CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

3M Health Care Quality Team Awards

Healthcare Quality Team Initiatives Executive Summaries 2014 Submissions

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Dear Healthcare Champions,

For 20 eventful years, the 3M Health Care Quality Team Awards have recognized and celebrated innovation, quality and teamwork in Canadian healthcare organizations and I would like to sincerely thank you for your interest and involvement in the 2014 Awards.

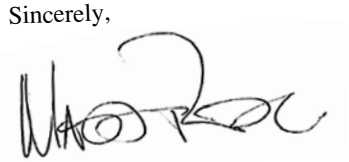
As you know, the awards are intended to draw attention to the teams that have worked together on quality improvement projects that result in sustained change within their organizations. As expected, the award submissions we received for this year's awards were all outstanding and I would like to offer my deepest personal thanks to all the teams that took the time to share their initiatives and congratulate all the nominees and winners.

The enclosed booklet includes executive summaries of all the 2014 initiatives that were submitted for award consideration. Despite the continuing challenges we all face in health care, these initiatives prove that creative thinking, innovation and best practice execution can dramatically improve the delivery of programs and services. I encourage you to share these executive summaries with others in your organization. If you need additional copies of the summaries, please contact the Canadian College of Health Leaders at 1-800-363-9056, ext. 213.

As we celebrate the achievements of our 2014 award recipients, I would also like to reflect on the positive impact the 3M Canada/ Canadian College of Health Leaders partnership and 3M Health Care Quality Team Awards have had on the quality of health care offered by our health care institutions over the past 20 years. It is both gratifying and encouraging to realize that we have accomplished so much together.

3M Canada is committed to facilitating quality initiatives in health care and is very proud of its 20 year association with the 3M Health Care Quality Team Awards.

Sincerely,



Matt Pepe
Vice-President, Health Care Business
3M Canada Company

In 1994, the Canadian College of Health Leaders and 3M Canada Company launched the 3M Health Care Quality Team Awards to encourage and recognize innovation in health services by linking two important concepts: quality and teams. Although two submissions were selected for special recognition: Mount Sinai Hospital's *Acute Care for Elders (ACE) Strategy*, in the Programs and Processes in an Acute Care Hospital Environment category and Island Health's *Better Patient Journeys: Community-Lead Strategies to Improve Hospital Flow*, in the Programs and Processes in a Non-Acute Environment category, the 2014 competition included many important quality improvement efforts. We are pleased to share a brief overview of the submissions and hope this document will encourage wider use of quality planning methods and tools in Canadian health services.

2014 3M Health Care Quality Team Awards Recipients

- Programs and Processes in an Acute Hospital Environment:
  Mount Sinai Hospital: ***The Acute Care for Elders (ACE) Strategy***
- Programs and Processes in a Non-Acute Environment:
  Island Health: ***Better Patient Journeys: Community-Lead Strategies to Improve Hospital Flow***

QUALITY TEAM INITIATIVES 2014 - OTHER SUBMISSIONS

Programs and Processes in an Acute Care Hospital Environment

- An Evidence-Based Approach to Improving Orthopedic Patient Flow and Wait Times
- Applying Lean Across the Continuum of Care
- Back-to-Basics Quality and Safety: Driven by Passion, Sustained by Culture
- CodeH for Help: A Patient and Family Activated Response System
- Collaborative Team Strategies to Decrease the Number of Alternate Level of Care (ALC)
- Creating System Re-design: Striving for Quality that Improves Clients' Journey through the Healthcare System
- Cytogenetics Productivity Improvement through Lean
- Driving Provincial Healthcare Policy from Local LHIN Initiatives – Improving Care for Critically Ill Patients
- Enhanced Activation and Restorative Care
- Enhanced Recovery after Surgery – Colorectal Surgery
- Hospital-Wide Falls Prevention Strategy for a Six Site Hospital
- Improving Patients' Access to Emergency Care at Ross Memorial Hospital
- Improving Quality and Patient Outcomes – Reducing the Number of Nurse Sensitive Adverse Events
- Lean Management: Innovative Tools for Engaging Teams in Continuous Quality Improvement
- Patient Flow Initiative DGH ED: Low Acuity Fast Track
- Patient Led Feedback Forums
- Pharmacy Practice Model Redesign at a Tertiary Care Teaching Hospital
- Providence Health Care Antimicrobial Stewardship Program - Improving Care and Reducing Costs through Optimal Antimicrobial Prescribing
- Radiation Program Peer Review Process for Radical Breast Cancer Therapy
- Reduce Wait Times for Echocardiography at the Saint John Regional Hospital
- Reducing Hospital Acquired Infections - C-Difficile

Programs and Processes in a Non-Acute Care Environment

- Applied Behaviour Autism Services (ABAS)
- Applying Lean Across the Continuum of Care
- BC IVIg Rheumatology Program
- Behaviour Support Services Mobile Support Teams
- Going Off the Rails! At Peel Long Term Care
- Inherited Coagulopathy and Hemoglobinopathy Information Portal (iCHIP)
- Innovating Care Delivery, Quality and Safety through a Person-Centred Provincial Approach for Ventilator-Assisted Individuals
- Innovative Redesign of Adolescent Inpatient Services
- Integrated Client Care Program (ICCP)
- Mindfully Integrating the Needs of Individuals with Chronic Conditions: Creating Innovative, Person-Centred and Sustainable Solutions
- Partners in Care: Rapid Access to Consultative Expertise (RACE)
- Reducing Antipsychotic Medications in Long Term Care
- The Caregiver Framework for Children with Medical Complexity and Caregiver Framework for Seniors Pilot Projects

The Acute Care for Elders (ACE) Strategy

Mount Sinai Hospital

Mount Sinai's ACE strategy was launched in 2010 to improve how care to older patients is delivered. The hospital, under this strategy, implemented a series of evidence-informed but tailored interventions. The strategy links these interventions to create a more seamless, integrated delivery-model spanning the continuum of care through strong partnerships with the Toronto Central Community Care Access Centre and Community Support Services Agencies. This strategy is enabled by an interprofessional team-based approach to care as well as technological innovations with a focus on maintaining the independence of older adults in our community for as long as possible.

The strategy includes a multi-year action plan to evaluate progress and make refinements using a balanced scorecard and a benchmarking system that allows for quarterly, regional performance comparators to identify areas of improvement.

Since 2009-10, Mount Sinai Hospital has seen a 31% increase in the number of admitted older adults (65+) it serves on an annual basis. In that time, the strategy allowed us to reduce our average total length of stay per patient by more than 28% and decrease our average ALC days by 18%. Our patients are now more likely to go directly home, are less likely to be readmitted and are more satisfied with our care. Despite the increase in patient volumes, our approach which required minimal financial investments, but rather a different approach to the way we work, has reduced our overall care costs by more than $6.4 million in 2012-13 alone.

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Better Patient Journeys: Community-Lead Strategies to Improve Hospital Flow

Island Health

This work began with the story of a client whose journey through our healthcare system identified many opportunities to improve transitions in care.

To support Island Health's strategic priority to improve the quality, coordination, and timeliness of transitions from hospital to community, the continuing health services team implemented community-lead strategies to support hospital flow in three large hospitals and four communities across Vancouver Island. These strategies were:

- Workflow Redesign: efficiency improvements in hospital flow processes to community, residential care and seniors tertiary mental health.
- Home is Best: creation of new home first and intensive integrated care management services to meet the needs of the most frail and complex clients within their home/ community.

Five inter-connected initiatives were identified within the two strategies, and were implemented starting in June 2011. This multi-site, multi-community, cross-continuum work included patient partners in service planning, and relied heavily on developing partnerships with hospital staff and community family physicians.

Key system-level outcomes over the last two years have been:

- 11,400 bed days saved;
- 57% reduction in hospital length of stay while awaiting assessment for residential care; and
- 28% reduction in ALC numbers.

The overall result has been significant improvement in hospital flow, including a shift towards managing complex clients in the community. Perhaps most importantly, our learning from this work is helping create better patient journeys.

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An Evidence-Based Approach to Improving Orthopedic Patient Flow and Wait Times

Eastern Health

An interdisciplinary team consisting of key decision makers and healthcare professionals came together in 2010 with a shared vision of improving client care and access for the orthopedic service in Eastern Health. Using best practices and supported by a strong change management model, this team worked tirelessly to overcome barriers and implement system wide changes to enhance care.

The implementation of a centralized access model has resulted in continuous improvements in orthopedic patient flow and significant reductions in wait times. The result was a process that centralized intake of all orthopedic referrals to improve access and throughput to specialized care. This enabled healthcare officials to establish, collect and share a comprehensive data set related to the demand for orthopedic services. To supplement the model, Eastern Health implemented methods to reliably match supply and demand for these essential services. Since its introduction, Eastern Health has reduced the median wait time for orthopedic services for high-priority patients by 72%. The median wait time for all other patients who require these services dropped by 45%. The new centralized access model has virtually eliminated duplicate referrals and has achieved a better balance of wait times for physicians. This team has succeeded in implementing a novel approach to access that has been sustained and transferred to other services within the organization and the province. The exchange and synthesis of knowledge gained through this project is an important strategy for leading and guiding innovations in wait time improvement and sustainable patient centered practice.

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Applying Lean Across the Continuum of Care

University Hospital, Toronto Western Hospital

Toronto Western Hospital, in partnership with Toronto Rehabilitation, has transformed the way care is delivered to spine, stroke and musculoskeletal-MSK patients across acute care and rehabilitation sites. Using the Lean approach, with its emphasis on creative problem solving, continuous learning, real-time feedback and participation from 300 patients, significant shifts in staff empowerment to lead change and outcomes for patients were achieved.

In particular, we focused on improving flow from acute care to rehabilitation to the community, decreasing wait times for follow-up care, providing timely information to patients and families, as well as across multiple disciplines. With the overall goal of ensuring "right patient, right time, right care", efficiencies have been found which have resulted in decreased wait times, pressure ulcers, length of stay (LOS), increased capacity, as well as better informed patients. Results include:

- For spine patients:
  - has decreased by 20% and overall capacity has improved by 18%.
  - 50% reduction in time from the beginning of a rehabilitation application until transfer to rehabilitation.
- For fractured hip patients, there has been a 20% improvement in transitioning to rehabilitation within the five-day target.
- A 25% improvement in the number of eligible stroke patients receiving tPA treatment within 60 minutes of arrival in the ED.

This approach has created an environment in which grassroots problem-solving is becoming the norm and in-the-moment, with staff sharing their experiences and relying upon each other and external partners to identify and prevent smaller challenges from becoming entrenched issues.

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Back-to-Basics Quality and Safety: Driven by Passion, Sustained by Culture

Southlake Regional Health Centre

Recently, Southlake Regional Health Centre introduced a new five-year strategic plan: *Transforming Healthcare with Our Patients, Our People, Our Partners*, a roadmap for furthering the development as a high-reliability organization.

Three priority directions form the heart of this plan: create the ultimate hospital experience; transform healthcare relationships; and seek and share better solutions. The cornerstone of our ability to achieve these directions is an understanding that delivering and sustaining excellence requires us to make a dedicated commitment to keep our patients safe.

Herein lays the challenge. With shrinking budgets and increasing costs, how do we improve and sustain patient safety? Southlake's patient-focused culture has enabled us to work together to create value without compromising quality. *Back-to-Basics Quality and Safety: Driven by Passion, Sustained by Culture* is a demonstration of innovative low, or no cost strategies that deliver quality and safety to our patients through the power of our people.

Southlake is known internationally as a centre of innovation and excellence. The innovation showcased in this initiative does not focus on technology-enabled devices or leading-edge procedures. Rather it is in back-to-basics approaches that put patients first. This is innovation driven by the passion of individuals who entered healthcare because they genuinely care about people.

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CodeH for Help: A Patient and Family Activated Response System

Providence Health Care

CodeH - a rapid response safety net which enables patients and families to call a clinical resource nurse (CRN) for support, 24 hours a day, seven days a week, has shown innovation in design and implementation since its inception in March 2013.

Since CodeH's inception, 22 calls have been made from patients and families to the CRN team which has resulted in improved patient, family, and staff satisfaction and communication in healthcare delivery. In addition to improvements made in communication and satisfaction between patients, families, and staff, one of the CodeH calls made by a family member resulted in an ICU admission and prevention of a cardiac arrest.

CodeH is just one example of innovation, quality, and teamwork that characterizes Providence Health Care's unique ability to bring patient and family voices and quality and safety together into the modern day healthcare provision.

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Collaborative Team Strategies to Decrease the Number of Alternate Level of Care (ALC)

Winchester District Memorial Hospital

In the past, Winchester District Memorial Hospital (WDMH) has experienced high alternative level of care (ALC) patient rates, high unplanned readmission rates and high Emergency Department (ER) revisit rates. This issue is a local, regional and province-wide challenge and WDMH has identified it as a priority quality and safety issue.

Over the past year, a dynamic and dedicated multi-disciplinary team at WDMH has been working closely with several partners to address this issue. In particular, WDMH, the Champlain Community Care Access Centre (CCAC) and local physicians have worked together to plan and implement a solution. Patients and families have played a key role as well.

The result is a significant reduction in the number of ALC patients, reduced unplanned readmissions rates and fewer ER revisits. Most importantly, patients and families are feeling supported and cared for by the entire team working together.

This initiative does not require additional resources. It can be easily transferred to other units, hospitals, or regions for adoption. It is a team solution.

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Creating System Re-Design: Striving for Quality that Improves Clients' Journey through the Healthcare System

Hamilton Health Sciences

The Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) established a project team to embrace the Behavioural Supports Ontario (BSO) provincial project as an opportunity for system re-designs. The quality improvement focus propelled the project team to facilitate the provincial mandate with tight timelines and high expectations. The project team recognized the necessity to develop, test and implement multiple improvement plans simultaneously in the community and long-term care sectors.

While the timelines placed pressure on the project team, it also fostered engagement with the stakeholders – witnessing new models, functions in roles and staff hired for mobile teams in 3-4 months. The project team developed local structures and processes to support the success of the project, and utilizing Provincial supports or offering support to other LHINs.

While it is important to recognize that new funding was approved with the BSO project, the focus of the strategy was not on new or increased resources but rather on determining how all resources, new and existing can be re-aligned (system re-design). This approach fosters a healthcare service model that is client-centric and intended to improve the health of the population, the person's healthcare experience, and promote sustainability of the healthcare system. The work of the project team is a spring-board for future work with both the BSO population specifically, but more broadly, for the work of system re-design in the HNHB LHIN.

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Cytogenetics Productivity Improvement through Lean

IWK Health Centre

The Cytogenetics laboratory at the IWK Health Center is the only full service laboratory of its kind in the Maritimes, providing comprehensive diagnostic services in all types of chromosome studies, including congenital disorders, prenatal diagnosis and hematologic/oncologic disorders. It is the only centre in the Atlantic Provinces that processes chorionic villi samples for prenatal diagnosis of chromosomal abnormalities, and the only site accredited by the Children's Oncology group to perform chromosome analysis on pediatric leukemia samples.

In alignment with the IWK's key directions, the cytogenetics productivity improvement through Lean initiative focused on patient safety and process improvement sustainability. It centered on using existing resources to improve the turnaround time (TAT) of oncology chromosome analysis, improve workflow efficiency, and realize cost savings.

Lean methodology was used to standardize workflow process, eliminate process waste and reduce variability in chromosome analysis among technologists. This innovative approach empowered staff with knowledge, ownership and accountability yielding immediate results on performance indicators through standardization of processes, increased target and case status visibility. TAT compliance improved dramatically from 59% to as high as 95%, and workload required to complete oncology cases reduced 27%. Savings of over $150K have been realized through repatriation of testing.

Successfully implementing multiple changes required an exceptional team of dedicated, collaborative staff committed to high performance and delivering excellence in care. The results show the positive impact embracing Lean philosophy can have on patient safety, team dynamics and operational costs.

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Driving Provincial Healthcare Policy from Local LHIN Initiatives – Improving Care for Critically Ill Patients

South West Local Health Integration Network

There are a number of transfer requests for critically ill patients with life or limb conditions that exceed the resources/expertise of the referring hospital and can only be cared for at specific hospital sites. It is important to ensure that these patients receive appropriate care expediently to reduce morbidity and mortality.

In early 2011, the South West LHIN brought a group of stakeholders together to implement a 'Life or Limb – No Refusal Policy.' This LHIN-wide policy, developed in consultation with all South West LHIN hospitals, outlined the diagnoses considered life or limb (requiring acute care within 4 hours) to ensure these referrals were not refused due to 'no ICU beds' and to determine the levels of care each hospital was capable of providing. Due to its success, it has now been implemented as a province-wide policy.

One year after implementation of the life or limb policy, the Adult Extramural Critical Care Response Team (ExCCRT) project was implemented to improve the life or limb process. This project provides immediate telephone access to a critical care physician for all life or limb calls and provides consultative support to community hospitals 24/7. Critical Care Services Ontario and the Ministry of Health and Long Term Care have now begun province-wide implementation of the Life or Limb Policy and the Adult ExCCRT process is also being considered.

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Enhanced Activation and Restorative Care

Brockville General Hospital

The emphasis of Enhanced Activation and Restorative Care (EARC) is identification of frail elderly deconditioned inpatients who may have potential for functional improvement. Outcomes include:

- a positive impact on patient and system outcome;
- significant teamwork and the inclusion of unregulated providers in acute care;
- a positive impact on patient flow, decreased length of stay and quality outcomes; and
- a collaborative effort with the community and Community Care Access Centre (CCAC).

The Enhanced Activation program promotes patient activity and independence from the time of admission. Through the use of a geriatric care plan, the patient attains/maintains maximum physical, communicative and cognitive functioning while addressing emotional, social, and spiritual needs to help them return to living in the community as independently as possible. The program delivers a range of services based on rehabilitation and reactivation principles that promote physical well-being and instrumental activities of daily living. In order to make this happen, following the initial assessment by a registered nurse (RN), early consults are made to the interdisciplinary team including but not limited to: the hysiotherapist (PT), occupational therapist (OT), and personal support workers (PSWs).

The early implementation of enhanced activity in the acute care setting decreases the risk for deconditioning during hospitalization. For patients no longer requiring acute care, but needing some additional time to become stronger they may be transferred to the restorative care program located at the hospital's Garden Street Site.

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Enhanced Recovery after Surgery – Colorectal Surgery

Providence Health Care

St. Paul's Hospital, part of Providence Health Care (PHC), is an academic teaching hospital located in downtown Vancouver. A concentration of sub-specialty trained colorectal surgeons at this site allowed for the creation of a centre for excellence in colorectal surgery (CRS). As an Academic Health Science Teaching and Research Centre training facility for multiple health disciplines and following the vision and values of the organization, there is a commitment to quality improvement and to be at the forefront of colorectal surgical care.

In 2010, the length of stay (LOS) for CRS patients was higher than anticipated. Simultaneously, internationally there was growing body of literature and awareness of Enhanced Recovery After Surgery (ERAS) protocols. A decision was made to adopt ERAS to decrease LOS and improve the CRS patient experience. ERAS protocols are evidence-based and patient-centered, aiming to decrease the stress response to surgery and to promote a better and faster recovery from surgery with less pain and little loss of function. Existing ERAS protocols were modified to fit in PHC and a carefully planned implementation strategy ensured a smooth transition from current to enhanced practice.

Results have been impressive. Median LOS decreased from 7 days to 5 days and 55% of patients are now discharged on post-op day 5 compared to 37% before implementation. Implementation of ERAS has not required any increase in resources or costs. A continuous audit process rapidly identifies strengths and areas requiring attention. Feedback from physicians, nursing, allied health staff and patients has been overwhelmingly positive.

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Hospital-Wide Falls Prevention Strategy for a Six Site Hospital

Niagara Health System

Challenged with the increasing acute inpatient falls, the Niagara Health System (NHS), a multisite acute care organization, has leveraged its strategic commitment to patient client-centered care and patient safety, involving all staff, physicians and volunteers in a falls prevention strategy. Using project management principles and the model for improvement, the NHS has made impressive improvements to the acute inpatient falls rate.

The aim of the Falls Prevention Strategy is to standardize an approach to falls prevention, by providing support for managing at risk adult inpatients and implementing evidence-based interventions. The NHS developed a Falls Prevention Steering Committee with an executive lead as well as four interprofessional Falls Prevention Site Teams. The NHS also used medical and health sciences students in a joint partnership with Brock University and McMaster University to help with continuous quality improvement initiatives connected to the strategy.

The strategy targets both patients and providers, encouraging patients to use their call bell for help before getting out of bed, and providing staff with tools to help prevent falls including special equipment and non-skid socks. Communication was also emphasized through signage with a risk of falls symbol on patient room doors, on their charts, and on magnets by their bedside. In addition, the NHS Corporate Communications Department produced a video to help raise awareness of the strategy among staff and community members.

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Improving Patients' Access to Emergency Care at Ross Memorial Hospital

Ross Memorial Hospital

At Ross Memorial Hospital, our team is comprised of exceptional people committed to providing exceptional care. This promise we make to our community is tangible throughout the hospital, and nowhere is it more evident than in the emergency department (ED).

It is there that unprecedented efforts have been focused with a primary goal: to improve patients' access to care by decreasing their waits. Since January 2011, the team has been trialling and implementing an impressive list of improvement initiatives, not one at a time, but concurrently.

In October 2012, the ED team trialled a rapid assessment fast track system to address the long waits faced by CTAS 3 patients—those whose conditions are considered urgent, but who are stable and mobile. By applying lean philosophy to processes, reconfiguring space in the department and involving all teams whose work is critical to the patients' care, the Ross Memorial Hospital has managed to achieve significantly improved patient waits, and enhance both patient and employee satisfaction.

The success of this system was emphasized on December 28, 2012, during the height of the influenza surge, when a record 205 patients were seen in the ED (120 is normal volume). Despite a 70% increase in workload, the team was able to meet patients' needs—and keep patient waits below provincial targets in every metric.

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Improving Quality and Patient Outcomes – Reducing the Number of Nurse Sensitive Adverse Events

Mackenzie Health

Preventable adverse events affect approximately one out of every 10 admitted patients (Vries et al, 2007) increasing the cost of care and negatively impacting the patient healthcare experience. As Ontario braces for a rise in the senior population in the coming years and an even greater financial burden on the healthcare system, health leaders have a responsibility to demonstrate accountability to improving patient outcomes and fiscal responsibility. Strategies aimed at preventing adverse events can make a significant difference to patients and families, hospitals and the healthcare system.

The Canadian Hospital Reporting Project (CHRP) is a quality improvement initiative developed by the Canadian Institute of Health Information (CIHI). The objectives are to provide comparable indicators to support performance measurement and quality improvement among Canadian hospitals. Nurse sensitive adverse events (NSAE) is one of the 21 clinical indicators CIHI collects data on. The four nursing sensitive clinical domains are: hospital acquired pneumonia, urinary tract infections, pressure ulcers, and in-hospital fractures.

Following publication of the 2011/12 NSAE results, the leadership at Mackenzie Health committed to the development of strategies to improve quality of patient care. The impressive reduction by an overall 52% in less than two years is a testament to the hard work and commitment of the organization and the dedicated inter-professional implementation team to improve patients' outcomes. This improvement can be translated into an estimate cost avoidance of $480,000 per year.

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Lean Management: Innovative Tools for Engaging Teams in Continuous Quality Improvement

Montfort Hospital

In less than a year since its implementation, Lean management has proven to be a sustainable method for ensuring a high level of patient care through innovation and teamwork. Lean management was found to be the best way to guarantee success as well as sustainability. This approach gave staff the opportunity to be part of the solution, engaging them in improving patient satisfaction and organisational performance.

Lean management is aligned with Montfort Hospital's strategic and quality improvement plans. It's allowed the unit teams to focus their efforts towards the improvement of organisational indicators in a standardized and engaging way. In only a few months, the two pilot units accomplished close to 50 improvements. A pre and post Lean questionnaire has shown very positive progress with regards to employee satisfaction.

Overall, Lean management pilot teams have adapted and implemented a method that ensures the monitoring of relevant organisational indicators that lead to continuous and sustainable improvements in both pilot units. Given these positive results, an implementation plan was developed to proceed with the implementation of Lean management on all other 13 clinical units including diagnostics and imaging and ambulatory care.

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Patient Flow Initiative DGH ED: Low Acuity Fast Track

Dartmouth General Hospital

Addressing overcrowding in emergency departments is such a challenge that Accreditation Canada is instituting a Required Organizational Practice on Client Flow beginning January 2015.

Dartmouth General Hospital's Patient Flow Initiative DGH ED: Low-Acuity Fast Track shows that we are at the forefront of this work. In fall 2012, low-acuity patients at the DGH ED were leaving without being seen. The department was overcrowded, wait times were long, patient complaints were growing and staff were stressed. The need for change was urgent. An interdisciplinary patient flow committee was created to gather data, survey patients and to challenge each other to find efficiencies in a facility already operating over capacity.

The result was a realigned door-to-physician process. Patients went from triage and registration to a repurposed area in the ED. Staff and physician schedules were shifted to match patient arrival patterns. Changes were evaluated monthly and adjusted as necessary. Staff were consulted every step of the way. Today, 50% of low-acuity patients are seen by a physician within 90 minutes compared to 12 per cent in 2012. Work is continuing to reach our goal of 100 per cent. Patient survey results showed a statistically significant improvement in satisfaction rates.

Accreditation Canada notes that improving client flow can only be achieved by "evaluating client flow data and considering all sources…and pattern of demand" and "strong leadership support." The patient flow initiative is helping the Dartmouth General Hospital to transform the person-centred healthcare experience.

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Patient Led Feedback Forums

Kingston General Hospital

Patient feedback forums are an opportunity for staff to meet with a recently discharged patient or family member and to receive feedback on the hospital experience. Patient led feedback forums bring the entire team together with the patient and/or family member providing direction and leadership. The forums allow staff to better understand what is important from the patient's perspective and to engage in continuous improvement cycles in order to improve that experience. There is great power in staff hearing directly from the patient and family as to what matters most in a hospitalization.

The forums also allow members of staff, who may seldom be recognized for their impact on the patient experience, to be recognized. Patients and families are given the opportunity in the forums to relay to staff what makes an average hospital experience into a great hospital experience or a good nurse into a fantastic one. It is this learning which has allowed us to begin to change the culture of our organization to one which actively partners patients and staff at every opportunity to work towards outstanding care always. The team that developed, trialed, and refined the forums worked together for an entire year to ensure they would provide the very best learning opportunity for staff while allowing the patient and family to be the guide. The team created an innovative process which not only partners staff and patients but also provides learnings for the entire organization on how to improve the patient experience.

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Pharmacy Practice Model Redesign at a Tertiary Care Teaching Hospital

Island Health

The Canadian Society of Hospital Pharmacists and Accreditation Canada clearly state that effective communication regarding medications is a critical component in delivering safe care. By identifying and resolving medication discrepancies, the likelihood of adverse events occurring within healthcare organizations across the continuum of care is reduced. To achieve this goal at Island Health, it was imperative to review and realign the clinical pharmacy program.

The objective of this project was to implement a pharmacy practice model redesign, integrating clinical and distributional functions into a unified program. This was to be done within existing budget with the common vision of excellence in pharmacy service delivery. This culture of excellence was created through staff engagement, mentoring and education, technology implementation and involvement in the care delivery model redesign resulting in the successful integration of pharmacists in the interdisciplinary team and redistribution of the pharmacists from the dispensary to the ward. The new model change has allowed all patients to have access to a clinical pharmacist and has facilitated Island Health's alignment with Accreditation Canada ROP's.

This practice model change has significantly improved the delivery of patient care by enabling pharmacists to effectively resolve patient specific drug therapy problems and to provide medication reconciliation at all transitions of care. This project held true to Island Health's vision of excellent care for everyone, everywhere, every time. An integrated team worked to overcome obstacles, align itself with organizational priorities and engage staff in a culture of clinical pharmacy excellence.

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Providence Health Care Antimicrobial Stewardship Program - Improving Care and Reducing Costs through Optimal Antimicrobial Prescribing

Providence Health Care

Antimicrobials are critical to modern medicine. However, inappropriate antimicrobial use is undermining their effectiveness. Antimicrobial misuse leads to Clostridium difficile infection (COl), adverse drug reactions and drug interactions, emergence of drug-resistant pathogens and escalating healthcare costs.

Numerous studies show that up to 50% of antimicrobial prescriptions are unnecessary. To address the critical public health threat of increasing antimicrobial resistance and to ensure patients with infections are optimally treated, an antimicrobial stewardship program (ASP) was urgently needed. ASP consists of coordinated and systematic interventions to ensure optimal antimicrobial selection, dosing, route of administration and duration of therapy. The ultimate goal of ASP is to achieve optimal patient outcomes while minimizing toxicity, adverse events and costs.

The Providence Health Care (PHC) antimicrobial stewardship program (ASP) was established in April 2013. The multifaceted, evidence informed interventions have multidisciplinary and inter-professional engagement. ASP supports the PHC strategic directions of quality, safety, and innovation. ASP is also consistent with the PHC foundational strategies of fiscal sustainability, research and learning. Since the implementation of ASP, PHC has realized antimicrobial expenditure savings in excess of $400,000. Additionally, there have been avoidable costs from COl, a decrease in unwarranted diagnostic tests and reduced drug adverse events. PHC physicians and nurse practitioners fully embrace ASP, and it is one of the first patient safety and quality initiatives with proven financial self-sustainability. Innovative teamwork has improved patient quality care. Our ASP is a model of ASPs for the province of British Columbia.

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Radiation Program Peer Review Process for Radical Breast Cancer Therapy

Trillium Health Partners

Cancer Care Ontario (CCO) has mandated peer review in radiation oncology for all treatment plans with adjuvant or curative intent. It is defined as the evaluation of components of a radiation treatment plan by a second radiation oncologist. The components include, but is not exclusive to, the evaluation of clinical decisions and treatment plans to ensure the most appropriate treatment plan from a safety perspective as it relates to each individual patient's clinical situation. The mandate requires peer review to take place before the start of treatment or before 25% of the total prescribed dose has been delivered. Peer review can also be completed should issues/concerns be identified during treatment.

Peer review has been proven to be effective in reducing variations in practice, promoting team building and communication, continuing education, process development and quality improvement within the radiation program at Trillium Health Partners. Hence, there is a commitment to surpass the target of 85% set by CCO and achieve 100% compliance. Traditionally, these cases are reviewed in a formal multidisciplinary quality assurance rounds forum. However, the volume of cases prohibits this approach.

In March 2013, a novel approach was implemented which enabled timely peer review of the clinical decision and/or target definition for all patients diagnosed with breast cancer who are to receive a radical course of radiation therapy.

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Reduce Wait Times for Echocardiography at the Saint John Regional Hospital

Horizon Health Network, Zone 2

Wait times for routine Echo exams (TTE's) at Saint John Regional Hospital had increased over 5 times since Q1 of 2009 where they had grown from a five week wait time to a 26 week wait time in 33 months. The project goal was to investigate this problem by analyzing the data and root causes, and to determine solutions to reduce this wait time without hiring additional staff.

The project took place over a four month period and was a huge success. Several root causes were identified and solutions implemented, resulting in improvements. Many standards of work and guidelines were created and rolled out to the staff as well as an improvement in wait time data collection. Wait times for Echo exams were at two weeks at the end of the project and continue to meet Canadian Cardiovascular Society (CCS) benchmarks.

The project team met weekly and completed several assignments outside the team meetings to ensure the project goal was met. They navigated through the change management issues that arose, removed non-value added activities and realigned work to make a more stream lined and efficient process.

The project goal was to accomplish the following:

- understand why the wait times continued to increase for routine TTE exams;
- reduce wait times by 41% or 9 weeks- stretch goal -50% or 11 weeks; and
- move wait times as close to CCS standards as possible.

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Reducing Hospital Acquired Infections - C-Difficile

Vancouver Coastal Health

Vancouver General Hospital, a 780-bed tertiary centre, had not been able to decrease its Clostridium difficile (CDI) cases since 2008/09. CDI is a bacteria that can cause a potentially devastating infection of the gastrointestinal system and, in extreme cases, can result in death. Unfortunately, patients can acquire CDI in hospital through unwashed hands and a contaminated environment. A clean environment is critical as this bacteria produces spores that can survive in the environment for prolonged periods of time.

Baseline work revealed that units had poor compliance with surface cleaning partly because of clutter on the units. There was also a lack of emphasis on equipment cleaning and a definite need to be innovative in regard to our cleaning practices. Working together with the units, we initiated a de-cluttering campaign, implemented the mobile equipment cleaning program, evaluated the use of innovative ultraviolet light for disinfection, and with our partners – Housekeeping, Facilities, Inventory Replenishment, and Biomedical Engineering, reduced our CDI cases by over 30%. Vancouver Coastal Health saved $331,408, 672 hospital days and prevented 112 patients from acquiring CDI.

This initiative has a multidisciplinary approach in preventing transmission of a very significant hospital-acquired pathogen; improved staff safety; and increased emphasis among staff on best practice.

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Applied Behaviour Autism Services (ABAS)

Mackenzie Health

Applied Behaviour Autism Services (ABAS) of York and Simcoe is an innovative project that continues to influence services for children and youth with autism across Ontario and provides exceptional quality services in a short term model.

The ABAS program was designed in response to an expression of interest (EOI) called by the Ministry of Child and Family Services in 2010. The EOI called for community agencies to come together to design evidence based services within an applied behaviour analysis framework for individuals that were diagnosed on the autism spectrum. The nature of the York and Simcoe proposal was supported by over 30 agencies and was to ensure the inclusion of quality clinical work through creative teamwork that included the input of parents. The leads for this proposal includes Kinark Child and Family Services, Kerry's Place Autism Services, the Children's Treatment network and Behaviour Management Services of Mackenzie Health that spans over two regions and employs over 40 staff members.

From satisfaction measures families report:

- 99% felt heard;
- 96% felt their consultant was knowledgeable and friendly; and
- 92% would recommend the service to other people.

Highlights of this innovative program include:

- Services for over 2000 patient/youth with autism;
- Development of an effective short term service delivery model;
- High rates of patient treatment success and satisfaction;
- Increased access to services for patients due to partnership;
- Presentations to local and international conferences.

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Applying Lean Across the Continuum of Care

University Hospital, Toronto Western Hospital

Toronto Western Hospital, in partnership with Toronto Rehabilitation, has transformed the way care is delivered to spine, stroke and musculoskeletal-MSK patients across acute care and rehabilitation sites. Using the Lean approach, with its emphasis on creative problem solving, continuous learning, real-time feedback and participation from 300 patients, significant shifts in staff empowerment to lead change and outcomes for patients were achieved.

In particular, we focused on improving flow from acute care to rehabilitation to the community, decreasing wait times for follow-up care, providing timely information to patients and families, as well as across multiple disciplines. With the overall goal of ensuring "right patient, right time, right care", efficiencies have been found which have resulted in decreased wait times, pressure ulcers, length of stay (LOS), increased capacity, as well as better informed patients. Results include:

- For spine patients:
  - LOS has decreased by 20% and overall capacity has improved by 18%.
  - 50% reduction in time from the beginning of a rehabilitation application until transfer to rehabilitation.
- For fractured hip patients, there has been a 20% improvement in transitioning to rehabilitation within the five-day target.
- A 25% improvement in the number of eligible stroke patients receiving tPA treatment within 60 minutes of arrival in the ED.

This approach has created an environment in which grassroots problem-solving is becoming the norm and in-the-moment, with staff sharing their experiences and relying upon each other and external partners to identify and prevent smaller challenges from becoming entrenched issues.

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BC IVIg Rheumatology Program

Provincial Health Services Authority

Rheumatology was chosen as the pilot project because the volume of IVIg issued in BC for rheumatology indications grew 96.6% between 2003/04 and 2007/08, which was higher than growth in any other single specialty over the same period (57.8%). A team of tenacious individuals set out to solve this problem in order to improve patient outcomes and decreased costs.

The program goals are to provide support to physicians across the province in clinical management of adult patients (>18 years) with rheumatologic conditions for which IVIg therapy is being considered and to promote appropriate evidence-based use of IVIg with the goal of reducing inappropriate use through sharing clinical expertise and physician education.

The BC IVIg Rheumatology Program has had a significant impact on BC IVIg use. Patients are receiving more accurate diagnosis and more appropriate treatment with input from fully qualified rheumatologists. The utilization results show that the growth rate of Rheumatology IVIg used has decreased from 11% annualized rate before the program to -3% after the program. This translates to over $9,000,000 cost avoidance in IVIg use in rheumatology alone as a result of the program to-date.

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Behaviour Support Services
Mobile Support Teams

Mackenzie Health

Older adults with cognitive impairments due to dementia, mental illness, addictions, or other neurological conditions can behave in ways that may be challenging to their caregivers. The Behavioural Support System (BSS) in the Central LHIN is a regionalized system of partners engaged in the delivery of safe, person-centred care for older adults with complex care needs. Through BBS, Mackenzie Health and LOFT Community Services have partnered to create multi-disciplinary mobile support teams to provide behavioural support that will enhance the quality of life for individuals with responsive behaviours and their families. These innovative mobile support teams assist long term care home providers in reducing risk and improving safety through coaching, peer mentoring and shared care person-centred planning.

Early intervention and in-home direct care behavioural support, including transitions in care across sectors, by specially trained mobile support team members enables older adults to safely remain in the place that they currently reside. It also reduces the need for physical or chemical restraints, reduces the number of avoidable transfers from long term care homes to the emergency department, reduces hospital readmissions, and reduces the ALC length of stay.

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Going Off the Rails! At Peel Long Term Care

Region of Peel, Health Services, Long Term Care Division

A growing body of evidence demonstrating the potential for bedrails to cause injuries and deaths resulted in changes to the regulations for Ontario's long term care sector under The Long Term Care Homes Act, 2007, passed into law in July 2010.

The Act requires all LTC centres to meet two critical expectations:

1. That all residents are assessed to determine if they need bedrails as a personal assistive service device (PASD). If bedrails are used, they are considered as either a restraint or a PASD with restraint properties, and, therefore, follow the same monitoring and documentation requirements as restraints.
2. That all resident bed systems, including bedrails, are assessed to ensure they meet safety standards that prevent residents from becoming entrapped or injured.

The Region of Peel operates five long term care centres and is licensed to provide 703 beds in Mississauga, Brampton and Caledon in Ontario. At the time the new act was passed into law, the great majority of Peel's resident beds were equipped with full or half rails, which were perceived as a norm by residents and families, as well as by staff. Through a combined program of centre-based, interdisciplinary tactics, two Peel long term care (Peel LTC) centres have successfully removed more than 48% of bedrails, to date.

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Inherited Coagulopathy and Hemoglobinopathy Information Portal (iCHIP)

BC Provincial Blood Coordinating Office

The Inherited Coagulopathy and Hemoglobinopathy Information Portal (iCHIP) is a first of its kind web-based software application designed to improve and advance patient care. iCHIP was developed in response to a need identified by the BC Inherited Bleeding and Red Cell Disorders (IBRCD) Program to support the unique clinical care needs of children and adults with these bleeding and red cell disorders.

IBRCD are rare, chronic and life-threatening conditions that are very costly and complex to treat. This is primarily because of their significant blood and blood product utilization – approximately $30 million in blood products alone in FY 2012/13. The majority of these products are used in a home environment; however, until now an accurate depiction of product utilization has been unknown.

iCHIP is the first of its kind application in North America. The development team has created a state of the art, leading edge application that has the potential to drastically change the way patients on home-treatment protocols are managed. Empowering patients to take ownership of their own care and enabling clinicians to see, in real time, how patients are self treating at home provides considerable improvement to current practice as it facilitates proactive, timely care and improved quality outcomes.

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Innovating Care Delivery, Quality and Safety through a Person-Centred Provincial Approach for Ventilator-Assisted Individuals

West Park Healthcare Centre

Since pioneering chronic assisted ventilatory care in 1986, West Park Healthcare Centre has expanded the concept beyond its walls in recent years to advance two overriding objectives benefiting patients, hospitals and the healthcare system:

- enhancing system capacity and alternatives to institutional care to provide safe care and improve quality of life for ventilator-assisted individuals; and
- improving patient flow from hospital intensive-care units (ICUs) to more-appropriate levels of care for this patient population.

Designated a provincial Centre of Excellence for Long-Term Ventilation (LTV) in 2007, West Park subsequently led the development and implementation of an LTV strategy and a transitional home ventilation program for two of Ontario's Local Health Integration Networks. The integrative aspect of these initiatives has brought together acute and critical care, rehabilitation and complex continuing care for adults and children, homecare, community agencies, attendant-care providers, telemedicine and others.

The target patient population, while relatively small, requires complex care for long periods of time, resulting in a high requirement for healthcare resources. These LTV initiatives have worked together synergistically in support of the priority in Ontario's 2012 Action Plan For Healthcare to provide the right care in the right place at the right time. Perhaps the greatest system impact has been on ICUs, where 23,315 inpatient days were avoided between December 2010 and December 2013. This is equivalent to a 20-bed ICU with an annual operating budget of $11-15M. The model is having positive impact on access to care, quality of care and quality of life, and healthcare costs.

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Innovative Redesign of Adolescent Inpatient Services

Ontario Shores Centre for Mental Health Sciences

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) provides specialized mental healthcare for the most severely impacted adolescents in Ontario. Our 2009 Quality Indicators showed that a disproportionate use of rehabilitation and treatment beds was affecting length of stay and waitlists. We also knew that families struggled with separation from loved ones and had very limited involvement in treatment planning. In response, Ontario Shores formed the Adolescent Transformative Steering Committee which reviewed evidence-based practice literature for inpatient adolescent treatment. The team quickly realized that a major shift in programmatic focus and staffing complement was needed.

Following extensive stakeholder engagement and a targeted change management process, a new program was created. Located in recently renovated space, this program is staffed by an interprofessional team. The program has a shared responsibility for delivering assessment, consultation, stabilization, treatment, and transition services to the most severely impacted adolescents in Ontario. Patients, aged 12-18, attain optimal levels of wellness before they are reintegrated into their home and communities across the province.

This service model has enhanced the quality of care available to youth with severe mental health symptoms. Ontario Shores has improved access to services for individuals and their families. This transformation has led to consistent occupancy rates, decreased lengths of stay, greater family involvement and aligns with Ontario Shores' strategic priorities. This work demonstrates that targeted transformation involving patients, families, frontline staff and community stakeholders can create positive and sustainable service improvements for adolescents in need of specialized mental healthcare.

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Integrated Client Care Program (ICCP)

Toronto Central Community Care Access Centre (TC CCAC)

The ICCP involves a unique team for a unique, highly successful project focused on frail seniors - the 1-5% of patients who use 30-60% of healthcare resources. ICCP involved key partners coming together to smooth transitions and form one 'care team' around each client. Each care team is quarterbacked by a TC CCAC care coordinator, who works with primary care to develop a coordinated care plan based on the priorities of the client and caregivers.

ICCP was developed by an extraordinary team involving executives and implementation team managers from many parts of the healthcare system within Toronto Central LHIN: TC CCAC, primary care, specialty, acute care, complex continuing care, rehabilitation, EMS, social services and others.

ICCP has been very successful in reducing demand for ALC (Alternative Level of Care) beds, long-term care beds, emergency medical services and acute care, while improving the satisfaction and comfort of clients and their family members. It is now being expanded to include palliative care clients and children with complex needs and who may be technology dependent.

Toronto Central's ICCP team is an inspiring group that demonstrates successful teams can be created across organizational lines when executives have the vision to break down silos and implementation team members find simple ways to find solutions for the health of their patients. This team is unique, but its success and processes can be duplicated quickly across the country with significant potential savings, to transform our healthcare system for the better.

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Mindfully Integrating the Needs of Individuals with Chronic Conditions: Creating Innovative, Person-Centred and Sustainable Solutions

Capital District Health Authority (CDHA)

Adults with chronic illness, and specifically those with multiple chronic conditions, find it challenging to apply self-management strategies for a particular disease that are not meaningful and relevant to their day to day activities. Effective self-management requires recognizing symptoms and taking appropriate actions, making difficult lifestyle adjustments and effectively dealing with associated psychosocial stressors.

A review conducted in the CDHA showed that over two-thirds of its patient population had more than one chronic condition. The impact of offering multiple self-management programs that are repetitive or have overlapping teaching modules in the context of disease-specific treatment can be ineffective and expensive. Recognizing these important challenges, the strategic priorities for CDHA are enhancing self-management strategies and care for individuals with multiple chronic conditions.

The integrated mindfulness intervention (IMI) initiative is directly aligned with the outlined strategic priorities for CDHA. The IMI is a novel and comprehensive intervention combining key elements of including mindful eating, mindfulness-based stress reduction, and mindful movement to assist in disengagement from automatic thoughts, unhealthy habits and behaviour patterns while improving self-awareness and self-efficacy. Over 300 individuals (80% having more than three chronic conditions) have participated in this intervention to-date. Outcomes of the intervention show significant improvements in functional health and quality of life post intervention in >85% of the participants. The spread of this initiative includes making it available to all service areas in CDHA and publishing the results in peer-reviewed journals.

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Partners in Care: Rapid Access to Consultative Expertise (RACE)

Providence Health Care

In 2010, a partnership was formed between Providence Health Care and the Shared Care Committee (a joint committee of the BC Ministry of Health and the BC Medical Association) in collaboration with Vancouver Coastal Health to:

- identify gaps in the care process for patients with chronic diseases, and
- develop and test prototypes for improvement.

The outcome of this work led to a successful model of shared care called rapid access to consultative expertise (RACE), a telephone advice line for family physicians (FPs). The RACE model allows FPs to call one phone number, choose from a selection of specialty services and be routed directly to the specialists cell phone or pager for "just in time" advice. The prototype began with 5 specialty areas and has grown to include more than 20. Additional specialties will be added based on the access needs of FPs.

More than 9000 calls have been logged to the RACE line in 3.5 years. Data indicates RACE is viewed as a model that reduces costs by avoiding unnecessary emergency department visits and face-to-face consultations, supports FPs, and utilizes specialist services more appropriately.

This grass root collaborative project was championed by a dedicated team of physicians, leaders, and patients who fostered a culture of innovation and improvement developing strategies and the RACE prototype for shared care to serve as a model for the provision of care across British Columbia.

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Reducing Antipsychotic Medications in Long Term Care

Winnipeg Regional Health Authority

Throughout the world, disruptive behaviors associated with dementia have been managed with antipsychotic medications, even though these drugs were never designed for this purpose. Evidence clearly demonstrates that antipsychotic medications can have serious side effects in the elderly.

For years, the Winnipeg Regional Health Authority (WRHA) has collected data using the minimum data Set (MDS) to assess the needs of residents residing in the organization's 39 Personal Care Homes (PCHs). WRHA aimed to determine whether the data could reveal insights on the use of antipsychotic medication and whether this usage could be reduced. In a pilot project at one site, they relied on the P.I.E.C.E.STM method of dementia care which encourages staff to use a person-centered, non-pharmacological approach to managing behaviors associated with dementia. In six months, 27% of residents were taken off their antipsychotic medication without causing any increase in behavioural symptoms or an increase in the use of physical restraint. In six months, the project yielded savings of $10,000. Given the success of the pilot, the improvement project is expanding to the remaining 38 PCHs in the WRHA.

This project demonstrates exemplary innovative, person-centered care that dramatically succeeds in tackling one of the nation's most persistent healthcare challenges, improving quality and reducing costs. The project's significant, ongoing impact, speaks to the hands-on difference healthcare leaders can make when they work collaboratively on innovative initiatives aimed at real results, in this instance improving the patient experience.

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The Caregiver Framework for Children with Medical Complexity and Caregiver Framework for Seniors Pilot Projects

The Hospital for Sick Children

The Caregiver initiatives are exemplars of innovative, appropriate, high quality, person-centred care which address key provincial priorities and highlight the importance of integration across the lifespan.

Both ground-breaking initiatives support at risk informal, unpaid caregivers of two vulnerable and potentially high cost populations: older persons with chronic health needs at the point of losing independence; and children with complex medical needs who would have previously lived their lives in hospitals but now live at home. Rather than promoting quality and safety once an individual is hospitalized, these initiatives proactively support caregiver capacity and resilience closer to home, thus avoiding unnecessary admissions (and re-admissions).

Both initiatives move beyond conventional clinical models recognizing that in addition to the needs of cared-for persons, caregiver stress and burnout (and consequent default to costly hospital and residential care) may stem from non-clinical factors such as poverty, lack of education, linguistic and cultural marginalization, as well as from challenges related to navigating fragmented care systems. Both employ specially trained care coordinators who engage caregivers in a dynamic process of problem-identification and problem-solving leading to the co-creation of individualized support packages helping caregivers to continue to care.

Both initiatives strengthen connections between providers. The caregiver framework for children with medical complexity, led by the Hospital for Sick Children, runs in partnership with the Toronto Central Community Care Access Centre (TCCCAC) and Holland-Bloorview Kids Rehabilitation Hospital. The caregiver framework for seniors' project, led by Alzheimer Society of Toronto, spans the TCCCAC and six community support service agencies.

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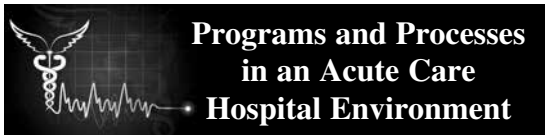

2013 - Vancouver Coastal Health
iCARE /ITH: One Integrated Model of Care

2012 - North York General Hospital
e-Care Project

2011 - St. Michael's Hospital
Inspiring Improvement: Working Together for Timely, Quality Patient Care at St. Michael's Hospital

2010 - IWK Health Centre
Twenty-four Hour Dial for Dining Program

2009 - Trillium Health Centre
Creating Excellence in Spine Care – Re-designing the Continuum

2008 - North York General Hospital
Patient Flow: Improving the Patient Experience

2007 - University Health Network (UHN)
ED-GIM Transformation Project

2006 - Providence Health Care
Improving Sepsis Outcomes

Acute Care Facilities

2005 - St. Paul's Hospital
Living PHC's Commitment to Excellence: The "Lean" Approach to Quality Improvement in the Laboratory

2004 - Providence Health Care
A Multidisciplinary Pathway for Surgical Patients from First Hospital visit to Discharge

2003 - Trillium Health Centre
Driving Performance Excellence at Trillium Health Centre: The Dashboard as a Catalyst for Change

2002 - Trillium Health Centre
Ambulatory Care That Takes Quality To The Extreme

Large/Urban Category

2001 - The Scarborough Hospital
A Change of Heart: Innovative Care Delivery for the CHF Patient

2000 - Rouge Valley Health System
Pediatric Clinical Practice Guidelines: Providing the Best for Our Children

1999 - Sunnybrook & Women's Health Science Centre
Long-Term Care Work Transformation Project

1998 - Scarborough General Hospital
Orthopaedic Future: Making the Right Investments

1997 - St. Joseph's Health Centre
Dialyzer Re-use: An Advance in the Cost and Quality in the Canadian Health Care System of the 1990s

1996 - London Health Sciences Centre
Breathing Easier: An Interdisciplinary Goal-Oriented Approach to Oxygen Therapy Administration

1995 - Tillsonburg District Memorial Hospital

1994 - Renfrew Victoria Hospital

Programs and Processes in an Acute Care Hospital Environment

2013 - Capital Health, QEII Health Sciences Centre
Palliative and Therapeutic Harmonization: Optimal Care, Appropriate Spending

2012 - Alberta Health Services
Glenrose Rehabilitation Hospital Services Access Redesign

2011 - Mississauga Halton Local Health Integration Network
Support for Daily Living Program - A Winning Community-based Solution for Addressing ED, ALC and LTC Pressures

2010 - Sunnybrook's Holland Orthopaedic & Arthritic Centre
A Team-based Approach to Chronic Disease Management That Improves Patient Access and Care

2009 - Whitby Mental Health
Whitby Mental Health Metabolic and Weight Management Clinic

2008 - Capital Health
Implementation of Supportive Living Integrated Standards

2007 - Providence Health Care (PHC)
Medication Reconciliation: Reducing the Risk of Medication Errors for Residents Moving in to Residential Care

2006 - Maimonides Geriatric Centre
Minimizing Risk of Injury

Other Facilities/Organizations

2005 - Capital District Health Authority
Organ and Tissue: Innovation in Donation

2004 - Vancouver Island Health Authority
Implementing the Expanded Chronic Care Model in an Integrated Primary Care Network Project

2003 - St. John's Rehabilitation Hospital, Toronto Rehabilitation Institute
Achieving Clinical Best Practice in Outpatient Rehabilitation: A Joint Hospital-Patient Satisfaction Initiative

2002 - Maimonides Geriatric Centre
Maimonides Restraint Reduction Program

Small/Rural Category

2001 - Woodstock General Hospital
Endoscopic Carpal Tunnel Release: An Example of Patient-Focused Care

2000 - Welland County General Hospital – Niagara Health System
Niagara Health System: Patient-Focused Best Practice Program

1999 - Headwaters Health Care Centre
Teamwork Key to Quality Care: Filmless Digital Imaging System Addresses Quality Issues for Patients, Hospital, Medical Staff and Environment

1998 - Alberta Capital Health Authority
Castle Downs Health Centre

1997 - Brome-Missisquoi-Perkins Hospital
Client-Centred Approach to Care Surgery Program

1996 - Crossroads Regional Health Authority
Pharmacy/Nursing Team Summary

1995 - Centenary Health Centre

1994 - The Freeport Hospital Health Care Village

Summary

Descriptions provided by the entrants indicate that quality teams empower employees by giving them knowledge, motivation and a strong sense of ownership and accountability. Multidisciplinary teams, united for a common purpose, achieve results that no one person, department or service can. By transcending departmental boundaries and learning about each other's functions, teams found workable solutions to organizational problems. This, in turn, enabled them to function as internal consultants and models for continued improvement. They developed healthy interprofessional relationships among themselves, other departments and the community. By setting up teams, organizations observed that management decision making became team-based decision-making; single assessment and evaluation turned into team assessment and evaluation; a focus on technical skills became a focus on process management skills; a focus on individual skills became a focus on the ability to be on a team; and subjective/intuitive evaluation became objective, evaluative tools.

The College and 3M Health Care are looking forward to receiving many new and innovative team initiatives for consideration for next year's 3M Health Care Quality Team Awards. The details and the entry form are available on-line at www.cchl-ccls.ca. For further information, or to request a copy of the College's 2015 National Awards Program brochure, please contact:

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The Canadian College of Health Leaders is a national, member-driven, not-for-profit association dedicated to ensuring that the country's health system benefits from capable, competent and effective leadership. As defined by the LEADS in a Caring Environment national framework, a leader is anyone with the capacity to influence others to work together constructively. Through credentialling, training, networking and mentoring, we support health leaders in every sector and region, from every professional background and at any stage of their career. Guided by a code of ethics, we help individuals acquire the skills they need to create change in their own organizations and, ultimately, the health system. The College achieves all of this within an environment of collaboration, cooperation and member engagement—through partnerships and chapters—promoting lifelong learning and professional development while recognizing leadership excellence. Situated in Ottawa, with more than 20 chapters across the country and representing more than 3,100 members and 90 corporate members, the College offers a range of programs and services, including capabilities-based credentialling, professional development for Canadian health leaders, and a nationwide career network.

CANADIAN COLLEGE OF HEALTH LEADERS
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3M is a diversified international company with a multinational dollar health care business consisting of more than 10,000 medical, surgical, consumer, health care and dental products. 3M Health Care is committed to supplying reliable products and services that make a difference in the practice, delivery and outcomes of health care.

3M *Innovation*