CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

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3M HEALTH CARE QUALITY TEAM AWARDS

Healthcare Quality Team Initiatives Executive Summaries 2018 Submissions

3M Canada Company
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Dear Dedicated Health Care Team Members,

For over two decades, the 3M Health Care Quality Team Awards has worked together with all of you to introduce and instill healthcare programs that improve our fellow Canadians' lives. This is an incredible realization and achievement. Today, I offer my thanks, both personally and professionally; 3M takes great pride in being part of this Award.

The Awards are intended to draw attention to the teams that work together on quality improvement projects resulting in sustained change within their organizations. Every year the quality of the award submissions we receive make selecting a winner extremely difficult. To all the teams that took the time to share their initiatives, thank you for all your efforts. And of course, congratulations to all the nominees and winners.

The enclosed booklet includes executive summaries of all the 2018 programs that were submitted for consideration. Despite the continuing challenges we all face in healthcare, these initiatives prove that creative thinking, best practice and execution can dramatically improve the delivery of support and care across our nation. It also highlights the incredible partnership of 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.

Finally, 3M Health Care looks forward to continuing to partner with our customers, business partners, industry, and The Canadian College of Health leaders to recognize leadership in the advancement of improved patient experiences and science based outcomes that advance the health of all Canadians.

Thank you for your commitment to advancing this vision and congratulations to all the winners and nominees.

Sincerely,

3M CANADA COMPANY
Britta Lesaux
Executive Director, Health Care Business

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 2018 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.

2018 3M Health Care Quality Team Awards Recipients

- Quality Improvement Initiative(s) Across a Health System:
  Trillium Health Partners - *Putting Patients at the Heart: A Seamless Journey for Cardiac Surgery Patients*
- Quality Improvement Initiative(s) Within an Organization:
  Primary Health Care - *"Getting the Care I need, When I Need it": Group Visits Empower Changes in Priority Areas Across Primary Health Care System*

QUALITY TEAM INITIATIVES 2018 - OTHER SUBMISSIONS

Quality Improvement Initiative(s) Across a Health System

- Breast Cancer Integrated Care Collaborative
- Inter-professional Spine Assessment and Education Clinics (ISAEC)
- Seniors' Community Hub
- Transitions from Acute Care to Community: Co-designing a Patient-Centred Discharge Pathway

Quality Improvement Initiative(s) Within an Organization

- Bravo!
- Enhance Recovery After Surgery (ERAS®) Bowel Surgery Pathway Implementation
- Improving Quality of Care & System Efficiency by Putting Patients First: ChELO(Checklist to Meet Ethical and Legal Obligations)
- Integrated Hip Fracture Inpatient Program (i_HIP)
- Mental Health: The Transformation of a Program
- Remote Patient Monitoring
- Untapped Potential – Engaging in Meaningful Client & Family Partnerships to Drive High Quality Safe Care

Putting Patients at the Heart: A Seamless Journey for Cardiac Surgery Patients

Trillium Health Partners

In 2015, Trillium Health Partners and Saint Elizabeth Health Care partnered with patients and families to redesign the journey for cardiac surgery patients from hospital to home. Responding to feedback about fragmented care on discharge, limited access to home care, demand for more hospital beds, and a need to reduce emergency department readmissions, we recreated the patient journey by seamlessly coordinating services around the needs of the patient through standardized post-operative care pathways, providing one team, 24/7 telephone line, community care, and an integrated health record. *"Putting Patients at the Heart"* was funded by the MOH LTC along with five other Integrated Funding Models. It is now the standard of care at this regional cardiac surgical centre which has the second highest cardiac volumes in Ontario.

As a result of continuous quality improvement, in FY16/17 post-operative hospital length of stay was reduced by 21%, readmission rates were reduced by 28%, and ED visits were reduced by 13%. Patient satisfaction with the PPATH program is very high at 98% and patients are more confident about their ability to care for themselves. Savings analysis for FY16/17 compared with FY 14/15 showed a total health savings of $1.4M through reduction of post-op LOS and readmissions.

This work is the result of meaningful patient engagement, courageous leadership and diligent team work across sectors, from senior executives to frontline staff, who eliminated silos of care and focused on what patients wanted. A deep and trusted partnership resulted in better continuity of care and increased patient satisfaction while lowering costs.

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

Primary Health Care

The "Getting the care I need, when I need it" initiative is a novel Primary Health Care (PHC) strategy to support the priority needs of patients, communities, and Nova Scotians. PHC is most often the first point of contact for patients and is the backbone of our healthcare system. Evidence has shown Group Medical Visits are a patient-centric, feasible, and cost-effective option to improve access to PHC and to address chronic disease management. This approach is a unique way to address important priorities for the health system and the specific population serviced, namely unattached patients, and particularly those requiring chronic disease and self-management as well as an innovative model of care for individuals with multi-morbidities.

At present, Nova Scotia is experiencing a shortage of family physicians and the introduction of Group Visits is seen as a viable solution to the issue of access to PHC. Beginning in 2015, over 50 clinicians, including physicians working in PHC, participated in systematic training, mentorship, research, and evaluation to build capacity to introduce Group Visits. By applying novel approaches and tools, including patient and provider engagement strategies, LEAN techniques, and validated measurement approaches, positive results are being realized. Quality improvements include increased access, satisfaction of receiving timely, relevant and continuous care, cost effectiveness, and system efficiencies.

With plans to expand implementation to other areas of the province, the project team believes Group Visits will continue to empower positive changes within PHC and provide comprehensive accessible care for patients across the province.

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Breast Cancer Integrated Care Collaborative

North York General Hospital

The traditional breast cancer journey is commonly fragmented, with poor collaboration between caregivers that result in delays in treatment and an uncoordinated, inefficient experience for the patient. In addition, breast cancer treatment is focused on the individual expertise of each specialist in isolation without collaborative cross-discipline input. Access to resources such as peer support and education is provided on an ad hoc basis.

North York General Hospital (NYGH) recognized that the complexity of breast cancer treatment necessitates a more collaborative and integrated approach to care and treatment. As a result, a passionate team of inter-professional providers and a patient advisor came together, and through extensive consultation co-designed the NYGH Breast Cancer Integrated Care Collaborative (ICC). Using an innovative approach to co-designing services together with, evidenced based practice as a lever for change, the ICC was developed to provide a seamless, integrated patient- and family- centred care approach from diagnosis to survivorship. Since inception, NYGH has achieved the following success in these key indicators:

- 100% of patients receive a multi-disciplinary case conference during diagnosis;
- Surgical wait times for breast cancer average 30 days for the goth percentile, consistently below the Central LHIN target of 38 days; and
- An increase from 51% to 81% of wait times within target from referral to consult for systemic treatment.

The ICC has transformed healthcare across the system and provides high quality outcomes and an exceptional experience for our patients, families and caregivers.

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Inter-professional Spine Assessment and Education Clinics (ISAEC) Program

University Health Network

Occasionally, the University Health Network (UHN) is provided the opportunity to disrupt the delivery of healthcare services across Ontario. Using innovative design, development, and implementation strategies, our UHN team created a program that brings together health service providers and experts from across the continuum of care to make a tangible difference to patient care, hospital services, and community care. Knowns as ISAEC, this inter-professional model of care provides patients with timely access to specialized spine assessments, education, and tailored treatment plans regardless of geographic location. When indicated, patients are provided with streamlined access to networked specialists and diagnostics.

ISAEC has demonstrated an ongoing focus on quality improvement and patient outcomes, unprecedented teamwork, and innovative solutions that span the delivery of care. The success of ISAEC is directly related in part to the team fostering a quality improvement environment that ensures; 1) solutions are rooted in strong clinical evidence; 2) a system's view of program management; and 3) the application of continuous PDSA learning methods to drive process change.

Since initiating program operations, ISAEC has provided services to over 7,000 patients. It has been successful in decreasing overall imaging utilization within the ISAEC network as well as documenting significant improvements in patient health outcomes while maintaining extremely high patient and primary care provider satisfaction rates.

ISAEC is a stellar example of a joint effort between clinical, program, and process design experts, focused on the common goal of quality care through teamwork.

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Seniors' Community Hub

Edmonton Oliver Primary Care Network

Edmonton Oliver Primary Care Network (EOPCN) supports 35 member clinics within the Edmonton Zone by providing resources and support to over 170 physicians. EOPCN is known to have the highest population of patients over the age of 70 within the Edmonton Zone and Alberta. Older adults are predisposed to frailty – a state of vulnerability that increases risk of adverse events like falls, hospitalizations and death. Frailty is associated with high costs, and with more individuals surviving into later life, there will be greater system-wide demands. Conceptualization of frailty as a multidimensional chronic condition presents an opportunity for a comprehensive primary care approach to frailty.

The Seniors' Community Hub is an innovative grassroots initiative, built within the EOPCN, to enable primary healthcare teams to proactively identify frailty using validated tools in community-dwelling seniors. Individualized care and support planning is created for identified high risk seniors, using collaborative goal setting between patient/caregiver (key stakeholders and equal partners in care delivery), family physician, and the interprofessional team.

The model aims to prevent functional decline of seniors living with frailty (i.e. prolong independence and build resilience), improve care experiences for seniors and their care providers, and strengthen community care collaborations. SCH hallmarks are evidence informed processes designed for primary care, capacity-building with education/mentorship, patient engagement, caregiver support, and innovations in health information technology.

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Transitions from Acute Care to Community: Co-designing a Patient-Centred Discharge Pathway

William Osler Health System

A significant issue affecting the healthcare system across Ontario is the number of patients admitted to hospitals that are then designated Alternate Level of Care (ALC). A patient is designated ALC when he or she no longer has any acute healthcare needs, but continues to occupy an acute bed. This scenario creates serious challenges for hospital access and flow, because other acute patients waiting in Emergency do not have access to those acute beds. The numbers in Ontario are staggering. In August 2017, 15.7% of Ontario inpatients beds were occupied by ALC-designated patients. Our team believed that if we could address this challenge, we could directly reduce the number of ALC-designated patients in hospital, increase capacity to meet the needs of acute patients, and increase access to community care after discharge (Chidwick et al, 2013). In 2012, William Osler Health System (Osler) co-designed a discharge process to be more patient-centred, using quality improvement processes, scripting, education, checklists, mentoring, and role clarity with great success. The key changes we made included alignment with patient wishes, elimination of common ethical errors leading to inappropriate ALC designation, and alignment with the laws of Ontario, i.e. the Health Care Consent Act (HCCA) and the Public Hospitals Act (PHA). Today, and for the past four years, Osler has the lowest ALC rates in Ontario, and our rate (6.6% as of December 2017) is significantly lower than any other hospital in the province.

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Bravo!

Horizon Health Network

Although the link from recognition to quality patient outcomes is not always easily made, Horizon has leveraged the powerful impact that recognition has on quality patient care with the launch of a values based recognition program Bravo!

By strategically embedding Horizons values into this program, thousands of employees have been recognized for exceptional demonstrations of behaviors linked to our corporate Vision of Exceptional Care. Every Person. Every Day.

During the first year, the Bravo! Program has exceeded established success measures including:

- Reduction in employee absenteeism resulting in over $638,000 in cost avoidance;
- 11,770 values based nominations;
- 25 monetary referrals to Foundations/Auxiliaries; and
- 10.6% increase in overall engagement levels.

The program has provided a strategic platform of successfully embedding corporate values into an organizational culture in a way that reminds, recognizes, and reinforces the behaviors linked to organizational success measures and quality patient care.

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Enhance Recovery after Surgery (ERAS®) Bowel Surgery Pathway Implementation

Eastern Health

Over the past 20 years, literature has been emerging which recognizes the benefit of implementing Enhance Recovery After Surgery® (ERAS) surgical pathways. These clinical pathways are evidence-based, standardized, patient-centred and interdisciplinary. Significant literature concludes that the implementation of these pathways can reduce postoperative complications, improve patients' surgical experience and allow early discharge from the acute care setting, without increasing readmission rates.

Eastern Health identified that the implementation of ERAS® pathways could improve surgical outcomes for the residents of Newfoundland and Labrador. In 2015, conversations began between Senior Management about the implementation of ERAS® at the various surgical sites within the health authority. It was recognized that a Program Coordinator would be required to facilitate this quality improvement program which spanned across the entire surgical continuum.

Upon hire into the position, the Program Coordinator developed an interdisciplinary team of front-line staff to plan, implement and sustain an ERAS® pathway for patients undergoing bowel surgery. Once presented with the evidence, this team quickly realized that there were opportunities for improvement within Regional Surgical Services, from patients' first appointment with the surgeon until discharge from the acute care site. Some of the areas required significant practice changes which challenged the traditional practice in place for decades. Each team member demonstrated a strong commitment to change, and leadership within their respective clinical areas. They rose above the challenges experienced and created innovative solutions, especially in times of fiscal restraint. Collectively, they've maintained a positive attitude and fostered a sense of ownership of the project, through the planning, implementation, and sustainability phases of the quality improvement initiative.

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Improving Quality of Care & System Efficiency by Putting Patients First: ChELO (Checklist to Meet Ethical and Legal Obligations)

William Osler Health System

ChELO (Checklist to meet Ethical and Legal Obligations) is an Osler innovation, Accreditation Leading Practice, and Canadian Medical Association (CMA) Joule Innovation Finalist that improves quality of care for patients and system efficiency. It is a six-question checklist that prompts healthcare providers to identify the correct substitute decision-maker(s) and reveal any advanced care plans, wishes, values, and beliefs held by the patient. In other words, it promotes a conversation with patients or their proxies to discover what is important to them, what their wishes and values are. It puts patients' voices back into the centre of decision-making about treatment. ChELO information is documented in the "ChELO Summary" in the patient's electronic medical record, which makes it easily accessible to the healthcare team. Knowing what's important to patients ensures that they receive treatment they want and can benefit from, and that they do not receive unwanted or non-beneficial treatment. ChELO transforms the culture of treatment decision-making so that it aligns with the laws of Ontario. Since its implementation in 2015, ChELO has: (1) reduced consent-related errors, (2) improved patient satisfaction, and (3) decreased the length of stay in the ICU. All the information about this innovation can be found at www.cheloproject.ca.

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Integrated Hip Fracture Inpatient Program (i_HIP)

Mount Sinai Hospital

The integrated Hip fracture Inpatient Program (i-HIP), initiated in 2011 at Mount Sinai Hospital, is one of the first academic hip fracture co-management models described in Canada. This collaborative co-management program was implemented to improve the care of hip fracture patients using the expertise of a multidisciplinary team, led by Orthopaedic Surgeons and Hospitalists to coordinate and manage patient care needs.

There is evidence suggesting that co-management models may be associated with improved outcomes such as Length of Stay (LOS), time to surgery, and complication rates. The goal of the program was to improve several domains of quality, including efficiency, timeliness, effectiveness and patient centeredness. The i-HIP program has been able to meet these goals. Innovative changes such as improvements to communication systems, access to the Operating Room, and standardization of clinical tools have had a significant impact on the care of the hip fracture patient under this model.

Success has been demonstrated in improved outcomes and a decrease in patient complaints. Post implementation, hip fracture patients at MSH have seen decreased wait-time from admission to surgery from 46 hours to 29 hours. The overall LOS for hip fracture patients was reduced by 14 days with an associated cost reduction of $4,953 per hospitalization (estimated annual cost avoidance of over $1,000,000). Other improvements include a decrease in pre-operative testing, and a reduction of mortality rate from 5.1% to 2% among the lowest rates in Ontario. Hospitalist leadership and executive sponsorship were crucial for sustainability.

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Mental Health: The Transformation of a Program

Queensway Carleton Hospital

The Canadian Mental Health Association estimates that, in any given year, 20% of Canadians experience a mental health issue. By age 40, approximately 50% of our population will have endured a mental health illness.

Over the past 5 years, the Mental Health Team at Queensway Carleton Hospital (QCH) has felt this acute demand through a 32% increase in Emergency Department (ED) visits, while their resources remained the same. The team began to ask itself the critical question: "What can we do differently to provide improved care for mental health patients in our community?"

In response, the hospital engaged an inter-professional team to review the Mental Health Program, co-designed changes with patients who had lived experience, and embedded continuous performance improvement (CPI) practices into the team's daily routines.

As a result, the team has successfully:

- Introduced Crisis Intervention Services into the ED, reducing admissions by 28%;
- ensured that 99% of patients discharged from the ED have personal care plans with community supports;
- reduced inpatient length-of-stay by 1.3 days, increasing unit capacity without increasing the cost-per-patient-day;
- decreased off-service mental health patient days by 34%; and
- reduced wait times for initial outpatient appointments by 5 months.

Concurrently the team:

- Improved clinical patient outcomes (3.9% - 10.4%);
- increased patient satisfaction scores (5% - 8%); and
- decreased readmission rates (3.2%).

The Mental Health Team has achieved a sustained transformation of their program with higher patient satisfaction, lower readmission rates, and better health outcomes for their patients. The CPI System continues to transform their services, and consequently creates higher satisfaction for the entire inter-disciplinary team.

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Remote Patient Monitoring

Eastern Health

Eastern Health is the largest integrated health authority in Newfoundland and Labrador, serving a regional population of approximately 306,259 and representing 59% of the province's population. Challenges facing the region include an aging population, rural access to health services, and a continued rise in chronic disease conditions.

The Remote Patient Monitoring (RPM) Project was implemented in November 2015 to support Eastern Health's vision of Healthly People, Healthy Communities and to support its strategic plan. Access to care and Population Health are just two of the strategic priorities which the RPM program addresses.

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.

In building the RPM program, clinicians were engaged in providing input into building content using evidence-based practice. As a core stakeholder to the RPM Program, the patient perspective was collected through interviews and focus groups. Ongoing feedback is elicited from patients and used in quality improvements.

Benefits analysis has shown a 68.7% decrease in hospital admissions, with potential savings in its current model to be approximately $1.9 million. And 97.7% of patients were satisfied with the care received.

A key component of the success of the program was the strong and enthusiastic team dynamic which drove success and positive patient outcomes.

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Untapped Potential – Engaging in Meaningful Client & Family Partnerships to Drive High Quality Safe Care

Holland Bloorview Kids Rehab Hospital

Holland Bloorview Kids Rehabilitation (HBKRH) developed an original and innovative framework that fully integrates 17 family and youth leaders in its accreditation steering committees and working groups across the hospital to drive its quality and safety improvements. The hospital established a formalized committee, the Family Leader Accreditation Group (FLAG) where staff and family leaders (FL) partnered equally to meet, update, and share quality and safety initiatives as part of the accreditation preparedness process. The Quality, Safety and Performance (QSP) team was driven to partner more deeply with clients and families to advance quality and safety, exceed compliance with Accreditation Canada's client and family-centered care standards, and build capacity within FL to drive change in quality and safety within and outside of HBKRH.

In addition to the FLAG group, the QSP team partnered with the Canadian Patient Safety Institute (CPSI), master facilitators, and FL's to update and contribute to existing learning modules in the patient Safety Education Program (PSEP-Canada). This partnership was anchored in the belief that providing knowledge and skills would ensure families had an equally knowledgeable voice in patient safety. The PSEP now has a new module developed by HBKRH with CPSI to reflect the client and family perspective and teach clients and families how to partner effectively with clinicians.

Our leadership and innovative partnerships are building capacity among clients and families, and provides a foundation for other organizations, sectors, and health systems to model in their approach to improve, transform, and provide quality and safe care.

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Quality Improvement Initiative(s)

Within an Organization

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.

Across an Health System

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

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
Breathing Easier: An Interdisciplinary Goal-Oriented Approach to Oxygen Therapy Administration

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

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

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

1998 - Alberta Capital Health Authority
Castle Downs Health Centre

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

1996 - Crossroads Regional Health Authority
Pharmacy/Nursing Team Summary

1995 - Centenary Health Centre

1994 - The Freeport Hospital Health Care Village

Summary

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

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

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The Canadian College of Health Leaders (CCHL), formerly known as the Canadian College of Health Service Executives (CCHSE), is a national, member-driven, non-profit association dedicated to ensuring that the country's health system benefits from capable, competent and effective leadership.

College members come from every health sector and region in Canada and are at varying stages of their careers. Members include students, and health leaders who work in a variety of environments including medical companies, health authorities, health consultants, multi-level care facilities, hospitals, public and private health agencies, health charities, the Canadian military and all levels of the Canadian government.

With 21 chapters across the country, representing thousands of individual and corporate members, the College offers capabilities-based credentialing, professional development opportunities, and an extensive career network. Guided by a Code of Ethics and the LEADS in a Caring Environment Framework, the College helps individuals acquire the skills they need to change their own organizations and, ultimately, the health system.

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

3M Science. Applied to Life.™

At 3M, science lies at the heart of everything we do. We apply the right science the right way to touch people worldwide - generating breakthroughs that make their lives better, easier and more complete. With $31.7 billion in sales, 3M employs 91,536 people worldwide and has operations in more than 70 countries. 3M Health Care is committed to supplying reliable products and services that advance the practice, delivery and outcomes in medical, oral care, health information systems, drug delivery systems and food safety. For more information, visit www.3M.com or follow @3MNewsroom on Twitter.