

Past EXTRA™ Cohorts and Projects: 2017-23

2023 EXTRA Improvement Projects

Alberta Health Services (AHS)

- Doran Walker, Patient Care Manager, Specialized Rehabilitation Older Adults, The Glenrose Rehabilitation Hospital
- Lynette Lutes, Senior Operating Officer, Alberta Health Services

With COVID-19 now endemic, the pre-existing faults in our healthcare system have been exacerbated, including staff burnout, psychological safety and staff wellness, which have been stretched to unhealthy levels.¹

Through a pulse survey, AHS found that staff engagement dropped significantly pre- to post-COVID. Specifically, issues of being short staffed, psychological safety, patient safety and feeling a lack of community. Survey results at the Glenrose Rehabilitation Hospital, part of AHS, showed low patient experience with only 68 percent of patients being always satisfied with their care. Patients felt a lack of being listened to and being involved in decision-making related to their care.

These results show that the pandemic, healthcare system stresses and societal pressures have created a disconnect between patients, staff and employers. This has led to an increasingly uncollaborative, psychologically and physically unsafe healthcare system for both patients and staff. Essentially, an unhealthy workforce.

To resolve these issues, AHS will use the Institute for Healthcare Improvement's Framework for Improving Joy in Work to rebuild connection, purpose and community in the workforce. AHS will work with the EXTRA program to learn from best-in-class engagement tools and models to improve engagement on pilot units. Learnings will then be scaled-up to apply a hybrid project management model for the Glenrose Rehabilitation Hospital, AHS and beyond.

Nova Scotia Health - Central (NSH Central) and Emergency Medical Care Inc. (EMCI)

- Lorianne MacLean, Manager, Integrated Access and Flow Clinical Service Network
- Melissa Buckler, Manager, Planning, Development and System Performance, Integrated Acute and Episodic Care Network
- Kate Melvin, Director, Integrated Acute and Episodic Care Network
- Paige Moorhouse, MD, Senior Medical Director, Integrated Acute and Episodic Care Network
- Derek LeBlanc, Senior Manager - Provincial Programs, Operations

¹ Grimes K, Matlow A, Tholl B, Dickson G, Taylor D, Chan MK. Leaders supporting leaders: Leaders' role in building resilience and psychologically healthy workplaces during the pandemic and beyond. *Healthc Manage Forum*. 2022 Jul;35(4):213-217. doi: 10.1177/08404704221090126. Epub 2022 May 21. PMID: 35603437; PMCID: PMC9127620.

NSH Central is implementing the SAFER Patient Flow Medicine Bundle (SAFER)² within acute medicine and surgical units across the province. SAFER has demonstrated reduced length of stay (LOS) by 0.4 days and improved discharge rates through daily consultant rounds (+29 percent), discharges before noon (+20 percent) and documented early discharge plans (+29 percent).

Generally, patients experience unnecessarily longer LOS due, in part, to delays in access to community supports. NSH Central, in partnership with EMCI, are planning to integrate two evidence-informed interventions to enable sustainability of SAFER principles. Implementation will initially occur on an inpatient unit with the goal to reduce LOS, using two programs.

1. **Bridge to Home:** An evidence-based framework to improve care transitions from hospital to community using patient-oriented discharge summaries.
2. **EHS Integrated Health program:** Patient support for interventions or diagnostic tests carried out from a patient's home, to support admission avoidance or supportive early discharge. A telecare registered nurse conducts an initial virtual visit and/or a community paramedic visits the patient at home within the first 12 to 72 hours of discharge.

This improvement project aims to enhance the patients' ability to return home safely, receive care outside of the hospital and self-manage at home. Anticipated outcomes include reduced LOS in hospital, reduced readmission rates and improved patient and provider satisfaction.

Nova Scotia Health - Eastern (NSH Eastern)

- Andrew Heighton, Director, Integrated Rural Health
- Sarah O'Brien, Eastern Zone Director, Primary Health Care
- Michelle DePodesta, Executive Director, Acute Health Services – Eastern Zone
- Rhea MacDonald, MD, Physician

NSH Eastern's strategic priority is to transform a rural model of care by enhancing timely and appropriate access to care. This improvement project will foster a responsive and resilient system in rural Cape Breton, while enhancing a culture of collaboration among physicians, nurse practitioners, nurses and staff to cultivate excellence within team-based care.

NSH Eastern seeks to develop and implement an operational framework that will create formal pathways from the emergency department (ED) to the primary healthcare collaborative team. This partnership would be the foundation of a sustainable rural health model of care.

The project will occur in a phased approach.

- Phase one: A focused approach on evolving the health home in the primary care setting. A health home is a sustainable hub that provides access to timely, coordinated and comprehensive health services based on the needs of the practice population. The evolution of the health home will include practice support implementation enhancing scope of practice, EMR utilization, and operational review to enhance capacity for same day/next day access.
- Phase two: Develop and implement an operational framework that discharges lower acuity patients to the collaborative care team within primary care.

The framework aims to promote timely access to care, and a person and family-centred approach to optimize care in a rural setting. It will be cost-effective, collaborative, adaptable and enhance continuity

2 Nova Scotia Health. SAFER Patient Flow Medicine Bundle. Retrieved from: <https://library.nshealth.ca/SAFERf/Bundle>

and coordination of care - allowing rural hospitals to meet the specific services their populations require, and further improve or implement tailored ED services (i.e. emergency care, telemedicine, access to tertiary care through transfer). In parallel, the rural hospital can support primary care services of preventive medicine, chronic disease management and have the potential to expand social services such as home healthcare, visiting nursing care, behaviour health and assessment of social needs.

Anticipated outcomes are timely access to appropriate care, more capacity in primary care, optimize existing resources, role clarity and improvement of the patient and family experience. Ultimately, this work will lead to an effective primary healthcare model and alleviate pressures and strains on the ED.

Government of Yukon

- Sheila Thompson, Director, Community Nursing Branch, Health and Social Services
- Todd Pryor, Manager, Community Mental Wellness and Substance Use Services, Health & Social Services
- Cathy McNeil, Director, Care & Community, Health & Social Services
- Cheryl Kates, Manager – Projects/Health

This project aims to improve the coordination of care for clients within a broad range of health and social services in the Yukon territory. An integrated, needs-based, holistic and culturally safe inter-professional model of care will be created at a pilot site in a rural Yukon community. This project will then spread throughout the Yukon health and social system.

The team, in partnership with the local community, will develop a scalable model of care and implementation toolkit for integrated wellness centres within the territory. The model will be rooted in research, cultural competency, patient and client stakeholder engagement and ethical decision-making. The team will trial and implement the model of care at their pilot site.

To help the Government of Yukon reorientate the health and social services system to focus on integrated person-centred care, this model will support the creation of wellness centres that provide a holistic, person-centred and culturally safe level of care to all Yukoners.

CHU de Québec – Université Laval

- Marie-Frédérique Fournier, Director, Surgical and Perioperative Clientele
- Julie Maranda, Assistant to the Director, Surgical and Perioperative Clientele - Care Trajectory
- Pascal St-Germain, Surgeon - General Surgery Department
- Philippe Lachapelle, Director, Clinical and Organizational Performance
- Danielle Goulet, Deputy President and CEO

The clinical deterioration of a patient awaiting surgery remains a major concern for the care teams, but especially for the patient and their family. While this was already problematic before COVID-19, it was only made worse by the pandemic, leading to much longer waiting lists, especially for non-oncological diseases. In turn, this has led to considerably longer wait times.

The CHU de Québec – Université Laval hospital is currently working on a number of initiatives, many successful, to expand surgical services. However, capacity is limited by the ongoing labour shortage.

Not only is there an imbalance between the services offered and what patients need, but there are issues with the current system of prioritizing patients on the surgical waiting list. Patients are prioritized for surgery based on a single, static, clinical assessment done by their surgeon during their initial visit.

There is no effective way to monitor or influence the patient's condition during the wait time, which can last several months and sometimes more than a year.

The fellowship team is proposing setting up a dynamic process for managing patients on the surgical wait list. This process will directly involve the patient, who will be able to report any changes in their physical or mental health. Additionally, it will allow for better communication between the patient and the care team. It could also lead to changes to the way patients are prioritized for surgery, resulting in an approach that's better tailored to the real needs of our clientele.

CIUSSS Mauricie-et-du-Centre-du-Québec (CIUSSS MCQ)

- Catherine Neault, Assistant to the Director, DQEPE
- Vincent Robichaud, Assistant Director, Quality and Contractual Relations
- Mylène Raymond, Department Head, Development of Professional Practices, DSM
- Corinne Brosseau, Manager, Nursing and Care Assistance Professional Practices, DSI
- Nathalie Thiffault, Executive Nursing Consultant - Critical Care, Cardiology and Neurology - North Shore

The CIUSSS MCQ fellowship team's improvement project aims to enhance the quality of care and services offered in accordance with the institution's LEADS model, in support of the performance model.

To do this, the fellowship team would like to produce an organizational framework document that both defines the concept of quality, and explains how to put it into practice. The challenge will be to make sure that all CIUSSS MCQ professionals—employees, physicians and managers—are equipped to improve the quality of the care and services they provide to patients or partners.

A limited trial in a specific sector will allow the fellowship team to bridge the gap between strategic orientations and operations. This project will determine the winning conditions for implementation at the institutional level.

CISSS Montérégie-Est (CISSS ME)

- Mélanie Malenfant, Direction de l'accès et la coordination des partenariats avec la première ligne (Access to and Coordination of Frontline Partnerships)
- Caroline Loranger, Director, Multidisciplinary Services
- Émilie Boisvert, Assistant Director, Professional Services, Frontline Partnerships
- Éric Tremblay, Director, Critical Care and Coordination of Hospital Activities

The CISSS de la Montérégie-Est recently created the Direction de l'accès et la coordination des partenariats avec la première ligne. The mission of this department is to improve access to quality care and services for the population.

This new department was created in the wake of data that indicate difficulties in accessing frontline services. For example, in Richelieu-Yamaska, 45 percent of patients triaged as level 4 or 5 periodically visit the emergency department. Yet 76 percent of the population on the same territory has a family physician.

The fellowship team's proposed improvement plan involves identifying and analyzing the bottlenecks or the root causes of problematic access to care and services. The objective is to ensure timely access for patients registered with an FMG, which would avoid needless visits to the emergency department.

More specifically, the fellowship team's project will allow us to work with patients and our FMG partners to co-design effective solutions that reflect their respective realities. The innovative measures put in place must meet the patients' needs and align with their experiences, knowledge and involvement throughout their care trajectory.

CISSS de Chaudière-Appalaches (CISSS CA)

- Julie Emond, Assistant Director, Direction du continuum soutien à domicile et partenariat communautaire-SAPA (Home Care and Community Partnerships Continuum)
- Paméla Laforest, Logistics Coordinator, Production and Distribution, Direction de la logistique (Logistics Department)
- Renée Berger, Assistant Executive Director, Performance, Support and Administration (DGPSA)
- Anne-Marie Goulet, Clinical-Administrative Coordinator, Direction des soins infirmiers - volet pratiques professionnelles et développement clinique (Nursing - Professional Practices and Clinical Development)

In the Chaudière-Appalaches region, and specifically in the Bellechasse sector, there is an increase in the proportion of the population aged 70 and over. And in nearly half the communities in this sector, the proportion of the population aged 70 and over is higher than the Québec average.

Given the aging population and the growing number of interventions with patients with physical health problems, the fellowship team has identified a problem with access to home care and support services for people aged 70 and over experiencing a loss of autonomy.

Several studies show that service users stay healthier when they are allowed to live at home. With the *Plan santé du Québec* laying the groundwork for a massive shift toward home care and support services, the fellowship team feels it is essential to meet the growing health needs of the population, especially seniors and their loved ones.

The fellowship team's project aims to offer home care services adapted to people in the Bellechasse sector aged 70 and over experiencing a loss of autonomy—at the right time, by the right person, using the right tools, thereby providing better access to services. The goal is a 10 percent increase in the number of service users seen by the home support team.

Through this improvement project, the fellowship team hopes to redefine a model of care that integrates, for example, activity planning based on the needs of service users, a sharing of responsibilities that draws on the expertise of each professional on the home support team, a reduction in non-clinical activities, and the use of technology.

CISSS de la Montérégie-Centre (CISSS MC)

- Vincent Desjardins, Director, Financial Resources
- Nancy Beaulieu, Director, Home Support Services
- Sonia Joannette, Senior Advisor, Nursing
- Xavier Tanguay-Rioux, M.D., MHSc, FRCP, Emergency Medicine Specialist

Cancer patients must contend with symptoms related to the disease and their treatments. The CISSS MC offers a 24/7 telephone nursing service to help people manage their symptoms at home. More than 28,500 calls are received annually. The goals of this service are early intervention, better referrals, fewer visits to Emergency departments or clinics, and a lower risk of hospitalization.

Some telephone assessments may require in-person follow-up by the nurse, for example, to take vital signs and neurological signs or perform a visual exam. Outside of business hours, the caller may need to be referred to a clinic or an emergency department. The fellowship team's improvement project aims to reduce the number of calls that require a trip to the Emergency department by 50 percent. Frontline teams could play a bigger role to make sure the person is able to stay at home safely.

As a pillar of a positive health experience, several studies have cited the importance of access to timely support services for patients and their loved ones. Home support paramedicine is currently being developed in Québec and more specifically at the CISSS MC. The involvement of paramedics, with their diverse scope of practice, would be one way to round out the current offer of oncology care and services.

2021 EXTRA Improvement Projects

Cree Board of Health and Social Services of James Bay

- Christina Biron – Regional Proximity Director, CBHSSJB
- Jannelle Dupuis – Coordinator, Specialized Services, CBHSSJB
- Helen Belanger – Director, Wiichihituwin, CBHSSJB
- Nora Bobbish – Assistant Director- Financial Management Units, Financial Resources, CBHSSJB
- Catherine Bessette – Regional Improvement Advisor, Strategy and Organizational Department, CBHSSJB

“Improving the efficiency and effectiveness of the kidney transplant process in Eeyou Istchee”

This project aims to address the development of a case management process that will reduce the amount of travel and number of stays, while providing more responsive and culturally safe services for Eeyou Istchee (EI) clients entering the kidney pre-transplant process. The EXTRA team hopes to reduce the amount of travel and the duration of the process, while improving the quality of care and services.

The current situation will be modified to a case management process that will seek opportunities that favour telehealth and on territory appointments. For services unavailable on the territory, or unavailable in a reasonable delay, the case manager will attempt to combine multiple appointments during the same stay.

Ultimately, the data and results of this project will guide decisions regarding clients’ travel policy and the reorganization of Wiichihituwin and Specialized Services processes.

CISSS de la Montérégie-Centre

- Isabelle Paradis – Assistant to the director, hospital services – emergency, operating block, and front-line services, CISSS de la Montérégie Centre
- Véronique Guimont – Director, hospital services – emergency, operating block, and front-line services, CISSS de la Montérégie Centre
- Nathalie Moreau – Director, oncology program, oncology, CISSS de la Montérégie Centre
- Lyne Noël – Director, multidisciplinary services, CISSS de la Montérégie Centre

“The perioperative trajectory: co-constructing the care episode for a better patient experience”

The objective of this project is to diminish anxiety associated with the surgical process through a co-construction of the thoracic surgery care episode. To this end, we want to create a partnership while maintaining a strong shared responsibility with the person and their loved ones as well as the care team. The project is aimed at integrating the patient-partner in the development of tools to support communication and collaboration in the clinical choices concerning them, in keeping with a holistic vision throughout the perioperative trajectory in pulmonary oncology. This approach is in line with our organization’s strategic directions, and we want to use validated measurement tools to demonstrate the positive impacts on anxiety management and patient satisfaction during their care episode.

CHU de Québec - Université Laval

- Mélanie Dubé – Director, DOSAS [ophthalmology and specialized outpatient services], CHU de Québec-UL
- Julie Asselin – Assistant director, critical care, CHU de Québec-UL
- Karine Martin – Assistant to the director / cross-cutting projects, general administration, CHU de Québec-UL
- Louis-Jacques Lalonde – Director, information resources, CHU de Québec-UL
- Julien Clément – Assistant director, professional services, surgery, CHU de Québec-UL

“Two heads are better than one – Strengthening medical-administrative leadership to better serve the patient”

Medical-administrative co-management is a “management model in which a physician and a clinical/administrative manager share management responsibilities within a client program or service unit.” – (Ann Langley, Ph.D., October 2011). The gap between the co-management behaviours expected by managers, the difficulty in moving toward common goals in managing activities, and the lack of management skills are some of the problems (among others) that slow down “attempts to overcome heroic and romantic conceptions of leadership based on a single individual.” At the CHU de Québec — Université Laval, physicians feel ill-equipped because of their lack of management training and skills, as well as their lack of knowledge and understanding of the administrative process and organizational hierarchy. This is also true of administrative managers, who have scarce knowledge of the medical hierarchy and lack the tools, operating structure, and follow-up mechanism for project co-management. The EXTRA project will serve to strengthen medical-administrative co-management at the CHU de Québec - Université Laval. Targeted co-management team: medical and administrative managers in gastroenterology.

Vitalité Health Network

- Nicole D. LaBrie – Regional Manager, Chronic Conditions, Primary Health Care, Vitalité Health Network
- Véronique Landry – Professor, Nursing, Vitalité Health Network
- Shelley Robichaud – Director, Primary Health Care, Vitalité Health Network
- Nicole Brideau – Nurse Practitioner, Primary Health Care, Vitalité Health Network

“Enhanced quality of care by improved practice support for nurse practitioners in primary health care”

The project takes a collaborative approach, with the members (managers, nurse practitioners in primary care (NP-PHC), professors, and professionals) working together to put in place a process and tools for improving the quality of nursing interventions by NP-PHCs. These activities will help managers support NP-PHCs in their work and thus promote best practices while ensuring safe, competent care and the assistance and resources required to fill and/or remedy gaps, as needed.

Finally, with this project, the EXTRA team hopes to improve patient and family care and to foster greater reflexivity in nurse practitioners in order to promote their professional development.

Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Est

- Robert James Borris – Assistant director, mental health and addiction programs, CISSS de la Montérégie- Est
- Annie Mongrain – Head of crisis services, mental health programs, CISSS de la Montérégie-Est, mental health and addiction programs, CISSS de la Montérégie- Est
- Andréanne Audet – Project manager, mental health and addiction programs, CISSS de la Montérégie- Est
- Christine Lobe – Care partnership and client experience advisor, Quality, assessment, performance and ethics, CISSS de la Montérégie- Est

“Establishing a service offer and a centre of expertise in crisis intervention throughout Montérégie-Est in accordance with the needs of the population and in collaboration with local partners.”

Designing an offer of community crisis intervention services adapted to the emerging needs of the population and the socio-health and cultural context is an organizational priority for the CISSS de la Montérégie-Est.

Based on best practices and influenced by the experiences of stakeholders, improvements to our service offer are expected to be made in accordance with the following four pillars:

1. A service offer and intervention methods in line with the needs of users and the new realities of the community
2. A positive client experience for patients and their loved ones
3. A positive employee experience
4. A permanent centre of expertise based on best practices

Each component will be supported by a cross-cutting framework for measuring the performance and satisfaction of the main stakeholders concerned (patients, employees, or community partners).

CISSS de Chaudière-Appalaches

- Patrick Simard – Interim president-CEO, general administration, CISSS de Chaudière-Appalaches
- Stéphanie Simoneau – Director of housing, support for elderly autonomy program – SAPA, CISSS de Chaudière-Appalaches
- Karine Dumont – Senior advisor, development of the university mission, university research and education – DREU, CISSS de Chaudière-Appalaches
- Mélanie Dostaler – Assistant to the director, technical services – DST, CISSS de Chaudière-Appalaches

“Democratizing learning and innovation: a pillar for excellence in care and services”

The premise of our improvement project is to bring about an organizational culture of learning by democratizing access to the best knowledge in order to accelerate its application in clinical, administrative, and management practices, while also promoting innovation in our technological and/or real estate solutions. In recent years, the CISSS de Chaudière-Appalaches (CISSSCA) has set up control rooms, which are tools supporting the organizational performance measurement and management system. These rooms are connected to the processes that the organization has put in place to better manage its portfolio of organizational projects. Our main objective is to improve

these processes in order to achieve a better balance between the four pillars of the performance of CISSSCA's Vrai Nord by putting greater focus on the "learning-innovation" dimension. Improving the management of this dimension will serve as a common thread, helping to more intensively share and mobilize the best available knowledge and promoting the co-construction of innovations by all participants in care and services. The project aims to adopt the means, in the context of SAPA control rooms, to better define and measure learning and innovation in an integrated, coordinated and sustained way, in order to continuously improve these elements and create real value.

CHU de Québec - Université Laval and CIUSSS de la Capitale-Nationale

- Caroline Drolet – Director, mother/child unit, Centre hospitalier universitaire de Québec
- Marie-Josée Laprise – Coordinator, pediatric services, Centre hospitalier universitaire de Québec
- Marie-Christine Laroche – Assistant to the director, DSM, Centre hospitalier universitaire de Québec
- Mireille Ouellet – Assistant director, DITSADP youth component, CIUSSS de la Capitale Nationale

“Continuum of integrated outpatient care and services - complex pediatric clientele”

This innovative project aims to develop a model of integrated outpatient care for pediatric clients with a complex clinical care profile requiring multidisciplinary care and health services. This model of integrated outpatient care aims to break down silos between institutions, promote clinical cooperation and service integration, and decrease hospitalization episodes. Consistent with the premises of the management model set forth by the MSSS, we will promote the integration and coordination of care and services by eliminating breaks in the continuity between transition points. We want to ensure that integrated services revolve around the child, and to prioritize evolving family needs and the maintenance of family dynamics in our decision-making, by bringing children's care closer to home. This will transform the hospitalization experience into an outpatient one, thanks to the values of diligence, compassion, and collaboration that will guide our decisions throughout our process.

CISSS de la Montérégie-Ouest

- Patrick Dubois – Assistant director, quality, assessment, performance and ethics, CISSS de la Montérégie-Ouest
- Martin Tétreault – Assistant director, mental health and addiction programs, CISSS de la Montérégie-Ouest
- Lyne Daoust – Director, critical and specialized care programs, CISSS de la Montérégie-Ouest
- Martin Turcotte – Head of addiction services, CISSS de la Montérégie-Ouest

“Ensuring that no one with a complex mental health issue has to suffer alone.”

The EXTRA team aims to develop adapted, integrated, and preventive services for "heavy users" of emergency services through an approach that promotes the recovery of the person in their natural environment and with the increased involvement of their loved ones.

In this way, the person and the various resources will be part of a single integrated network in which all parties interact to create a coherent trajectory from the standpoint of the service user's experience.

Implementing an intervention plan tailored to the complex needs of patients will ensure the fluidity and continuity of care within the community consistent with the life project of the person living with the issues.

It would be interesting to explore a new interdisciplinary team model, which, in a 24/7 context, could assist patients in planning their discharge from the hospital to an adapted resource or home. The objective is to accelerate patients' return to their own environment after long, repetitive hospital stays.

With this project, we hope to improve the service offer in the community in order to provide effective and efficient services for these people who are often caught in the "revolving door" syndrome.

2020 EXTRA Improvement Projects

Health PEI

- Mrs. Allison Wyatt, Wellness and Safety Manager, Human Resources
- Mr. Jason Rendell, Director of Human Resources

The Prevention and Reduction of Workplace Violence in Long-term Care

The project will initially focus on developing a violence prevention and response model to be piloted in a long-term care (LTC) dementia unit with a goal of implementing the project developments to all Health PEI LTC sites. The model will be based on models seen in other jurisdictions and will outline processes, employee education/training, and using client-centered activities in care plans to reduce workplace violence. Engaging employees is vital to the project's success. A survey and a focus group will be completed at the pilot site to identify workplace violence concerns and to determine which component(s) of the prevention and response model require developments.

The improvement project will help develop consistent processes to ensure timely incident investigation, debriefing and communication of corrective actions.

Health PEI will involve union representatives in the project design, implementation, and evaluation. The improvement project is expected to equip employees and managers with appropriate processes and education/training, which will decrease violence incidents in LTC. The project will contribute to improving staff safety and experience, as well as increase resident safety and quality of care.

St. Boniface Hospital

- Mrs. Katarina Lee-Ameduri, Clinical Ethicist, Health Care Ethics Service
- Mrs. Emily Hyde, Continuing Education Instructor, Cardiac Sciences Program
- Mrs. Sarah Gilchrist, Director of Critical Care, Education Services and Respiratory Therapy
- Dr. Thang Nguyen, Cardiologist

St. Boniface Hospital Harm Reduction Improvement Project

Healthcare facilities within the Winnipeg Regional Health Authority, including St Boniface Hospital (SBH), have been challenged with increasing emergency room visits and hospital admissions related to substance use. Manitoba does not have a safe consumption site nor provides harm reduction supplies in acute care settings or for outpatients.

SBH formally adopted a harm reduction philosophy policy in August of 2019.

The policy is the first step in formally developing harm reduction programs at SBH. This project aims to develop and implement harm reduction programming at SBH. The project has three stages so we can learn and develop as we move through providing harm reduction supplies from one unit to the entire hospital to SBH outpatients:

- Harm reduction supply distribution to inpatients in the Cardiac Sciences Program (CSP) at SBH;
- Harm reduction supply distribution to the broader inpatient population at SBH; and
- The development of an outpatient harm reduction supply distribution center.

SBH would become the first hospital in Winnipeg to participate in inpatient harm reduction as well as outpatient harm reduction. We have partnered with Public Health Manitoba to provide free harm reduction supplies.

We are dedicated to moving forward and bringing harm reduction programs to SBH; however, the complexity of the project demonstrates the value of developing and fostering leadership skills.

Ministry of the Solicitor General, Ontario

- Ms. Melanie Mayoh, Director, Corporate Health Care and Wellness Branch (CHCWB)
- Ms. Linda Ogilvie, Manager, Corporate Health Care, Operational Support
- Ms. Carrie Collier, Deputy Superintendent, Programs, Hamilton Wentworth Detention Centre

Nurse Practitioner Led Integrated Primary Care Model for Corrections

This project aims to improve primary care through the implementation of a nurse practitioner led (NP-led), integrated primary care model for correctional institutions in the province of Ontario, where the NP is the most responsible provider.

In Ontario's provincial correctional system there are currently six staff NPs providing primary care collaboratively with physicians. This integration has reduced wait times for admission assessments in alignment with Ministry of the Solicitor General policy requirements. The NPs have pro-actively educated nurses on clinical subjects such as the management of withdrawal, hypertension and diabetes to improve patient outcomes. This has also received positive feedback from patients who are cared for by NPs.

Beginning with three early adopter sites, SolGen will recruit 14 additional full-time nurse practitioners to serve as the most responsible provider providing NP-led primary care with the intention of expansion of the model to 24 correctional institutions across the province. This model will dramatically increase access to, and consistency of, primary care provided in provincial correctional institutions. This initiative aligns with other MOH supported NP-led models of care such as the Attending NP in Long-Term Care Homes initiative and Nurse-Practitioner Led Clinics.

NP-led primary care will facilitate a holistic and comprehensive approach to corrections health care. This will be accomplished by merging an innovative medical and nursing lens and enabling leadership.

Department of Health and Social Services, Government of Yukon

- Mr. Justin Wallace, A/Director Program Support
- Ms. Laura Hillier, Director Population and Public Health Evidence and Evaluation
- Dr. Samantha Salter, Epidemiologist

Indicators Framework for Yukon's Health and Social System

This project will develop an indicators framework to support the implementation of the anticipated changes to the system arising from the Putting People First review. The department has primary responsibility for leading system transformation through partnership with stakeholders. A key component is the development of a framework for health status reporting, including publicly reporting key indicators from a broad range of health and social domains. As referenced in the Truth and Reconciliation Commission's Calls to Action, we will work with Indigenous governments and citizens in Yukon, using OCAP principles, to develop indicators that measure outcomes for Yukon's Indigenous population, with the goal of eliminating health inequities across the system.

While interventions focused on individuals and integrating care services for key population groups are important, these must be part of a broader focus on promoting health and reducing health inequalities across whole populations. Collaboration across a range of sectors and the wider community is required both within a population health system and an integrated care model (Alderwick, Ham and Buck 2015).

The department views an indicator framework as foundational to the Government of Yukon's 2020 strategic planning process. It will also facilitate Health and Social Services' long-term objectives of becoming an evidence-driven organization. The department is committed to moving forward with full implementation of this initiative.

Centre intégré de santé et de services sociaux de la Montérégie-Centre

- Mr. Étienne Veilleux, director, deficiencies program, intellectual, physical and visual deficiencies and autism spectrum disorders
- Mrs. Alexandra Plourde, assistant to the education and university affairs director, department of education and university affairs
- Dr. Sophie Gosselin, assistant chief, department of Emergency Medicine
- Mr. Daniel Morris, massage therapist, dietitian, patient partner

The SENSÉ Project, What Work is All About

The project's goal is to improve the daily lives of visually impaired individuals by helping them join the job market through a position at the CISSS, the corollary being increased staff recruitment and retention. Our approach will focus on using the untapped potential of this group of individuals to offset local labour shortages. Our strategy is based on creating a talent development continuum, i.e. implementing a chain consisting of "schooling – internship at CISSSMC – employment at CISSSMC".

Among other things, creating this continuum requires developing partnerships with the education sector. These partner institutions will introduce mechanisms to adapt their teaching methods and tools in order to meet the specific needs of visually impaired students throughout their learning experience. The purpose of this approach is to ensure materials, tools and equipment used for education and training are both accessible and compatible.

Centre intégré de santé et de services sociaux de la Montérégie-Est

- Mr. Bruno Petrucci, Assistant Managing Director, Support, Administration and Performance
- Ms. Maryse Hébert, Director of Multidisciplinary Services, Health and Social Services - Multidisciplinary Services
- Ms. Nathalie Blanchard, Executive Advisor - Health and Social Services, Psychosocial Component - Multidisciplinary Services
- Ms. Hassiba Hihat, Acting Assistant Director of Quality, Evaluation, Performance and Ethics

Developing and Implementing network case management for users who make repeat visits to the emergency department

This project aims to make it possible for vulnerable populations to access quality, coordinated and continuous care that is in sync with other departments within the organization and the community. These personalized follow-ups will allow patients and families to actively participate in their care while being mindful of their personal experience, their level of literacy and their ability to self-manage. Case managers will also address determinants of health and other factors relating to vulnerability, whilst providing appropriate care and services. The support and assistance provided will enhance skill

development in both patients and the various clinical teams that work with them. Personalized follow-up care will enable us to provide primary care that is adapted to the needs of each patient. The support will also extend to community care as we determine what local care and services patients require.

This project will allow the team to provide the appropriate care that are based on the needs of each patient, their experience, their knowledge and their involvement throughout their care journey. In addition, the strategic monitoring of this project will ensure innovative clinical practices are implemented while promoting the best use of human, clinical and organizational resources.

Ministère de la Santé et des Services sociaux, Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal and Centre intégré de santé et de services sociaux de la Montérégie-Ouest

- Ms. Carine Sauvé, Ministère de la Santé et des Services sociaux, Director of Access to Local Care, Montérégie
- Mr. Philippe Lachance, Ministère de la Santé et des Services sociaux, Director of Local Physical Care; Academic, Medical, Nursing and Pharmaceutical Branch
- Ms. Prolet Tocheva, Centre intégré de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal, Business Processes Specialist, Bureau de l'accès aux services médicaux de proximité de Montréal
- Ms. Mélanie Lapointe, Centre intégré de santé et de services sociaux du Centre-Ouest-de-l'Île-de-Montréal, Planning, Programming and Research Officer, Bureau de l'accès aux services médicaux de proximité de Montréal
- Mrs. Chantal Benoît, Centre intégré de santé et de services sociaux de la Montérégie-Ouest, Executive Assistant, DSP, développement 1re ligne, Enseignement et affaires médicales

Access to Local Services for Patients Without a Family Physician, How to Achieve It?

This project aims to improve access to local care and services, while taking into account the new challenges, constraints and levers in the wake of the pandemic. The newly established local teams are mandated to work with front-line medical teams, in collaboration with the Regional Director of General Medicine (DRMG), to facilitate the adoption and implementation of various measures to improve access to medical services. They must analyze bottlenecks in the care trajectory and propose solutions to improve access.

The objective of the project is to develop and implement solutions that are relevant, effective and adapted to clinical settings, following an in-depth analysis of the root causes of the problems.

The sub-objectives of the project are as follows:

1. Develop a culture of access in local organizations and clinical settings to ensure that each patient is receiving the right care at the right time;
2. Improve collaboration and communication between community organizations and the Ministry to take action which will improve access to care for local populations;
3. Develop common knowledge and understanding of the problems regarding access to local healthcare throughout the patient care journey;
4. Define support mechanisms to implement measures aimed at improving access in clinical settings

and train local teams to support clinics in implementing these measures.

In the Montreal and Montérégie areas, the Ministry created “Access Offices”. These 2 offices are tasked with engaging regional stakeholders, as well as coordinating and supporting projects whose aim is to improve access to local healthcare services via Access Teams from their respective regions. Access Teams are defined in collaboration with patient partners, physicians and local medical clinics in order to maximize their positive impact on overall access to local healthcare services.

Local teams will be tasked with becoming experts in access to local care and services. They will support physicians and professionals who will be implementing new models to support access to primary care. They will be custodians of evidence, knowledgeable about innovative initiatives, equipped to support project and change management, and they will be conduits for communication between patients, professionals, the field and decision makers to improve and develop primary care and services.

Centre intégré universitaire de santé et de services sociaux de l’Ouest-de-l’île-de-Montréal and McGill University, Ingram School of Nursing

- Ms. Mylène Lévesque, A/ Chief of University Education and Medical Internships, Academic Affairs, Teaching and Research Directorate
- Ms. Beverley-Tracey John, Director of Nursing
- Dr. Bruce Campbell, Managing Director, Medical Education, Academic Affairs, Education and Research Branch
- Mr. Jérôme Ouellet, Assistant to the Director of Nursing, Nursing Branch
- Mrs. Irene Sarasua, Nurse Practitioner Program Director and Assistant Professor, Ingram School of Nursing

Developing an Interprofessional Education Program to Supervise Specialized Nurse Practitioner (SNP) Students

The proposed Improvement Project would involve designing, experimenting and evaluating an interdisciplinary training program (physicians-nurses) by facilitating the acquisition of skills required to supervise of SNP students. The goal of this action plan is to address issues identified by stakeholders that currently undermine the integrity of our organization’s SNP clinical training program and the interest of physicians in becoming supervisors. Ultimately, the project aims to increase the number of physicians and SNP supervisors to bolster internship opportunities.

Developed as part of a healthcare organization-university partnership, the project will include citizen partners. As potential patients of SNPs, these citizens will be actively involved in the project, in particular through their contribution to SNP student training as co-educators or even facilitators in the case of simulations.

The action plan will be monitored with specific indicators and include documenting the SNP internship pathway in order to lay the foundations for what will become an SNP student induction program, including support for supervisors. Informed by our data collection findings, the action plan will focus on learning activities that target barriers and enablers to the interprofessional supervision of SNP trainees.

Our preferred methodological approach is to partner in collaborative research, which recognizes the specific skillset each stakeholder group contributes to the search for solutions and changes. Following the data collection phase, we intend on identifying interprofessional learning activities to help develop a model for the SNP internship pathway.

Ultimately, the foundations of the induction program identified by the EXTRA project will pool together the viewpoints of scientists, citizen partners, supervisors (physician-SNP students), SNPs, advanced practice advisers and managers. The project will produce a series of structuring activities that will lay the groundwork for an SNP student induction program. The project will take place in the CIUSSS's U-FMG (University Family Medicine Group) as well as in a partner community FMG (Family Medicine Group) where CIUSSS SNPs practice and student SNPs also do placements. The combination of these two very different settings will provide an interesting sampling of cases that should help design and test a program that meets the needs of various settings and internship environments. This will also facilitate the project's transferability, where applicable, to a wider range of clinical internship settings.

2019 EXTRA Improvement Projects

Centre intégré de santé et de services sociaux de la Montérégie-Est (QC) / Association Québécoise en retraitement des dispositifs médicaux (QC)

- **Dr. Richard Marchand**, Microbiologiste et infectiologue
- **Mme Mélissa Giroux**, Chef de la prévention et du contrôle des infections
- **Mme Sylvie Paradis**, Coordonnatrice URDM et endoscopie, répondante URDM pour Montérégie-Est

Mapping Out Medical Device Reprocessing Risks

Incidents and accidents related to the reprocessing of medical devices are underreported at Centre Intégré de Santé et de Services Sociaux (CISSS) de la Montérégie-Est facilities. This improvement project aims to improve monitoring procedures relating to medical device reprocessing. The project has three goals:

- Reduce annual incidents and accidents related to medical device reprocessing by 25% at the Pierre-Boucher Hospital (CISSS Montérégie-Est facility);
- Increase incident and accident reporting by 25%;
- Ensure staff receive training on the importance of reporting incidents and accidents.

Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale (QC)

- **Mme Caroline White**, Coordonnatrice des services spécifiques
- **M. Louis-Philippe Emond**, Chef de service
- **M. Patrick Corriveau**, Directeur adjoint de la protection de la jeunesse
- **Mme Marie-Josée Santerre**, Chef de programme mandats transversaux

Acting Early and Jointly in Cases of Neglect

This improvement project aims to reduce reports of neglect by March 2020 and enhance coordination among partners who share these clients. The team will develop a service continuum aimed at early prevention and intervention in cases of neglect. This continuum will include universal measures as well as specific and specialized services.

This approach will consolidate a screening pathway for vulnerable pregnant women and families in order to provide them with individualized services. It will also strengthen the SIPPE (Services intégrés en périnatalité et pour la petite enfance) prevention program's implementation, with a view to maximizing the potential health and well-being of mothers and fathers. The program will promote optimal development in unborn babies and young children (ages 0-5) in vulnerable situations by:

- Monitoring physical and mental health in pregnant women;
- Developing and strengthening parent-child bonds;
- Stimulating cognitive, emotional, social and psychomotor development in children;
- Improving home safety;
- Fostering the development of new and existing parenting skills;
- Including the birth and development of children in a successful life plan for parents.

The service continuum between the SIPPE and neglect programs will help address service gaps and strengthen professionals' knowledge and skills in detecting and acting in cases of neglect.

Centre intégré universitaire de santé et de services sociaux du Centre-sud-de-l'île-de-Montreal (QC)

- **Mme Isabelle Savard**, Directrice adjointe des services professionnels-Volet affaires médicales
- **Mme Kristine Vitez**, Directrice adjointe des services multidisciplinaires-Volet opérations
- **M. Bobby Paré**, Coordonnateur Clinico-Administratif continuum de chirurgie
- **Dre Amélie Foucault**, Chef du service de chirurgie générale de l'Hôpital Notre-Dame

Embedding Mindfulness in the Operating Room

This improvement project aims to improve the well-being of staff, physicians and operating room managers at the Notre-Dame Hospital. In a second phase of the project, the team's goal will be to improve patient experience of care in the operating room by reducing their perception of pain and improving anxiety management in participating patients. Physicians and operating room managers will be:

- Trained in mindfulness with continuous practice techniques and;
- Provided with guided meditation vignettes for patients undergoing surgery at Notre-Dame Hospital.

In order to achieve this, operating room professionals and managers will be trained in mindfulness, and mindfulness techniques will be embedded into the surgery process. In addition, patients undergoing surgery at Notre-Dame will have access to guided meditation capsules upon pre-admission.

Centre hospitalier universitaire du Québec - Université Laval (QC)

- **Mme Caroline Imbeau**, Directrice générale adjointe soutien et administration
- **Mme Caroline Fortin**, Coordonnatrice service de néphrologie
- **Mme Isabelle Vézina**, Directrice adjointe des soins infirmiers, volets pratiques professionnelles, enseignement et recherche
- **Mme Marie-Hélène Boulanger**, Directrice adjointe de la logistique

Improving Access to Nursing Care through Hospital Logistics

Decision-makers and care and support teams are changing their mindset about current workforce conditions in hospitals. This improvement team wants to positively impact the quality and safety of patient care and optimize patients' experience of care. Tasks with a lower added-value currently performed by nursing staff will be shifted to a logistics team, allowing for more fulsome and consistent care throughout the patient's journey. Specialized healthcare staff workflows will change in order to increase the time they spend with patients.

This will create interdisciplinary workflow models for all teams involved in patient care, both at the clinical and logistical levels. Roles, responsibilities, work schedules and job descriptions will be reviewed according to patient needs. Tasks will be assigned for every 24-hour period and assessed in order to optimize the presence of clinical staff. The Improvement Team will review processes and workflows with a view to optimizing and streamlining them. This should eliminate a large number of non-value-added tasks for all staff and allow them to focus on their primary mission and, ultimately, improve the quality of care.

Centre intégré de santé et de services sociaux de la Montérégie-Ouest (QC)

- **Mme Marie-Eve Bernard**, Adjointe au président-directeur général
- **Mme Linda Haworth**, Directrice adjointe des programmes jeunesse et activités de santé publique
- **M. Jean-Marc Ricard**, Directeur des programmes déficiences

Labour issues: Barriers to the Rehabilitation of Residents in RACs (residential centres with conituous care)

Labour issues in the health and social services network make it difficult to achieve the Rehabilitation Program's goals for residents in RACs (group homes with continuing care) who have a behavioural disorder or a serious behavioural disorder (BD/SBD). These problems have become more pronounced in recent years. Some examples of these issues include shortages of qualified personnel, absenteeism, staff turnover, work schedules and inadequate training of staff to support these residents.

By the end of the project, we expect the chosen solutions to address labour issues in the targeted RACs to improve three key components of patient care plans by 20%:

- Rate of patients with a behavioural disorder/serious behavioural disorder (BD/SBD) who underwent a multimodal analysis;¹
- Rate of patients with a BD/SBD who are closely monitored post-intervention;
- Rate of patients with a BD/SBD who currently have a rehabilitation/treatment goal.

Building on scientific evidence and client experiences, the project aims to identify best practices for clinical improvements, human resources management and promoting a healthy work environment. Based on these findings, the team will work closely with a RAC's stakeholders who are experiencing labour challenges. Our goal is to identify the best strategies to meet the needs of this program's clients and mitigate the RAC's workforce challenges. Clients and families of this RAC will work closely with the project team.

(1) A Multimodal Analysis and Intervention (MMAI) combines the principles of positive approaches to care and individual quality of life and, based on developed causal and overall assumptions, sets in motion targeted intervention strategies whose effectiveness and relevance can be assessed through monitoring (Service québécois d'expertise en troubles graves du comportement).

Health and Social Services, Government of Yukon (YK) / Justice Department, Government of Yukon (YK)

- **Ms. Mary Vanstone**, Director, Mental Wellness and Substance Use, Health and Social Services
- **Mr. Cameron Grandy**, Clinical Manager Mental Wellness Substances Use, Health and Social Services
- **Mr. Jayme Curtis**, A/Director Corrections, Department of Justice
- **Ms. Sarah Gau**, Manager, Health Services, Department of Justice

Creation of the forensic mental wellness therapeutic services program

Research suggests that developing targeted programs to address the mental wellness and substance use of criminal justice clients can reduce re-contact with the system. This improvement project aims to address the structural problems that create barriers for justice clients accessing mental health and substance use treatment. We will create a team, including a Clinical Manager and three masters level

clinical counsellors dedicated to forensic clients, which include incarcerated and community clients. The team will have an understanding of forensic risk, forensic treatment and a strong background in mental health and substance use treatment.

Effective assessment and treatment requires partnerships with many, including the courts, counsellors/psychologists, corrections staff, policy makers, and Yukon First Nations. Inmates will receive access to assessment and/or treatment even if they are in the centre for a short time, including continuity of care when transitioning from the centre back into the community. The team will liaise with partners to deliver the proper treatment and support plans for the client. The team will develop and deliver appropriate treatment to address the underlying issues contributing to criminal behaviour.

BC Cancer (BC)

- **Ms. Bernice Budz**, VP, Patient Experience and Interprofessional Practice
- **Dr. Caroline Lohrisch**, Medical Oncology Department Head, Vancouver Centre
- **Mr. John Larnet**, Senior Regional Director, Kelowna Centre
- **Ms. Cecilia Li**, Provincial Director, Professional Practice Nursing
- **Mr. Ranjit Mattu**, Coordinator, Planning & System Development

Advanced specialized oncology access: transforming the interdisciplinary patient family centered approach

This improvement project aims to minimize delays, reduced duplication of historical information patients provide to healthcare professionals, foster the creation of care plans, and reduce the number of patient visits before definitive therapy begins by creating an interdisciplinary consult service that focuses on the first oncology appointment. The model will start with breast cancer referrals and can be generalized to other tumor sites by embedding the specific disciplines and services unique to each population.

A nurse will meet with the patient at the first appointment to ensure the provider has the information they need and to help patient with any anxiety he/she may be feeling from waiting. The patient will also receive a phone call following the appointment to ensure he/she understands the information provided, including instructions for prescribed medication. For patients who are receiving radiation treatment, the service would aim to expedite radiation oncology consultation. Ultimately our goal is to reduce wait times for consultation, while also reducing time until treatment begins.

A physician rotation of coverage will eliminate the cancellation of appointments that occur when a clinician is away. This improvement project will allow the team to align specialist oncology clinics to prevent blacked out schedules and ensure continuity of care.

Nova Scotia Health Authority (NS)

- **Mr. Matthew Murphy**, Director, Performance, Analytics & Accountability
- **Mr. Steven Carrigan**, Manager - Performance and Analytics
- **Ms. Tanya Penney**, Sr Director, Emergency Program of Care and Sr Director, Critical Care Program
- **Mr. Andrew Nemirovsky**, Sr Director and CIO

Predicting the Patient Journey: Volume & Flow Forecasting

A key objective of Nova Scotia Health Authority is efficiency in care. How can we safely maximize the patients seen and cared for with available resources so that we meet the care needs of Nova Scotians? This improvement project is focused on a greater understanding of patient flow to forecast patient

volumes and bottlenecks at multiple points along the patient journey. An applied analytics approach will be used to forecast patient flow in emergency and inpatient services to better understand queues and constraints.

The project will focus on understanding the link between service demand, individual patient care needs, provider requirements and system level factors and how they intersect to form a patient flow journey. This improvement project aims to support decision-making that provides consistent, sustainable, high-quality person-centred care to Nova Scotians.

Nova Scotia Health Authority (NS)

- Mr. Lewis Bedford, Director, Trauma
- Dr. Robert Green, Senior Medical Director, Trauma Program
- Mrs. Cynthia Isenor, Health Services Director, Central Zone Critical Care, Policy and Planning, NSHA Critical Care Program
- Mrs. Angela Stairs, Director, Rehabilitation Services, Eastern Zone

'Get Moving': Mobility as an integrated approach to improve outcomes

Implementing an early mobilization program in the Intensive Care Unit (ICU) is safe and can improve important patient outcomes.

In 2012, the inter-professional team at the Queen Elizabeth II Health Sciences Centre developed an early mobilization program for all ICU patients in their units. Dedicated services were put in place, and mobilization was promoted as an expected standard of care. The project found a reduction in trauma patient ICU mortality and in overall hospital mortality.

Based on the outcomes and lessons learned through the experience at the two tertiary sites, this improvement team will develop the approach, plan and tools necessary to enable the dissemination of this practice change to pilot Regional and Community ICUs and to additional ICU and non-ICU patient care locations across Nova Scotia and beyond.

This improvement project will promote best-practice initiatives, including appropriate sedation and pain control.

British Columbia Emergency Health Services (BC)

- **Mrs. Suzanne Fuller Blamey**, Corporate Director, Quality and Safety
- **Ms. Jessica Jaiven**, Director, Quality, Patient Safety and Accreditation
- **Dr. Wilson Wan**, Medical Director, Fraser Health and Acting Medical Director, Patient Care Communications and Planning
- **Mr. Ole Olsen**, Paramedic Practice Leader

Improving Trauma Patient Outcomes with Advanced Province Wide EMS Triage

The provincial Pre-hospital Triage and Transport Guidelines standardized the definition of major trauma in adult and pediatric patients in British Columbia. In addition, it established a current list of Lead Trauma Hospitals (LTH), designated by each Health Authority to accept and manage major trauma patients within each region of the province.

Regional efforts to improve short- and long-term outcomes after severe trauma will be focused on the optimization of access to pre-hospital care. This project will first look at implementing the guideline within

two trauma designated hospitals in the Fraser Region, as the testing site, before expanding it to the rest of the province. The focus will address four main domains:

- Reviewing current and proposed changes to practices in the Trauma Designated ERs;
- Communication and knowledge translation;
- Improving documentation practices;
- Measuring clinical performance indicators linked to patient outcomes.

The team will test different change ideas to establish a comprehensive multipronged communication and knowledge translation strategy that ensures successful implementation of the guideline in the biggest urban area in BC. The approach will build on this and focus on two components: online communication and face-to-face learning support.

In addition, with the recent implementation of an electronic health record platform (SIREN). Using SIREN, paramedics will be asked if a patient meets major trauma criteria on every encounter. It also allows the team to develop a unique documentation form for major trauma with specific data fields that are meaningful for evaluation. Fields can be made mandatory with specific selections for answers rather than free text, improving documentation rate and reducing variability of the responses which has well documented success in the patient safety and health quality literature.

The team envisions using the learnings from this project as an opportunity to rollout future changes in the organization.

Michael Garron Hospital (ON)/ VHA Home Health Care (ON)/ Woodgreen Community Services (ON)

- **Ms. Ashnoor Rahim**, Vice President, Community Care, WoodGreen Community Services
- **Mr. Courtney Bean**, Director, Client Services, VHA Home HealthCare
- **Mrs. Sandra Dickau**, Director Medicine & Critical Care, Michael Garron Hospital
- **Dr. Christopher N.C. Smith**, Staff Physician, General Internal Medicine, Michael Garron Hospital
- **Mr. Mark Fam**, VP, Clinical Programs, Michael Garron Hospital

Home 2day: Acute Care of Admitted COPD Patients at Home

Chronic Obstructive Pulmonary Disease (COPD) admissions are a significant burden to hospitals. Michael Garron Hospital discharges 450 COPD patients annually with an average length of stay of seven days. After a brief acute phase (1-2 days), patients under usual care remain in hospital to recover and are at risk for hospital acquired infections, caregivers are burdened with travel, and care delivery is inefficient due to low acuity.

Home 2day identifies low-risk medical patients who can safely receive acute treatment in their own homes with appropriate supports. In-home and virtual care is provided for up to one week by an interdisciplinary team from hospital and home care partners. Home 2day is expected to be as safe as regular care while being more patient-centred, less costly per case, and freeing up specialized resources to care for more acute patients (Echevarria, 2018).

This improvement project relies on evidence-based tools to identify low-risk patients and a standardized transition pathway to deliver wraparound care, education, and navigation. The model consists of in-home care driven by the needs of the patient, physiological monitoring, virtual consultation, case management, 24/7 emergency contact number, and access to a rapid response clinic. At discharge from Home 2day, patients are linked to traditional home care supports.

By defining and refining a standardized care transition pathway, the integrated model clarifies roles of hospital, home and community-based teams and helps to determine critical conditions that support transition to home. The model will expand to other conditions with similar resource utilization patterns such as congestive heart failure, pneumonia, and cirrhosis.

2018 EXTRA Improvement Projects

Centre hospitalier universitaire de Québec (QC) - Université Laval (QC) / Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale (QC)/ Université Laval (QC)/ Réseau universitaire intégré de santé de l'Université Laval (QC)

- **Dr Bruno Piedboeuf**, Coordonateur clinique
- **Mme Katia Boivin**, Chef de services des activités d'enseignement
- **M. Érik Plourde**, Chef du service de l'enseignement médical
- **Mme Marielle Lapointe**, Adjointe au Vice-recteur et coordinatrice des sciences de la santé

Enhancing Support for Practitioners in Outlying Areas to Improve Access to Care

This project aims to improve employee retention and the quality of care provided by the health and social services practitioners who work in outlying regions. The team will conduct a current state analysis to pinpoint specific challenges for health professionals in these areas, as well as their need for continuing education and support for their professional practices. The selection criteria will consider the multidisciplinary aspect of the project, the need for integration of services, the needs of the populations served in these areas and the potential to use telehealth in certain cases.

Physicians will not be included in this project since their professional status and the rules governing their professional development are different. However, lessons learned from physician education can be used where relevant to other professionals in health and social services. Given the limited duration of this project, nurses will also not be included in the first phase.

The project team will conduct a current state analysis to pinpoint appeal and retention challenges for health professionals, as well as ensuring the appropriate expertise is available in the region. We will document barriers and then establish a framework to make use of various training methods, and will then test a specific project.

Centre intégré de santé et de services sociaux de la Montérégie-Centre (QC)

- **M. Benoit Geneau**, Directeur des programmes de santé mentale et dépendance
- **Dr. Pierre Guay**, Médecin psychiatre et médecin-conseil
- **Mme Josée Fournier**, Directrice adjointe des services multidisciplinaires - volet opérations
- **Mme Maryse Poupart**, Directrice des ressources humaines, des communications et des affaires juridiques

Mental Health, the Main Thrust of Organizational Performance

According to data from Montreal's Institut universitaire de santé mentale, disability costs related to mental health now exceed those of cardiovascular disease and are becoming the fastest growing category of healthcare spending in Canada. This trend also impacts health professionals.

According to Professor Alain Marchand of the University of Montreal's Fernand-Seguin Research Center (2009), a career in health and social services can contribute to the onset of mental health problems, but other factors, such as family dynamics, social networks, local communities and personality traits, may also play a role and can be difficult to disclose in the workplace.

Faced with the complex nature of mental health problems, organizations and their management staff are poorly equipped to offer alternative work arrangements to accommodate mental health issues. This improvement project seeks to develop and implement an organizational performance improvement strategy focused on mental health in the workplace, so that healthcare providers can deliver optimal care and services. The strategic model is based on three specific intervention aims:

- Ensure continued employment and productivity for staff dealing with a mental health issue or potentially affected by one;
- Identify and introduce mental health protection factors in the workplace and reduce psychosocial risks;
- Reduce the impact of stigma and discrimination associated with mental health issues in labour relations.

The intervention will focus on new employee integration, continued employment and reintegration following a leave in two clinical settings. It will be rooted in measures that have been initiated at the local and national levels in order to develop an integrated response model.

Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'île-de-Montréal (QC)

- **Mme Nancie Brunet**, Directrice adjointe qualité, risques et éthique
- **Mme Nathalie Charbonneau**, Directrice adjointe continuum en déficience physique 1re, 2e, 3e ligne
- **Mme Julie Lauzon**, Directrice adjointe, santé mentale jeunesse, réadaptation enfants et adolescentes
- **Mme Isabelle Matte**, Directrice adjointe de l'hébergement

Enhancing the Client Experience by Standardizing the Human Aspect of the Intake Process and Relationship, and the Continuity of Care and Service Pathways

This project aims to improve the experience of users and their families from three branches of the CIUSS: the Youth Programs Directorate (DJ), the Independent Living Support for Seniors Directorate (SAPA) and the Intellectual Disabilities, Autism Spectrum Disorders and Physical Disabilities Programs Branch (DI-TSA-DP). The interventions will include patients, families and community care partners to ensure care plans are aligned with patient life goals, preferences and experiential knowledge in all care decisions. They will also involve staff and executives in a variety of positions from these areas.

The approach will be rooted in the organization's culture and values and be reflected in every action and decision. It involves promoting much more than client satisfaction; but also, a real commitment to patient and family personal, physical and mental well-being, as well as enhancing care for all.

Implementing and sustaining improvements for these groups will require the active engagement of all relevant staff and executives, helping them understand they can make a difference by caring and showing compassion in their interactions, and by making sure care and services are properly coordinated, especially during transitions.

Health and Social Services (YK)/ Yukon Hospital Corporation (YK)

- **Ms. Amy Riske**, Director, Care and Community
- **Mr. Dallas Smith**, Manager, Mental Wellness System Improvement Projects
- **Ms. Laura Salmon**, Director, First Nations Health Programs

- **Ms. Stefanie Ralph**, Executive Director of Patient Experience

Co-developed care plans supporting transitions of care for older adults

Our improvement project aims to co-develop an integrated care plan and process with a group of older adults who are users of the health and social services system. A small sample of older adults (Group 1) who representative of all areas of the Yukon, including a mix of clients from urban and rural areas, and who use two more healthcare services, will be selected. The sample will also include clients who are traditionally underserved, or under supported, such as rural First Nations. The project team will work with these clients and their care and support providers (e.g. primary care, therapy, family) to ensure that all the areas important to the care of the client are captured.

The co-development of the integrated care plan tool and process will involve client questionnaires, story mapping, focus groups, case review, structured and informal interviews. Once the plan and process have been drafted, a pilot will be launched with Group 1 to further refine the tool and the process. The care plan would be accessible to—and updated by—all providers participating in the care of the client. The mechanisms for sharing and updating the care plan will be defined as part of the project. Once a final draft has been completed, a separate test group of clients (Group 2) will be chosen to further pilot the tool and the process, and identify readiness for spread and scale.

Health PEI

- **Ms. Donna MacAusland**, Program Development Lead, Primary Health Care
- **Mr. Paul Young**, Administrator for Community Hospitals West
- **Ms. Anita MacKenzie**, Manager Primary Care Network Queens East

Provincial Orthopedic Hip/Knee Assessment Clinic

Data shows that 75 percent of hip and knee referrals to orthopedic surgeons do not result in surgery. The Health PEI team will open a Centralized Orthopedic Assessment Clinic, staffed by a specially trained nurse practitioner who will triage all hip and knee referrals with a goal to shorten the current 12-14 month wait to see an orthopedic surgeon.

Patients requiring surgical intervention would be referred to the next available orthopedic surgeon or the surgeon of their choice. They would also have their condition optimized in anticipation of surgery, thereby reducing length of stay. Patients that do not require surgical intervention would be offered other treatment, when appropriate, such as joint injection, physiotherapy and nutritional planning; thereby improving their condition and keeping them out of the orthopedic surgeon's office.

Health PEI

- **Ms. Marion Dowling**, Chief of Nursing, Allied Health and Patient Experience
- **Mrs. Kelly Wright**, Director of Nursing and Operations, Prince County Hospital
- **Ms. Leslie Warren**, Provincial Manager, Acute Care Mental Health and Addictions
- **Mrs. Edna Miller**, Administrator, Community Hospitals East

Integrating Nursing Sensitive Patient Outcome Documentation in Acute Care

The Canadian Health Outcomes for Better Information and Care (C-HOBIC) data set was endorsed as a Canadian approved standard in January 2012.

It is evidence-based and when implemented demonstrates improved patient outcomes. Health PEI proposes to integrate the C-HOBIC acute care nursing data set into clinical documentation within the

electronic clinical information system currently in place across PEI hospitals. It will be implemented in 1-2 test sites and then spread to all acute care sites. Integration will capture and improve nursing sensitive assessments and interventions by providing reportable, measurable and comparable information about the patient's condition on admission and at discharge. This information will be sharable and transferrable between acute care, home care, long term care and primary care when a patient is admitted or discharged to these services from acute care.

This improvement project will result in a change in nursing documentation at admission and discharge in acute care. It will incorporate input from frontline staff, patient and family advisors and steering committee members to accommodate patient flow and work flow; design, change and implement documentation in the clinical information system, educate and prepare staff for the change; and measure/evaluate the success and sustainability of the improvement.

Ministère de la santé et des services sociaux (QC)/ Centre intégré universitaire de santé et de services sociaux de la Mauricie-et-du-Centre-du-Québec (QC)

- **M. Daniel Garneau**, Directeur, Direction des services en déficience et en réadaptation physique
- **Mme Natalie Rosebush**, Directrice, Direction générale adjointe des services sociaux et des services aux aînés
- **Mme Lyne Girard**, Directrice générale adjointe programmes sociaux et réadaptation en déficience intellectuelle, trouble du spectre de l'autisme et déficience physique
- **Mme Jacinthe Cloutier**, Directrice adjointe services spécifiques et spécialisés Di-TSA adulte

An Integrated Network of Socio-Occupational and Community Services

Continuity of care is closely linked to the timely intervention of all relevant network stakeholders (health and social services, education, labour and community organizations) to better support users and encourage their full participation in society. The Centre intégré universitaire en santé et services sociaux (CIUSSS) de la Mauricie et du Centre-du-Québec will examine the levels of service integration with partners and implement an integrated network of complementary socio-occupational services that is tailored to meet individual patient profiles and needs, as well as to offer better continuity of care.

These measures will help ensure that users receive the right care, at the right time, by the right people. They will also promote stakeholder accountability based on their role in the continuum of care. This project includes an implementation assessment of users (number to be determined) to identify the contribution of each local network partner to each patient's care. The goal is to improve access and ensure a smooth flow of users through the various transitions between services and organizations in the catchment area, as well as care coordination among stakeholders.

Nova Scotia Health Authority (Nova Scotia)

- **Ms. Alissa Decker**, Program Manager, Bone and Joint Team & Orthopedic Assessment Clinic
- **Mrs. Lisa MacDonald**, Rehabilitation Services Manager
- **Mrs. Sally Blenkhorn**, Manager Rehabilitation Services and Hip and Knee Clinic
- **Dr. Marcy Saxe-Braithwaite**, Senior Director, Perioperative/Surgical Services

Optimizing Access to Joint Replacement Surgery in Nova Scotia

In Nova Scotia, the wait time for total knee replacement is approximately 457 days and 388 days for total hip replacement. The goal of this improvement project is to reduce wait times for surgical consultation for

Joint Replacement Surgery (JRS) from referral to surgical consultation (Wait 1). Currently the national benchmark for Wait 1 is 90 days.

Common improvement approaches that have worked in other jurisdictions have included: standardized provincial care pathways for JRS, centralized referral intake processes, electronic methodologies for data collection and evaluation, and establishing ongoing mechanisms for patient and family engagement to ensure care pathways and outcomes are in line with patient expectations. In April 2011, Eastern Health in St John's NL achieved a 71 percent decrease in Wait 1 through the implementation of a centralized referral intake system, which allowed for formal data collection processes to inform further areas for focused improvement.

Our team hope to implement similar strategies to improve our Wait 1 times, and eventually Wait 2 times from surgical decision to surgery date. Our proposed provincial pathway will include: a centralized referral intake process and data collection, standardized assessments and criteria to determine surgical candidacy and level of urgency, pre-surgical preparation and optimization of JRS candidates.

Nova Scotia Health Authority (Nova Scotia)

- **Ms. Bethany McCormick**, Senior Director, Planning, Performance & Accountability
- **Ms. Noella W. Whelan**, Professional Practice Leader, Interprofessional Practice and Learning
- **Ms. Nancy MacConnell-Maxner**, Director, Interprofessional Practice & Learning, Northern Zone
- **Ms. Nicole Lukeman**, Director Policy and Planning Acute Medicine Services

Applying evidence-based assessment to improve patient care models

Our improvement project will integrate qualitative and quantitative evidence to assess model of care, as well as quality improvement and system drivers, to inform decision making and service planning. The evidence to inform decision-making will include: 1) patient and population needs; 2) provider requirements (experience, staff mix, processes); and 3) system level factors (political, socioeconomic and operational context).

We will focus on a rural acute medicine pilot unit which, the evidence suggests, have a mismatch of patient population need to the level of care that is currently provided including inter-professional staff mix, unit processes, and other resources. In addition, there is instability of the health human resources, patient flow challenges, and opportunities to improve transitions in care.

The project will use a continuous improvement and planning process focused on three key phases: 1) identifying the needs of the patient population to inform the service level required, 2) requirements will guide the design of the interprofessional team, resources and processes within the unit, and 3) regular evaluation of patient and system level outcomes to signal when there is a match or mismatch between the patient population and service model and a need for re-assessment. Broad stakeholder engagement of staff, physicians, patients and families will be integral within the process. The project will work with local stakeholders to develop and implement a change management and implementation plan in response to service planning.

Vancouver Coastal Health (BC)

- **Mrs. Sujata Connors**, Director, Community & Family Health
- **Ms. Kim Markel**, Manager, Acute Care, Powell River
- **Ms. Lauren Tindall**, Director, Sunshine Coast

Optimal, sustained access, flow and transitions in rural sites

Transitional care is defined as “a set of actions designed to ensure the coordination and continuity of care received by patients as they transfer between different locations or levels of care” (Parry, Mahoney, Chalmers & Coleman, 2008, p. 317). When a patient’s transition from the hospital to home is less than ideal, the repercussions can be devastating and may include unnecessary hospital admissions and readmissions, adverse medical events and even mortality. Effective discharge planning is required to ensure that patients are cared for in the right place at the right time.

Our project is focused on improving the flow of care across Vancouver coastal sites which will include the development of a shared vision to guide planning for an effective, sustainable improvement. Collaboration and cooperation are essential on issues related to access, flow and capacity. Project working groups will be made up of key stakeholders impacted by patient flow, including patients, their families, acute/community staff and leadership. Staff will share their experiences and concerns by engaging in the inquiry process to gain a clearer understanding of the situation and to formulate appropriate solutions to the challenges they are facing.

2017 EXTRA Improvement Projects

British Columbia (BC) Cancer Agency / Fraser Health (British Columbia)

- **Tammy Currie**, Senior Director, Regional Clinical Operations Abbotsford Centre, BC Cancer Agency, Abbotsford, British Columbia
- **Marie Hawkins**, Executive Director / Primary Health Care, Chronic Disease Management and Medicine Clinical Network, Fraser Health Authority, Surrey, British Columbia
- **Shallen Letwin**, Vice President / Regional Operations, BC Cancer Agency, Vancouver, British Columbia
- **Gary Pansegrau**, Regional Medical Director, Fraser Valley Centre, BC Cancer Agency, Surrey, British Columbia
- **Astra Pereira**, Coordinator/ Regional Operations, BC Cancer Agency, Vancouver, British Columbia

Enhancing the Community Oncology Network in British Columbia

The BC Cancer Agency has oversight for the service delivery of systemic therapy, is responsible for funding all cancer drugs and for leading the development, implementation and evaluation of systemic therapy related quality standards across BC. Currently, systemic therapy (i.e. chemotherapy) is provided by both the BC Cancer Agency and the regional health authorities in BC. At the BC Cancer Agency, systemic therapy is provided across 6 regional BC Cancer Centres and within the 5 regional health authorities, systemic therapy is provided across 43 pharmacies and clinics as part of the Community Oncology Network (CON). The CON administers approximately 40% to 50% of chemotherapy within BC.

In a CON environmental scan conducted in 2016, issues were identified related to sustainability, effective care delivery, resources, quality and coordination of cancer care between organizations. By moving to an evidence-based decision-making model to help inform the CON planning, decision making and operations, the IP will be tasked with the creation of provincial CON Levels of Service and CON Performance Metrics. This will improve the quality of the patient experience, help measure and monitor performance, allow for a comparison to other organizations and ensure operational excellence.

This IP is well aligned with the BC Cancer Agency, Ministry of Health and all health authority strategic priorities. It will serve to increase accountability for all providers and health care systems, while ensuring the services that support the cancer care continuum operate like an integrated system versus a fragmentation of service providers.

Centre intégré de santé et de services sociaux (CISSS) de Chaudière-Appalaches (Québec)

- **Carole Bordes**, Directrice adjointe Logistique, CISSS de Chaudière-Appalaches, Lévis, Québec
- **Véronique Boutier**, Directrice administrative de la recherche, CISSS de Chaudière-Appalaches, Lévis, Québec
- **Josée Chouinard**, Directrice du programme soutien à l'autonomie des personnes âgées, CISSS de Chaudière-Appalaches, Montmagny, Québec
- **Daniel Paré**, Président Directeur Général, CISSS de Chaudière-Appalaches, Sainte-Marie, Québec

The Care Attendant: FOR the user THROUGH Logistics

The CISSS de Chaudière-Appalaches must innovate to enhance the well-being of its population while providing good value for money. The increasing burden of cognitive disorders in long-term care facilities (CHSLDs) poses a challenge for our organization, which requires a refresh to offer a quality client experience. In this respect, the shortage of healthcare staff is a major issue.

Our project aims to maximize the tasks performed by care attendants so that they may play a pivotal role in the services provided to patients. Our working assumption is that by upgrading care attendants' skills through a logistical analysis to pool and synchronize all work flow tasks affecting patients, care attendants will be empowered to play a privileged role in caring for patients and ensuring their well-being. These tasks should be sufficiently optimized to permit their integration without any additional cost to the organization. Beyond service optimization and greater job satisfaction for care attendants, we also expect clinical benefits for patients such as an increase in the use of non-pharmacological approaches and a decline in disruptive behaviors thanks to the presence of the care attendants.

In order to test our assumptions, we propose to carry out a comprehensive scan of planned and unplanned activities for patients in two CHSLDs in our catchment area, and to assess our interventions afterward. From an organizational standpoint, the benefits of this project will foster excellence within our institutions.

Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Centre (Québec)

- **Danièle Moore**, Coordonnatrice Maladies infectieuses, gestion des menaces et santé environnementale, CISSS de la Montérégie-Centre, Longueuil, Québec
- **François Pilote**, Professionnel équipe planification-Évaluation, Direction de santé publique, CISSS de la Montérégie-Centre, Longueuil, Québec
- **Mathieu Lanthier-Veilleux**, Médecin-conseil – équipe de planification et d'évaluation, CISSS de la Montérégie-Centre, Longueuil, Québec

Public Health Piloting Room: Enhanced Performance to Improve Population Health

Following the significant restructuring of Quebec's healthcare system in 2015, every institution in the healthcare network (CISSS) set up a strategic piloting room. This proven performance management tool is used by their steering committees. Piloting rooms are used to coordinate initiatives derived from strategic plans including targets, transformative projects and completed activities.

The overarching goal of this IP is to adapt and implement a piloting room at the Direction de santé publique (DSP) de la Montérégie (Montérégie's public health directorate), which would serve all three of its CISSS. Through its regional responsibilities, its concern with fostering staff and management engagement, as well as the challenge posed by the identification of indicators that adequately measure public health initiatives, the Directorate is looking to create a unique and adapted piloting room : democratized and multi-institutional with innovative indicators. Accordingly, through design and inclusive use (multiple professionals, orientations, stakeholders and institutions), this IP will democratize and engage resources around common priorities.

By participating in the IP's development, the three CISSS will ensure public health related activities in our region are more consistent. Thanks to indicators that will measure public health related activities, the DSP will be in a better position to coordinate its activities and better inform other directorates with respect to their own activities, which will benefit our population's health. Finally, the evaluation and the

experimentation of this IP should inspire other directorates and other institutions to follow suit and adopt an innovative management tool.

Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Est (Québec)

- **Marianne Dion-Labrie**, Conseillère cadre Expérience client et Éthique, CISSS de la Montérégie-Est, Saint-Hyacinthe, Québec
- **Bernard Lachance**, Conseiller cadre intérimaire à la gestion intégrée de qualité, CISSS de la Montérégie-Est, Saint-Hyacinthe, Québec
- **Annie Lemoine**, Directrice adjointe de la qualité, de l'évaluation et de l'éthique, CISSS de la Montérégie-Est, Saint-Hyacinthe, Québec
- **Michèle Ouellet**, Chef à la gestion intégrée de la qualité, CISSS de la Montérégie-Est, Saint-Hyacinthe, Québec

Involving Patient Advisors in Serious Adverse Events Reviews

Risk management translates into a corrective approach aimed at reducing the consequences of an adverse event and identifying improvement measures (CISSSME, 2017). For the past few years, new approaches have been developed to foster patient and family engagement. They are directly related to the concept of "patient and family centered care" and an improved client experience. Improving Client Experience is a "set of perceptions, interactions and facts experienced by clients and families" (Beryl Institute, 2015). Patient engagement improves the quality and safety of care (Sage, 2002). Although some data points to the benefits of greater patient and family involvement, few studies confirm their actual involvement in the analysis of a serious adverse event.

This project was designed to foster the involvement of patients in reviewing these events, their voice then becoming a powerful lever for improvement. Although some patients may feel comfortable being part of such an initiative, a poorly supported and hasty involvement could lead to negative experiences. To avoid this type of outcome, the appointment of a person to support patients should lead to improved experiences. This is why patient and family support by a team of patient advisors is recommended. This project will enable the development of strategies for patient and family engagement in improvement work. It will provide the opportunity to focus on their needs, improve communication and relationships and prevent serious adverse events.

Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Ouest (Québec)

- **Stéphane Dubuc**, Directeur des services multidisciplinaire et de l'enseignement universitaire, CISSS de la Montérégie-Ouest, Châteauguay, Québec
- **Mélanie Caron**, Chef du département de pharmacie, CISSS de la Montérégie-Ouest, Châteauguay, Québec
- **Sophie Poirier**, Directrice adjointe, Direction des services multidisciplinaires, CISSS de la Montérégie-Ouest, Châteauguay, Québec
- **Marie-Josée Roy**, Directrice adjointe ID-ASD-PD(DI-TSA-DP), CISSS de la Montérégie-Ouest, Châteauguay, Québec

Innovating to Establish Community Care and Services for Stroke Patients

The healthcare reform initiated under Bill 10 requires that organizations meet a series of objectives in order to comply with the Ministry of Health and Social Services (MSSS)'s strategic plan. Among these is the implementation of a local care continuum for people who are at risk of or have suffered a stroke. An environmental scan enabled us to identify various challenges currently experienced by stroke patients such as access to care, continuity of care, especially at transition points, flow of information between different stakeholders and coordination of services.

In our current organizational structure, implementing a local continuum would depend upon the coordination of work between six clinical directorates to achieve specific time-sensitive targets. The fact that clients are spread across the entire catchment area is an additional challenge for implementing state-of-the-art practices across the continuum. Therefore, the creation of an integrated management structure for all stroke-patient related activities under a single clinical management entity appears to be an innovative solution to this sizable challenge. This project reflects our organization's desire to focus on achieving the MSSS's strategic priorities, the expectations of the Steering Committee regarding organizational capacity and the willingness of the Board of Directors to promote a patient as partner approach for all large-scale projects.

Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Centre-Sud-de-l'île-de-Montréal (Québec)

- **Donald Haineault**, Directeur des soins infirmiers, CIUSSS du Centre-Sud- l'île-de-Montréal, Montréal, Québec
- **Julie Grenier**, Directrice adjointe au PDGA/Partenariat et soutien à l'offre de service, CIUSSS du Centre-Sud- l'île-de-Montréal, Montréal, Québec
- **Julie Lajeunesse**, Directrice des services professionnels, CIUSSS du Centre-Sud- l'île-de-Montréal, Montréal, Québec
- **Nicole Parent**, Adjointe au Directeur des soins infirmiers et directrice du projet, CIUSSS du Centre-Sud- l'île-de-Montréal, Montréal, Québec

PATH-C HND: Improvement Project - The Transition Between Hospital Care and Community Care at Notre-Dame Hospital

The integration of the Notre-Dame Hospital (HND) within the Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal requires the transformation of its current vocation. The HND will change from a teaching hospital that provides subspecialty care to a community hospital that provides community care to the catchment area. A new service offering will be put together for Montreal's downtown population to address urban healthcare issues. Population data point to poor health outcomes, mental health issues, vulnerable clients, social inequalities, and a poor fit between the population's needs and the actual care provided.

The Improvement Project to enhance the Transition between Hospital Care and Community Care (PATH-C HND) aims to: 1) Plan a service offering in order for the HND community hospital to meet the needs of its population, including vulnerable patients who live in the city's core, through strong local front-line care; 2) develop an optimal transition between hospital care and community care and prevent the use of emergency services through an integrated approach that promotes access, continuity and flow across the entire care journey. Based on the analysis of population's characteristics and available evidence, the PATH-C HND project aims to define a new service offering and establish the connections required with the community to better meet the needs of downtown Montreal's population.

Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Saguenay-Lac-St-Jean (Québec)

- **Céline Benoit**, Directrice adjointe des services professionnels responsable de la cancérologie et des soins palliatifs, CIUSSS du Saguenay-Lac-Saint-Jean, Dolbeau-Mistassini, Québec
- **Danielle Delisle**, Adjointe du directeur du programme jeunesse, CIUSSS du Saguenay-Lac-Saint-Jean, Chicoutimi, Québec
- **Martyne Gagnon**, Conseillère-cadre services psychosociaux, CIUSSS du Saguenay-Lac-Saint-Jean, Jonquière, Québec
- **Jimmy Martel**, Chef de l'administration des programme équipe spécialisée en santé mentale et dépendance et services ambulatoires jeunesse, CIUSSS du Saguenay-Lac-Saint-Jean, Dolbeau-Mistassini, Québec

Quality, Accessibility and Proximity of Pediatric Palliative Care Services and Practices

From the outset, it is relevant to mention that 65% of the population served by the CIUSSS du Saguenay-Lac-Saint-Jean lives in a rural area and that our extensive catchment area is spread across 95,900 square kilometers. Quebec's 2006 standards for pediatric palliative care define 6 categories for deaths among children: children whose condition is appropriate for a curative treatment, the outcome of which is uncertain; children whose condition will inevitably result in their premature death; children with a progressive condition with no hope of recovery; children with severe neurological problems; new-born babies whose life expectancy is very limited and family members who have unexpectedly lost a child.

In Quebec, between 1997 and 2001, the average number of annual deaths for all 6 of these categories was 840 (pediatric palliative care standards, 2006, p. 20). If one considers that Saguenay-Lac-Saint-Jean represents 3 per cent of Quebec's total population, this translates into an average of 20 children per year on a regional basis. A quick review of 2015-16 shows 2 deaths at home, 4 deaths in hospital for non-traumatic causes and 7 youth who sought follow-up palliative care within the health and social services network. This suggests that part of our clientele dies and receives services outside of our region, information that we were unable to validate. Therefore, with a view to offer quality local care based on best practices and to meet standards established by the ministry (MSSS) in pediatric palliative care, we intend on creating a model for the organization of care and services that ensures both quality and proximity for pediatric palliative care clients despite low case volumes. In fact, most palliative care models recommend community involvement, in a broad sense, for this type of care (Plan de développement 2015-20 soins palliatifs et de fin de vie, MSSS, Québec, 2015). This aspect could be included in potential solutions to consider.

Nova Scotia Health Authority (Nova Scotia)

- **Susan Stevens**, Senior Director, Continuing Care, Nova Scotia Health Authority, Halifax, Nova Scotia
- **Glenda Keenan**, Director, System Performance, Continuing Care, Nova Scotia Health Authority, Halifax, Nova Scotia
- **Scott McCulloch**, Physiotherapist, Team Leader, Nova Scotia Health Authority – Senior LINCS Program, Middleton, Nova Scotia
- **Bob Jenkins**, Director, Continuing Care, Nova Scotia Health Authority, Yarmouth, Nova Scotia

There is No Place Like Home: Building a Home First Philosophy in the Nova Scotia Health Authority and Beyond

Since 2003/04, Nova Scotia's health care system has experienced an important shift with more patients in hospital being discharged home with home care and fewer patients being discharged to nursing homes. Over the last several years, NSHA has seen some success in advancing the home first approach in parts of the province, however, further work is needed to develop and support a comprehensive home first culture provincially, and in particular, attention needs to be directed to those areas which haven't achieved change.

This project will thoroughly investigate the root causes of barriers to implementing a home first culture among continuing care staff, nursing home and home care providers, acute care, primary care and mental health colleagues, physicians and individuals and families receiving continuing care. This project will also investigate the successes that have occurred in specific areas of the province to better understand best practices and critical ingredients that can be spread in other areas who have not had success. Using key performance indicators, interRAI HC data, client narratives and experiences, lessons learned from across the province and best practice literature, we will develop a Home First culture and approach. This approach will result in targeted work in specific areas to realize not only improvement to the quality of care and quality of life dimensions for individuals and families, but important health system outcomes including health care resource optimization and sustainable stewardship.

Ottawa Regional Cancer Foundation (Ontario)

- **Linda Eagen**, CEO, Ottawa Regional Cancer Foundation, Ottawa, Ontario
- **Johanne Levesque**, Senior VP Survivorship Care, Professional Practice, People and Culture, Ottawa Regional Cancer Foundation, Ottawa, Ontario
- **John Ouellette**, Executive VP, Ottawa Regional Cancer Foundation, Ottawa, Ontario

Improving and Spreading Cancer Coaching

Cancer Coaching is a person-centered community service developed by the Cancer Foundation in 2011. This innovative health and social care practice actively engages clients in their care to improve their quality of life and overall wellbeing. Cancer Coaching is the synthesis of global best practices. It draws from patient navigation models put forth by the Canadian Partnership Against Cancer; survivorship care (i.e., post-treatment care) from the US-based Livestrong Foundation; and, the person-centered care model designed by the UK's MacMillan Cancer Support. It is also based on broader evidence from health coaching practices which have been shown to outperform other advice-giving approaches in 80% of clinical trials.

The Foundation has adopted the HealthChange® Methodology (Australia) which has demonstrated the value of coaching in terms of adherence to treatment plans and behavioral change when implemented across a health system. With increasing evidence of its effectiveness, the Cancer Foundation is interested in scaling up Cancer Coaching. To that end a professional training program has been developed in collaboration with York University and a community of practice has been established. Health care providers at the Winchester District Memorial Hospital, Hospice Care Ottawa, the Vanier Community Resource Center and the Rockland Family Health Team are now offering Cancer Coaching and, virtual Coaching will soon be available. The spread of Cancer Coaching will support the integration of care closer-to-home.