CANADIAN COLLEGE OF HEALTH LEADERS
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3M

3M HEALTH CARE QUALITY TEAM AWARDS

Healthcare Quality Team Initiatives Executive Summaries 2022 Submissions

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Dear Dedicated Health Care Team Members,

In these unprecedented times, it has never been more apparent how crucially innovations in healthcare can impact our quality of life.

As always, healthcare professionals are tasked with the need to balance their adoption of new technologies and the need to improve patient outcomes with their obligation to provide the level of personal care that people need and deserve – all while dealing with the now ever-present threats that a global crisis has presented.

For this reason, 3M Canada is once again proud to have partnered with the Canadian College of Health Leaders for over two decades to recognize achievements in maintaining that balance even in times of crisis.

The 3M Health Care Quality Team Awards proudly recognize healthcare programs that improve the delivery of patient care and, by extension, the lives of our fellow Canadians. We thank you for once again letting us be a part of this event. These awards highlight the teams that work together on quality improvement projects resulting in sustained change within their organizations and, as in every previous year, the quality of the award submissions we receive make selecting a winner a difficult task.

Each team that took the time to share their initiatives deserves our congratulations and I want to thank all the nominees and winners for your efforts in moving healthcare in Canada forward. The enclosed booklet includes executive summaries of all the 2022 programs that were submitted for consideration. Despite the extraordinary times we are facing in healthcare, these initiatives prove that creative thinking, sharing best practices, and patient centered approach to care can dramatically improve the delivery of support and care across Canada. It also highlights the incredible partnership between 3M Canada and the Canadian College of Health Leaders.

The 3M Health Care Quality Team Awards provide a forum for all of us to celebrate these amazing accomplishments with the hope of creating systematic change.

As a science company, 3M Health Care values our partnerships with customers and industry stakeholders that allow us to provide solutions to health care professionals so they can focus on what is most important: their patients. Thank you for efforts to find ways to reduce complications, improve patient outcomes, and provide people with the care we receive and deserve. We are proud to celebrate you all today.

Sincerely,

Drew McCallum, Division Leader
Medical Solutions Division, 3M Healthcare Business Group

In 1994, the Canadian College of Health Leaders and 3M Canada Company launched the 3M Health Care Quality Team Awards to encourage and recognize innovation in health services by linking two important concepts: quality and teams. Although two submissions were selected for special recognition, the 2022 competition included many important quality improvement efforts. We are pleased to share a brief overview of the submissions and hope this document will encourage wider use of quality planning methods and tools in Canadian health services.

2022 3M Health Care Quality Team Awards Recipients

- Quality Improvement Initiative(s) Across a Health System:
  Island Health - *STEPS for expedient acute care discharge: Cowichan Short Term Enablement and Planning Suites (STEPS)*
- Quality Improvement Initiative(s) Within an Organization:
  Humber River Hospital - *Elderly Assess and Restore Team (HEART)*

QUALITY TEAM INITIATIVES 2022 - OTHER SUBMISSIONS

Quality Improvement Initiative(s) Across a Health System

- Red Lake COVID Assessment Centre Team - Red Lake Family Health Team
- The Long-Term Care and Assisted Living Coordination Center in the Fraser Health Authority - An Effective Response Strategy to the COVID-19 Pandemic in Long-Term Care and Assisted Living - Fraser Health
- Windsor-Essex Community Response and Stabilization Team - Erie Shores HealthCare
- BPSO OHT - Registered Nurses' Association of Ontario
- COVID Care @ Home Bundled Care Team - Halton Healthcare
- Team Vaccine - University Health Network (UHN)
- North York Toronto Health Partners Vaccine Program - North York General Hospital
- BCEHS Prehospital and Transport Blood Program - British Columbia Emergency Health Services

Quality Improvement Initiative(s) Within an Organization

- The Glenrose Rehabilitation Hospital Virtual Health Initiative for Autism Assessment - Glenrose Rehabilitation Hospital
- Regional Access and Flow Coordination Centre - Fraser Health
- COVID Community Virtual Care Team (CCVCT) - Nova Scotia Health
- Organizational Design - The Good Samaritan Society
- The Zero Suicide Project Team - St. Joseph's Health Care London
- Central COVID-19 Testing Program and Vaccination Program - Extendicare Inc.
- RPM/Virtual Care Team - Eastern Health
- Royal Victoria Regional Health Centre
- Hamilton Health Sciences
- Improved Team Based Care in Moose Jaw - Saskatchewan Health Authority

STEPS for expedient acute care discharge: Cowichan Short Term Enablement and Planning Suites (STEPS)

Island Health

STEPS is an innovative collaboration between community health services, long term care, acute care and assisted living that creatively repurposes subsidized assisted living spaces into a transitional care unit, supporting acute patient flow. The STEPS unit is the first of its kind on the Island, and improves:

- acute length of stay
- alternate level of care rates
- readmission rates
- clinical outcomes
- client and family experience

Using a transformational leadership approach and quality improvement methodology this team has combined its resources to create a transitional care environment to support individualized, patient centered and culturally safe discharge plans. This integrated and engaged project leadership team, consisting of both internal and external partners, revamped community care processes, communication pathways, billing practices and many other systems.

Collaborative/creative problem solving; ongoing PDSA process improvements and a common vision were critical in creating a viable and sustainable solution. Success of STEPS was demonstrated through evaluation. Specifically:

- a reduction of 5.6 in-patient beds
- a reduction in cost for each bed day was realized (STEPS cost is 1/3 of an acute bed day)
- provision of high quality patient care in the right place, at the right time
- alignment to our corporate vision, mission and values and strategic plan
- expansion from 6 to 10 suites was supported to meet demand
- interest in Island wide replication

STEPS success is testament to the power of collaboration and innovation to support a network of care for the Cowichan community.

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Humber River Hospital - Humber's Elderly Assess and Restore Team (HEART)

Humber River Hospital

Launched in September 2018, HEART, an innovative mobile service that operates 7 days/week with both inpatient and outpatient components, was implemented to optimize patient function, reduce length of stay, facilitate home discharge, and promote healthy aging in the community.

HEART is comprised of Occupational Therapists, Physiotherapists, Rehabilitation Assistants, and Registered Practical Nurses and serves a subset of "high-risk" seniors that have restorative potential and can benefit from assess and restore interventions. Through the HEART program, patients are screened for eligibility and assessed upon admission. Once enrolled, patients are followed to discharge and receive post-discharge continuity of care. Assessments use validated tools to ensure that HEART services are made available to the most complex and difficult to discharge patients who also have a functional restorative potential.

Electronic capture tools measure key performance indicators and patient and family input is gathered through surveys. From September 2018 to September 2021, HEART served 1109 patients. Of these, 98.3% maintained or improved their functional capacity, with an average 36.7% improvement in function, and 87.7% were discharged home to their baseline. Furthermore, HEART participants had a lower average length of stay when compared to similar non-participants (7.5 vs. 12 days), resulting in savings of 4990 bed days and approximately $4.6 million in cost savings. 90% of HEART participants reported that they would recommend this program to others. HEART helps patients maintain their independence in the community, improves inpatient capacity, and provides a basis for scale and spread.

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Red Lake COVID Assessment Centre Team

Red Lake Family Health Team

Red Lake's COVID team, led by Physician Dr. Lisa Habermehl, has been instrumental in keeping our community informed, safe, and cared-for during this pandemic. Red Lake is a remote community, served by a small Physician, Hospital and Public Health team. Having COVID here entails significant risk, as critical care services require urgent air transport over 500 km away. Thus, we aggressively prevented, found and treated COVID.

Our COVID Team is a Family Health-Hospital-Public Health alliance. The Team provided wrap-around services for all things COVID, from the pandemic's outset. They adapted their work, schedules, and lives to cover the full-service gamut, from prevention, through to assessment, treatment and follow-up, providing:

- Thorough virtual and in-person assessment of patients with respiratory or COVID-like symptoms
- Virtual care, including Physician assessment, diagnosis and treatment
- Contact tracing well beyond what Public Health could do alone
- Consistent, evidence-informed guidance to healthcare staff (Physicians, Assessment Centre, Hospital, Family Health Team, Isolation Centre and others) by off-site Physician Lead, well beyond the hours of the Assessment Centre
- Regular Facebook posts and Q&As
- Education to major employers (e.g. mines, schools, businesses) on various COVID-related topics
- Informing community response to outbreaks
- Fostering immunization through pre-screening, calling patient lists, booking assistance, risk assessment, and vaccination
- Inpatient treatment

Even though our community sees numerous fly-in contractors, posing travel-related COVID risks, we have had zero hospital outbreaks in COVID's first four waves, and only two hospitalizations. Our COVID team has undoubtedly contributed to this. The Team also alleviated stress on Primary and Emergency healthcare.

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The Long-Term Care and Assisted Living Coordination Center in the Fraser Health Authority - An Effective Response Strategy to the COVID-19 Pandemic in Long-Term Care and Assisted Living

Fraser Health

The Long term Care and Assisted Living Coordination Center team represents an example of how team-work, engagement of a diverse group of providers as well as residents/tenants and families, best practice and leadership can come together in a crisis to focus on quality, reducing risk and protecting those for whom we provide care.

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Windsor-Essex Community Response and Stabilization Team

Erie Shores HealthCare

COVID-19 wreaked havoc on many regions of Ontario in 2020, but few were as hard-hit as Windsor-Essex County, where the population's most vulnerable were contracting the virus at an unprecedented rate for a variety of medical, economic, and social reasons. Recognizing the risk of uncontrolled community spread, Erie Shores HealthCare and Essex-Windsor EMS banded together to build on the provincial emergency assistance to Long-Term Care model and launched a permanent Community Response and Stabilization Team (CRST) to deliver care where and when it was needed the most.

Through daily analysis of patient data, CRST was able to identify the region's "hot spots" by postal code in real time and then identify strategic locations for temporary testing and vaccination clinics staffed by clinical professionals and EMS personnel. The CRST took healthcare to the doorsteps of high-priority communities, strengthening ties with other healthcare organizations while building new inroads with the unrostered and underserved.

In no small part due to the CRST's efforts, the pandemic scales tipped back in Windsor-Essex's favour and the rate of infection fell back in line with the provincial average, during each of the five waves. The initiative not only prevented a tsunami of patients from overwhelming the region's healthcare infrastructure, it saved lives. Its impact was so profound, the regional Ontario Health Team endorsed plans to continue existing pandemic operations for another year while working towards post-pandemic

plans that will augment the delivery of care to Windsor-Essex's at-risk communities when and where they need it most. Revolutionary care.

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BPSO OHT

Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario (RNAO), in collaboration with Best Practice Spotlight Organization® (BPSO®)-Ontario Health Teams (OHT), has designed a new model to scale up and spread best practices within integrated systems of care. The BPSO OHT is built on the decades of success of RNAO's Best Practice Guidelines (BPG) Program and its BPSO model at home and abroad.

Using implementation science and social movement methodologies, BPSO OHT Champions supported by RNAO, are actively advancing evidence-based practice and engaging frontline providers to fortify person-centred and co-ordinated care across public health, primary care, mental health and social service organizations, home care, hospital care and long-term care.

Starting with the first foundational best practice guideline (BPG), Person- and Family-Centred Care (2015), BPSO OHTs develop expertise and build the relationships and infrastructure required to implement and sustain best practices across their region.

The COVID-19 pandemic accelerated the need for an integrated health system to effectively serve persons and families. During the ongoing pandemic, BPSO OHTs have been a source of energy and motivation as they work together to deliver care that is truly person- and family-centred.

The successes, innovations and learnings from BPSO OHT teams in Cohort 1 are profound, and already influencing the uptake of BPSO OHTs second cohort, now in progress. This novel program is nested within RNAO's larger BPSO global network of 1,000 organizations in 15 countries—all offered free of charge.

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COVID Care @ Home Bundled Care Team

Halton Healthcare

The COVID Care @ Home Bundled Care Team developed and implemented an innovative pathway that served the dual goals of creating capacity in the hospital system during a time of significant resource pressures, while wrapping care around patients to ensure they felt confident and safe in their recovery at home. The team was comprised of stakeholders from across various parts of Halton Healthcare, a tri-site community hospital, in collaboration with representatives from Home & Community Care Support Services Mississauga Halton and Halton and Peel Community Paramedics. The group worked quickly and collaboratively to address barriers to implementation and to adjust the program as needed to improve the experience for patients. Hospitalizations for patients on this pathway decreased by up to three days and health confidence scores of patients on this pathway were high. Patients from the various communities within Halton and beyond to Peel and other areas were served by this innovative pathway. The collaborative nature of this team inspired great commitment and engagement from team members, This team embodied the principles of innovation, collaboration and patient safety and experience in health care, keeping patient care at the core of every decision.

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Team Vaccine

University Health Network (UHN)

The COVID-19 pandemic has significantly affected the health and well-being of all Ontarians. To overcome this system-wide challenge, a diverse group of stakeholders came together to form Team Vaccine, a cross-sector team consisting of individuals from Michael Garron Hospital, City of Toronto, Maple Leaf Sports & Entertainment (MLSE), Toronto Public Health, and University Health Network.

Team Vaccine implemented a data-driven, equitable and community-led Toronto-wide vaccination strategy. This innovative approach allowed the team to target the city's most vulnerable individuals: from Long-Term Care residents and staff hardest hit in the early waves of the pandemic, to residents in high-risk areas with high prevalence of disease and low vaccine uptake. During the summer of 2021, Team Vaccine partners also came together to set a North American clinic single-day vaccination dose record at Scotiabank Arena, home of the Toronto Maple Leafs and Toronto Raptors, on June 27, 2021.

Patients and families were at the heart of the Team Vaccine approach. Community outreach, accessible venues and locations, and walk-in clinics are only a few of the examples the team used to successfully support the vaccine roll-out.

This evolving quality improvement initiative has set a national standard of practice for vaccination campaigns. It would not have been possible without the tremendous efforts in setting up a robust governance structure with representation from health, community and municipal partners, and a focus on health equity and low barrier access to vaccines. The frameworks and collaborations developed will become a model for patient and community-centered approaches to care.

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North York Toronto Health Partners Vaccine Program

North York General Hospital

In January of 2021, Canada began to implement its COVID-19 vaccine strategy. A call-to-action was made by the Province of Ontario and Toronto Public Health to Hospitals in the Toronto area to assist in opening vaccine clinics. Both mass vaccine clinics and mobile community clinics that target specific high-risk populations were required and there was high demand for vaccine related information from our community. Vaccine services had to account for the lack of clarity on vaccine supply while providing a meaningful touchpoint as a trusted source of information and guidance.

NYGH is known for advancing quality in the care and experience that we provide at the hospital, and this challenge presented us with a new problem: how do we rapidly scale that high-quality service experience across our community? Leveraging previously established community relationships built with the North York Toronto Health Partners (NYTHP), our local Ontario Health Partner, we quickly worked to lead a large group of allies in implementing the North York Community Vaccine Program.

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BCEHS Prehospital and Transport Blood Program

British Columbia Emergency Health Services

British Columbia Emergency Health Services Prehospital and Transport Blood Program have successfully delivered critically required transfusions in rural and remote regions of British Columbia. The BCEHS Prehospital and Transport Blood Program brought together a multidisciplinary team of physicians, paramedics, nurses, laboratory technicians, and transfusion specialists to deliver much-needed blood products to those patients suffering from severe hemorrhagic shock hours earlier than was previously possible. This program, that now utilizes thawed plasma as well as packed red blood cells, a first of its kind in Canada, was a key step in addressing the critical needs of some of the sickest and traumatically injured patients within British Columbia.

The initial results from this program have found that for the first 48 patients demonstrated that an average of over one hour was saved in time to transfusion and was associated with improved clinical stability upon arrival at the trauma centre. There were no adverse events related to the prehospital transfusion of uncrossmatched packed red blood cells. These advancements were achieved despite the vast geography and logistical challenges associated with critical care transport in British Columbia.

This work has also spurred the creation of a blood transfusion registry utilizing the electronic patient records and collaboration across Canada with other prehospital and transport blood organizations. Further developments and improvements within the program will be ongoing, focusing on best patient care.

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The Glenrose Rehabilitation Hospital Virtual Health Initiative for Autism Assessment

Glenrose Rehabilitation Hospital

An innovative virtual assessment pathway for autism spectrum disorder (ASD) was created at the Glenrose Rehabilitation Hospital (GRH) to support appropriate and timely access to assessment for preschool age children with social-communication and behavior challenges – crucial in maximizing cognitive and developmental outcomes. Increasing ASD prevalence, lack of community capacity, access inequity, and the COVID-19 pandemic created a perfect storm that necessitated a redesign of assessment/ diagnostic services. To meet the emerging needs of patients and families, the GRH Infant Preschool Assessment Service (IPAS) streamlined intake/ assessment processes, increased diagnostic capacity of community pediatricians, and most importantly created a pioneering no-fee, open-source virtual ASD assessment tool – the Autism Assessment for Preschoolers with Language Element Sequence (AAPLES). The IPAS team undertook a continuous quality improvement approach, using caregiver and clinician experience and confidence feedback, to inform the redesign initiative and development of the AAPLES. Focus was three-pronged: greater accessibility; a standardized approach to virtual health for diagnosing ASD; and addressing diagnostic needs of preschool children. Clinician and caregiver feedback indicates high levels of satisfaction with the virtual approach, with 89% of caregivers reporting they are confident with the assessment results. Key learnings informed intake criteria that support a successful virtual assessment. Access has improved, and caregiver involvement in the assessment has supported a true collaboration with clinicians. Feedback from attendees at the international launch of the AAPLES is a strong indicator of its sustainability, with 80% intending to use the AAPLES in their practice, and 84% indicating they intend to share it.

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Regional Access and Flow Coordination Centre

Fraser Health

Fraser Health is one of Canada's largest health authorities. Despite being home to the most diverse and populous region as a health authority, and despite supporting the greatest number of patients impacted by the pandemic, this application will demonstrate how an integrated access and flow system has allowed the health authority to continue to deliver quality improvement when other health authorities were collapsing. This includes changes in systemic, cultural, partnership and quality improvement initiatives that were delivered to sustain the already taxed healthcare system, and see it lead the province in many patient care areas. These 'challenges' include five waves of the COVID pandemic, coupled with a series of provincial states of environmental emergencies. We DARE you not to be inspired!

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COVID Community Virtual Care Team (CCVCT)

Nova Scotia Health

Self-isolation after a COVID-19 diagnosis is crucial to protecting the health of our families, communities and healthcare system. However, knowing when to ask for help and dealing with COVID-19 alone posed a challenge for many. In April 2020, the COVID Community Virtual Care Team (CCVCT) was established to support at-home-patients with their COVID-19 disease progression and recovery via virtual care. The team utilized technology to support the healthcare system in Nova Scotia by encouraging self-management, at-home-monitoring, virtual care, and safe self-isolation.

Throughout the COVID-19 pandemic, the team worked collaboratively with Public Health on positive case notifications, and developed an innovative approach to allow safe self-monitoring at home during isolation. A pathway was also created for direct admission from the community to minimize hospital exposures. Additionally, CCVCT provided a real-time picture of community disease burden, helping the acute care system proactively prepare for short-term demands. Groundwork for other self-management virtual programs and responses has been laid, all while achieving high levels of both patient and provider satisfaction. Quality improvement initiatives included hiring, engaging, training, and educating, additional health care providers and staff, as well as reviewing PDSA cycles consistently. Decisions were based on current data, and changes were made based on patients' needs and satisfaction. National promotion and sharing of CCVCT is the next key step in demonstrating the development and need for virtual health care support. Nova Scotia Health proudly supports the nomination of the COVID Community Virtual Care Team to the 3M Health Care Quality Team Awards Program.

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Organizational Design

The Good Samaritan Society

Over the past decade, The Good Samaritan Society and Good Samaritan Canada (GSS) have experienced many senior leader transitions, resulting in a variety of different leadership styles, structures, and change. Culture had begun to erode with silos being created and distrust and apprehension was permeating at all levels of the organization. At a time when quality was paramount in healthcare, teams were struggling to meet standards, and sustainability as an organization was deeply threatened. Furthermore, families and residents were concerned about how we were responding to significant issues.

GSS took a targeted and systematic approach to implementing organizational design. Building on the CEO's extensive research in this subject, GSS built an "Organizational Design Toolkit©" which in and of itself describes a process for quality improvement. The toolkit included a project plan, human resource tools such as leader assessments and matching guides, organizational structure charts, position descriptions, and a communication plan. Good Samaritan's journey of organizational design was the first-ever GSS-generated and led research in history.

Outcomes from our initiative include: advancing our mission by adding new business lines, such as Indigenous Health; enhancing the caliber of leaders we are recruiting to the organization which results in enhanced quality of care; achieving savings (we achieved nearly a 1% reduction in overall organizational expense annually - $2,000,000); and strengthening the rigor and overall quality in our organization.

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The Zero Suicide Project Team

St. Joseph's Health Care London

As the first Canadian health care organization to implement the Zero Suicide framework, St. Joseph's Health Care London put into effect evidence-based best practices for suicide prevention management. Recognized in 2019 as a Leading Practice (Health Standards Organization) and for engagement of care partners, ("Recognizing Excellence in Patient Engagement for Patient Safety" Award, Canadian Patient Safety Institute, HealthCareCAN & HSO), continuous quality improvement remains our focus.

Zero Suicide builds a standardized internal approach

to implementation. Training includes mandatory, role aligned, e-learning modules for all staff. Standardization came from the development of a digital audit and feedback mechanism to ensure adherence to required screening tools. With real time prompts for staff and leaders, this system was instrumental to achieving our Quality Improvement Plan. Between summer 2020 and today suicide risk screening assessments completed within 72 hours of a mental health admission increased from 48% to 88%. The target for 22-23 QIP is 90 per cent and will increase to include all inpatients and ambulatory patients.

External dissemination and work with key partners (e.g., Suicide Prevention Resource Council) resulted in the adaptation of the framework into a community implementation toolkit. Created for services not formally a part of the health care system, this ground-breaking resource will be launched in spring 2022 and uses a project management lens to support implementation and CQI of evidence-based, community-focused, suicide prevention strategies.

St. Joseph's London aspires to continue to lead and grow a collective vision of suicide becoming a never event for those we serve.

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Central COVID-19 Testing Program and Vaccination Program

Extendicare Inc.

With the arrival of a novel coronavirus identified in China in late 2019 and arrived in Canada by January 2020, Extendicare Inc. has been unrelenting in its pursuit to protect residents, families, and staff from COVID-19 over the last 24 months.

In May and December 2020 respectively, Extendicare developed and implemented the Central COVID-19 Testing Program and Vaccination Program to identification and prevent the spread of COVID -19 across our 120 LTC homes and retirement communities in Alberta, Saskatchewan, Manitoba, and Ontario.

The testing program provides centralized governance, oversight, and operational support for on-site surveillance testing of ~15,000 staff. Similarly, once the COVID-19 vaccine became available, Extendicare prioritized vaccination of LTC and retirement residents, staff, and caregivers and prior to any provincial mandates (e.g., Ontario), Extendicare collaborated with other large seniors' care organizations to mandate the COVID-19 vaccine for staff, students, volunteers working in LTC homes.

To date, this program has supported the completion of over one million PCR and rapid antigen tests; the administration of over 75,000 doses of vaccine to residents and staff; and has advanced our culture of evidence-informed decision making. Moreover, by engaging with and listening to needs of residents and families, we have begun to further build trust and confidence in Extendicare by being transparent in our approach to testing and vaccination and inclusive of essential caregivers in the program.

Overall, the Central COVID-19 Testing Program and Vaccination Program at Extendicare is an example of our commitment to continuous quality improvement and safe resident care.

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RPM/Virtual Care Team

Eastern Health

The Remote Patient Monitoring (RPM) Expansion Project was initiated in 2017 to further support Eastern Health's vision of Healthy People, Healthy Communities and to support its strategic plan. Access to care, quality and safety and sustainability are just three of the strategic priorities which the RPM program addresses.

Expansion has continued to grow with each successive year and was accelerated with the onset of the pandemic in 2020.

RPM is a patient-centric model of care which utilizes innovative technology to support patients with chronic disease in their self-management journeys. By partnering with patients in goal setting, and providing coaching, education and monitoring, patients are empowered and become experts in their own care – regardless of their geographical location. This model has been expanded to include other conditions, including the high acuity monitoring of clients with COVID.

In building the RPM program, clinicians and clients are engaged in providing input into building content using evidence-based practice. As a core stakeholder to the RPM Program, the patient perspective is collected through a variety of modalities, including focus groups, and patient experience surveys to be used in quality improvement initiatives. A Patient Safety and Quality Forum was held to enhance this involvement and a there is a patient partner involved fully with the project.

A key component of the success of the program is the strong and enthusiastic team dynamic which drives innovation, success and positive patient outcomes.

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Royal Victoria Regional Health Centre

Within the "Drive Clinical Excellence" pillar of Royal Victoria Regional Health Centre's My Care strategic plan is the goal to reduce 30-day readmissions rates, specifically for Congestive Heart Failure patients, as they have negative patient outcomes and are costly at an operational and system level. This initiative aimed to increase the use of the Heart Failure Pre Printed Order Set and Clinical Pathway, to reduce readmissions and to reduce the average length of stay for patients admitted with Congestive Heart Failure.

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Hamilton Health Sciences

Hamilton Health Sciences redesigned care processes in 2 emergency departments (ED) and implemented an adaptation of Discharge to Assess (DTA) – a model developed by the National Health System (NHS). DTA positions an interdisciplinary team at the "front door" of the hospital to conduct initial assessments and coordinate plans with community partners who continue with post-discharge assessments in patients' homes. DTA enables patients who are medically ready for discharge to return to a familiar environment thereby spending less time in the acute care setting.

Between April 1, 2020 and December 31, 2021, 7,959 patients were assessed of which 93% were aged 60+ years and 52% were aged 80+ years. 63% of the total population were identified as being highest risk for frailty or frail, with 597 patients referred for the DTA pathway for higher intensity service that includes same-day in-home assessment by a Registered Nurse, initiation of services and close monitoring for up to 7 days following discharge from the ED.

Results to date include admission avoidance rates of 44%. Feedback from patients, families, and providers indicates improved patient and provider experience. Early learning confirms that patients with medical complexity and frailty, impacted by the social determinants of health and/or poor health literacy require timely in-home assessment to identify and enact required health and social services. Additionally, direct relationships between hospitals and specific home care agencies (versus multiple agencies) provides an opportunity to develop and implement evidence-based models of care across the continuum.

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Improved Team Based Care in Moose Jaw

Saskatchewan Health Authority

Connected Care is the long-term, transformational strategy of the Saskatchewan Health Authority (SHA) to ensure care is provided as close to home as possible by the right provider at the right time. Core to the strategy is interdisciplinary teams in multiple settings empowered and enabled to work together to provide seamless patient care, with an enhanced focus on everyday health services. The SHA actively seeks opportunities to organize services and resources better to deliver more reliable and consistent team-based care as close to home as possible. In the fall of 2020, the SHA care teams serving the people of Moose Jaw and area came together to apply the principles of the connected care strategy, taking a systems approach to addressing long standing overcapacity pressures at the F.H. Wigmore Regional Hospital. The team sought to do things differently through innovation and new models of care. A quality improvement approach that engaged patients and their families in the care model was applied in a cross-functional community network perspective. For the past year, the F.H. Wigmore Regional Hospital has seen a 300% decrease in Alternate Level of Care days, an average length of stay reduction, reduced 7 day readmissions from the ER, reduced Internal Medicine consultations from the ER, sustained elimination of admissions of inpatients to the ER, and a reduced wait to placement in a long term care bed. All the while surgical capacity increased by 130%. All of this has resulted in the sustained elimination of overcapacity pressures.

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Quality Improvement Initiative(s)

Quality Improvement Initiative(s) Across a Health System

2021 – Alberta Health Services
Connect Care

2020 – Mackenzie Health
Improving Stroke Outcomes Utilizing Data and Technology

2019 – North York General Hospital
Breast Cancer Integrated Care Collaborative

2018 – Trillium Health Partners
Putting Patients at the Heart: A Seamless Journey for Cardiac Surgery Patients

2017 – London Health Sciences Centre
Connecting Care to Home (CC2H)

2016 – BC Cancer Agency and Provincial Health Services Authority
Get Your Province Together! BC Cancer Agency Emotional Support Transformation

Quality Improvement Initiative(s) Within an Organization

2021 – Nova Scotia Health
Newcomer Health Clinic

2020 – Island Health
Prevention & Reduction of Open Heart Surgical Site Infections

2019 – Providence Health Care
Megamorphosis: Shifting from an Institutional to a Social Model in Residential (Long-Term) Care

2018 – Primary Health Care
"Getting the Care I Need, When I Need it": Group Visits Empower Changes in Priority Areas across Primary Health Care System

2017 – University Health Network (UHN)
UHN Quality Improvement Plan Discharge Summary Program

2016 – Mississauga Halton LHIN
Weaving a Mosaic of Support: Caregiver Respite in Mississauga Halton LHIN

Programs and Processes in an Acute Care Hospital Environment

2015 – St. Paul's Hospital, Providence Health Care
Evolving Care Systems: The hemodialysis renewal project, a co-location model for change

2014 – Mount Sinai Hospital
The Acute Care for Elders (ACE) Strategy

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

2012 – North York General Hospital
e-Care Project

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

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

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

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

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

2006 – Providence Health Care
Improving Sepsis Outcomes

Acute Care Facilities

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

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

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

2002 – Trillium Health Centre
Ambulatory Care That Takes Quality to the Extreme

Large/Urban Category

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

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

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

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

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

1996 – London Health Sciences Centre

1995 – Tillsonburg District Memorial Hospital

1994 – Renfrew Victoria Hospital

Programs and Processes in a Non Acute Environment

2015 – Capital Health
My Care My Voice: ICCS Initiative to Improve Care for Complex Patients by Providing a "Voice to the Patient"

2014 – Island Health
Better Patient Journeys: Community-Lead Strategies to Improve Hospital Flow

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

2012 – Alberta Health Services
Glenrose Rehabilitation Hospital Services Access Redesign

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

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

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

2008 – Capital Health
Implementation of Supportive Living Integrated Standards

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

2006 – Maimonides Geriatric Centre
Minimizing Risk of Injury

Other Facilities/Organizations

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

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

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

2002 – Maimonides Geriatric Centre
Maimonides Restraint Reduction Program

Small/Rural Category

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

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

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

1998 – Alberta Capital Health Authority
Castle Downs Health Centre

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

1996 – Crossroads Regional Health Authority
Pharmacy/Nursing Team Summary

1995 – Centenary Health Centre

1994 – The Freeport Hospital Health Care Village

Summary

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

The College and 3M are looking forward to receiving many new and innovative team initiatives for consideration for next year's 3M Health Care Quality Team Awards.

The details and the entry form are available on-line at www.cchl-ccls.ca. For further information, please contact:

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Canadian College of Health Leaders

The Canadian College of Health Leaders (CCHL), a national member-driven non-profit association, is the connected community that develops, supports, and inspires health leaders across Canada. The College strives to provide the leadership development, tools, knowledge and networks that members need to become high impact leaders in Canadian healthcare.

As defined by the LEADS in a Caring Environment framework, a leader is anyone with the capacity to influence others to work together constructively. The College's LEADS Canada team provides LEADS-based leadership development services, and partners with organizations, authorities and regions to facilitate not only the adoption of the framework, but a cultural shift required to fully imbed LEADS throughout an organization.

Through LEADS, the CHE designation, credentialing, training, conferences, mentoring and a nationwide careers network, we support health leaders in every sector and region, from every professional background and at any stage of their career.

Located in Ottawa, the College collaborates with 20 chapters across the country and engages with its 4,000 members and 80 corporate members to promote lifelong learning and professional development while recognizing leadership excellence.

Visit www.cchl-ccls.ca for more details. Follow us on Twitter @CCHL_CCLS and on Facebook at https://www.facebook.com/CCHL.National/.

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ