Capital Health Accepted Leading Practices

Title of Leading Practice	Brief description	Key Contact	Year Accepted
Care by Design	The Care by Design program enhances patient-centered primary care for Capital District Health Authority's (CDHA) long-term care residents. The process of reorganizing primary care for systems transformation began in September 2010,and now more than two thousand Long Term Care (LTC) residents have improved access and coordinated care through regular weekly visits from one of sixty physicians assigned to his/her floor and an on-call system for urgent care, 24 hours, seven days/week. Care by Design (CBD) physicians collaborate with the care team in CDHA's nursing homes improving the continuity of care, and timeliness of quality care as evidence by a 72% reduction in transfers form continuing care facilities to emergency departments.	Barry Clarke Barry.clarke@cdha.nshealth.ca	2015
Management of Anticoagulation Pre/Post Interventional Radiology Procedures in Hemodialysis Patients	A functioning vascular access is vital to hemodialysis (HD) patients. To maintain a functional vascular access, patients often require Interventional Radiology (IR) for a CVC insertion, exchange or a fistula (angio) plasty. HD patients on oral anticoagulant therapy and at risk for thromboembolic (TE) complications present a challenge when they require IR procedures to maintain a functional vascular access. Historically, there was variation related to medication and the timing of INR blood work. An anticoagulation protocol was developed for patients at low risk for TE complications who require temporary interruption of warfarin for IR procedures. A physician pre-printed order was developed to systematically manage the patients. Patients discontinued warfarin 5 days prior to their procedure and obtained an INR the day prior to the IR procedure to ensure it was below 1.5. Patients resumed warfarin post-procedure at twice their usual daily dose to a maximum of 10 mg provided hemostasis was achieved. A patient education pamphlet was provided outlining required pre & post medication & blood work.	Paula Mossop paula.mossop@cdha.nshealth.ca	2014

Integration of a Radiotherapy Patient Safety Reporting Category into the District Reporting System	In light of an early proposal by the Canadian Partnership for Quality Radiotherapy (CPQR) for the creation of a national incident reporting system and the Dec. 2012 publication of a radiotherapy incident reporting taxonomy by the American Association of Physicists in Medicine (AAPM), the department began to assess gaps in patient safety incident reporting. Through successful collaboration, the District Performance Excellence Risk Management/Patient Safety Team (RMPS) was able to use the existing PSRS to program the AAPM reporting taxonomy into a specific category, and create a patient safety incident follow-up workflow that would be specific to radiotherapy, while meeting the needs of the organization and eliminating the use of an in house technical variance form.	Kathryn Moran Kathryn.moran@cdha.nshealth.ca	2014
An electronic data management system for management of patients with Inflammatory Bowel Disease	The Cancer Care Application for Screening Platform Electronic Record (CCASPER) is a patient information system that records and stores patient data over extended periods of time. Prior to CCASPER, there was no efficient means of quickly accessing IBD patients' health history which presented patient safety issues and fragmentation in care. In 2009, our team negotiated with Cancer Care Nova Scotia to adapt their provincial database application for IBD. Demonstrating considerable ingenuity, this in-house developed solution was built utilizing existing resources and represents the first CH clinician driven database launched via the clinical PORTAL.	Barbara Currie Barbara.currie@cdha.nshealth.ca	2014
Frailty Assessment for Care Planning Tool (FACT)	The Frailty Assessment for Care Planning Tool (FACT) screens the essential domains that contribute to frailty based on performance of cognition, mobility, function and social situation. The evaluation uses a combination of patient assessment and caregiver report, which takes approximately 5 minutes to complete. The FACT is meant to be routinely performed as a first step in bringing frailty burden to the foreground for decision-making.	Dr. Laurie Mallery laurie.mallery@cdha.nshealth.ca	2014
STEP: Standardized Team Education Program & CoCGA: Collaborative	To integrate the complex issues associated with frailty, we developed two processes that are specific for frailty: (1) Standardized Team Education Program (STEP) (2) Collaborative Comprehensive Geriatric Assessment (CoCGA);	Dr. Laurie Mallery laurie.mallery@cdha.nshealth.ca	2014

Comprehensive Geriatric Assessment	also known as the PLAN (Plan for Appropriateness Now) STEP is an ambitious hands-on program of team reorganization and capacity building to: 1. eliminate repetitive assessments 2. improve the relevance of the patient assessment 3. optimize team communication 4. assure assessment accuracy 5. make better use of the assessment for care planning 6. improve system navigation The CoCGA, central to STEP, is an organized and standardized evaluation of critical frailty domains. The shared tool is meant to enhance the collective and longitudinal understanding of patient issues throughout the healthcare continuum.		
Community Health Teams Citizen& Stakeholder Engagement	The CHT model recognizes that each community has different needs, and therefore may require different programs, services, supports, and interdisciplinary team members. An engagement framework document based on the IAP2 principles and processes of public participation supported the CHT in engaging multiple stakeholders in conversations. Over 300 citizens and stakeholders were initially engaged to determine an appropriate model for the community being served.	Graeme Kohler Graeme.kohler@cdha.nshealth.ca	2014
Community Cardiovascular Hearts in Motion	Community based Cardiac Rehabilitation (CR) Program designed to go beyond the walls of tertiary care and beyond coronary artery disease alone. 12 week program to ALL patients at high risk for and with established cardiovascular disease populations. Use a behavior change model applied by all team members. This single team, made up of dieticians, nurses and physiotherapists manages three sites throughout the Capital Health Community. Program referral is focused on the Family Doctor as opposed to the traditional methods of CR referral. Our goal was to prove that aggressive	Dr. Nicholas Giacomantonio Nicholas.giacomantonio@cdha.nshealth.ca	2014

	intervention across the entire atherosclerotic population would decrease the risk of major Atherosclerotic events by both sustained lifestyle change and risk factor reduction.		
The Community Health – Health & Wellness Program Framework	CHTs were created to improve citizens' confidence in self managing chronic conditions and increase access for underserved groups, supporting individuals and families to build knowledge, confidence, and skills in making healthy lifestyle choices and managing risk factors common across chronic conditions. The framework was based on extensive review of evidence, stakeholder feedback, citizen engagement, and an audit of local data.	Graeme Kohler Graeme.kohler@cdha.nshealth.ca	2013
Community Health Team - Low Intensity Exercise Program	It is a 10 week community based exercise program, supervised by physiotherapists, available to patients who are not able to participate in other exercise programs due to one or more limiting chronic illnesses. Participants are empowered to safely self manage their signs and symptoms of over-exertion and how to progress their physical activity. They are guided to establish realistic goals using behaviour change principles, and work together with the physiotherapists to develop individualized home exercise programs, using problem-solving to find solutions to barriers to physical activity that exist in their lives.	Graeme Kohler Graeme.kohler@cdha.nshealth.ca	2013
Patient Initiated Family Screening Program for Hereditary Aneurysm Syndromes	We have developed, implemented and evaluated a patient initiated family screening program for hereditary aneurysms, including thoracic aortic aneurysms and other presentations suspected of being hereditary aneurysm syndromes.	Dr. Gabrielle Horne Gabrielle.horne@cdha.nshealth.ca	2013
Implementing a Novel and Supportive Program of Individualized Care for Patients and Families Living with Respiratory Disease	Eligible patients are identified during hospital admission, and after discharge, they enroll in a structured program that provides dedicated case management, orchestrated by a skilled respiratory therapist educator, who also acts as a care coordinator across care transitions. Patients are	Dr. Graeme Rocker Graeme.rocker@dal.ca	2013

(INSPIRED)	followed in their homes. Emphasis is placed on providing proactive care through home-based self-management, provision of individualized action plans for both acute exacerbations of COPD and dyspnea crises, sensitive advance care planning in the home, plus help with navigating the local healthcare system to gain access to allied support services.		
The Palliative and Therapeutic Harmonization (PATH) for treating older adults	Meets the needs of frail elderly patients with multiple medical issues through comprehensive assessment, clear communication to patients and family, and careful medical decision-making using a standardized approach. The goal of this program is to educate patients and families about how to take current and future health status into account when making health care decisions.	Dr. Laurie Mallery Laurie.Mallery@cdha.nshealth.ca	2010
Capital Health Ethics Support (CHES)	CHES' primary goal is to build the ethics capacity of the (Nova Scotia) Capital Health community. It achieves this through delivery of four integrated, laterally-organized components: Ethics Education, Policy Development & Review, Clinical Ethics Consultation, and Organizational Ethics.	Jeffrey Kirby Jeffrey.kirby@dal.ca	2010
Addressing compassion fatigue in cancer care	Capital District Health Authority has a program to address compassion fatigue in cancer care. Through formal evaluation, the program has shown to have a statistically significant impact on reducing the level of compassion fatigue among health professionals.	Laura Lee O'Connor Laura-Lee.OConnor@cdha.nshealth.ca	2010
Reducing repeat emergency department visits	Since findings show that a large portion of emergency department (ED) visits are for unexplained physical symptoms, CDHA implemented on site in the emergency department an emotion focused assessment and treatment service to assess emotional contributors to these visits and to provide clients symptom relief.	Allan Abbass Allan.Abbass@cdha.nshealth.ca	2010
Connective Tissue Clinic (CTC)	Health care disciplines work collaboratively within existing resources to provide patient and family centred care. Innovations include integrating psychological counseling	Susan Brander-Murtha Susan.Brander-Murtha@cdha.nshealth.ca • Dr. Gabrielle Horne should be key	2010

	into routine clinical care, protocols for assessing and managing high risk pregnancy as a multidisciplinary team, pre-operative connective tissue anaesthesia assessments for high risk syndromes, collaboration with a multimodality pain management clinic for patients with chronic pain syndromes, and simplified access for family members for screening.	contact	
Clerical triage of cancer centre referrals	The Clerical Triage practice has improved work flow efficiency and utilization of skill sets of clerical and medical team members at the Nova Scotia Cancer Centre. This streamlined process has helped alleviate patient anxiety because it reduces the time from referral to the time the patient is contacted with their appointment to see a cancer specialist.	Laura Lee O'Connor Laura-Lee.OConnor@cdha.nshealth.ca	2010