2015 Capital Health Quality Award Winners

**GOLD:** My Care My Voice: Integrated Chronic Care Service (ICCS) initiative to reduce wait times to care for complex patients by providing a “Voice to the Patient”

Project team: Tara Sampalli, Rob Dickson, Gail Sedgwick, Lindsay Landry, Minakshi Dhir, Mike Desy, Gail Blackmore, Cheryl Carter, Mary Upton, Sylvia Eddy, Jonathan Fox, Heather Livingston, ICCS care team, Lynn Edwards, Rick Gibson, Barbara Hall.

**Brief Summary:**
Integrated Chronic Care Service (ICCS) treats individuals with complex chronic conditions and multi-morbidities, receives referrals from within Nova Scotia, across Canada and internationally. Due to this and other related factors, wait times have been significantly high over the past several years. Recognizing the impact of long wait times, the care team applied a novel customer value-based approach and methodology (value-stream mapping) to reduce wait times to care and improve care experiences. The outcome of this review has resulted in changes to new patient and individual treatment modalities processes. Process changes for new patients include bringing all individuals on wait list to a series of group intervention programs and a modified group medical visit. Sessions are offered in multiple ways such as onsite, telehealth, telephone, as group and individual appointments to improve access and early engagement. Process changes to individual treatment modalities include offering group intervention and patient self-selection strategies.

The care team has successfully reduced wait times from >24 months in 2002 to 2 months in 2014 with no wait times to care anticipated in 2015. Increased patient engagement and satisfaction are also outcomes of this innovative initiative. The successful transformations resulted in resource efficiencies without increase in costs. Patients have shown significant improvements in functional health following ICCS intervention. The methodology will be applied to other chronic disease management areas in Capital Health and the province.

**SILVER:** Strengthening Primary Health Care for Frail Persons (Frailty Portal Pilot)


**Brief Summary:**
Primary Health Care and the District Department of Family Practice, in partnership with Palliative and Therapeutic Harmonization, piloted a web-tool to screen and plan care for frail persons. The aims of the Frailty Portal Pilot included to: Raise awareness of frailty; engage stakeholders in prioritizing care issues; Explore usability of a web-based tool; and Strengthen partnerships across providers.

This initiative engaged providers across the care continuum in prioritizing screening instruments and considerations in care of frail. Instruments and considerations were developed into an electronic tool. Eleven family practices used the Frailty Portal web-tool to screen and collect data on 136 patients.
Evaluation included: family practice needs assessment/survey; advisory group and participant pre and post surveys; participant qualitative feedback through practice visits, debrief session and self reflective Exercise; and team member debrief and capture of lessons learned. All of which will inform Frailty Portal Phase 2. Collaboration through this initiative has led to a district-wide Frailty Strategy.

**BRONZE:** Community Health and Wellness Centre – A Community-Driven Model


**Brief Summary:**
Aligned with CDHA priorities for person-centred care and public engagement, the Community Health and Wellness Centre (CH&WC) is focused on establishing strong community partnerships in an effort to build trust and gain acceptance in the communities of North Preston, East Preston, Cherrybrook, and Lake Loon. This is enabled through key relationships within the health sector, system level partnerships across CDHA and IWK, as well as a commitment to prioritizing community-identified needs. A series of community-wide engagement sessions were held to listen to the community priorities. Through this process, the CH&WC determined there were adaptations that needed to be made to the delivery of wellness programs, primary care service delivery, community partnerships, and community outreach activities such as a health fair.

The CH&WC developed a Kitchen Table Talk Series that provides opportunities for community groups or small groups in the community to request a topic specific educational program. The Primary Care model was adapted to be a balance of pre-booked and open access appointments. Establishing community partnerships were prioritized by all team members with individuals building strong relationships with existing groups. Community outreach activities were planned and implemented with community leadership and commitment for the future. As a result of this strong community focus, there has been an increase in the number of Primary Care visits as well as strong wellness programming attendance since its implementation in Spring 2014. While trust is slow to build, the CH&WC is making progress in these communities.