a family doctor for all Quebec residents; increases accessibility of services, especially for vulnerable patients; improves quality of care; promotes continuity of care and coordination between primary care and other health care sectors; and enhances the role of family physicians. The practice was launched throughout Quebec and involves family physicians and other primary care clinicians, particularly nurses.

CONTACT INFORMATION:

Johanne Caseault Conseillère en affaires intergouvernementales Direction des affaires intergouvernementales et de la coopération internationale Ministère de la Santé et des Services sociaux 1005, chemin Ste-Foy, 1er étage Québec (Québec) G1S 4N4 Téléphone: (418) 266-5838 Télécopieur: (418) 266-8755 Courriel: johanne.caseault@msss.gouv.qc.ca

20. Family Health Teams

Implementation Year: Vendredi, décembre 9, 2005 - 14:45	**Location: Ontario**	**Practice Website: http://www.health.gov.on.ca/en/pro/programs/fht/**

SNAPSHOT:

This innovative practice, which was launched in Ontario, improves access to and the quality of primary care. The 185 family health teams involve a broad range of primary health care providers and administrative support personnel.

CONTACT INFORMATION:

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

21. Community Health Centres in Ontario

Implementation Year: Dimanche, décembre 9, 1979 - 14:45	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

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

CONTACT INFORMATION:

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

22. Sault Ste. Marie Group Health Centre

Implementation Year: Mardi, décembre 9, 1997 - 14:30	**Location: Ontario**	**Practice Website: http://www.ghc.on.ca/index.php**

SNAPSHOT:

This innovative practice facilitates improved accessibility and comprehensiveness of primary care service delivery. The Group Health Centre was originally founded in Sault Ste. Marie in 1962. As a progressive, multi-specialty, ambulatory health organization, the health centre integrated an electronic health record system in 1997 and now serves 71,000 residents of Sault Ste. Marie and Algoma District (population 75,000), with 81 doctors and 350 employees.

CONTACT INFORMATION:

Name: Garry Walsh Title: Vice President of Communications Organization: Group Health Centre Email address: walsh_gary@ghc.on.ca Telephone number: 705-759-5562 Information last updated on: November 13, 2013

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

Implementation Year: Jeudi, décembre 9, 1999 - 14:15	Location: International	Practice Website: http://www.dfdrussell.org/

SNAPSHOT:

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

CONTACT INFORMATION:

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

24. The Caring Together Project

Implementation Year: Lundi, décembre 9, 2013 - 14:00	Location: Ontario	Practice Website:

SNAPSHOT:

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

CONTACT INFORMATION:

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

25. Bridging Relationships Across Interprofessional Domains (BRAID)

Implementation Year: Samedi, décembre 9, 2006 - 14:00	Location: Nouveau-Brunswick	Practice Website: http://www.unb.ca/saintjohn/vp/tuckerpark/

SNAPSHOT:

CONTACT INFORMATION:

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

26. Infirmière pivot en oncologie

Implementation Year: Dimanche, novembre 27, 2005 - 10:00	Location: Québec	Practice Website: http://www.msss.gouv.qc.ca/sujets/prob_sante/cancer/index.php?accueil

SNAPSHOT:

Cette pratique novatrice aide les patients atteints de cancer à cheminer dans le système de santé en améliorant l'accessibilité des ressources, la coordination des soins, la continuité des soins ainsi que les communications avec les fournisseurs. Le premier poste d'infirmière pivot en oncologie a été créé en 2005 au Centre hospitalier de l'Université Laval, à Québec. Le poste a été conçu pour permettre aux patients atteints d'un cancer du cou et de la gorge d'avoir un lien direct avec le système de soins de santé. On dénombre actuellement plus de 250 infirmières pivot en oncologie au sein des équipes de soins en milieu hospitalier dans la province du Québec.

CONTACT INFORMATION:

Nom : Lise Fillion Titre : Infirmière autorisée Organisme : Faculté des sciences infirmières, Université Laval Courriel : lise.fillion@fsi.ulaval.ca Téléphone : 418-525-4444, poste 15754 Dernière mise à jour : Le 20 août 2013

27. Clinique de chimiothérapie express

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

SNAPSHOT:

Cette pratique novatrice accélère les services de chimiothérapie pour les enfants qui combattent une leucémie lymphoblastique aiguë. Fondée en 2004, sous forme de projet pilote à The Hospital for Sick Children de Toronto, cette clinique express est encore en activité aujourd'hui. Le modèle porte au maximum les effectifs en santé et l'efficacité des soins, sans pour autant accroître les coûts, en réaffectant les ressources.

CONTACT INFORMATION:

Nom : Eleanor Hendershot Titre : Infirmière clinicienne spécialisée, infirmière praticienne, conférencière Organisme : The Hospital for Sick Children, Université de Toronto Courriel : eleanor.hendershot@sickkids.ca Téléphone : 416-813-7515 Dernière mise à jour : Le 15 juillet 2013

28. Advanced Clinician Practitioner in Arthritis Care Program (ACPAC) ou le programme destiné aux cliniciens de niveau avancé qui soignent des patients souffrant d'arthrite

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

SNAPSHOT:

Cette pratique novatrice vise à améliorer les compétences des cliniciens de niveau avancé qui soignent des patients souffrant d'arthrite. Lancé en 2005 à l'Hôpital St. Michael, en collaboration avec The Hospital for Sick Children à Toronto, le programme interprofessionnel compte maintenant plus de 37 diplômés qui travaillent dans des milieux cliniques variés aux quatre coins de l'Ontario.

CONTACT INFORMATION:

Nom : Katie Lundon, B.Sc. (physio.), M.Sc., Ph.D. ou Dre Rachel Shupak, M.D., FRCP(C) Titre : Directrice générale du programme Organisme : Advanced Clinician Practitioner in Arthritis Care, Hôpital St. Michael Courriel : k.lundon@cogeco.ca Dernière me à jour : Le 1er août 2013

29. Inclusion des patients et de leur famille au sein des conseils d'action d'unités des hôpitaux afin de promouvoir des soins interprofessionnels intégrés et centrés sur le patient

Implementation Year: Samedi, novembre 26, 2011 - 14:30	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

Cette pratique innovatrice illustre un modèle de pratique en collaboration pour la prestation de soins interprofessionnels centrés sur le patient en suscitant la participation des patients et de leur famille en tant que membres des conseils d'action d'unités (CAU). Ce projet fut inauguré en 2011 en Ontario au sein d'une alliance de quatre hôpitaux communautaires en milieu rural.

CONTACT INFORMATION:

Nom : Dianne Gaffney Titre : Responsable de l'organisme, Exercice professionnel Organisme : Huron Perth Healthcare Alliance Courriel : dianne.gaffney@hpha.ca Téléphone : 519-272-8210, poste 2316 Dernière mise à jour : 31 juillet 2013

30. Équipes de santé d'infirmières et infirmiers et de diététiciens pour prévenir les complications liées au diabète

Implementation Year: Vendredi, novembre 26, 2004 - 14:00	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001687**

SNAPSHOT:

Cette pratique innovatrice améliore la qualité du contrôle du diabète en ayant recours à des équipes interprofessionnelles de soins de santé effectuant des interventions auprès des personnes âgées de 17 ans et plus atteintes de diabète et d'hypertension ou d'albuminurie. Le projet pilote initial a été inauguré dans cinq collectivités au nord de l'Alberta en 2004. On a développé depuis le programme dans huit collectivités au total (deux collectivités urbaines et six rurales), desservant plus de 3 000 patients.

CONTACT INFORMATION:

Nom : Carolyn Good Titre : Coordonnatrice du bureau Organisme : Diabetic Nephropathy Prevention Clinics (cliniques de prévention de la néphropathie diabétique), Alberta Health Services Courriel : carolyn.good@albertahealthservices.ca Téléphone : 780-407-1443 Dernière mise à jour : 26 juillet 2013

QuickCare Clinics

LOCATION:	**Manitoba**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Émergente**

SNAPSHOT: This innovative practice is designed to meet low-complexity, primary health care needs, thereby addressing unnecessary visits to the emergency room, duplicated diagnostics, testing, and imaging, and shortages around availability of family physicians. The first QuickCare Clinic opened in Winnipeg, Manitoba in 2012, followed by three more QuickCare Clinics in the same year. Collectively the four QuickCare clinics had over 45,000 patient visits by the fall of 2013.

PRACTICE DESCRIPTION:

QuickCare Clinics operate as 'nurse-led care models'. This means that registered nurses and nurse practitioners share the responsibility of seeing patients and make referrals outside of the clinic when necessary. Basic services offered at these centres are based on episodic primary care needs, and include treating infections, rashes, sprains, etc.; prescribing birth control; and administering immunizations. Patient intake is organized on the principles of the 'Advanced Access Model' and combines walk-in services with scheduled appointments to enable more immediate patient visits. In contrast to traditional payment systems where physicians bill per service provided, nurses are paid through block funding so that the flow of financial resources matches the input of the health human resources on-site.

By treating more basic health care needs within the scope of practice of the attending nurse, this model is designed to improve efficiency of health care services, theoretically diverging inappropriate demands away from urgent care centres and emergency departments. The clinics address issues of accessibility of primary care by providing extended hours and are open during weekends, evenings and holidays.

QuickCare Clinics are funded through the Regional Health Authorities, and are part of a broader provincial plan to ensure that every Manitoban who wants a family physician will have access to one by 2015. These clinics are therefore not considered a replacement to family practice clinics, but are integrated within the primary care network strategy to decrease the overall work burden on physicians, enabling them to accept more patients into their practice.

IMPACT:

This innovative practice has been implemented since February 2012 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

APPLICABILITY/TRANSFERABILITY:

The success of QuickCare Clinics has been facilitated by the broader provincial agenda to increase accessibility of family physicians, collaboration across regional health authorities, the staffing model, the convenient locations for the clinics, and having established an electronic medical record from the onset.

In terms of health human resource planning, challenges around nurse practitioner recruitment have been experienced province wide. For the case of the QuickCare Clinics, full nurse practitioner staffing was not achieved until the fall of 2013.

This particular nurse-led model is unique to Manitoba. The four Quick Care Clinics that are currently operational are: Steinbach, Selkirk, McGregor Avenue in Winnipeg, and St. Mary's Road in Winnipeg, which opened most recently in November 2012. Four more Quick Care Clinics are scheduled to open in the next few years.

CONTACT INFORMATION:

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Organization: Primary Care Network Implementation, Manitoba Health

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Telephone number: 204-786-7342

Information last updated on: December 11, 2013

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

Personal Communications:

Marta Crawford; November 22, 2013 [telephone]

External Source: http://www.gov.mb.ca/health/primarycare/quickcare.html

Winnipeg Regional Health Authority Palliative Care Program (WRHA-PCP)

LOCATION:	**Manitoba**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Émergente**

SNAPSHOT: This innovative practice aims to improve the quality of life for patients receiving palliative care through the development of interprofessional health care teams delivering services across the continuum of care. The WRHA-PCP was initiated in the Winnipeg region in 2011, receives ongoing support and funding from the Regional Health Authority, and continues to expand its health human resource capacities.

PRACTICE DESCRIPTION:

In 1999, administrative structures were regionalized across the province of Manitoba. During that process, new visions for the health care system emerged which included the creation of a palliative care model in order to better respond to patient needs, particularly with an aging demographic. In 2011, the WRHA received funding to put this model into action. An interprofessional palliative care team was developed, comprising of registered nurses, clinical nurse specialists, general practitioners, and social workers, with established referral systems to community programs such as mental health service provision. The entire program is organized through a centralized system to manage the coordination of care services across home, long-term or acute care settings. For example, with this centralized system, patients' needs can be prioritized to determine relative eligibility for unit beds (rather than leave determination of accessibility to site-specific availability). Moreover the centralized management enables coordinated communication so that patient information can be shared more easily across settings and providers. Providers are paid through block funding so that the supply and distribution of health human resources can be determined based on the community needs.

What makes this practice particularly innovative is its integration of the interprofessional health care team. Usual models of palliative care would be predominantly provided by nurses. In this model, the variety of health care team members enables the provision of more comprehensive care—this includes physicians visiting patients in their homes. Overall, this model aims to deliver the right care in the right place, mitigate unnecessary emergency room visits, and enable patients to stay in their homes, particularly during end-of-life care.

IMPACT:

This innovative practice has been implemented since 2011 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

APPLICABILITY/TRANSFERABILITY:

The organization behind the WRHA-PCP was developed internally, specific to the region's health care needs. The unified vision of the way in which this model was conceptualized and has been implemented to better meet patient has supported the successes of the program thus far. The greatest operational barrier over the last two years has been noted around the challenge of upgrading the technological infrastructure. With ongoing support for this program from the region, there are currently plans in place to expand health human resource capacities and the ability to provide more comprehensive services through the inclusion of psychosocial resources, clinical pharmacists, and health care aides into the palliative care team.

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Information last updated on: December 12, 2013

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

Personal Communications:

Lori Embleton; December 12, 2013 [telephone]

Alternative Profiles:

Community Model of Palliative Care: http://www.manitoba.ca/health/mpan/pdf/palliative.pdf

External Source: http://www.wrha.mb.ca/prog/palliative/

The Taber Clinic

LOCATION:	**Alberta**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Émergente**

SNAPSHOT:

This innovative practice addresses the issue of accessibility and quality of care to primary care services in the context of an aging demographic. The practice has existed in Taber, Alberta since 1947, and in 2000, implemented the 'Taber Project', a demonstration project including new payment and service delivery system. The Clinic has operated within the Chinook Primary Care Network since 2005, and currently serves over 16,000 patients in the community. Functioning with a team-based model of care, this practice involves 12 physicians, 4 licensed practical nurses, 2 nurse practitioners as well as 6 registered nurses, a registered psychiatric nurse, behaviorist, Respiratory Therapist, dietitians, Diabetes Educator (RN), medical office assistants and health coaches.

PRACTICE DESCRIPTION:

Of a population of 20,000 persons between the communities of Taber and Vauxhaull, Alberta, the Taber Clinic is able to link over 16,000 patients to a health care provider through improved patient intake processes and the efficient use of health human resources. This clinic is designed to meet the majority of patients' primary care needs by bringing the expertise of dieticians, physicians, diabetes educators, asthma teams, RPNs, LPNs, RNs and nurse practitioners under one roof to create a centralized patient Medical Home. The medical office assistant plays a crucial role in this health care team, working directly with a physician and taking standard patient metrics. While every patient is attached to his or her own family physician and team, a patient can chose to see any one of the team during any given appointment, dependent upon the need presented at the time of visit.

Data is collected at each point of care. This data is then used to inform care pathways and determine appropriate provider allocation. There is a particular focus on preventative measures such that algorithms have been created for approximately 60 different types of screening and are automated to alert health personnel depending on patient profiles. On an aggregate level, this data collection also helps to inform the clinic's progress relative to heath care guidelines and population benchmarks. The integration of the electronic medical record system provides the infrastructure to enable both the data collection and communication among health care providers.

In the spring of 2000, the clinic moved away from fee-for-service payment structure and turned to 'blended' funding, based on Capitation funding for the designated population, plus fee-for-service for those patients attending from outside that population and procedure based services. Effective since September 2000, this 'Alternative Relationship Plan', now managed by Alberta Health has provided funding for patient care within the clinic. Effective with the inception of the Primary Care Network (PCN) in 2005, the clinic receives PCN funding to support the development and employment of the practice team. The Chinook PCN provides facilitation and evaluation support to assist with Quality Improvement within the clinics.

The "Taber Project" was initially launched on a three-year term and received funding from the Canadian Health Services Research Foundation, the Alberta Heritage Foundation for Medical Research, Chinook Health Region, and Alberta Health and Wellness. After 2003, the clinic was able to continue serving the communities through its standard Alberta Health funding sources. The clinic receives no additional sources of funding beyond that available to all Family Physicians in Alberta.

IMPACT:

There has been no system-based evaluation publically shared on this initiative. Various grey sources have referenced the positive impact of these primary care services on relative health services such as emergency department visits and acute care services. One paper noted that emergency asthma visits have been reduced from 340 in 2001 to 24 in 2011. Anecdotal evidence states that allied health professionals have been well accepted and integrated into the system by patients and other health professionals.

The Taber Clinic has been profiled nationally in 2011 in the Premier's Report and highlighted by the Health Care Innovation Working Group as one of Canada's leading innovative health care models in 2012.

APPLICABILITY/TRANSFERABILITY:

The clinic is currently in the process of changing facilities in order to capacitate a broader range of services included public health, homecare, mental health, addictions, family and community services.

In 1999 the Regional Health Authority hired project coordinator to share the work and knowledge gained during the development of this model of care and how it can be applied to different parts of the region however this position was discontinued in 2004.

The electronic medical record system is noted as an essential element to the functionality of a practice on this scale; however, the continuity of services, upgrading, and user knowledge around the electronic system remains as a constant challenge.

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Information last updated on: January 3, 2013

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

Tholl, B., Grimes, K. (2012). Strengthening Primary Health Care in Alberta through Family Care Clinics: From concept to reality. Part One: Issue Brief http://www.health.alberta.ca/documents/PHC-FCC-Concept-to-Reality-2012.pdf

Alternative Profiles:

Wedel, R., Kischuk, R., Patterson, E. (2007) Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada. Healthcare Policy, 3(1): 80-95.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645121/pdf/policy-03-080.pdf

Healthcare transformation in action- Alberta's Taber Clinic. A Commentary. Technologies for Doctors online. (2013). http://www.canhealth.com/tfdnews0885.html

Taber clinic recognized nationally. The Taber Times. (2012).

http://internetgroup.ca/docs/cpcn/file/Taber%20Clinic/Taber%20Times%20-%20August%2022%202012.pdf

Spotlight on Collaboration. (2006). http://www.eicp.ca/en/spotlight/taber.asp

Personal Communications:

Rob Wedel; January 3, 2013 [email]

External Source: http://www.chinookprimarycarenetwork.ab.ca/clinics/clinic.php?view=19

Physician-Pharmacist Collaborative Care Management

LOCATION:	Québec	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	Prometteuse

SNAPSHOT: This innovative practice aims to address issues around access to primary health care services and improving the quality of drug-related chronic care management. Collaboration between pharmacists and physicians is becoming increasingly common across Canada. The practice highlighted here describes a high-impact study that has contributed to the broader provincial shift to expand scopes of practice of pharmacists in Quebec. This study was part of a larger study launched in Montreal from 2007 to 2010. It involved eight physician-pharmacists collaborative care management locations, twenty-seven physicians, twenty-eight pharmacists, and 108 patients. This study, among others, is linked to the most recent bill passed in Quebec in May, 2013 which allows pharmacists to extend prescriptions for one year, adjust medications, order and interpret laboratory tests that monitor drug use.

PRACTICE DESCRIPTION:

Variations of the pharmacist-physician collaborative model have been explored for several years but still lack systematic integration across jurisdictions. The province of Quebec is advanced in their legislation around the expanded scope of pharmacists relative to the other provinces and territories. This study highlights a portion of the evidence behind innovative practices around pharmacist involvement and is associated with subsequent studies that are continuing to push this agenda forward.

The physician-pharmacist collaborative care management study was implemented as a clustered design and targeted patients with pre-existing lipid disorders in a Montreal hospital from 2007-2010. Responsibilities were clearly demarcated so that physicians were responsible for diagnosing and prescribing lifestyle changes and statin treatment and pharmacists were responsible for monitoring changes, tolerance, efficacy; adherence to pharmacotherapy, requesting lab analyses, and adjusting statin dosage. After each visit, communication protocols were established so that the pharmacist faxed the physician a report form summarizing the intervention. Pharmacists in the intervention group received a one-day protocol training workshop. The physician-pharmacist collaborative care model was then compared to a ‘usual care’ model in which physicians adjusted pharmacotherapy and the pharmacists provided basic counseling and dispensed medications. (Funding for this research was grant-based from the Canadian Institutes of Health Research, as well as AstraZeneca Canada Inc., Merck Frost Canada Inc., and Pfizer Canada Inc.).

Since this study, (and other similarly oriented studies conducted within Quebec), Bill 41 legislation was introduced in May 2013 to amend previous pharmacy laws and expand pharmacists’ scope of practice. The six new front-line services proposed for pharmacists include:

- Renewing a doctor’s prescription but not beyond one year
- Modifying or adjust a prescription’s form, dosage and quantity
- Prescribing a medication when no diagnosis is required
- Substituting medications when there’s a supply disruption
- Ordering and analyze laboratory tests to monitor medication use
- Administering injections as a demonstration for educational purposes

IMPACT:

The study described above was nested in a larger study entitled, Trial to Evaluate an Ambulatory primary care Management program (TEAM).The results from this nested study describe the impact of pharmacists adjusting statin treatments from the perspective of patients, pharmacists, and physicians. Patients and physicians reported appreciating the intervention as compared to usual models of care, whereas pharmacists experienced more difficulties around professional and organizational barriers.

Given how recently Bill 41 has been introduced into the system, there is no completed evaluation at this time but is suggested to be impacting on the proliferation of greater pharmacist involvement in the primary care setting.

APPLICABILITY/TRANSFERABILITY:

According to the Canadian Pharmacists Association's most recent summary of pharmacists' expanded scope of practice activities across Canada, Alberta, New Brunswick, and Nova Scotia at similar levels of legislation, regulation, and policies for pharmacists, compared to Quebec (http://www.pharmacists.ca/cpha-ca/assets/File/ExpandedScopeChart.pdf.)

In terms of other studies that evaluate models where pharmacists are responsible for adjusting medications to reach a therapeutic target, the literature is extensive. The articles listed below provide just a few examples of related interventions indicating promising outcomes around the management of oral anticoagulation, hypertension, and diabetes.

Stanschi, V., Chiolero, A., Paradis, G., Colosimo, A., Burnand, B. (2012). Pharmacist Interventions to Improve Cardiovascular Disease Risk Factors in Diabetes. *Diabetes Care*, 35(12): 2706-2717.

http://care.diabetesjournals.org/content/35/12/2706.full.pdf+html

Santaschi, V., Wuerzner, G., Chiolero, A., Burnand, B., Paradis, G., Burnier, M. (2012). [Team-based care involving pharmacists and nurses to improve the managment of hypertension]. *Rev. Med Suisse,* 8(353): 1694-1996.

http://www.ncbi.nlm.nih.gov/pubmed/23029981

Stanschi, V., Chiolero, A., Burnand, B., Colosimo, A.L., Paradis, G. (2011). Impact of pharmacist care in the management of cardiovascular disease risk factors: a systematic review of meta-analysis of randomized trials. *Arch Intern Med,* 171(16): 1441-1453. http://archinte.jamanetwork.com/article.aspx?articleid=1105914

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Publications

Lalonde, L., Hudon, E., Goudreau, J., Belanger, D., Villeneuve, J., Perreault, S., Blais, L., Lamarre, D. (2011) Physician-pharmacist collaborative care in dyslipidemia management: the perception of clinicians and patients. *Res Social Adm Pharm*, 7(3): 233-45.

http://www.ncbi.nlm.nih.gov/pubmed/21272548

Cote, L., Normandeau, M., Maheux, B., Authier, L., Lefore, L. (2013) Collaboration between family physicians and community pharmacists: Opinions of graduates in family medicine. *Canadian Family Physician*, 59: e413-e420.

http://www.ncbi.nlm.nih.gov/pubmed/24029528

Alternative Profiles:

Fidelman, C. (2013). Quebec to expand pharmacist's role to ease pressure on doctors, ERs. Global News. http://globalnews.ca/news/409064/quebec-to-expand-pharmacists-role-to-ease-pressure-on-doctors-ers/

Personal Communications:

Lyne Lalonde; September 26, 2013 [email]

External Source: http://www.opq.org/fr-CA/grand-public/nouvelles-activites-des-pharmaciens/

Interprofessional Communications Skills Development Workshops

LOCATION:	Nouvelle-Écosse	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Acute Care	**CADRE CATÉGORIE:**	Prometteuse

SNAPSHOT: This innovative practice aims to improve community cancer care for patients and families by enhancing the communication skills of health care professionals across disciplines. The pilot series of interprofessional communications skills development workshops were initially implemented in 2005 and formally commenced in 2006 through Cancer Care Nova Scotia and Dalhousie University's Continuing Medical Education. Since the pilot year, these workshops have been informally integrated into the Health Professional Education workshops.

PRACTICE DESCRIPTION:

In 2004, a needs assessment was conducted with health care professionals working with oncology patients in community care settings across Nova Scotia. From this assessment, interprofessional communication emerged as one of the priority areas requiring improvement in order to strengthen both quality of services and effective use of health human resources. The initial development the interprofessional communication skills development workshops involved an integrated evaluation to assess the process and impact of four 2-hour workshops. These workshops focused on the following areas:

1) Essential Communication Skills

2) Delivering Difficult News and Providing Support

3) When Patients and Families Are Angry

4) Managing Conflict in the Workplace

Targeted for trained health professionals, these workshops were structured to present the background evidence behind the interventions, enable opportunities to observe practice skills through role play scenarios by professional actors, and provide a platform to debrief different approaches. All of the workshops were facilitated by communication experts.

This innovative practice received funding from Health Canada's Transition Fund and continues to collaborate with acting services provided by Irondale Ensemble Theatre, Halifax. Other stakeholders include The Alliance for Continuing Medical Education, the Society for Academic Continuing Medical Education, the Council on Continuing Medical Education, and the Association for Hospital Medical Education.

IMPACT:

Evaluations were conducted pre- and post- the initial implementation of the workshops, as well as three months after for follow-up. At the time of this assessment, 518 professionals representing over 20 health professions attended a total of 17 workshops. Of these health professionals, nurses comprised over 50% of participants, followed by care coordinators and social workers. Comparisons from before and after the workshops indicated that self-reported communication skills showed statistically significant improvement and 92% of respondents indicated intension to change their communication practices after the workshops. Of the 68 respondents that participated in the follow-up, 59 (87%) reported positive changes of reception among respective patients, including patients asking more questions. In terms of interprofessional impact, 98% (299/306) reported that interacting with other health professionals enhanced their learning and increased understanding around respective roles.

APPLICABILITY/TRANSFERABILITY:

As an approach for integrating some level of sustainability, the workshops included a "train the trainer" program for highly skilled facilitators and actors. Twenty-six health professionals completed 3-days of training and offered 6 workshops in teams of 3 to 5. Despite positive responses to extend the program beyond its initial workshops there have been significant challenges to

maintain the sustainability of the volunteer facilitator program. In order for the facilitator teams to continue to be integrated, volunteer facilitators identified that institutional and direct management support would be needed.

Lessons learned from the implementation of these workshops included: a) that interactive workshops can be used as effective tools to improve interprofessional communication skills and behavior; b) that interprofessional communication is a highly sought competency area for health professional participants; and c) that the interaction among different types of health professionals was considered to enhance learning. The main challenge was reported around gaining commitment from volunteers to continue as professional facilitators of the program.

Several continuing professional development initiatives focused on interprofessional competency development exist across the country. This particular series of workshops are unique to the province of Nova Scotia based on the level of coordination enabled through Cancer Care Nova Scotia, reaching as many affiliated health care professionals as possible.

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Information last updated on: December 18, 2013

Content has been adapted from the following sources and relevant links

Personal Communications:

Brian Taylor, Project Officer, Cancer Care Nova Scotia [email]

Publications:

Seargeant, J., MacLeod, T., Murray, A. (2011) An interprofessional approach to teaching communication skills. *J Contin Educ Health Prof*, 31(4): 265-7. http://www.ncbi.nlm.nih.gov/pubmed/22189990

Sargeant, J., Hill, T. (2008) Partners for Interprofessional Cancer Education (PICE): Cultivating Communities of Practice for Collaborative care, Evaluation Report.

External Source: http://www.cancercare.ns.ca/en/home/healthprofessionals/education/excellence/default.aspx

Hospital Home Team (Virtual Ward)

LOCATION:	**Manitoba**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Prometteuse**

SNAPSHOT: This innovative practice aims to reduce frequencies of emergency department visits, hospital admissions, re-admissions and duration of stay through the provision of accessible, comprehensive health care services. Established in 2011 out of Access River East, a Health and Social Services Centre in North East (NE) Winnipeg, this team managed an original caseload of ten select patients with complex health care needs and has since continued to expand patient intake.

PRACTICE DESCRIPTION:

A common consequence of poor access to primary care services is the overreliance on emergency departments to provide frontline care. Often times, patient needs would be more appropriately met in other settings; however, the structure of the system is not designed to provide such care, particularly after hours and on weekends. The Hospital Home Team was initiated on a pilot project basis from 2011-2012 to improve access, continuity of care and quality of life by enabling patients to safely and happily stay at home. This pilot was funded by Manitoba Health through the Manitoba Patient Access Network.

This pilot used a predictive risk model to identify individuals most likely to benefit from the program. The identified individuals included in the first cohort were all existing clients of Home and Primary Care at Access River East and due to their health care complexity were frequent visitors to hospital emergency units. The initial interprofessional health care team included a physician, a home care case coordinator (social worker) and a registered nurse. The current expanded team has other community and hospital staff that includes other existing medical, allied health, nursing and support staff. As the model continues to expand, there is intention to include mental health professionals and pharmacists. The team does weekly rounds. Patient documentation occurs via the Electronic Medical Record and the Resident Assessment Instrument (RAI), Home Care, Minimum Data Set (MDS). Patients are contacted by telephone to arrange appropriate timing of home visits. The team is notified when patients attend emergency and emergency staff have access to MDS. An evolving characteristic of this model is the availability of the on call primary care team during evenings and weekends.

IMPACT:

An assessment was conducted pre- and post-implementation of the pilot virtual ward model. The initial ten patients had sought care in the emergency department a total of 27 times over the 12-month period in 2011 which was compared to 64 times in the 12 months previous in 2010. Length of hospital stay for these patients was also compared at 138 in 2011 to 319 in 2010. Qualitative feedback from the families identified that they felt supported in caring for their loved one in the community and appreciated the timely response of the team. For patients living on their own, they reported greater confidence living independently with complex needs. From the palliative care coordinator, they reported patients and families expressing satisfaction with the care received and from the palliative care physician, they considered the team approach to be vital to keeping patients in their home communities. The original pilot used existing staff and potential cost reduction for inpatient bed days alone were approximately $140,000 based on a bed cost of $800/day. These savings are not extractable but represent an ability to care for more patients within the same budget allocation.

APPLICABILITY/TRANSFERABILITY:

The concept of the virtual ward is linked to development in the United Kingdom in the early 2000's. A Canadian-led research team has since developed the 'LACE' index (L—length of stay; A—acuity of admission; C—Charlson Comorbidity Index; E—number of emergency room visits in the last six months) to predict otherwise unplanned readmission within 30 days post hospital discharge and provides a transferrable algorithm for calculated appropriate case management for this type of care model.

The successes of the Hospital Home Team in Winnipeg are related to the well-established relationships between the NE Winnipeg staff and leadership across community and acute care and the health and social services programs of the Winnipeg Regional Health Authority and Government of Manitoba, Family Services.

The Hospital Home Team expansion will increase patient capacities to 100 over the next few years and include Access Transcona, a second Health and Social Services site in NE Winnipeg. In addition a second team has been established in West Winnipeg with another planned for South Winnipeg. Additionally, there are three other virtual wards at various stages of development in Canada.

- Toronto Central Community Care Access Centre (and in some hospitals associated with the University of Toronto).

http://www.ncmn.ca/Resources/Documents/LKS_15_-_NCMN-VirtualWard-Oct2012_-_Effie_Galanis.pdf

- South East Toronto Family Health Team (for patients being discharged from Toronto East General Hospital)

http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/Kavita_Mehta.sflb.ashx;
http://www.uwo.ca/fammed/csfm/siiren/documentation/AHRQ_Virtual_Ward_Pre...

- St Mary's Hospital in Quebec (which focuses on patients with mental illness)

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Information last updated on: January 2014

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

The Use of Virtual Wards to Reduce Hospital Readmissions in Canada. Canadian Agency for Drugs and Technologies in Health. (2011). http://www.cadth.ca/media/pdf/ES-27_virtual_wards_e.pdf

Personal Communications:

Debra Vanance; January 2, 2013 [email]

Other:

Virtual ward, real results: Doctor, nurse, home-care coordinator team up in a year-long project keeping elderly, chronic patients in their homes instead of hospital beds. (2012)

http://www.winnipegfreepress.com/breakingnews/virtual-ward-real-results-148364425.html

Communities of Practice

LOCATION:	**Alberta**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Émergente**

SNAPSHOT: This innovative practice facilitates the implementation of interprofessional learning and care environments for students and providers. Through the support of Alberta Health Services, 'Communities of Practice' were initially piloted at seven practice sites across the province in 2006-2007. This model has continued to develop and now, there are over fifty Communities of Practice integrated within Alberta Health Services.

PRACTICE DESCRIPTION:

Communities of Practice involve health care providers from various disciplines who work together to develop solutions around ways to better meet patient needs. Practice changes generated focus on the expanded capacities health human resources through interprofessional collaboration. Examples of practice changes introduced include improving communication processes through regular staff meetings across all health care personnel located at different health care centres and streamlining admission and discharge processes through the consolidation of multiple patient intake forms. Communities of Practice also promote interprofessional mentoring programs for students to benefit from learning about the roles and capacities of other health care providers they will be working with in the practice setting. These mentoring experiences are offered in addition to formal preceptorship or clinical supervision.

The pilot phase of this project was funded by Health Canada's initiative,Interprofessional Education for Collaborative Patient-Centred Practice. The project team had members from two former regional health authorities (Calgary Health Region and Capital Health in Edmonton), two universities (University of Calgary, University of Alberta) and three colleges (Mount Royal College [now Mount Royal University], Bow Valley College, SAIT Polytechnic).

IMPACT:

No formal evaluation has been conducted. Anecdotally, improved relations and a greater sense of cohesion have been reported among participating health care providers where Communities of Practice is active and changes have been introduced. Communities of Practice have been viewed as a way to increase awareness around the importance and efficacies of integrating interprofessionalism into education and practice. Furthermore, it has enabled a space to assess existing structures and processes and to explore new ways of doing things.

Successes were found in improvements to communication processes, internally or externally, allowing providers to exchange patient care information more effectively. Changing admission or discharge information processes eliminated unnecessary or duplicate documentation, increased opportunities to jointly examine patient issues and engage in shared decisions.

For participating students, interprofessional mentoring was reported to improve students' clinical practicum experiences and the classroom activities enhanced students' interprofessional competencies. Areas most affected were knowledge of roles (e.g., understand and appreciate the roles and responsibilities of other professions, demonstrate awareness of how the roles of providers relate to each other), communication skills (e.g., use language that is appropriate to the target audience, model interpersonal skills in building consensus and problem solving) and collaboration skills (e.g., engage in shared goal settings and decision making, partner with other organizations to coordinate patient care).

APPLICABILITY/TRANSFERABILITY:

After the completion of the pilot phase in 2007, one of the Communities of Practice facilitators took on a permanent position with the Knowledge Management Team in Alberta Health Services. This facilitator has been integral for the development and implementation of the Communities of Practice training programs and educational resources that have been used across health care settings in the province. The facilitator has provided consultations and mentoring to persons interested in developing Communities of Practice in their own locations. More recently the facilitator has been supported by a team of 6 to 8 co-consultants dedicated to integrating Communities of Practice across Alberta. The program is now in the fifth cohort of facilitator training, with 20 people having completed in each cohort. The spread of 7 to 50 Communities of Practice over the last

seven years is indicative of the scalability of this mode of quality improvement. They have also covered a variety of health care areas such as accreditation, community mental health, patient engagement, quality metrics, emergency medical services, senior's health, demonstrating the programs' broader applicability.

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Information last updated on: November 15, 2013

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Personal Communications:

Esther Suter; November 15, 2013 [email]

Publications:

Suter, E., Taylor, L., Arthur, N., Clinton, M. (2008) Creating an interprofessional learning environment through communities of practice: An alternative to traditional preceptorship - Final report

http://www.albertahealthservices.ca/Researchers/if-res-hswru-iecpcp-report-2008.pdf

Suter E, Arndt J, Lait J, Jackson K, Kipp J, Taylor L, Arthur N. How can front line managers demonstrate leadership in enabling interprofessional practice? Healthcare Management FORUM, 2008, 20(4):38-42.

White D, Suter E, Parboosingh J, Taylor E. Communities of practice: creating opportunities to enhance quality of care and safe practices. Quarterly Healthcare Quarterly, 2008, 11(Sp):80-84.

Suter E, Arndt J, Arthur N, Parboosingh J, Taylor L, Deutschlander S. Role understanding and effective communication as core competencies for collaborative practice. Journal of Interprofessional Care 2009, 23(1):41-51.

Suter E, Arndt J, Arthur N, Parboosingh J, Taylor L, Deutschlander S. Role understanding and effective communication as core competencies for collaborative practice. Journal of Interprofessional Care 2009, 23(1):41-51.

Trojan L, Suter E, Arthur N, Taylor E. Evaluation framework for a multi-site interprofessional practice and education intervention. Journal of Interprofessional Care, 2009, 23 (4): 380-389.

Collaborative Practice & Learning Environments

LOCATION:	**Alberta**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	

SNAPSHOT: This innovative practice aims to develop, implement and evaluate innovative interprofessional (IP) approaches to health care delivery across selected health care practice sites in Alberta, British Columbia, Manitoba and Saskatchewan. The multi-jurisdictional initiative began in 2010 and has been carried out by The Northern and Western Health Human Resource Forum in partnership with the Western Canadian Interprofessional Health Collaborative (WCIHC). The selected sites will constitute Collaborative Practice & Learning Environments (CP&LEs), providing a model for exemplary collaborative practice and hosting IP clinical student placements.

PRACTICE DESCRIPTION:

In Alberta, two community mental health outpatient clinics were recruited for this project. Staff at both clinics demonstrated a collaborative, client-centred care philosophy with following objectives: 1. Increase IP competencies of providers; 2. Develop structures and processes to facilitate collaborative practice; 3. Develop staff competencies to act as IP mentors for students; and 4. Increase capacity for IP student placements. At both sites, students from different disciplines started their practicum and were also interested in learning more about collaborative practice. External facilitators guided the staff and student discussions every two weeks for about one hour to focus on areas for change and to assist with the design of the strategies. Most team members also attended three workshops for in-depth discussions on current concerns.

Tools and approaches from Human Systems Dynamics were used to structure the conversations and arrive at meaningful strategies at the practice and systems levels (http://www.hsdinstitute.org/). Staff used the *Legacy Sustainability Framework* as developed by Royce Holladay to plan a sustainable interprofessional mentoring strategy by considering relevant factors (e.g., coherence, commitment, connections, constructs, communication, capacity building and continuous assessment). The Canadian Interprofessional Health Collaborative (CIHC) Interprofessional Practice Competency Framework laid the foundation for the competency discussions (www.CIHC.ca).

Funding was provided by Alberta Health through the Health Workforce Action Plan and Health Canada.

IMPACT:

Following the initial research and development stages of the project in 2010, an evaluation was conducted to assess the outcomes, process, and context (staff and manager interviews). The evaluation was designed specifically to monitor changes in knowledge, attitudes, skills, and behaviours among program participants. Two validated tools were used to quantitatively measure these changes, in relation to interprofessional practice and changes in communication and relationships. Overall, staff reported having developed a greater awareness for the need to collaborate, identify issues within each team, and implement collaborative practice changes. Team members concurred that the overall level of collaboration at the clinics had increased. The majority of students stated that they gained greater awareness about how other practitioners work at the clinics and that collaborative practice is an important part of client care. At the time of the evaluation, client processes that had associated improvements included triage, discharge, treatment of clients with concurrent mental health and addictions issues.

APPLICABILITY/TRANSFERABILITY:

This approach to creating Collaborative Practice & Learning Environments is highly transferrable to other practice settings for both students and staff. While the initial project was limited to one year, this model of education and effort to improve IP care has since been formally integrated into the Health Professions Practice & Strategy Portfolio at Alberta Health Services.

One of the greatest benefits to this practice has been the ability to increase capacity for interprofessional mentoring of students (e.g., evaluating interprofessional skills, recognizing interprofessional opportunities). Staff indicated that external facilitators and internal champions endorsing the project were crucial to the successful development and completion of the project. The Interprofessional Mentoring Guide enabled supervisors to systematically develop and evaluate the learning modules across disciplinary backgrounds.

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Deutschlander, S, Suter, E. 2011. Interprofessional Mentoring Guide. Available at:

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Personal Communications:

Esther Suter; November 14, 2013 [email]

Publications:

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Adopting Research to Improve Care Project (ARTIC)

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Émergente**

SNAPSHOT: This innovative practice aims to integrate evidence-based research into the systematic improvement of health care service quality.The 'Adopting Research to Improve Care' Project (ARTIC) was launched through the network of the Council of Academic Hospitals of Ontario (CAHO) in 2010 and has initiated six evidence implementation projects to date.

PRACTICE DESCRIPTION:

The Council of Academic Hospitals of Ontario is a non-profit association involving 24 academic hospitals across Ontario. Each member hospital is directly affiliated with a university medical or health sciences faculty and focuses on the bridging of research and teaching to provide innovative and specialized patient care. Based on the Council's Strategic Plan for 2010-2015, the internal governance is structured to facilitate collaboration among experts and prioritize multidisciplinary leadership.

The projects below represent the six projects that have been implemented to date. Each project was selected after undergoing a rigorous research application process. In 2010, the ARTIC Projects were funded by the Council of Academic Hospitals in Ontario with each participating hospital providing in kind support and human resources. After recognizing the impact of these programs on systematic implementation of new evidence, CAHO received another $6.3 million over three years, aligning with the Excellent Care for All Strategy (http://www.health.gov.on.ca/en/public/programs/ecfa/).

2010-2011:

1) 'Handy Audit'—an innovative auditing tool that measures hand hygiene compliance in health care settings.

2) 'Canadian C-Spine Rule'—a clinical decision tool for emergency department nurses; designed to reduce wait times and approve appropriateness of care by identifying patients who do not require immobilization.

2011-2012:

3) 'Move-On'—an interprofessional approach to focus on mobilization of elderly patients staying in hospital.

4) 'Antimicrobial Stewardship Program'—optimization of antimicrobial use in intensive care units.

2012-2013:

5) 'Transitional Discharge Model'—support of successful transition from hospital to the community for people diagnosed with mental illness.

6) 'Implementing an Enhanced Recovery after Surgery'—a guideline to implement a range of interventions for patients undergoing colorectal surgery.

Affiliated hospitals and research institutes include: Baycrest Centre for Geratric Care, Baycrest Centre for Addiction and Mental Health, Bruyère Continuing Care, Children's Hospital of Eastern Ontario, Hamilton Health Sciences, Health Science North, Hôpital Montfort, Hotel Dieu Hospital Kingston, Kingston General Hospital, Lawson Health Research Institute, London Health Sciences Centre, Mount Sinai Hospital, North York General Hospital, Ontario Shores Centre for Mental Health Sciences, Providence Care, Royal Ottawa Health Care Group, St. Joseph's Healthcare Hamilton, St. Joseph's Health Care London, St Michael's Hospital, Sudbury Regional Hospital, Sunnybrook Health Sciences Centre, The Hospital for Sick Children, The Ottawa Hospital, Toronto Rehabilitation Institute, Thunder Bay Regional Health Sciences Centre, University Health Network, and Women's College Hospital.

IMPACT:

As part of CAHO's mandate, each initiative under ARTIC has involved an integrated evaluation. To briefly summarize reports on the successes of the respective initiatives:

1) The 'Handy Audit' was completed as of December 2011 and 15 of the 16 participating hospitals have renewed their contracts with the Handy Metrics distribution company.

2) The 'Canadian C-Spine Rule' has passed testing for accuracy, reliability, and safety among triage nurses and has been widely adopted by emergency department physicians across member hospitals.

3) The impact of 'Move On has not yet been publically shared but it is working collaboratively with 14 member hospitals and is expected to improve rates of regular mobilization in hospitalized of elderly patients (currently estimated at less than 30%).

4) The anticipated effect of the 'Antimicrobial Stewardship Program' will reduce antimicrobial use in intensive care units by 12-25% and reduce antimicrobial costs to the units by 23-41%; the program is currently participating with 12 collaborating health centres/hospitals.

5) In a study involving 4 psychiatric facilities, length of stay was reduced by an average of 116 days per client after the introduction of the 'Transitional Discharge Model'. This resulted in $12 million worth of freed bed space from the 200 intervention group compared to the control group and $4,400 of reduced consumption of hospital and emergency room services per person in year post discharge.

6) The 'Implementing an Enhanced Recovery After Surgery' project demonstrated a 50% decrease in postoperative complications and reducing average length of stay postoperative care by 2 or more days.

APPLICABILITY/TRANSFERABILITY:

ARTIC is one of two broad-reaching partnerships working under the support of the Council of Academic Hospitals for Ontario. The other innovative partnership developed is the Physician Quality Improvement Initiative. This physician-led collaborative program involves all 24 of its member hospitals and provides an opportunity for physicians to share best practices, gain feedback performance, access tools for continuing professional development (http://caho-hospitals.com/partnerships/physician-quality-improvement-initiative-pqii/).

ARTIC is currently developing its Knowledge Translation tools in order to advance adoption of research evidence into practice to broader settings.

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Council of Academic Hospitals in Ontario. (2013). Ontario Research Hospitals : Building a Healthier, Wealthier and Smarter Ontario. 2012-13 Annual Report

http://caho-hospitals.com/wp-content/uploads/2013/09/CAH-103-AR2013_Web.pdf

External Source: http://caho-hospitals.com/partnerships/adopting-research-to-improve-care-artic/

Longitudinal Elderly Person Shadowing Project

LOCATION:	**Saskatchewan**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Home and Community Care**	**CADRE CATÉGORIE:**	**Prometteuse**

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

PRACTICE DESCRIPTION:

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

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

factors contributing to this program's success and continuation.

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Publications:

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

Personal Communications:

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

Alternative Profiles:

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

Learning Together with Cases

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Prometteuse**

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

other health care providers. Despite positive evaluations, the program was discontinued due to obstacles around incongruent curricula between faculties and through this, the Learning Together with Cases platform.

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

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Publications:

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

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http://www.patientsafetyinstitute.ca/english/research/cpsiresearchcompetitions/2006/documents/davidson/reports/davidson%20full%20report.pdf

Personal Communications:

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

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

Interfaculty Course Development for Interprofessional Collaboration

LOCATION:	Québec	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	Émergente

SNAPSHOT: This innovative practice improves the quality of health care services by providing an interprofessional program for health sciences students at pre-licensure levels. The program was introduced in Laval University in Quebec in 2007, and it continues to involve faculty and students from 10 health science disciplines.

PRACTICE DESCRIPTION:

As a strategy to better prepare the incoming health workforce to meet population health needs, Laval University developed an interfaculty program to involve students from medicine, pharmacy, kinesiology, nutrition, community health, nursing, psychology, physiotherapy, and more recently, occupational therapy. The program consists of three courses in Interprofessional Collaboration (levels I, II, and III) that focus on patient- and family-centred care. Each course is 15 hours and is conducted during weekends to increase accessibility for students with full course loads.

Despite motions from the university steering committee on interdisciplinary programing in 1998, this program did not come to fruition until nearly 10 years later. This was accomplished via funding from Health Canada and its initiative on Interprofessional Education for Collaborative Patient-Centred Practice. The design of the program was guided by the National Interprofessional Competency Framework, which promotes health care professionals learning “with, from, and about one another” to improve family- and patient-centred primary care. The program focuses on developing skills and competencies related to involving patients, collaboration, communication, and understanding respective roles and responsibilities. Baseline research was conducted on perceptions of necessary skills for acquisition, prospective practice environments, and attitudes towards the program in order to inform further program development.

This program has also focused on intensive training for associated educators—including four half-day sessions to develop collaborative skills, one half-day to present educational activities and materials, and four 90-minute workshops held during a six-week period. To facilitate the continuation of interprofessional education into the practice setting, training was also incorporated into the family medicine residency program at each family medicine unit.

IMPACT:

A pre-and-post study was conducted from both the students’ perspective and the educators’ perspective. The former evaluation was conducted in 2010, and involved 342 students, 215 of whom completed questionnaires. Comparing attitudes from baseline to program completion, average satisfaction rate regarding quality of courses, teaching approaches, and perceptions of knowledge and skill acquisition was reported at 4.05 out of 5.00. Overall, respondents felt that this program contributed to the preparation of the incoming health workforce to better meet contemporary practice requirements and patient needs.

For the evaluation of educators’ training and process implementation, both quantitative and qualitative methods were used. Professionals from six family medicine units participated in the training and evaluation. They reported an average of 4.26 out of 5.00 regarding the appropriateness of content and general positive reflections on pedagogic strategies and opportunities to work as a team to understand respective roles.

APPLICABILITY/TRANSFERABILITY:

A common challenge of these types of innovative programs is transferring the developed interprofessional competencies into the practice setting. This was addressed through

• the ongoing preparation of family medicine unit professionals;

• training preceptors;

• training residents and trainees; and

• the designated training leader providing support to educators.

For active student participation, the mandatory nature of the program was reported positively and reaffirming around the importance of this style of learning.

Several other interprofessional education programs exist across Canada. However the commitment, requirements, and accreditation of these programs remain sporadic.

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Publications:

Dumont, S., Briere, N., Morin, D., Houle, N., Iloko-Fundi, M. (2010). Implementing an interfaculty series of courses on interprofessional collaboration in prelicensure health science curriculums. *Education for Health, 23*(1), 395. Retrieved from http://old.educationforhealth.net/publishedarticles/article_print_395.pdf

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Personal Communications:

Dumont, S. (October 17, 2013).

External Source: http://www.cihc.ca/regional/overview/atlanticlist/ficcp

Regional Departments of General Medicine (Départements régional de medicine générale; DRMGs)

LOCATION:	Québec	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	

Snapshot: This innovative practice coordinates the supply and planning of primary care services at the regional level. The practice was launched in each of Quebec's 18 health regions and involves all family physicians practicing in the region.

Practice Description:

Départements régional de medicine générale (DRMGs) operate under the aegis of regional health authorities, and they make recommendations to and report to the health authority CEO. DRMGs are composed of all general practitioners practicing in the region. The head of the DRMG is elected by the membership. DRMGs inform human resources planning by generating a region-specific list of "particular medical activities" (Activités médicales particulières; AMP)) that general practitioners are expected to perform, and by proposing and implementing a regional medical staffing plan (Plan régional d'effectifs médicaux) aligned with those activity requirements. The staffing plan may include emergency department coverage, care in nursing homes and rehabilitation centres, home care, acute hospital care, obstetrics, and management of vulnerable patients. In their first 20 years of practice, general practitioners are required to perform a specified number of hours of AMP. The requirement is higher for physicians in their first 15 years of practice. The specific activities a physician performs are negotiated between the physician and the DRMG.

Impact:

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

This innovative practice has been implemented since 1991 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

Applicability/Transferability

The DRMG model has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings.

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

Agence de la Sante et des Services Sociaux de Montréal. (2012). *Looking backward to move forward: A synthesis of primary care reform evaluations in Canadian provinces*. Agence de la Sante et des Services Sociaux de Montréal and Canadian Foundation for Healthcare Improvement. Retrieved from http://www.inspq.qc.ca/pdf/publications/1439_RegarderArriereMieuxAvancer_SynthEvalReforSoins1Ligne_VA.pdf

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Primary Care Networks

LOCATION:	**Alberta**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Prometteuse**

Snapshot: This innovative practice involves the establishment of a new model of primary care that increases access to and the effectiveness of primary care. The practice was launched throughout Alberta and currently includes 41 primary care networks (PCNs) and involves more than 2,700 family physicians and about 900 other health professionals.

Practice Description:

PCNs are supported and administered by Alberta Health. They were established in 2003 by Alberta Health and Wellness (now Alberta Health), the Alberta Medical Association, and Alberta's regional health authorities (now Alberta Health Services) to improve access to and effectiveness of primary care services. The PCNs were created as a vehicle for achieving the following objectives:

- increase the proportion of residents with ready access to primary care;
- provide coordinated 24-hour, 7-days-per-week management of access to appropriate primary care services;
- increase the emphasis on health promotion, disease and injury prevention, care of medically complex patients, and care of patients with chronic diseases;
- improve coordination and integration with other health care services, including secondary, tertiary, and long-term care through specialty care linkages to primary care; and
- facilitate the greater use of interprofessional teams to provide comprehensive primary care.

Over 80% of Alberta's family physicians participate in PCNs, providing a defined set of 16 core primary care services to about three million Albertans (72% of the population). PCNs work in partnership with Alberta Health Services to address population health care needs. Physician participation in PCNs is voluntary. PCNs vary in size from four to 346 physicians (median 34.5 physicians). Non-physician health care providers in PCNs can include registered nurses, nurse practitioners, social workers, pharmacists, mental health workers, kinesiologists, exercise specialists, medical office assistants, and dietitians. PCNs may be located in a single or, more commonly, in multiple sites. They operate under an agreement between the PCN physicians (organized as a not-for-profit corporation) and Alberta Health Services. Depending on the specific governance model, PCN staff other than physicians may be employed exclusively by the corporation or by either the corporation or Alberta Health Services (Scott and Lagendyk, 2012). Apart from the payment (usually fee for service) that physicians receive for the primary care services they provide, the PCN receives an annual payment of $62 per patient per year to support network operations (including the salaries of non-physician personnel and payment to physicians for administrative or additional clinical work they do on behalf of the PCN).

For purposes of the per-patient funding, patients are assigned to specific physicians based on their use of primary care services over the previous 36 months.

The PCN model allows for wide local variation in the organization and delivery of services. This facilitates innovation and tailoring of programs and services to the needs of the local community and the PCN's patient population. However, the model can also lead to uneven performance across PCNs. In a qualitative, longitudinal comparative case study of eight PCNs over a three-year period, it was found that five sites were "surging ahead"; two sites were "cautious planners" and had not made substantial changes even after frequent team meetings; and one site was "mired in antagonism" because professionals showed little interest in trying new practices (Reay, Goodrick, Casebeer and Hinings, 2013).

The PCNs that were most successful were able to obtain buy-in from professionals, entice people to try new practices, encourage structured disagreement, and focus on overall goals of change.

The 2012 Alberta Auditor General's report noted variation of PCN development in the province and stated there were "significant weaknesses in the design and implementation of the accountability systems for the PCN program" (Auditor General Alberta, 2012). To improve accountability, the Auditor recommended that the Department of Health establish clear expectations and targets for PCN program objectives; implement systems to evaluate performance and support PCNs and Alberta Health Services to achieve objectives; proactively inform Albertans about which PCN they are informally assigned to; and improve its systems for oversight of PCNs to assess compliance with financial and operating policies.

The provincial government is currently focusing on enhancing the role of PCNs. Alberta Health has tasked the Primary Care Alliance (PCA) of the Alberta Medical Association to lead the development of a blueprint and action plan for an enhanced PCN program in Alberta. The PCA will review policy, review operational and performance issues related to the current program, and identify the key principles for a revised program.

In early 2012, the Alberta Government announced the creation and implementation of family care clinics (FCC) as a complementary model to PCNs. FCCs differ from PCNs in that:

• providers will be required to provide certain hours of service;

• the governance model will be community led;

• the range of services delivered to patients will be more comprehensive (e.g., emphasis on wellness, self-management, patient education, addiction and mental health treatment, chronic disease prevention and management, and injury prevention);

• services will be provided to underserved and high-needs patients;

• linkages and partnerships will be formed with the community;

• patients will be attached to the team; and

• FCCs will be required to report on their objectives through measurement of clearly defined indicators (Alberta Government, 2012).

FCCs are expected to have a minimum of five members on their board of directors: two types of health care providers, one client representative, and two external community leader(s)/representatives (Alberta Government, 2012).

Impact:

R.A. Malatest & Associates Ltd. was commissioned to complete an evaluation of the PCN for the period from December 1, 2008, to March 31, 2011. The evaluation examined 29 operational PCNs by collecting information from baseline and follow-up survey data with PCN staff, interviews with key stakeholders, and site visits. To compare the outcomes of patients receiving care in PCNs in comparison to those receiving care in non-PCNs, the evaluation examined administrative databases and administered surveys to patients, physicians, and other providers. In addition, focus groups were held to gain additional feedback from patients receiving care from PCNs. A comparison of PCNs and non-PCNs showed the following:

- More PCN patients were attached to a regular family physician and reported access to appointments after hours.
- More PCN physicians reported having the capacity to book same-day appointments for urgent patients, provide care to non-urgent patients within three days, and provide after-hours care.
- Emergency department use was lower among PCN patients than among non-PCN patients.
- PCN physicians were considerably more likely to offer screening tools for health promotion and disease prevention (e.g., smoking cessation, tetanus/diphtheria immunization, clinical breast exam, mammography, and bone density). PCN patients were more likely than non-PCN patients to obtained information about healthy living.
- PCN physicians reported greater use of evidence-based drug therapies for chronic conditions.
- PCN patients were more satisfied with their involvement in treatment plans, and those with chronic obstructive pulmonary disease and diabetes had better outcomes than non-PCN patients.

The Interdisciplinary Chronic Disease Collaboration (ICDC) studied diabetes care and outcomes in patients managed in PCN and non-PCN practices using a controlled before-after research design. Their results "suggest that patients with diabetes who are managed in PCNs may have lower rates of hospitalization and emergency room visits for diabetes specific ACSCs [ambulatory care sensitive conditions], although this was only noted in patients with prevalent disease [as opposed to those with newly diagnosed (incident) diabetes]. Care in a PCN also appears to be associated with better glycemic control in patients with incident and prevalent diabetes, and improved use of metformin in patients with incident diabetes" (ICDC, 2011).

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

Applicability/Transferability

Although PCNs have not been directly adapted from another jurisdiction, interprofessional primary care teams and/or networks of varying size and composition are in place in many countries and have been implemented widely in Ontario and Quebec.

The success of this specific program is dependent on investment of resources, obtaining the formal buy-in of stakeholders, strong evidence to support interprofessional teams, support of the initiative by patients, human resource capacity, alignment of incentives to support interprofessional teams, and appropriate public marketing of the initiative.

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Physician Assistants in Manitoba

LOCATION:	Manitoba	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Acute Care	**CADRE CATÉGORIE:**	Prometteuse

Snapshot: This innovative practice aims to "ensure more timely access to team-based care for Manitoba families" (Government of Manitoba, 2012) through the use of physician assistants. The integration of physician assistants (PAs) into practice was launched in a variety of acute and primary care settings and involves government funding of PA clinical positions in these settings.

Practice Description:

In 2008, the University of Manitoba introduced a two-year Master of Physician Assistant Studies program, the only graduate-level PA program in Canada, with the capacity to admit 12 students per year. In 2009, the provincial government amended the Medical Act to allow the province's College of Physicians and Surgeons to regulate and register PAs. PAs are registered on the Physician Assistant Register (Canadian Association of Physician Assistants, 2012). As of August 2013, there were 52 PAs on the College registry, including both acute and primary care PAs.

PAs practice medicine under the supervision and direction of a physician, acting as physician extenders. Their scope of practice includes obtaining medical histories, performing physical examinations, ordering and interpreting laboratory and diagnostic tests, providing therapeutic procedures, prescribing medications, and educating and counselling patients. The base salary for PAs in Manitoba is $75,000 to $110,000 per year.

The Government of Manitoba has funded positions in the province for graduates of the PA educational program. Regional health authorities have partnered with government to provide placements for the PAs in their own sites and to facilitate their incorporation into rural and urban fee-for-service family practices.

In 2012, the Manitoba Department of Health committed to a major initiative to implement and evaluate the impact of PAs on primary care system development. In particular, the evaluation examined the potential of PAs to increase the number of patients attached to a primary care provider, to support continuity of care, and to improve access for all patients. To this end, an initiative was launched in three primary care settings with an associated evaluation. In 2013/14, additional PAs will be introduced into primary care settings and family medicine practices.

Impact:

A study of the addition of three PAs to a four-surgeon arthroplasty program in a Winnipeg hospital "saved" an estimated 200 hours of orthopedic surgeons' time per surgeon per year. It also increased surgical volumes and reduced surgical wait times for primary hip and knee replacements compared to the previous year (Bohm, Dunbar, Pitman, Rhule, and Araneta, 2010).

Although international research indicates a number of benefits to the PA role in primary care related to access, attachment, and cost-effectiveness, the potential roles and impact of PAs in primary care in Canada has not yet been assessed.

Early findings suggest that PAs could have a significant impact on:

• the ability of primary care practices to accept new patients;

• patient access (i.e. timeliness of care);

• improved continuity of care for patients across the continuum (e.g., hospital, community, personal care home);

• improved patient/family communication in community and hospital settings; and

• reducing patient volumes in high-intensity care settings.

The Introducing Physician Assistants in Primary Care Steering Committee (IPAPCSC) is currently exploring research funding alternatives to systematically explore impacts and determine the roles and settings in which PAs may be more effective in primary care in Canada.

Applicability/Transferability:

Manitoba has an established history of using PAs, but to date PAs have been mainly employed in acute care sites, where benefits have been demonstrated (Bohm et al., 2010). Whereas PAs have long been an integral part of primary care provision in many parts of the world, including the US, this role is relatively new in Canada. Manitoba's physician assistant initiative has been adapted from the Canadian Forces Physician Assistant Program and from PA programs in the United States. PAs have recently been introduced with provincial government support in Ontario, New Brunswick, and Alberta.

Evaluation activities and the research literature have identified a number of factors associated with successful implementation of this specific practice. These include: support and leadership from provincial stakeholders; physician engagement, support, and education; appropriate "match" between supervising physician and PA; ensuring appropriate resources for implementation; appropriate community education; and mechanisms for early troubleshooting. The current evaluation is focusing on identifying (and incorporating into implementation guidelines) principles to guide planning in other Canadian jurisdictions.

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Integration of Pharmacists in Family Health Teams

LOCATION:	Ontario	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	Prometteuse

Snapshot: This innovative practice improves the appropriateness and outcomes of medication management by including pharmacists in primary health care practices. The practice was launched in Ontario in family health teams (as well as community health centres and nurse practitioner–led clinics) and involves pharmacists and primary care clinicians.

Practice Description:

Pharmacist positions have been incorporated into family health teams (FHTs) on a part- or full-time basis with funding from the Ontario Ministry of Health and Long-Term Care. Ninety-five full-time equivalent (FTE) pharmacists currently work in 110 (60.5%) of Ontario's FHTs. An additional 21.5 FHTs (11.6%) have approved funding for pharmacist services but do not yet have a pharmacist in place. The number of FTE pharmacists per FHT varies from 0.1 (in eight FHTs with physician complements varying from one to 10 physicians) to nine (in a networked FHT of 147 physicians). Pharmacists work as a member of the interprofessional team, providing on-site care to FHT patients and contributing to a common medical record. Pharmacists in FHTs frequently participate in quality improvement initiatives directed towards improved use of medications.

Impact:

This innovative practice has been implemented since 2006. While the practice has not been fully evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

Dolovich et al. (2008) conducted a two-year multi-faceted study of pharmacist integration into family practice teams in Ontario from 2004 to 2006. Seven non-dispensing pharmacists were incorporated into seven physician-led group family practices, varying in size from seven to 14 family physicians. Three of the seven practices had recently incorporated nurse practitioners into the practice, but none had well-developed interprofessional teams or previous experience working with pharmacists in their practice setting. The pharmacists, who worked approximately half-time in the family practices, provided medication assessments and follow-up for referred patients, drug information and education for clinicians, and office-system enhancements to optimize drug therapy. Sixty (94%) of the physicians referred at least one patient to the pharmacist during the two years of the study. The referred patients had an average of 4.8 medical conditions and were taking an average of 7.0 prescription medications and 3.4 over-the-counter medications. The pharmacists identified at least one drug-related problem in 94% of the referred patients. The most common problem was a required therapy that the patient was not receiving. One year after the pharmacists began working in the practice, physicians reported several benefits, including having a colleague who provided reliable drug information, getting fresh perspectives, having increased security in prescribing, and liaising with community pharmacies.

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

Applicability/Transferability

The practice informant did not identify other practices that the pharmacist integration in family health teams had adapted and was unaware if it was used as a model elsewhere. However, research indicates that a variety of approaches to pharmacist integration in primary care are being applied in other Canadian and international jurisdictions.

The success of this specific program is dependent on supporting the establishment of effective governance structures, administration, and organizational development (e.g., interprofessional team functioning) and optimizing roles within the team.

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Integration of Primary Health Care Nurse Practitioners (PHC NPs)

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Prometteuse**

Snapshot: This innovative practice improves accessibility and quality of primary care through the use of nurse practitioners The practice has been implemented in Ontario in more than 300 primary care settings and involves provincial government funding of nurse practitioner (NP) education and clinical positions in family health teams, community health centres, nurse practitioner–led clinics, and other primary care practices and organizations.

Practice Description:

NPs are "registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice"(CNA, 2009).

Education

The Ontario Primary Health Care Nurse Practitioner Education Program, established in 1995, is a standardized educational program delivered cooperatively by a nine-university consortium. The program uses multiple delivery modalities, including distance education, and is offered in both English and French. Baccalaureate-trained RNs studying full time can complete the seven core graduate-level courses that comprise the NP certificate program in one year. A combined Masters of Nursing/NP Certificate program has been available since 2008, and in most of the participating universities the combined program is now the only option available. The annual number of spaces in the PHC NP education program for full- and part-time students is currently 200.

Regulation

Ontario legislation providing for the registration of PHC NPs was proclaimed in 1998. Initially, NPs were allowed to order only a specified set of medications and diagnostic tests. Restrictions on NPs prescribing (except for controlled substances) and ordering laboratory tests were eliminated in 2011.

NP Practice

The nature and scope of NP practice varies across primary care settings. Some NPs provide care to a general primary care population while others focus on a specific population or health condition. Their work may involve varying combinations of acute illness care, chronic disease management, illness prevention, and health promotion. Some NPs have their own patient panel, but most share responsibility for a patient population with one or more family physicians.

Impact:

Ontario was home to the first randomized controlled trial (RCT) of NPs, which was carried out in a Burlington family practice setting by Spitzer et al. (1974). Since then, many RCTs have been conducted internationally, mainly in the US, the UK, and the Netherlands. Systematic reviews of these RCTs have consistently concluded that NPs deliver safe, effective care (Horrocks, Anderson, and Salisbury, 2002; Newhouse et al., 2011).

A study by Russell et al. (2009) of chronic disease management in Ontario primary care practices concluded that "Across the whole sample and independent of model, high-quality chronic disease management was associated with the presence of a nurse-practitioner." Ducharme, Alder, Pelletier, Murray, and Tepper (2009) evaluated the addition of PHC NPs and physician assistants to community hospital emergency departments in Ontario. In emergency departments that had NPs and/or physician assistants, the wait times, lengths of stay, and proportion of patients who left without being seen were significantly reduced.

While the integration of PHC NPs has not been fully evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

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

Applicability/Transferability

All provinces and territories have legislation in place for the NP role, although implementation has been most widespread in Ontario. The practice informant did not indicate whether the provinces and territories have worked collaboratively in defining the role of the NP.

The success of this specific program is dependent on:

• educating patients, providers, and insurance companies about the role and responsibilities of nurse practitioners and NPLCs;

• establishing effective governance structures, administration, and organizational development (e.g., interprofessional team functioning, information technology);

• engaging nursing stakeholders;

• providing appropriate NP compensation;

• optimizing roles within the team; and

• aligning financial incentives to ensure specialists are not disadvantaged by referrals from NPs.

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Full Service Family Practice Incentive Program

LOCATION:	Colombie-Britannique	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	Prometteuse

Snapshot:

This innovative practice improves patient care by supporting and compensating the delivery of guideline-based care by general practitioners (GPs). The practice was launched province-wide in British Columbia and is available to all GPs.

Practice Description:

In 2003, the General Practice Services Committee (GPSC), a joint committee of the Ministry of Health and the British Columbia Medical Association, developed the Full Service Family Practice Incentive Program (FSFPIP), which provides fee-for-service incentive payments to family physicians for enhanced primary care. Physicians receive incentive payments for:

• providing care to patients with diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, and hypertension, according to clinical guidelines;

• delivering babies (low-volume obstetrics);

• training for maternity care skills;

• developing clinical action plans and discharge plans for frail elderly, palliative care patients, patients with mental illness, or patients with co-morbidities;

• developing plans for high-risk patients with two or more chronic illnesses;

• conducting health risk assessments of patients in targeted populations;

• providing ongoing management services to mental health patients; and

• promoting shared care with specialists and interprofessional health care providers.

Impact:

This innovative practice has been implemented since September 2003. The practice has been externally evaluated, and personal testimonials, observations, and evaluation results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

In 2007, the provincial government commissioned an evaluation of FSFPIP. The evaluation found there was a high uptake of financial incentives in 2007/08 by regular GPs for patients to whom the physician provided a majority of the patient's primary care services (referred to as "majority source of care" (MSOC) patients). Ninety-two percent of physicians were billing for at least one incentive. Uptake was highest for diabetes (85.9%) and complex care (87.5%) and lowest for congestive heart failure (47.4%). After controlling for age and gender, costs were found to be consistently lower for patients who received incentive-based care compared to those patients who did not (Hollander, 2009).

Between 2006 and 2010, an increased number of patients were seen for congestive heart failure, diabetes, hypertension, complex care, and mental health issues (BCMA, 2012).

In 2009, an evaluation found that GPs who actively used incentive payments increased the proportion of attached (i.e. MSOC) patients (Hollander, 2009; Hollander & Tessaro, 2009). Attachment to a primary care practice is inversely related to the cost of care for high-needs patients with diabetes and congestive heart failure. The average annual cost (fiscal year 2007/08) for high-needs diabetic patients who had less attachment to a practice (used fewer services) was $16,988, whereas the cost was

$5,909 for those who were more attached to a practice (Hollander et al., 2009). Thus, attachment of high resource users to a primary care practice and increased continuity of providers reduced overall costs to the health care system due to the lower cost of hospital services (Hollander et al., 2009).

A physician survey (reported by GPSC, 2010) indicated that complex care incentives encouraged GPs to be more proactive, pay attention to the frequency of patient visits and ordering of tests, examine laboratory tests more closely, and identify patients who met the billing criteria. Chronic disease management incentives resulted in adoption of more complex patients and providing more proactive care. Maternity health incentives encouraged physicians to stay in obstetrics. Mental health incentives resulted in the adoption of more mental health patients and more time spent on planning care by some physicians. On the other hand, results of a patient survey revealed there was no perceived difference in the quality of care with the introduction of financial incentives (Hollander, 2009).

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

Applicability/Transferability

The practice informant did not identify other practices that the Full Service Family Practice Incentive Program adapted and was unaware of whether the practice was used as a model elsewhere. However, financial incentives for priority services have been implemented in other jurisdictions, both internationally and in Canada.

The success of this specific practice is dependent on:

• establishing formal structures (committees) that allow for collaboration among all partners (ministry, medical association, and regional health authorities);

• consulting with primary care physicians on their support needs;

• building a program that is based on evidence;

• creating an environment that allows for changing incentives over time as needed;

• access to data that allows for analysis of gaps in service and continuous evaluation of incentives;

• innovative approaches that allow for the inclusion of comprehensive incentives within a fee-for-service payment structure; and

• willingness of primary care providers to participate in the initiative.

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External Source: http://www.primaryheathcarebc.ca/gpsc_incentives.html

Family Medicine Groups

LOCATION:	Québec	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	Prometteuse

Snapshot:

This innovative practice provides access to a family doctor for all Quebec residents; increases accessibility of services, especially for vulnerable patients; improves quality of care; promotes continuity of care and coordination between primary care and other health care sectors; and enhances the role of family physicians. The practice was launched throughout Quebec and involves family physicians and other primary care clinicians, particularly nurses.

Practice Description:

In response to the recommendations of the Clair Commission in 2000, the provincial government established family medicine groups (FMGs). FMGs are accredited organizations that have contractual agreements with Quebec's regional health authorities. FMGs can be private entities or be part of Centres locaux de services communautaires (CLSCs; Local Community Service Centres). They often consist of six to 10 physicians, two nurses, and two administrative staff, who serve approximately 15,000 people (1,300 per physician). An on-call telephone service is available to enrolled patients 24 hours a day, seven days a week, and limited walk-in services are available to patients during holidays and weekends.

The compensation model for FMGs is based on fee-for-service and is supplemented with per capita payments and incentive payments for registering vulnerable patients. Additional funding is provided for operating costs (e.g., rental costs for space for additional staff, salaries of administrative staff), enrolment of patients, administrative activities by the clinical lead, 24/7 phone access, the inclusion of nurses and administrative support staff, and computer resources. These payments are also available to physicians in non-FHG practices, weakening the incentive for physicians to practice in FMGs but allowing private practices to function in a similar way to FMGs. As of April 2011, there were 223 accredited FMGs. The Ministry of Health and Social Services plans to increase this to 300 FMGs, with the aim of having 75% of the population registered with an FMG.

FMGs vary significantly in their organizational structures, in the physicians' conception of the role of nurses, and in the degree of collaboration among providers.

Impact:

A variety of studies have examined the impact of the FMGs and found that this model improved:

• accessibility outside of regular working hours (Beaulieu et al., 2006);

• accessibility during regular working hours (Ministère de la santé et des services sociaux, 2009; Beaulieu et al., 2006);

• knowledge of patients (Beaulieu et al., 2006);

• physician-nurse collaboration (Beaulieu et al., 2006; Aubin et al., 2007);

• provider and patient satisfaction (Aubin et al., 2007);

• patient communication with the FMG physicians (Ministère de la santé et des services sociaux, 2009);

• quality of relationships with physicians (Ministère de la santé et des services sociaux, 2009); and

• access to a regular source of care (Ministère de la santé et des services sociaux, 2009; Tourigny et al., 2010).

The model has also encouraged family physicians to participate in and influence the structuring of services in their region (Aubin et al., 2007). A comparison of FMGs and non-FMG practices indicated a lack of impact on the use of emergency departments

and on avoidable hospitalizations (Ministère de la santé et des services sociaux, 2009).

A study examining the perception of patients before and after the implementation of five FMGs found that patients' perceptions of continuity (relational and informational) increased, but there was no change to organizational and first-contact accessibility and service responsiveness (Tourigny et al., 2010). The proportion of participants reporting visits with nurses and use of FMGs' emergency services increased. However, physician-nurse coordination remained unchanged, and primary care physician tospecialist coordination was perceived to have declined.

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

Applicability/Transferability

The practice informant did not identify other practices that FMGs have adapted and was unaware if FMGs were used as a model elsewhere. However, research indicates that team-based primary care models are being developed and implemented in many Canadian and international jurisdictions.

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Family Health Teams

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Émergente**

Snapshot:

This innovative practice, which was launched in Ontario, improves access to and the quality of primary care. The 185 family health teams involve a broad range of primary health care providers and administrative support personnel.

Practice Description:

The impetus for creating the Family Health Team (FHT) model in Ontario was a “crisis in access” due to the lack of primary care capacity (i.e. shortage of family physicians, orphan patients, and medical graduates having low interest in family medicine). The key objectives of the provincial government’s FHT initiative are improved access to primary health care, quality and comprehensiveness of care (with an emphasis on chronic disease management, health promotion, and disease prevention), interprofessional teamwork, patient engagement, and integration and coordination of care (system navigation).

Two hundred FHTs were created in Ontario between 2006 and 2011. They have since been amalgamated into 185 organizations .

FHTs are interprofessional primary care organizations that vary in family physician complement from one to 147. Only six FHTs include more than 50 family physicians and the two largest are networks of smaller physician groups. As of September 2013, these teams included 2,716 family physicians, 2,022 other primary health care professionals (most commonly nurses (739), social workers (355), nurse practitioners (496), dietitians (161), pharmacists (95), and registered practical nurses (95)), and 936 administrative support staff. A majority of FHTs (71%) receive funding for sessional payments to specialists, but fewer than half that have approved funding have been successful in engaging specialists to provide on-site services. There are three defined FHT governance models: physician (54%), community (12%), and mixed (34%). One in five FHTs serves a community of less than 10,000 population. Almost three million Ontarians (22% of the province’s population) are currently enrolled with an FHT physician.

The Ministry of Health and Long-Term Care funds FHTs through an annually approved global budget. However, this funding is not for physician services or for the minority of clinical and support staff who are employed by FHT physicians rather than by the FHT directly. FHT physicians are remunerated through a blended capitation or blended salary model, and they must meet the requirements of the payment model to which they belong.

Impact:

This innovative practice has been implemented since 2006 and does not have a completed evaluation at this time. A multi-year evaluation of the Family Health Team initiative, commissioned by the Ontario Ministry of Health and Long-Term Care, will be completed in 2014.While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

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

Applicability/Transferability

The practice informant did not indicate other practices that FHTs had adapted or whether FHTs themselves were being used as a model. However, interprofessional primary care models are becoming increasingly common internationally and in Canada. Primary care networks and family medicine groups have been widely implemented in Alberta and Quebec, respectively. Alberta is launching family care clinics, which resemble FHTs.

The success of this specific practice is dependent on:

• being committed to funding for wide-scale implementation;

• establishing one legal entity with accountability mechanisms for the organization and all its providers;

• supporting the establishment of effective governance structures, administration, and organizational development (such as the functioning of interprofessional teams); and

• conducting comprehensive evaluations based on analysis of qualitative and quantitative

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

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

Personal Communications

Graham, P. (August 20, 2013).

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

Community Health Centres in Ontario

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**De pointe**

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

Practice Description:

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

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

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

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

Impact:

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

Applicability/Transferability

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

The success of this specific program is dependent on:

• significant investment of resources;

• consistent oversight of CHCs;

• similar compensation being provided to all physicians;

• basing evaluations on comprehensive data; and

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

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Personal communications:

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Sault Ste. Marie Group Health Centre

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Prometteuse**

SNAPSHOT: This innovative practice facilitates improved accessibility and comprehensiveness of primary care service delivery. The Group Health Centre was originally founded in Sault Ste. Marie in 1962. As a progressive, multi-specialty, ambulatory health organization, the health centre integrated an electronic health record system in 1997 and now serves 71,000 residents of Sault Ste. Marie and Algoma District (population 75,000), with 81 doctors and 350 employees.

PRACTICE DESCRIPTION:

The Group Health Centre provides ambulatory care, diagnostic services, integrated care with primary, secondary, and other health care services such as for congestive heart failure, nutrition, physical therapy, and surgery. A range of health care professionals are located on-site, including doctors, nurses, nurse educators, physiotherapists, optometrists, kinesiologists, dietitians, and lab technicians. The centre focuses on providing same day care as well as offering on-site services including laboratory facilities and longer term chronic care support.

Prior to 1997, there was recognition that patients, particularly those with chronic conditions, were slipping through cracks in the health care system and better record-keeping systems were required. Sault Ste. Marie now has the largest primary care electronic medical records system in Canada. With this system ('Epic' http://www.epic.com/software-ambulatory.php), each patient has their own, single electronic medical record. This mode of information storage enables different types of health care providers to access patient data as needed, and facilitates real-time referrals to specialists, thereby increasing interprofessional collaboration and continuity of care. This system allows for greater patient engagement, as patients can access their own health information via an online patient portal and the system generates treatment plans based on best practice templates and algorithms. Another capability of the electronic system is the possibility to aggregate data to track trends and outcomes. With regular monitoring and evaluation, this system can link to the development of new programming based on patient-population needs and integrate accordingly, based on clinical practice guidelines. New programming initiatives are processed through the Committee of Health Promotion Initiatives.

The Group Health Centre functions under an alternative funding structure with support from the Ontario Ministry of Health and Long-Term Care.

IMPACT:

A third-party evaluation of the impact of the electronic medical record system was conducted by Health Informatics Institute (http://www.hiiau.ca/) at Algoma University in 2011. Data were collected through observation, one-on-one interviews, focus groups, and surveys, however, this information is not publically available. Anecdotal evidence from participating health care providers suggests that improved health outcomes can be attributed to the integrative functioning of the electronic medical record and greater satisfaction attributed to being able to devote more time to clinical practice rather than administration.

Group Health Centre has won National Best Practice Awards for four consecutive years and was featured in Maclean's Magazine as one of Canada's top ten models of health care.

APPLICABILITY/TRANSFERABILITY:

'Epic' electronic medical records system functions out of Wisconsin, USA and manages over 170,000,000 American patients. Group Health is one of four health care organizations (Children's Hospital of Eastern Ontario, Women's Health Centre in Toronto, and Hamilton Health Sciences) in Canada to use 'Epic', but is unique in its care for outpatients. The continued and increasing coverage of the Sault Ste. Marie Group Health Centre is exemplary of the possibility for this type of health care model to successfully function within a Canadian community and is therefore theoretically transferrable elsewhere.

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Garry Walsh; November 13, 2013 [telephone]

External Source: http://www.ghc.on.ca/index.php

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

LOCATION:	International	**THÈME DE LA SANTÉ:**	Ressources humaines de la santé
HEALTH SECTOR:	Primary Health Care	**CADRE CATÉGORIE:**	

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

PRACTICE DESCRIPTION:

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

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

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

IMPACT:

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

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Publications:

Blash, L., Chapman, S., Dower, C. (2011). *DFD Russell medical centers—Engaging medical assistants in quality improvement efforts*. Retrieved from http://www.futurehealth.ucsf.edu/Content/11660/2011_06_DFD_Russell_Medical_Centers--Engaging_Medical_Assistants_in_Quality_Improvement_Efforts.pdf

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

The Caring Together Project

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Home and Community Care**	**CADRE CATÉGORIE:**	**Prometteuse**

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

PRACTICE DESCRIPTION:

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

IMPACT:

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

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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Personal Communications:

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Bridging Relationships Across Interprofessional Domains (BRAID)

LOCATION:	**Nouveau-Brunswick**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Prometteuse**

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

PRACTICE DESCRIPTION:

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

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

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

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

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

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

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

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

IMPACT:

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

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

APPLICABILITY/TRANSFERABILITY:

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

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

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

Publications:

Bridging Relationships Across Interprofessional Domains (BRAID). (2008). *Final BRAID project report*. Saint John, NB: BRAID. Retrieved from

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Personal Communications:

Clark, R. (October 21, 2013).

Alternative Profiles:

BRAID. (n.d.). *A logic model in action: Interprofessional education for collaborative patient-centred chronic disease care*. Retrieved from http://www.cihc.ca/files/projects/atlantic/BRAID_LogicModel_07.jpg

Canadian Interprofessional Health Collaborative. (2007). *BRAID: Bridging relationships across professional domains*. Retrieved from http://www.cihc.ca/files/projects/atlantic/CIHC_IPE-BRAID.pdf

External Source: http://www.unb.ca/saintjohn/vp/tuckerpark/

Infirmière pivot en oncologie

LOCATION:	**Québec**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Prometteuse**

APERÇU :

Cette pratique novatrice aide les patients atteints de cancer à cheminer dans le système de santé en améliorant l'accessibilité des ressources, la coordination des soins, la continuité des soins ainsi que les communications avec les fournisseurs. Le premier poste d'infirmière pivot en oncologie a été créé en 2005 au Centre hospitalier de l'Université Laval, à Québec. Le poste a été conçu pour permettre aux patients atteints d'un cancer du cou et de la gorge d'avoir un lien direct avec le système de soins de santé. On dénombre actuellement plus de 250 infirmières pivot en oncologie au sein des équipes de soins en milieu hospitalier dans la province du Québec.

DESCRIPTION DE LA PRATIQUE :

Devant le fardeau de plus en plus lourd du cancer pour les populations et les systèmes de soins de santé au Canada, de nouvelles stratégies s'avèrent nécessaires afin d'améliorer l'expérience des patients qui ont des besoins complexes continus ainsi que l'efficacité des soins qu'ils reçoivent. Théoriquement, le pivot offre un service polyvalent afin de faire en sorte que les patients, en particulier ceux qui sont soignés par plusieurs fournisseurs dans des milieux variés, aient un point d'accès direct au système de soins de santé, qu'ils se sentent épaulés et qu'ils soient informés de toutes les options qui s'offrent à eux.

Pour amorcer la création du rôle et l'arrivée du poste d'infirmière pivot en oncologie au Centre hospitalier de l'Université Laval, un comité de représentants des secteurs clinique et administratif et du domaine de la recherche à l'hôpital universitaire a présenté une proposition dans le cadre du Programme québécois de lutte contre le cancer. Le projet a finalement été financé par la Régie régionale de la santé et des services sociaux et le Centre de coordination de la lutte contre le cancer au Québec. Le poste d'infirmière pivot en oncologie est comblé par une infirmière qui a reçu une formation universitaire, qui possède de l'expérience en oncologie et qui peut détenir un certificat en oncologie. Le rôle actuel que l'infirmière pivot en oncologie est appelée à jouer est déterminé par les interactions et les besoins dans le milieu local, en conservant toujours une approche orientée sur le patient. Par exemple, ses tâches peuvent consister à assister les patients pour prendre leurs rendez-vous et à communiquer avec les médecins afin d'élaborer des stratégies d'adaptation pour aider les patients à gérer leur maladie, surtout en ce qui concerne les changements liés à l'apparence ou à la perte de la parole, à amener les patients à maintenir un mode de vie relativement normal, à offrir un soutien social afin d'apaiser l'anxiété générale engendrée par les circonstances des patients et à servir de ressource pour les autres fournisseurs de soins de santé.

RÉPERCUSSIONS :

Des entrevues ont été réalisées auprès des patients, des familles, des aidants et des autres fournisseurs de soins de santé qui collaboraient avec le Centre hospitalier universitaire avant, pendant et environ un an après la première phase de mise en place. Les questions s'articulaient autour des perceptions à l'égard des activités et des fonctions de l'infirmière pivot en oncologie et des changements liés à l'attitude, au comportement et à l'adaptation des patients.

Les patients et leur famille étaient extrêmement satisfaits de la création du poste d'infirmière pivot en oncologie. Ils ont déterminé que le soutien social organisé par cette infirmière constituait l'aspect le plus important de son rôle et ils estimaient, dans l'ensemble, qu'elle avait amélioré globalement la prestation des services interprofessionnels ainsi que la continuité des soins, ce qui était avantageux pour tous les intervenants.

Une recherche se déroule à l'Université Laval afin d'éclairer de façon continue l'évolution du rôle de l'infirmière pivot en oncologie. On cherche de plus en plus à améliorer les compétences liées aux soins psychosociaux et à concevoir des mesures afin d'étendre la normalisation du nouveau rôle.

APPLICABILITÉ/TRANSFÉRABILITÉ :

Les intervenants-pivots sont de plus en plus présents dans les systèmes de santé du Canada. Le poste d'infirmière pivot en

oncologie au Centre hospitalier universitaire est différent dans le sens où il s'adresse à une population particulière dans l'ensemble de la structure des soins de santé. Comme il n'y a pas de centres de soins contre le cancer au Québec, une planification spéciale s'avère nécessaire pour intégrer le poste d'infirmière pivot en oncologie dans les milieux interprofessionnels. Chaque hôpital participant, parmi les 28 établissements répartis dans sept régions, a établi son budget de manière à inclure au moins une infirmière pivot en oncologie au sein de chaque équipe de soins de santé en oncologie.

Depuis la première mise en place d'une infirmière pivot en oncologie au Centre hospitalier universitaire en 2005, il y a maintenant plus de 252 infirmières qui tiennent ce rôle et la pratique a été adoptée dans le cadre de l'initiative provinciale pour des soins et des services de soutien contre le cancer pour le compte du ministère de la Santé et des Services sociaux. La nécessité de mobiliser les intervenants, la création d'une vision commune et le maintien des patients au centre de soins font partie des recommandations formulées dans le but de mettre sur pied des modèles similaires en dehors du Québec.

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Le contenu a été adapté à partir des sources et des liens suivants :

Publications :

Fillion, L., de Serres, M., Lapointe-Goupil, R., Bairati, I., Gagnon, P., Deschamps, M., … Demers, G. (2006). « Implementing the role of patient-navigator nurse at a university hospital centre », *Canadian Oncology Nursing Journal*,vol. 16, n° 1, p. 11–7, 5–10. Résumé extrait de : http://www.ncbi.nlm.nih.gov/pubmed/17078346

Santé et Services Sociaux du Québec–Comité consultatif des infirmières en oncologie. (2008). *Rôle de l'infirmière pivot en oncologie ; Direction de la lutte contre le cancer*. Extrait de : http://collections.banq.qc.ca/ark:/52327/bs2034490

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Communications personnelles :

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External Source: http://www.msss.gouv.qc.ca/sujets/prob_sante/cancer/index.php?accueil

Clinique de chimiothérapie express

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Accès et temps d'attente**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Prometteuse**

APERÇU : Cette pratique novatrice accélère les services de chimiothérapie pour les enfants qui combattent une leucémie lymphoblastique aiguë. Fondée en 2004, sous forme de projet pilote à The Hospital for Sick Children de Toronto, cette clinique express est encore en activité aujourd'hui. Le modèle porte au maximum les effectifs en santé et l'efficacité des soins, sans pour autant accroître les coûts, en réaffectant les ressources.

DESCRIPTION DE LA PRATIQUE :

Les enfants qui suivent une chimiothérapie et leur famille doivent se rendre régulièrement à l'hôpital, où ils doivent passer par de longs processus d'inscription à des registres, combler les temps morts entre l'obtention des résultats de laboratoire, l'évaluation du patient et la préparation des agents chimiothérapeutiques et subir les conséquences des ressources infirmières limitées et de l'espace restreint par rapport aux nombreux patients. Afin de diminuer les incidences de ces visites en milieu hospitalier sur les patients en traitement, la clinique de chimiothérapie express a été créée dans le but d'accroître l'efficacité globale des ressources humaines en santé, de la rapidité d'exécution et de la qualité des soins.

Afin de mettre sur pied la clinique de chimiothérapie express, un comité de planification des programmes, composé principalement d'infirmières, a établi les critères d'admissibilité des patients, déterminé les protocoles et les plans de traitement adéquats, encouragé la collaboration entre les services, dressé un plan de communication entre le personnel et les familles, assuré la présence d'une couverture médicale et négocié l'aménagement de l'espace physique. Durant les phases de lancement de la nouvelle clinique, les médecins et le personnel infirmier ont eu des séances d'information sur les critères d'admissibilité des patients et les protocoles prévus. Les stratégies pour accélérer le système consistaient notamment à faire rédiger les ordonnances de chimiothérapie à l'avance par le médecin ou l'infirmière praticienne afin que la pharmacie puisse les exécuter avant 16 h la veille de la visite du patient à la clinique, à mettre sur pied un processus d'inscription rapide, à réserver l'espace physique au moment où les infirmières sont sous-utilisées, c'est-à-dire entre 8 h 30 et 10 h tous les jours, et à vérifier la numération globulaire à l'avance afin de s'assurer de la pertinence de la visite prévue.

RÉPERCUSSIONS :

Le projet pilote a duré un an, soit de 2004 à 2005, et a servi 75 patients en tout à raison de quatre patients par jour en moyenne. Une évaluation a été réalisée tout au long du projet. Chaque membre de l'équipe interprofessionnelle devait répondre à un sondage, puis les familles étaient interviewées séparément par une infirmière de recherche. Le taux de réponse des familles s'est situé à 61,5 % et, comme 58 % des répondants avaient reçu des soins avant l'arrivée de la clinique express, ils étaient en mesure de comparer les changements apportés.

En ce qui concerne les perceptions de l'efficacité, 89 % des familles ont déclaré que la chimiothérapie avait été donnée dans les délais prescrits. En ce qui touche aux perceptions de la qualité des soins, la plupart des répondants ont indiqué que la clinique express avait allégé le fardeau pour le reste de la clinique. Quant aux perceptions de l'impact sur le mode de vie, les commentaires sur la capacité de la clinique express de diminuer les répercussions des visites continues à l'hôpital sur le mode de vie quotidien était extraordinairement positifs. Du côté des fournisseurs de soins de l'équipe interprofessionnelle, 11 infirmières autorisées, cinq infirmières-ressources, quatre médecins, deux infirmières praticiennes, cinq commis à l'inscription et trois pharmaciens ont répondu au sondage. La plupart des membres du personnel ont affirmé que la réaffectation des tâches n'avait pas augmenté leur charge de travail dans l'ensemble.

Même si les détails sur la fréquentation de la clinique sont encore consignés dans le cadre de ce programme pour des besoins de gestion interne, il n'y a pas eu de collecte de données officielle dans le but de les diffuser à l'externe depuis la mise en place initiale du programme en 2004.

APPLICABILITÉ/TRANSFÉRABILITÉ :

Cette pratique novatrice n'a pas été adaptée à partir d'une autre administration. Même s'il ne s'est pas étendu à d'autres

provinces ou territoires, le modèle express a pris de l'expansion dans deux autres domaines de la division : la salle des traitements par intraveineuses et l'hôpital de jour. Dans ces milieux, le système de triage simplifié permet aux patients admissibles de s'inscrire directement au lieu d'avoir à passer par une clinique de consultations externes. La durabilité de ce modèle est fort intéressante, car il ne nécessite pas de financement supplémentaire puisque les ressources sont réaffectées. Sa capacité d'améliorer l'efficacité globale des soins et sa faisabilité sur le plan opérationnel sont démontrées par la continuité du projet pilote, une décennie plus tard, et par son application élargie. La direction de la clinique express indique qu'elle reçoit encore des demandes de renseignements informelles au sujet de la possibilité d'appliquer ce modèle de soins dans d'autres milieux au Canada et aux États-Unis. Il n'y a toutefois pas de documentation officielle sur ce facteur d'impact externe. Un élément important à prendre en considération qui touche à la transférabilité de ce modèle est le nombre de patients par rapport aux ressources humaines et physiques en place.

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Publication :

Hendershot, E., Murphy, C., Doyle, S., Van-Clieaf, J., Lowry, J. et Honeyford, L. (2005). « Outpatient chemotherapy administration: Decreasing wait times for patients and families », *Journal of Pediatric Oncology Nursing,* vol. 22, n° 1, p. 31–37. Extrait de : http://www.ncbi.nlm.nih.gov/pubmed/15574724

Communications personnelles :

Hendershot, E. (entrevues, 20 août 2013).

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

Advanced Clinician Practitioner in Arthritis Care Program (ACPAC) ou le programme destiné aux cliniciens de niveau avancé qui soignent des patients souffrant d'arthrite

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Soins de santé primaires**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Prometteuse**

APERÇU : Cette pratique novatrice vise à améliorer les compétences des cliniciens de niveau avancé qui soignent des patients souffrant d'arthrite. Lancé en 2005 à l'Hôpital St. Michael, en collaboration avec The Hospital for Sick Children à Toronto, le programme interprofessionnel compte maintenant plus de 37 diplômés qui travaillent dans des milieux cliniques variés aux quatre coins de l'Ontario.

DESCRIPTION DE LA PRATIQUE :

Le programme ACPAC a été conçu dans le but de s'attaquer aux problèmes liés à l'accessibilité des services offerts par des spécialistes du traitement de l'arthrite pour les personnes qui vivent avec la polyarthrite rhumatoïde et l'arthrose et de se réorienter vers une approche interprofessionnelle de la prestation des soins qui met davantage l'accent sur le patient. Le programme ACPAC vise à offrir une formation avancée complète en rhumatologie et en orthopédie en optimisant la portée des ressources humaines en santé existantes. Ce programme de formation théorique et clinique destiné aux titulaires d'un permis d'exercice s'adresse aux physiothérapeutes, aux ergothérapeutes et au personnel infirmier de niveau avancé qui désirent perfectionner leurs connaissances et leurs pratiques pour le traitement des troubles musculosquelettiques et de l'arthrite. Le programme d'études normalisé, qui est donné par plus de 90 enseignants de plusieurs disciplines en Ontario, respecte des normes de formation et d'évaluation rigoureuses. Les personnes qui suivent le programme reçoivent un certificat du département de l'éducation permanente et du perfectionnement professionnel de la faculté de médecine de l'Université de Toronto. Les diplômés de ce programme sont appelés à faire un triage efficace, à fouiller les antécédents des patients de manière exhaustive et à soumettre ces derniers à un examen physique, à interpréter les résultats des tests de laboratoire et de l'imagerie diagnostique, à procéder à un dépistage précoce ou à entreprendre une surveillance et un suivi du traitement, à évaluer les médicaments et les complications et à éduquer les patients dans le contexte des troubles musculosquelettiques afin d'améliorer l'efficacité globale des soins.

Jusqu'à présent, le financement du programme ACPAC a été assuré principalement par le ministère de la Santé et des Soins de longue durée de l'Ontario et, en partie, par les droits de scolarité individuels. Le programme est approuvé par l'Alliance de l'arthrite du Canada ainsi que par la Société canadienne de rhumatologie. La Société de l'arthrite, les acteurs de l'industrie et le milieu universitaire (éducation permanente et perfectionnement professionnel de la faculté de médecine de l'Université de Toronto) figurent parmi les autres intervenants clés.

RÉPERCUSSIONS :

Les évaluations d'impact ont ciblé les fournisseurs de soins de santé qui participent au programme. Ces évaluations comportent des sondages qui recueillent de façon continue les impressions des étudiants inscrits au programme ACPAC à la ligne de départ, au milieu du parcours, puis à des intervalles de six et de 12 mois après l'obtention de leur diplôme. Des mesures des résultats, qui ont été créées avant la mise sur pied du programme, ont contribué à éclairer la conception du programme pour les années ultérieures. Les points particulièrement intéressants de ces évaluations sont notamment la détermination des modifications à apporter aux compétences nécessaires pour assumer les rôles, l'élaboration de normes pour les pratiques exemplaires et le repérage des obstacles et des outils habilitants pour les diplômés récents qui doivent s'acquitter de leur nouveau rôle dans des milieux cliniques diversifiés.

Selon les sondages réalisés et publiés en 2011, tous les diplômés étaient satisfaits du programme et l'ont trouvé très utile pour leurs pratiques cliniques. Les évaluations à l'échelle du système ont révélé des améliorations de l'accès, surtout dans les

régions rurales et éloignées, de l'incidence perçue des résultats pour les patients et des possibilités pour mieux faire connaître et élargir les rôles. Une évaluation exhaustive des services de santé menée auprès des diplômés du programme ACPAC peut être consultée dans le rapport sur les résultats du programme ACPAC à l'échelle du système (http://www.stmichaelshospital.com/pdf/programs/acpac-executive-summary.pdf), qui a été présenté au ministère de la Santé et des Soins de longue durée de l'Ontario en janvier 2012.

Le programme ACPAC a récolté plusieurs distinctions, y compris le prix d'excellence Colin Woolf pour l'élaboration de cours décerné par le département de l'éducation permanente et du perfectionnement professionnel en 2007, le prix d'excellence Ted Freeman pour la conception et la prestation d'une formation théorique sur les soins de santé destinée aux titulaires de permis d'exercice de l'Ontario attribué en 2008 et le prix d'innovation en ressources humaines remis par le ministère de la Santé et des Soins de longue durée de l'Ontario en 2009.

APPLICABILITÉ/TRANSFÉRABILITÉ :

S'appuyant sur les retombées positives signalées depuis la mise sur pied du programme ACPAC, on cherche actuellement à obtenir un autre engagement d'aide financière échelonné sur cinq ans auprès du ministère de la Santé et des Soins de longue durée de l'Ontario ainsi qu'un appui non financier auprès des intervenants déterminés. Pendant cette période de transition, la Société de l'arthrite a financé généreusement le programme pour 2013-2014. L'accent sera accordé à l'élaboration d'un cadre national pour une formation normalisée sur le traitement de l'arthrite destinée aux titulaires d'un permis d'exercice, dont l'Université de Toronto demeurera le site central, et à l'expansion possible des affiliations avec d'autres établissements universitaires afin de créer des constituantes dans l'ouest et l'est du Canada. Au fur et à mesure que ce programme continuera d'évoluer, les points à aborder seront notamment les obstacles liés à la réglementation des établissements et des professions, l'accès et l'efficacité des soins ainsi que les indicateurs de coûts. En ce qui concerne les facilitateurs, les directives médicales et le soutien administratif auraient aidé à surmonter les problèmes d'ordre juridique afin que le fournisseur de soins le plus adéquat puisse fournir les services nécessaires, ce qui a pour effet de diminuer la dépendance directe envers les médecins et d'accroître l'efficacité globale du système. Les directeurs des programmes soulignent l'importance de l'effet de retombée sur les diplômés du programme ACPAC, dont la présence pourrait changer la prestation du traitement de l'arthrite dans leur lieu d'exercice respectif au sein des milieux cliniques diversifiés.

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Autre profil :

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

Communications personnelles :

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

Inclusion des patients et de leur famille au sein des conseils d'action d'unités des hôpitaux afin de promouvoir des soins interprofessionnels intégrés et centrés sur le patient

LOCATION:	**Ontario**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Acute Care**	**CADRE CATÉGORIE:**	**Émergente**

APERÇU : Cette pratique innovatrice illustre un modèle de pratique en collaboration pour la prestation de soins interprofessionnels centrés sur le patient en suscitant la participation des patients et de leur famille en tant que membres des conseils d'action d'unités (CAU). Ce projet fut inauguré en 2011 en Ontario au sein d'une alliance de quatre hôpitaux communautaires en milieu rural.

DESCRIPTION DE LA PRATIQUE :

Il y a une reconnaissance accrue de la nécessité pour les professionnels de la santé dans l'ensemble des secteurs de travailler au sein d'équipes interprofessionnelles afin d'améliorer la qualité, la sécurité, la continuité et la rentabilité de la prestation des soins de santé. Pour assurer la réussite, les patients et leur famille doivent participer de façon constructive à des équipes interprofessionnelles en tant que partenaires à part entière en ce qui concerne la conception, la prestation et l'évaluation des services de soins de santé.

La Huron Perth Healthcare Alliance (HPHA) regroupant quatre hôpitaux communautaires en milieu rural a commencé la mise en œuvre d'un modèle de pratique interprofessionnelle en 2010. La création de conseils d'action d'unités (CAU) dans les unités de soins aux patients constitue l'une des principales initiatives visant à promouvoir des soins interprofessionnels (SI) et à améliorer les soins centrés sur le patient et la famille (SCPF). Toutefois, par tradition, ces conseils comprenaient seulement des professionnels de la santé. En partenariat avec la Fondation canadienne pour l'amélioration des services de santé (FCASS), la University of Western Ontario et le Fanshawe College, la HPHA a inauguré un projet d'engagement des patients qui permettrait l'inclusion des patients et des membres de leur famille au sein des CAU, afin de créer un modèle unique de pratique en collaboration pour la prestation de soins interprofessionnels centrés sur le patient.

Le projet, d'une durée de deux ans, fut inauguré en 2011 et a débuté à l'aide d'une collection de témoignages rédigés par des patients et des membres de leur famille qui ont été validés lors de discussions libres dans des forums communautaires. Ces témoignages faisaient part d'expériences positives et négatives et ont établi les valeurs de base des receveurs de soins. Ces données ont ensuite été utilisées par les CAU afin d'orienter les travaux dans le cadre du projet qui permettraient d'améliorer les SI, les SCPF ainsi que la qualité des soins offerts.

Le projet pilote se compose de 15 CAU, dont huit comprennent un patient et un membre de la famille au sein du conseil (intervention). Les sept autres CAU comprennent seulement des professionnels de la santé (contrôle). L'ensemble des responsables et des fournisseurs de soins de santé à chaque hôpital ont assisté à un atelier de formation sur les SI et les SCPF avant la composition des CAU. Les patients et les membres de la famille qui ont été recrutés ont également participé à un atelier de formation avant la première réunion de leur CAU.

L'ensemble des 15 CAU ont maintenant élaboré des modèles de soins centrés sur le patient afin de réviser les modèles de prestation de soins selon les valeurs déterminées à l'aide des témoignages et forums. En tant que membres de conseil, les patients et les membres de leur famille participent à l'établissement de nouveaux processus et nouvelles structures afin de refléter le modèle de SCPF, à la collecte de données afin de surveiller les extrants et à l'évaluation des répercussions de l'intervention sur les résultats. À la suite de l'étude d'une durée de deux ans, les CAU demeureront dans le cadre de la structure organisationnelle des hôpitaux.

RÉPERCUSSIONS :

Les données qualitatives à l'appui des projets ont été obtenues à partir des témoignages de patients, des forums communautaires et des groupes de discussion qui ont eu lieu avec les unités de contrôle et d'intervention. Des thèmes communs ont été dégagés, notamment le moment opportun, la communication, l'attention, le respect et la continuité des soins.

Un plan d'évaluation est en place. On évaluera l'efficacité et l'incidence des CAU à l'aide de diverses mesures. On évaluera les membres des CAU à l'aide d'outils validés qui mesurent la collaboration, la qualité de vie et l'habilitation. On mènera des sondages auprès des patients et de leur famille à l'aide d'outils validés qui mesurent la qualité et la sécurité des soins et l'auto-gestion en matière de santé. De plus, on recueillera des données cliniques liées à la qualité des soins et aux résultats en matière de sécurité. On effectuera des évaluations sommatives et formatives à cinq étapes au cours de l'étude. Dans ces évaluations, on mettra en comparaison les résultats en matière de contrôle et d'intervention afin de déterminer l'incidence de l'inclusion des patients et de leur famille en tant que membres des CAU. Un rapport final est prévu en novembre 2013.

Le projet a été financé en partie dans le cadre de l'initiative d'engagement des patients de la FCASS en 2011. Chacun des sept projets a obtenu un soutien, un mentorat et un investissement de l'ordre de 700 000 dollars qui était doublé d'un financement de co-commandite. Après novembre 2013, les coûts seront assumés à l'aide des budgets de fonctionnement dans chaque hôpital.

APPLICABILITÉ/TRANSFÉRABILITÉ :

Le projet d'engagement des patients des CAU n'a pas été adapté d'une autre compétence ou mis en œuvre ailleurs; il s'agit du premier projet visant à susciter l'engagement des patients et de leur famille au sein des CAU. Toutefois, cette initiative est, en théorie, transférable à d'autres établissements. On utilise déjà ce modèle d'engagement des patients afin d'améliorer la participation des patients et de leur famille au sein d'autres comités de soins aux patients dans l'ensemble des organismes faisant partie de la HPHA. Les résultats de ce projet pilote sont, en théorie, applicables à d'autres organismes de soins de santé.

Leçons retenues aux fins de possibilité d'application et de transférabilité :

- Les séances de sensibilisation pour le personnel, les cadres dirigeants et les patients et les membres de leur famille étaient essentielles afin de favoriser et soutenir le changement de culture en faveur d'un nouveau modèle de soins.
- Les patients et les membres de leur famille offrent davantage que leurs simples points de vue sur les soins; ils mettent à profit diverses compétences qui complètent celles du personnel. Toutefois, le recrutement peut être plus long que prévu.
- Le mentorat est utile pour le personnel qui accomplit le rôle de facilitateur pour les CAU.
- L'harmonisation selon les stratégies et priorités organisationnelles, ainsi que le soutien de l'équipe de cadres supérieurs, des directeurs de programmes cliniques et du conseil s'avèrent essentiels.
- L'engagement significatif des médecins tôt dans le processus s'avère nécessaire.

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Le contenu a été adapté à partir des sources et des liens pertinents suivants :

Communications personnelles :

Gaffney, D. (examen en date de juillet 2013). [Huron Perth Healthcare Alliance].

Autres :

Gaffney, D. Présentation de résumé dans le cadre du Symposium national sur les soins intégrés du Conseil canadien de la santé (2012).

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Équipes de santé d'infirmières et infirmiers et de diététiciens pour prévenir les complications liées au diabète

LOCATION:	**Alberta**	**THÈME DE LA SANTÉ:**	**Ressources humaines de la santé**
HEALTH SECTOR:	**Primary Health Care**	**CADRE CATÉGORIE:**	**Prometteuse**

APERÇU : Cette pratique innovatrice améliore la qualité du contrôle du diabète en ayant recours à des équipes interprofessionnelles de soins de santé effectuant des interventions auprès des personnes âgées de 17 ans et plus atteintes de diabète et d'hypertension ou d'albuminurie. Le projet pilote initial a été inauguré dans cinq collectivités au nord de l'Alberta en 2004. On a développé depuis le programme dans huit collectivités au total (deux collectivités urbaines et six rurales), desservant plus de 3 000 patients.

DESCRIPTION DE LA PRATIQUE :

Pour aborder le fardeau de plus en plus grandissant du diabète et de la maladie chronique du rein, on a mis sur pied des équipes interprofessionnelles afin d'inclure une infirmière autorisée ou un infirmier autorisé et un diététicien autorisé dans les cliniques comportant un endocrinologue, un néphrologue, une infirmière ou un infirmier praticien avancé et gestionnaire de projet, un pharmacien et un commis. Parmi les fonctions de l'infirmière ou de l'infirmier et du diététicien, mentionnons la promotion de l'élaboration et de l'utilisation de lignes directrices et protocoles fondés sur des données probantes, aidant à contrôler les facteurs de risque à l'aide d'une assistance professionnelle sur le mode de vie, de suivis réguliers et de l'adaptation d'interventions multifactorielles selon le perfectionnement individuel.

On a fait la promotion des cliniques auprès des fournisseurs de soins de santé afin d'entreprendre le processus d'orientation-recours. L'admission de nouveaux patients comprenait une évaluation normalisée menée par l'infirmière ou l'infirmier et le diététicien (d'une durée de deux heures); les visites subséquentes étaient d'une durée d'une heure et on a envoyé les rapports de chaque visite au médecin orienteur. Le programme d'éducation pour les infirmières et infirmiers et diététiciens associés à la mise en place de ce modèle de soins comprenait un programme de formation initiale en classe d'une durée de cinq jours, suivi de séances de formation mensuelles d'une journée, de séances de télésanté toutes les deux semaines et d'un mentorat continu sur place par l'infirmière ou l'infirmier praticien avancé du programme.

Au départ, le projet pilote était financé par le gouvernement provincial, avec un budget initial de 800 000 dollars par année. Le financement relève maintenant du Programme rénal du nord de l'Alberta, et de la régie régionale de la santé en tant qu'employeur intérimaire.

RÉPERCUSSIONS :

Lors de la période initiale de collecte de données entre 2004 et 2005, on a reçu 570 clients dirigés, dont 99 p. cent étaient admissibles et provenaient essentiellement de médecins de famille (au lieu de spécialistes). Une période d'évaluation plus longue s'est poursuivie jusqu'en 2007, au cours de laquelle on a effectué le suivi de 235 patients pendant une année d'obtention de services. On a signalé des améliorations importantes du point de vue clinique chez les patients pour l'ensemble des indicateurs en ce qui concerne la tension artérielle, la glycémie, les taux de lipide et l'albuminurie. Toutefois, les patients qui ne respectaient pas les changements de mode de vie comme le renoncement au tabac présentaient de moins bons résultats cliniques. La réussite a été attribuée au rôle de l'équipe interprofessionnelle et aux visites de suivi visant à renforcer les conseils des médecins pour mettre en pratique les changements de mode de vie. Le coût des visites de suivi s'élevait à 130 dollars chacune, mais aucune évaluation officielle du rapport coût-efficacité n'a été effectuée.

APPLICABILITÉ/TRANSFÉRABILITÉ :

Cette pratique innovatrice est considérée transférable, tel que le démontre son développement dans d'autres collectivités du nord de l'Alberta suivant la période initiale du projet pilote. Bien que l'une des premières cliniques à Red Deer soit fermée, il y

a maintenant huit collectivités hébergeant ces cliniques interprofessionnelles, qui effectuent le suivi de 1 800 patients au total. Parmi les cliniques actives, mentionnons les suivantes :

• Edmonton, Centre de santé communautaire du Nord-Est (date d'établissement en janvier 2004);

• Vermilion (date d'établissement en janvier 2004);

• Hinton (date d'établissement en janvier 2004);

• Wetaskiwin (date d'établissement en janvier 2004);

• Edmonton, Hôpital des Sœurs-grises (date d'établissement en octobre 2005);

• Edson (date d'établissement en janvier 2007);

• Grande Prairie (date d'établissement en février 2007);

• Fort McMurray (date d'établissement en juin 2008).

Parmi les défis dans le cadre du contexte qui ont été notés, mentionnons la sous-utilisation continue de thérapies éprouvées, la pénurie de médecins en milieu rural et les systèmes de paiement à l'acte qui ne sont pas conformes à la gestion continue des maladies chroniques. En ce qui a trait notamment à la mise en place de nouveaux programmes, une communication méthodique s'avérait nécessaire afin d'établir la confiance concernant la transcendance des rôles traditionnels exercés par les infirmières et infirmiers autorisés et de gérer les perceptions concernant le recoupement des services avec les programmes préexistants. Parmi les principaux facteurs contribuant à la réussite de ce programme, mentionnons le partenariat avec les régies régionales de la santé et la réception positive des collectivités participantes.

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Publications :

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Communications personnelles :

Senior, P.A. (25 juillet 2013). [Professeur adjoint et chercheur principal, Université de l'Alberta].

McKenzie, J. (July 25, 2013). [Gestionnaire de projet, Alberta Health Services].

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