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... with people in mind / la technologie au cœur de l’homme
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Accreditation Canada is a not-for-profit independent organization that provides health services organizations with a rigorous and comprehensive accreditation process. We foster ongoing quality improvement based on evidence-based standards and external peer review. Accredited by the International Society for Quality in Health Care, Accreditation Canada has helped organizations strive for excellence for more than 50 years.

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Inroads in Access

Access is one of the dimensions of quality care. Whether an organization identifies, six, seven, or eight dimensions, access is invariably included. It is a pervasive and perennial issue in Canadian health care; it is all-encompassing and affects patients waiting for care, overburdened service providers, and data management systems throughout the continuum of care.

It is important to remember that a balanced approach to quality care is vital. Access is one of the important dimensions in achieving high-quality care, and yet, it must not be overemphasized to the jeopardy of other dimensions of care, such as safety and efficiency.

In this, our final issue of 2011, we asked our authors to share their wide-ranging perspectives and experiences regarding access.

Sandra Cook begins by taking us through Nova Scotia's Cancer Patient Navigation Program, which helps patients and their families access appropriate services, navigate the continuum of care, and remove barriers during the course of their treatment and recovery.

Lawrence Cheng, Devin Harris, and Eric Grafstein discuss how Diagnostic Treatment Units are helping emergency departments improve patient flow and overall efficiency and reduce short-term medical admissions.

Raj Bhatla helps us understand how the Royal Ottawa Mental Health Centre is using technology to access patients in remote and rural areas, who might not otherwise have access to the mental health services they require.

Sandra Fedirchuk and Jeannine Roy explain how Winnipeg's Language Access Interpreter Services reduce the risks that arise when friends or family members interpret medical information. These language services have the capacity to enrich patients' and care providers' experiences, and to improve health outcomes by increasing access to appropriate services.

David Armstrong shows us how a patient-centered approach may be the key to addressing wait times and improving access to digestive health care services in Canada. He discusses the expansion of the Quality Program–Endoscopy [the Global Rating Scale (GRS), and the Colonoscopy Practice Audit] across Canada, as a means of helping more patients access endoscopic care.

Su Huynh, the Director of Information Management at Accreditation Canada, considers how technology has made our accreditation processes easier for clients and surveyors, and how it has changed the type of information our clients can access. Clients now have more detailed information to use when planning their quality improvement initiatives.

Francine Lemire explores the ways in which same-day access, shared care, inter and intraprofessional care, group visits, electronic communication, and health information technology help us move toward accessible and patient-centred health care.

Jamie MacDonald, Gailyne MacPherson, and Theresa Callaghan review PEI’s astounding decrease in wait times for CT and MRI appointments and results. CT wait times diminished from 22 weeks to 3 or less and MRI wait times decreased from 33 weeks to 8.

Sean O’Brien provides an account of how the Winchester District Memorial Hospital’s web-based initiative evolved into a district-wide initiative supported by the Champlain LHIN. It now helps hundreds of practitioners in a community of care stay connected, and access highly relevant information about patients as they move through the continuum of care.

As this issue is dedicated to access, I would like to draw your attention to Accreditation Canada’s recently developed standards for Remote/Isolated Health Services. These apply to health facilities serving Aboriginal communities in remote and isolated areas (i.e., areas with limited access to an acute care hospital), where health care is provided by general practitioners or non-physician providers, or where specialist support is either limited or not immediately available. Such facilities offer a range of health care services, from health promotion and prevention, to acute, urgent, and emergent care. The Remote/Isolated Health Services Standards contain the following sections, all of which address access in one manner or another:

- Investing in remote health services
- Engaging prepared and proactive staff
- Providing safe, accessible, and appropriate services
- Maintaining accessible and efficient clinical information systems
- Monitoring quality and achieving positive outcomes

Thank you to all of our authors and readers for your continuing enthusiasm for Qmentum Quarterly, which fosters knowledge exchange across the country. I look forward to hearing from you in 2012 as we take on new health care themes that will engage you, and generate discussion and quality improvement initiatives.

May you all have a wonderful holiday season; take time to celebrate the accomplishments of this past year and consider how we might challenge ourselves to implement positive change as we move into 2012.

With warm regards,

Wendy Nicklin
President and Chief Executive Officer
Accreditation Canada
Cancer Patient Navigation Program
In 2001, Cancer Care Nova Scotia (CCNS) developed and implemented the Cancer Patient Navigation program as an innovative way to optimize patient access to care, and to support patients and the health care professionals who deal with systemic challenges on a daily basis. The collaborative nature of the Nova Scotian patient navigator model brought tremendous gains to patients and the health care system. It enabled patients to receive care closer to home and enhanced the community’s capacity to care for and support cancer patients and their families.

“I was the navigator who reminded me to breathe. It was the navigator who identified questions and things that needed further investigation. I learned then and there that she was the ‘go to person.’ I was in charge, but she was the hub of the wheel that was taking me along this journey.” ~ Anon. CPN Program patient from Nova Scotia

The concept of cancer patient navigation emerged after Cancer Care Nova Scotia (CCNS) recognized common challenges faced by patients and their families in a complex cancer care system. A new cancer diagnosis, followed by an intensive diagnostic work up and treatment regimen, can often result in patients and their families feeling fearful, anxious, and confused as they attempt to navigate a complicated care pathway.

It is not uncommon for a cancer patient to be required to visit a number of health care professionals in several departments at varied inpatient, ambulatory, or community health care settings. Contemporary combined modality cancer treatment often involves multiple treatments over an extended time period. These experiences place patients with cancer at risk of increased psychosocial morbidity and open them to the possibility of becoming lost in the health care system as a

Map of Patient Pathways

- Family doctor/health centre
- Routine screening
- Local hospital or cancer centre to undergo tests
- Diagnosis of cancer
- Treatments
- End of treatment
- Long-term monitoring and follow up
- Cure
- Long-term survival
- Supportive Care is provided at all stages of the pathway from pre-diagnosis onwards
result of fragmented care (Health Canada, 2001). Many have difficulty finding and obtaining appropriate support to deal with the physical, social, emotional, psychological, informational, spiritual, and practical challenges created by a cancer diagnosis (Fitch, 2008).

Furthermore, increasing numbers of patients are living longer with cancer, and they need long-term follow up. The intensity of cancer treatments is also leaving a growing number of survivors with heavy burdens in terms of symptoms and long-term side effects.

Fragmented services, delays in system access, a lack of coordination among providers, and inadequate patient information are common barriers in the cancer care system. Cancer patients, survivors, and health professionals repeatedly cite information, support, and communication as critically important in dealing with the challenges imposed by a cancer diagnosis.

Therefore, in 2001, Cancer Care Nova Scotia (CCNS) developed and implemented the Cancer Patient Navigation program as an innovative way to optimize patient access to care, and to support patients and the health care professionals who deal with systemic challenges on a daily basis.

CCNS’s program development approach was community-centred, used a quality improvement framework, and involved relevant stakeholders; the initiative was built on research and best practices. The desired outcomes of the program included:

- Providing timely and appropriate access to supportive care services
- Raising the consistency of cancer care via coordination
- Increasing the continuity of cancer care via collaboration
- Helping patients and families feel supported and empowered
Improving communication and collaboration within the cancer care team(s)

Improving access and education for groups that have traditionally found it difficult to access cancer care (e.g., rural and remote communities, and linguistic, cultural, and ethnic minorities)

Having cancer patients and families feel guided and supported through “the maze”

**What is Cancer Patient Navigation?**

Navigation is a proactive, intentional process of collaborating with a person, their family, and the interdisciplinary care team to provide clinical interventions, education, emotional support, and logistical assistance. This is done to help patients negotiate the treatments, services, and potential barriers they may encounter throughout the continuum of care.

In Canada, professional navigation is carried out by paid health care providers, usually nurses or social workers, located in a variety of settings. They bridge patients and their families with a multidisciplinary team, cancer centres, and community agencies. The navigator helps patients access care; they also coordinate services and deal with the emotional turmoil, informational needs, and logistical challenges associated with a cancer diagnosis. Navigators provide a single point of contact for the coordination and integration of services and they serve as a link between the patient and the cancer system, promoting the patient as a member of the health care team. They also support health professionals – in particular, family physicians – by linking them to appropriate experts in the cancer system and advising them on relevant resources.

The program is proactive and as such, can alleviate or manage what would otherwise result in high levels of patient distress. This type of patient navigation is a new early intervention that results in an enhanced capacity to support cancer patients and their caregivers.

**Customer Expectations Exceeded**

In March 2004, evaluation findings confirmed that cancer patient navigation has significantly benefited patients dealing with a cancer diagnosis. It has improved the quality and consistency of community cancer care in Nova Scotia by addressing challenges in access, integration, coordination, and the continuity of care. The following results were noted in the evaluation:

- Patients and their families reported that patient navigators became a central contact whose support resulted in decreased anxiety, stress, and fear
A patient-satisfaction survey revealed that navigators are closely matching expectations in terms of helping patients and families.

Physicians reported that navigators enabled physicians to use their time more efficiently to address medical issues.

Senior leaders and health professionals in the district’s health authorities in NS view patient navigation as essential and critical.

The project has contributed to the body of knowledge in supportive care by:

- Providing a better understanding of the psychosocial impacts of a catastrophic disease such as cancer.
- Confirming that logistical issues such as transportation and finances need to be addressed to improve timely access to treatment.
- Confirming that well-informed patients cope better with stress.
- Proving that patients who participate in decisions about their care comply better with treatment.

The evaluation of the cancer patient navigation model identified some of the benefits of navigation programs for people living with cancer. These include:

- Improved diagnostic wait times, access to services, and coping skills.
- An increased understanding of their cancer and the treatment plan, such that they are able to make more informed decisions.
- More education, which increased their ability to recognize critical side effects.
- Important emotional, informational, and logistical support.
- Early recognition of issues and challenges.
- A better ability to participate in decision-making about care for consultations and treatments.
- Increased patient compliance with treatment.

For health care providers, the benefits have included:

- The identification of systemic issues (e.g., the referral process for cancer centre treatment was not well known by community physicians; a redesigned process resulted in better access for patients).
- Improved collaboration and an increased interest in teamwork.
- The ability of physicians to use their time more efficiently to address medical issues.
- An increased appreciation of interdisciplinary cooperation.
- Higher workplace satisfaction.
- Greater satisfaction with the care provided to patients.

Overall systemic benefits have included:

- Improved access to optimal care for patients.
- Increased patient satisfaction.
- Improved management of oncological emergencies.
- Enhanced coordination between hospital and community-based services.
- A reduction of service duplication.
- Improvements in the continuity, quality, and consistency of cancer care.
- A potential for increased efficiencies and cost savings through better use of community services.
- The possibility of improved retention of health care providers.

**Effective Continuous Quality Improvement**

The collaborative nature of the Nova Scotian patient navigator model brought tremendous gains to patients and the health care system. It enabled patients to receive care closer to home and enhanced the community’s capacity to care for and support cancer patients and their families. Navigators are in a key position to enable continuity because their practice incorporates advanced knowledge and skills in assessment,
facilitating coordination of services, providing supportive care (including psychosocial support), managing distress, providing information and coaching, and clinical care. The development of the project brought together patients, families, physicians, health professionals, administrators, community partners, and volunteer organizations. They were all seeking long-term, sustainable changes and improvements in the access and delivery of cancer care in Nova Scotia. The project has clearly established that a continuous quality improvement approach is an effective way to make innovative changes to health service delivery by creating effective communication with a focus on listening to patients; promoting strong leadership and buy-in by key decision makers; and demonstrating that team involvement and commitment are critical to the success of any program.

Patient navigation is now recognized by many provinces as a key component of an integrated system of cancer care. Different navigation models have emerged, including professional, lay person (or peer/volunteer), and self-navigation (through virtual or online aids). There is a growing interest in navigation programs among patients, health care providers, and policy makers across Canada as a means of improving access, coordination, and continuity of care.

The Cancer Journey Advisory Group of the Canadian Partnership Against Cancer is currently engaged in a “Strategic Initiative: Moving Toward Person-Centred Cancer Care,” with the aim of increasing and enhancing the implementation of navigation programs across Canada. While these navigation programs ultimately aim to improve care, the characteristics of each differ according to their specific goals and the needs of the local population.

This initiative has been an effective and efficient health service delivery innovation for people in Nova Scotia who are living with cancer, those acting as their health care providers, and for the health care system in general. Cancer Patient Navigation has contributed to the body of knowledge that will shape the future of chronic-disease management in Canada.

It has also demonstrated the importance of helping people cope with and better manage their disease and provides evidence for an effective model for service delivery that improves patient flow through a very complex system. Finally, it demonstrates that quality improvement initiatives can also result in improved access to health care.

For more information on the Cancer Patient Navigation program in Nova Scotia, please visit the CCNS web site at www.cancercare.ns.ca. To learn what is happening nationally regarding navigation, please visit the CPACC web site at www.cancerview.ca. Q

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REFERENCES


DTUs Improve Patient Care
Emergency Department Observation Units (EDOUs) emerged in the 1960s as a way to improve patient care and diagnostic accuracy. Early EDOUs were based on chest pain pathway models and later expanded to include many conditions, such as congestive heart failure and transient ischemic attack (Cooke, 2003; Baugh, 2011; Harris, 2011). In Canada, formal EDOUs have emerged in the last five years as a result of Emergency Department (ED) overcrowding and the recognition that preventing inpatient admissions helps ED flow and efficiency. There are now seven EDOUs in Ontario as part of a pay-for-performance pilot project (Schull, 2011). In the pay-for-performance model, institutions are rewarded for increased efficiency and productivity, unlike traditional funding models. Typically, more efficient processes simply result in treating more patients without correlating budgetary increases.

EDOUs go by a variety of names, including Diagnostic Treatment Units (DTUs), Clinical Decision Units (CDUs), Medical Admission Units (MAUs), Emergency Department Short Stay Units (EDSSUs), and sometimes they are – quite cynically – called “Can’t Decide Units.” In this article, we use the term Diagnostic Treatment Unit or DTU.*

The DTU Model

The key to the DTU model is the highly protocol-driven nature of its admissions and the fact that the length of stay in the DTU is tightly regulated. DTUs are designed for patients who cannot be diagnosed and treated within the usual 2 to 4 hours that an emergency physician spends on moderately ill patients. In the classic care delivery model, patients who need more time before being discharged are referred to consultants for admission. However, many of these patients will improve and be ready for discharge within 12 to 24 hours. Inpatient admissions are therefore problematic because reassessment is measured by the day, while ED patients are usually reassessed hourly. Some people may therefore stay longer in inpatient care than necessary.

Effective DTUs have some common features. They have dedicated ward space and do not pilfer beds from the ED proper. Ideally, they are located beside the ED and employ previously unused or unfunded beds. Having a dedicated DTU increases the ED footprint in the hospital, which is generally considered beneficial. Ideally, the DTU space also provides patients with a quieter and more private space than a regular ED; patients should be less disrupted in DTUs.

Many loosely structured “virtual” units also exist throughout the country. In these units, any bed can be used as a DTU bed for up to 24 hours. However, if the bed physically remains in the regular ED, then the patient will not have the benefit of added privacy and quiet during their recovery.

One of the first DTUs in Canada was established at St. Paul’s Hospital in Vancouver, BC, in 2006. In the St. Paul’s Hospital model, a patient’s maximum length of stay in the DTU is 24 hours from their arrival in the ED. As soon as the patient’s situation becomes clear to the emergency physician, they are transferred to the DTU. This usually happens within 4-6 hours of ED arrival. Between hours 12-18 of their stay in the DTU, a decision to discharge or admit them is made. By the 24th hour the patient has either left the DTU for a ward bed or has been discharged. It is critical that patients do not dwell for an unnecessarily long time in the DTU.

A variation of the traditional admission order is created for every patient admitted to the DTU. St. Paul’s Hospital uses electronic physician order entry forms. Physicians use these forms to write a brief synopsis of the patient’s condition, and a binary algorithm is usually identified for their care. For example, if a patient with a minor gastrointestinal bleed remains stable, they can be discharged; if they cannot be stabilized, they are admitted.

What are the Benefits of DTUs?

DTUs can improve ED efficiency and decrease the number of short term admissions to hospitals. Schull recently

*This article is only about DTUs run by emergency physicians. Units run by internists or hospitalists tend to have lengths of stay longer than 24 hours and are therefore outside the scope of this article.
Katie Laferty reported on the ability of DTUs to reduce the length of stay for low-acuity non-admitted ED patients and to create a small reduction in hospital admissions for moderately ill patients; this cohort included virtual DTUs (2011).

DTUs are effective for several reasons, including the fact that they:

- Decrease the number of short-term admissions and thereby increase the capacity for long-term inpatient admissions
- Increase the ED “dwell time” available for diagnostic testing, which reduces the likelihood of missing serious problems
- Decrease the number of hospital-acquired/iatrogenic illnesses/infections (e.g., clostridium difficile colitis) by reducing the number of unnecessary admissions
- Eliminate the need for additional short-term outpatient clinic follow up in the case of TIA management
- Improve ED efficiency for pay-for-performance initiatives
- Decrease the number of ED physician handovers, which are a potential source of risk
- Are more cost effective than admitting patients to more expensive inpatient beds (Sieck, 2005; Baugh, 2011)

**DTU Data**

The overall inpatient admission rate from the DTU at St. Paul’s Hospital is around 15 to 17 per cent; this is in keeping with published data from other hospitals (Ross, 2001). It is notable that in the St. Paul’s Hospital DTU cohort, twice as many patients over 70 required admission as those below 70 years of age. One hospital study suggests that the most common factors associated with admitting inpatients from the DTU include persistent pain, an inability to ambulate, multiple consults, and seeing multiple allied health consultants (such as physiotherapists) in the DTU (Chan, 2008).

At the St. Paul’s Hospital DTU, the average time from triage in the ED to a DTU order is 3.4 hours. The average DTU length of stay is 8.5 hours; this reflects the large number of chest pain pathway patients who enter the DTU. Figure 1 shows the breakdown of common diagnoses for DTU patients from 2008-2010.

**Figure 1. Top Five St. Paul’s Hospital DTU Admissions 2008-10**

1. Chest pain not yet diagnosed
2. Abdominal pain not yet diagnosed
3. Alcohol intoxication (acute)
4. Pneumonia
5. Diarrhea/Gastroenteritis (no obvious food poisoning)

**Staffing the DTU**

Approximately 4 to 10 per cent of annual ED visits is a reasonable target volume for a new DTU (Baugh, 2011; ACEP, 1988). Therefore, if approximately 8,000 patients per bed are seen in the ED, approximately 320 to 800 patients per bed should be seen in the DTU. Nurse to patient ratio requirements make four beds the minimal effective DTU size; this is the size of the St. Paul’s Hospital DTU.

At St. Paul’s Hospital, a multidisciplinary team manages our patients, including a nurse practitioner (Monday to Friday), a nurse (24/7), and an emergency physician. We have the equivalent of five hours of emergency physician coverage per day to manage patients. The binary nature of most DTU decisions (i.e., admit or discharge patients) makes it reasonable for the DTU to fall under the emergency physician’s care. The nurse practitioner has proven invaluable in ensuring smooth discharge planning and a minimal workload for the DTU’s emergency physician.

**Summary**

St. Paul’s Hospital continues to enjoy some of the shortest ED lengths of stay in the region for both low and high acuity patients. Admittedly, flow and efficiency are complex issues and the presence of the DTU is likely only partially responsible for these results. Interestingly, in 2009 the number of short term medical admissions from the ED rose in all Vancouver regional EDs except St. Paul’s Hospital, whose short-term ED medical admissions stayed flat (Vancouver Coastal Health Decision Support, 2009). At the time, St. Paul’s Hospital was the only ED in the region with a DTU.

We estimate that our 4-bed DTU prevents about 300 admissions a year and saves about 1000 bed days that can be used for other admissions, thereby helping to decongest the ED. It is worth underscoring that the DTU has functioned without significant degradation in performance for 4+ years.

DTUs are helpful in improving ED flow and efficiency. They can also help reduce short-term medical admissions. A legitimate
case can be made for their implementation based on the opportunity costs of a less crowded hospital that requires fewer surgical cancellations due to bed shortages. Furthermore, DTU beds are less expensive than inpatient beds.

The key to the successful implementation of DTUs resides in their having dedicated space and rigorous protocols to ensure that patients are discharged within 24 hours. Q

Lawrence Cheng, MD, CCFP(EM), MPH, is an ER physician and the Physician Operations Leader at St. Paul’s Hospital Emergency Department. His main focus has been redesigning health care delivery in the ED by combining best clinical practices with business operational excellence. Dr. Cheng has led a number of innovative initiatives at St. Paul’s including the Diagnostic Treatment Unit and the Rapid Assessment Zone that have been recognized at both the regional and provincial levels.

Devin Harris, MD, CCFP(EM), MHSc., PhD (candidate), is a Clinical Associate Professor, Department of Emergency Medicine, at the University of British Columbia (UBC) and a Staff Emergency Physician at St. Paul’s Hospital, in Vancouver. He completed medical school, residency, and graduate studies at UBC. He has authored publications, given presentations, and been an investigator for multiple studies on the management of patients with transient ischemic attack and stroke. He is currently completing a PhD with a focus on improving the quality and efficiency of the delivery of health services to patients with cerebrovascular disease in the emergency department.

Eric Grafstein, MD, FRCPC, is the Head of Emergency Medicine at Providence Health Care and the Chair of the Vancouver Coastal Health Regional Emergency Services Council. He is the former Director of ED Informatics at Providence Health Care. He spearheaded several IT projects at Vancouver Coastal Health and at St. Paul’s Hospital. He has also been involved in Health Services Research for the last 12 years, having developed an extensive emergency medicine administrative database.

REFERENCES


Taking Telemedicine to New Heights
Telemedicine has given the staff at The Royal Ottawa Mental Health Centre (The Royal) the capacity to offer services to people who might otherwise be out of reach. This includes the ability to serve Canada’s first long-duration mission in space, Canadian military personnel returning from Afghanistan, seniors living in long-term care homes in northern Ontario, and even providing service to a federal courtroom in the Yukon.

As Chief of Staff and Psychiatrist-in-Chief at The Royal, I know that telemedicine is an innovative way to expand the reach of our mental health care to outlying areas. There is a health care need that must be met through expanded telemedicine services. As a champion of telemedicine, I am excited to have the opportunity and the staff support required to push it to new heights.

The Human Factor

In Ontario, psychiatry/mental health consultations in 2009-2010 accounted for 53 per cent of all clinical telemedicine activity (53,960 consultations), according to the Ontario Telemedicine Network in its annual report. Yet, there are not enough physician specialists to fill the demand for this service. Despite tremendous advances in telemedicine technology, its success still hinges on human resources.

Many more specialists could participate in this activity, but not all of them can or want to engage in telemedicine provision. I currently shuffle my practice from my office to the telemedicine studio for approximately 100 consultations per year.

Dr. Peter Yellowlees, Head of the Department of Psychiatry at the University of Queensland, and the Director of the Queensland Telemedicine Network, is one of the world’s leading telemedicine researchers. He is also its active proponent and the author of dozens of journal articles and electronic publications including Successful Development of Telemedicine Systems — Seven Core Principles, in which he states (Yellowlees, 1997):

“While the technology is rapidly evolving, changing, and fascinating, it is still the human factors that tend to determine success or failure of telemedicine projects. These cannot be ignored. ... Telemedicine involves major changes for clinicians — learning new technology, new interviewing skills, new group skills, and how to present themselves on TV. And it’s a slightly more threatening way of working because a nurse or another doctor may be watching at the other end. For some doctors, that is difficult. For most, it is fine.”

Mainstreaming Telemedicine

At The Royal, our telemedicine program has increased access to care for previously under-served populations in rural and urban communities across Canada. Since the first teleconsult in 1996, the program has created new and innovative possibilities and partnerships, as with Veterans Affairs Canada, the University of Ottawa’s Northern Ontario Francophone Psychiatry Program, and the Canadian Space Agency.

As an early adopter of this technology, some of The Royal’s staff members actively participated in the development of the National Initiative for Telehealth Guidelines in 2003. These guidelines were used as a framework by Accreditation Canada when developing telehealth standards for its accreditation program. As a pilot site for the new standards, The Royal was one of the first health care providers in Canada to be assessed using Accreditation Canada’s new criteria for telemedicine services.

We have continued to develop telemedicine services and are excited about our latest innovation — using it in our
Operational Stress Injury Program to support Canadian veterans suffering from post-traumatic stress disorder. The clinical team has also added relaxation therapy programs to its roster of telemedicine services and the response thus far from clients has been encouraging.

The Royal's geriatric psychiatry program was also the first to offer telemedicine access to clients for care and follow-up services. This eliminated the need for some of their long-distance travel to appointments, which can be costly, inconvenient, and possibly dangerous.

For example, people with a mental illness have a higher risk of getting into a car accident than other drivers. According to the Canadian Psychiatric Association Journal, 34,000 dementia patients drive in Ontario, and in the next 24 years that number will jump to 100,000 people, “all with a condition that will make them more likely to crash” (Hopkins, 2004).

Telemedicine is an acceptable tool for providing mental health care access to these patients and many others who live in remote areas.

**Partnership and Support**

In the fall of 2010, The Royal received one of the largest philanthropic gifts ever made to a mental health care centre. Bell Canada gave one million dollars to help The Royal become a centre of excellence in telemedicine.

Among other endeavors, The Royal will use some of this funding to establish a national best-practices model that will inform and inspire other mental health providers across the country. A portion of the funding has also been allocated for the creation of literature about quality components that are integral to telemedicine services. This will help us determine which measureable efficiencies best support the case for making telemedicine a part of mainstream health care delivery.

The Royal currently has 18 videoconference systems set up at sites between Ottawa and Brockville, Ontario, and is planning to add many more through partnerships with companies and organizations that support people living with mental illness. We also plan to move the newest state-of-the-art technologies closer to points-of-care.

**Conclusion**

In 2007, Dr. Richard O'Rielly, Dr. Jakinter Takhar, and Dr. Michael Fisman of the University of Western Ontario's Department of Psychiatry, studied the effectiveness of telemedicine consultations versus traditional face-to-face encounters. After assessing the results from a randomized controlled equivalence trial, they concluded that “…psychiatric consultation and follow-up delivered by telepsychiatry produced clinical outcomes that were equivalent to those achieved when the service was provided face-to-face” (O'Reilly, 2007).

Furthermore, patient evaluations of our telemedicine services have been overwhelmingly supportive. During the pilot project phase of the telemedicine program, 90 per cent of clients were satisfied with their consultations. For most patients, the burden of receiving treatment includes long waits for appointments, travel time and costs, time away from work and loved ones — oftentimes this burden is also shared among family and friends. Telemedicine is helping to reduce this burden and provide people with access to services that they might not otherwise receive.

At The Royal, we will continue to focus on expanding our reach, providing quality care, and taking telemedicine to new heights! Q

**Dr. Rajiv Bhatla** joined the Royal Ottawa Hospital in 1992. He is Psychiatrist-in-Chief and Chief of Staff of the Royal Ottawa Health Care Group and is an Associate Professor at the University of Ottawa. He holds the position of Vice-Chairperson of the Consent & Capacity Board of Ontario. In addition to his expertise in concurrent disorders, Dr. Bhatla has an interest in psychiatric ethics and is a member of the Editorial Committee of the Journal of Ethics in Mental Health.

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Language Access Interpreter Services in Winnipeg
Providing accredited interpreter services in a patient’s primary language helps address serious issues. It removes barriers between health care providers and patients who do not share a common language. Language Access Interpreter Services (LAIS) enhances patients’ access to high-quality and safe services, increases patient understanding and satisfaction, improves their quality of care, ensures informed consent, protects confidential patient information, builds relationships between the health care providers and patients, and assists health care providers in meeting their professional and legal obligations.

While language services have existed for decades for some constituencies within the Winnipeg health region (e.g., French and Aboriginal communities), formalized interpreter services for immigrants and refugees were not available until 2007. Prior to that time, family members often assisted with communication between providers and patients, causing safety concerns and complicating access for patients. Winnipeg’s Regional Health Authority (WRHA) Language Access Interpreter Services (LAIS) program aims to improve health care access for patients and reduce the risks associated with language barriers and the use of untrained interpreters (family members, friends, visitors) (Bowen, Gibbens, Roy, Edwards, 2010).

Casual or family interpreters generally do not have the skills or training necessary to interpret medical information accurately; confidentiality and impartiality are also important concerns. Furthermore, there are health care risks associated with language barriers in general, including (Bowen, 2001; Flores, 2005; Bowen et al., 2010):

- Decreased access to care and preventive health services
- Poorer health outcomes because of delayed access to appropriate care
- Decreased patient compliance with prescribed treatments
- Increased risk of misdiagnosis and critical incidents due to the patient and the care provider not fully understanding each other
- Duplication of tests and medical visits
- Decreased patient and provider satisfaction
- Increased health system costs due to re-visits resulting from not accessing the right service at the right time

To enhance accessibility for four particular constituencies of patients – Aboriginal, French, Deaf, and immigrants/refugees – the WRHA conducted research and then developed, implemented, and evaluated the LAIS initiative in the Winnipeg health region between 2004-2008 (Bowen, 2004, 2005; Gibbens, Bowen, 2008).

An environmental scan of language services in 2004 revealed that interpreter services in the Winnipeg health region varied in quality and availability, lacked centralized service coordination, and were frequently not accessed when needed (Bowen, 2004). Furthermore, there were no language services specifically for immigrants and refugees and there was minimal awareness of the risks associated with language barriers.

Providing accredited interpreter services in a patient’s primary language helps address these issues. It removes barriers between health care providers and patients who do not share a common language. LAIS enhances patients’ access to high-quality and safe services, increases patient understanding and satisfaction, improves their quality of care, ensures informed consent, protects confidential patient information, builds relationships between the health care providers and patients, and assists health care providers in meeting their professional and legal obligations.

The LAIS Program: Innovation in Access

Language assistance services are provisions for enhanced communication. There are two main services in this category:

1) Interpretation – converting a spoken message in one language to an equivalent spoken message in another language

2) Translation – converting a written message in one language to an equivalent written message in another language

The WRHA LAIS focuses on trained health interpreter services. These services are available free-of-charge to all WRHA and WRHA-funded services, Cancer Care Manitoba, funded dental services, and fee-for-service physicians in the region. Services are also provided on a cost-recovery basis in social service, legal, and educational settings.

LAIS is a unique, evidence-informed, coordinated service
model (Bowen, 2005), and access is available 24 hours per day, 365 days per year for all four language constituencies, across the continuum of care, through a single phone number. The program’s delivery is informed by ethics and standards that are articulated in the WRHA Code of Ethics and Standards of Practice for Health Interpreters (WRHA, 2011).

Since the inception of this innovative program in June 2007, it has been continually expanded and enhanced. In 2010, Accreditation Canada designated this program as a Leading Practice. Today, approximately 60 trained, accredited interpreters provide in-person services in 29 languages; they are all LAIS employees and are called upon on an as-needed basis. Immediate over-the-phone services are also available 24 hours per day, 365 days per year in over 170 languages when urgent situations arise.

Notable aspects of the LAIS service model include:

- Centralized coordination of access to services
- Trained interpreters who are neutral (i.e., they do not support a particular intervention – they simply interpret information)
- One phone number to access interpreters 24 hours per day, 365 days per year
- A customized in-house training program for interpreters
- Standards of practice and a code of ethics for WRHA health interpreters
- Access to services across the continuum of care
- An evidence-informed strategy for determining priority service areas for LAIS
- Client-centered services that follow the patient (services are provided at no cost even when patients access services not funded by the WRHA)
- A multi-stage knowledge translation strategy to promote evidence-informed action that addresses language barriers throughout the Winnipeg health region
- Adoption of a region-wide policy, regarding access to and use of WRHA-authorized trained interpreter services
Consultation and collaboration with other WRHA services such as French Language Services, the Aboriginal Health Program, and external partners such as Kivalliq Inuit Services (Bowen et al., 2010)

Following the development of LAIS, a 5-month educational project was launched to increase awareness about the benefits of using the service. A significant part of the training focused on changing health care providers’ practices when they access interpreter services (e.g., having them access trained interpreters rather than relying on family members), and tips for working with trained health interpreters. The benefits of working with a trained interpreter include:

- Increasing health services access for patients
- Enhancing patient safety
- Increasing patient understanding of treatments and diseases/illnesses
- Improving overall quality of care
- Promoting informed consent
- Protecting confidentiality
- Building relationships between providers and patients
- Helping health service providers meet professional and legal obligations

The LAIS in the WRHA tracks utilization statistics related to the service, such as the number of incoming calls per week, the number of calls delayed, and the length of the delay. The LAIS team is now ready to take its data to the next level, using it to create quality improvement within LAIS, with clearly defined goals that will report on outcomes and service enhancements.

Lessons Learned/Reflections

Access to trained interpreter services allows patients with limited English proficiency to participate in their own care plan and treatment. This allows friends and family to continue in their role of providing emotional support and care, which is so important during the course of health services provision.

Staff, patients, and family members have all told us they benefit immensely from LAIS, and we are proud of how they speak about the services.

“Without this service, patient safety is compromised.”
~ Oncology social worker

“Could we please have the interpreter every visit? I can listen better when I don’t have to translate. It is easier.”
~ English-speaking family member of a patient

“Thank you; we understand better now. Before, our only choice was to trust the doctors.” ~ Mandarin-speaking patient’s spouse

“Truly an innovation in improving access for all to required health services.” ~ Pediatric nurse Q

Sandra Fedirchuk, PHEc, CNM, is the Director of Quality Improvement and Accreditation Services for the WRHA. She has held many management positions in her health care career including in acute care, long-term care, and regional and governmental positions. She is responsible for the day-to-day operation of many aspects of quality improvement within the Winnipeg health region, including client relations and feedback, accreditation services, and quality improvement methodology and education.

Jeannine Roy, RET, R EEG T, BA, has been the Manager of Language Access for the WRHA since 2006. She began her health care career in electroencephalography and dedicated over 20 years of service to the Pediatric Neurophysiology Department at the Winnipeg Children’s Hospital. In 1994 she became the Coordinator for French Language Services at the hospital, and in 2000 she became the Manager of French Language Services for the WRHA.

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Promoting Access and Quality in Endoscopic Services
In the last decade, the Canadian Association of Gastroenterology (CAG) has undertaken several important initiatives to help improve access to timely, high quality digestive health care for Canadians. The CAG was one of the first national specialty societies in Canada – and the only one in digestive health care – to define wait time benchmarks (Paterson et al., 2006), monitor wait times (Leddin et al., 2008, 2010; Armstrong et al., 2008), and examine human resources (Moayyedi et al., 2007). Our published data confirmed that many wait time targets are not being met and that wait times for digestive health care remain excessive. However, as a member of the Wait Time Alliance, the CAG continues its efforts to address wait times and improve access to digestive health care services in Canada.

Human resource constraints and limited capacity in the face of increasing demands have highlighted the need for safe, high-quality, patient-centred health care delivery and the appropriate use of limited resources. The adoption of patient-centred approaches could help bridge gaps between demand for access and limited resources. For example, the National Health Service in England, reported that a patient-centred approach to quality improvement in endoscopy improved both quality and access.

The CAG is leading a national program, in collaboration with the Canadian Partnership Against Cancer (CPAC), to drive quality assessment and quality improvement in digestive endoscopy and gastroenterology. Our primary goal is to support access to high-quality digestive health services for all Canadians.

Endoscopy is crucial for the effective management of diverse digestive problems, including gastroesophageal reflux disease (GERD), peptic ulcer disease, celiac disease, and inflammatory bowel disease, as well as the detection and prevention of gastrointestinal cancers. With 1.6 million endoscopic procedures performed annually in Canada (Canadian Institutes of Health Information, 2008-2009), it is essential that all processes related to endoscopic procedures function smoothly in order to provide all patients with timely access to high quality endoscopic investigations. This can only be achieved if care is provided by well-trained health care professionals working in an appropriate environment with the proper equipment to deliver care that is responsive to patients’ needs. In order to achieve this, assessment tools – like the ones described in this article – should be put in place to identify gaps in care and areas for improvement.

The ‘Quality Program – Endoscopy’

The Quality Program – Endoscopy (QP-E) provides a means of assessing and, ultimately, improving the delivery of patient-centred endoscopic services in Canada. It began in 2008 as a pilot program, and has now expanded to hospitals and clinics across Canada. The two main elements of the QP-E are the Global Rating Scale (GRS) and the Colonoscopy Practice Audit.
1. Global Rating Scale

Developed in the U.K. and adapted for the Canadian environment, the GRS is an online tool that enables endoscopy unit personnel to assess how well they provide the various elements of patient-centred service (Global Rating Scale, 2011). The scale was constructed to help units determine the quality of their service and guide them through a series of quality improvement interventions.

At each participating site, representatives from the nursing, medical, and administrative teams meet twice yearly to perform an online comprehensive evaluation of their service using 12 key markers of patients’ experiences (see Table 1). The GRS is patient-centred and requires regular monitoring of quality and safety indicators with a commitment to sustained, iterative quality improvement.

Table 1. Markers of Patient Experience

<table>
<thead>
<tr>
<th>Quality of the Procedure</th>
<th>Customer Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appropriateness</td>
<td>7. Equality</td>
</tr>
<tr>
<td>2. Information/consent</td>
<td>8. Timeliness</td>
</tr>
<tr>
<td>5. Quality</td>
<td>11. Aftercare</td>
</tr>
<tr>
<td>6. Timely results</td>
<td>12. Ability to provide feedback to the service</td>
</tr>
</tbody>
</table>

Table 2 contains statements pertaining to information/consent which can all be answered with yes or no. Each statement is assigned a level, from D to A – D being the most basic quality criteria and A being the highest. Progression from one level to the next can only be achieved if all of the criteria for the previous level have been met (i.e., are answered with “yes”).

Table 2. Questions Regarding Information/Consent in the Patient Experience

<table>
<thead>
<tr>
<th>2. Information/Consent</th>
<th>Level</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a published patient information sheet for all diagnostic procedures performed in the unit</td>
<td>D</td>
<td>?</td>
</tr>
<tr>
<td>The policy for consent is available in the unit in written and electronic form</td>
<td>D</td>
<td>?</td>
</tr>
<tr>
<td>There is a published patient information sheet for all endoscopy procedures performed in the unit</td>
<td>C</td>
<td>?</td>
</tr>
<tr>
<td>All patients are given an opportunity to ask questions about the procedure prior to the endoscopy by a professional trained in the consent process</td>
<td>C</td>
<td>?</td>
</tr>
<tr>
<td>Signatures are obtained on a consent form for all patients who can sign the form and procedures are in place for patients who require assistance with the process (e.g., disability, language, activity)</td>
<td>C</td>
<td>?</td>
</tr>
<tr>
<td>All patients are given sufficient time to ask questions before entering the procedure room</td>
<td>B</td>
<td>?</td>
</tr>
<tr>
<td>All consent signatures are obtained outside the procedure room</td>
<td>B</td>
<td>?</td>
</tr>
<tr>
<td>There is written guidance within the unit for withdrawal of consent during an endoscopic procedure</td>
<td>B</td>
<td>?</td>
</tr>
<tr>
<td>All published patient information sheets are reviewed annually and changed as necessary</td>
<td>A</td>
<td>?</td>
</tr>
<tr>
<td>Patients’ frequently asked questions are incorporated into the patient information sheets</td>
<td>A</td>
<td>?</td>
</tr>
<tr>
<td>There is at least one annual survey of patients’ experience of consent for endoscopic procedures</td>
<td>A</td>
<td>?</td>
</tr>
<tr>
<td>Findings of the patient survey are reviewed and acted upon within three months of completion</td>
<td>A</td>
<td>?</td>
</tr>
<tr>
<td>Failure to comply with withdrawal of consent guidelines established by the unit is registered as an adverse clinical incident</td>
<td>A</td>
<td>?</td>
</tr>
</tbody>
</table>
The GRS offers benefits from many perspectives as it provides or promotes the following:

**Overall**
- A means to facilitate patients’ access to endoscopy as a result of the efficient and appropriate use of resources
- A mechanism to support quality and service improvement by helping endoscopy staff identify and address areas in need of attention
- A process to involve all members of the endoscopy service and promote teamwork with the common goal of improving services
- A system to facilitate communication between the different endoscopy services in Canada, enabling the exchange of patient information sheets and processes, thereby minimizing duplication and accelerating quality improvement

**Endoscopist**
- Efficient reporting processes for endoscopy and pathology, which promote patient satisfaction and minimize the risk of miscommunication or repeated communications with patients and their referring physicians
- Access to archives of endoscopy-related publications
- Objective quality improvement processes and the promotion of educational programs to assist endoscopists in maintaining and improving their skills
- Clearly-identified quality outcome measures that provide documentation of endoscopists’ performance when they apply annually for the renewal of their institutional privileges and re-credentialing

**Endoscopy Nurse**
- A working environment conducive to high-quality patient care
- The availability of valid, procedure-related information for all patients
- Objective criteria for assessing patient comfort during the procedure and responding appropriately to patient concerns
- The availability of facilities to allow private, respectful communication with patients

**Endoscopy Unit Manager**
- Knowledge that all adverse events are identified and acted on
- Knowledge that indications for all procedures are evidence-based and that resources are not wasted on inappropriate procedures
- Efficient resource utilization based on the minimization of cancellations and rescheduling
- Proactive identification of patient concerns
- The availability of documented processes to address hospital accreditation requirements

**Patient**
- Comprehensive information on all procedures to ensure that consent is based on a full understanding of the risks and benefits of a procedure
- Knowledge that the quality of their experience and their feedback is important
- Reassurance that concerns about any aspect of the endoscopic procedure can be registered and that they will be addressed
- Reassurance that procedure-related pain or discomfort will be identified and managed in a safe, sensitive, and effective manner
- Timely health care based on the:
  - Effective, data-based management of waiting lists
  - Prompt communication of test results to patients and their physicians

2. **Colonoscopy Practice Audit**
Practice audits allow physicians to review patient records related to a specific area of their practice; this allows them to reflect on their practice and implement changes that will lead to practice improvement. In the colonoscopy practice audit of the QP-E, endoscopists complete a short audit of outpatients who underwent colonoscopy in a two-week period. Anonymous data are collected with respect to patient characteristics and the colonoscopy at the point of care in the endoscopy suite using a smartphone (e.g., BlackBerry, iPhone) or personal...
computer. Using a secure login, endoscopists can review their data promptly online and compare it to national results recorded by their peers. Data on wait times for consultation, procedure, and total wait times – along with quality indicator measures such as insertion and withdrawal times, completeness of the procedure, and quality of the bowel preparation – inform physicians about their colonoscopic practice. Using this data, they can then identify personal learning and professional development opportunities.

Audit participants may claim section 3 credits (3 credits/hour) in accordance with the Royal College of Physicians and Surgeons of Canada (RCPSC) Maintenance of Certification (MOC) program guidelines. This provides endoscopists with an additional incentive for skills maintenance and improvement.

The CAG was honoured to receive a 2011 RCPSC Accredited Continuing Professional Development Provider Innovation Award for the colonoscopy practice audit. The review committee was impressed with this innovative educational tool which supports the life-long learning strategies of gastroenterologists and other endoscopists and which contributes to the improvement of patient outcomes by addressing wait times.

Conclusion

Tools like the GRS and the practice audit have enabled staff in endoscopy units to identify and implement targeted interventions to improve the timely, quality, and safety of their services. Hospitals and clinics participating in the QP-E that meet the criteria are presented with the CAG’s Quality Endoscopy Recognition Award in acknowledgement of their commitment to continuous quality improvement. Twenty endoscopy facilities across Canada received this award for 2010-2011.

Whenever these types of tools are used, they should be repeated after several months – hopefully there will be demonstrable improvements in targeted areas, and staff will be able to look for other aspects of service delivery to enhance. Patients’ ability to access high-quality services should improve as a result of creating this type of continuous quality improvement loop.

For more information on the QP-E, please visit the CAG website at http://www.cag-acg.org/special-projects/quality-program-endoscopy or email QP-E@cag-acg.org.

David Armstrong, MA, MB BCHir, FRCP (UK), FRCPC, FACP, AGAF, is a gastroenterologist and has been Medical Director of the Hamilton Health Sciences Home Parenteral Nutrition Program since 1997, and Coordinator of the McMaster IBD Clinic since its formation in 2009. As Chair of the CAG’s Endoscopy Committee, he has been closely involved with the Canadian credentialing guidelines for gastrointestinal endoscopy, the Cancer Care Ontario Colonoscopy Standards Expert Panel, the CAG Quality Endoscopy Project, and the CAG Endoscopy Quality Consensus Conference, 2010.

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IT Innovations in the Accreditation Program
Accreditation Canada’s information technology (IT) capabilities have changed a great deal since 2000, when automating the accreditation process began. When the Qmentum accreditation program was implemented in 2008, additional features were added to enable greater and faster data exchange between Accreditation Canada and its client organizations.

Automating Qmentum made it possible for more client organization staff to participate in the accreditation process — strengthening staff buy-in to the process and the end results. In turn, Accreditation Canada can provide more detailed and robust feedback to each organization.

The focus of the Information Management team is always on optimizing the accreditation experience for clients — providing easier access to standards, reports, and other information; simplifying the data input process; and minimizing paperwork. IT is not the destination, but it can certainly make the journey smoother and more interesting.

AccrediMap

This past fall, Accreditation Canada launched a feature designed to help health care stakeholders, including the public, connect more easily with accredited organizations. AccrediMap is an interactive map that makes it easy to find Canadian health organizations that are accredited by Accreditation Canada. The AccrediMap is available at www.accreditation.ca, and shows all of the accredited organizations in a given region.* Users can click on a name to find the organization’s location and contact information. This feature makes it easy to find health organizations that prioritize quality and safety.

For those who want to be more directly involved in their own or their family members’ health care, AccrediMap makes it possible to find reputable organizations — be they hospitals, health clinics, or long-term care facilities — that make quality and safety a priority. AccrediMap supports informed choice and makes accredited health care providers more accessible to the public.

Quality Performance Roadmap

The Quality Performance Roadmap is another unique online tool, and it serves as a central hub for a client organization’s accreditation activities. It is an electronic means of organizing and tracking large amounts of information, and is an integral part of managing the Qmentum cycle.

Through the Roadmap, organizations can access the standards, view their aggregate self-assessment results, identify strengths and address areas for improvement, track indicator and instrument data, and monitor quality improvement initiatives. Self-assessment results are shown using green, yellow, and red flags so a client organization can easily identify gaps and develop action plans to address them.

Data Reports

Clients can generate reports to identify a team or a department’s strengths and areas for improvement, even drilling down to see results based on job roles or specific areas of care, while maintaining respondents’ anonymity. The final accreditation report is posted on the portal 10 to 15 days following the on-site survey.

Electronic reporting helps Accreditation Canada track and trend aggregate data, providing a unique perspective on health sector strengths and areas for improvement.

Looking Ahead

Each year, Accreditation Canada adds IT features and capabilities to support the accreditation process. For example, a dashboard is in the works for the client organization portal, to better display self-assessment and on-site survey results. As the technology becomes more interactive, clients are able...
to more effectively manipulate the data to meet their own priorities, and use it to coordinate targeted quality and safety initiatives and monitor the outcomes. As users of these features, surveyors and client organizations provide invaluable feedback, which is critical to ongoing IT development.

**Su Huynh** is the Chief Information Officer at Accreditation Canada. He has over 18 years of experience in information management. Su has led the conceptualization, development, and implementation of many strategic information management projects at Accreditation Canada. Su is a true champion in rendering the accreditation process more efficient, as well as more meaningful to clients and surveyors.
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(1) In select GO coverage areas.
Access to Person-Centred Care in Family Practices
Access is an important indicator of quality care. Timely access should not happen at the expense of other dimensions of care; it should be part of a strategy to deliver high-quality care. As new models of care evolve, it will be important for us to be innovative and flexible if we are to continue providing the kind of care that Canadians have a right to expect from us. This means care at the right time, in the right place, from the right provider, while at the same time maintaining a close link between patients and their main provider. This requires paying attention to access-related issues and to the many elements that relate to the organization of family practice/primary care.

In a recent issue of Qmentum Quarterly, Dr. June Bergman reiterated the importance of access as one of the key dimensions of an effective primary care system, along with coordination, continuity, and comprehensiveness of care (Bergman, 2011). There are many innovative plans under way to improve access to care in family practice/primary care in Canada. These include same-day access, shared care, inter and intraprofessional care, group visits, electronic communication, and health information technology.

Same Day Access

The concept of same day access or same day scheduling was disseminated by the Institute for Healthcare Improvement in the United States and it is taking hold in many parts of Canada. It is about “doing today’s work today” and eliminating the distinction between urgent and routine appointments (Murray, 2000). Using this system, it is possible for a patient to be seen on the same day they call for an appointment. The physician must initially work harder to clear the backlog of patients waiting to be seen, but eventually, it is possible to leave a significant number of appointments open (up to 40 per cent of all appointments). With this system, physicians can still accommodate patients with a regularly scheduled appointment or those with complex conditions that require more time or the involvement of several professionals.

Early evaluation of same day access practices has shown improved patient and provider satisfaction. There is also evidence of greater office efficiency, better clinical care, continuity of care, and the avoidance of duplicate services (Murray, 2003).

Shared Care

The College of Family Physicians of Canada and the Canadian Psychiatric Association has also considered collaborative approaches to care by involving family physicians and psychiatrists (Kates, 1997).

In some settings, a psychiatrist spends a half day seeing patients referred by the family physician in the same practice. A note is then entered on the patient’s chart with a clear management plan which may be the subject of subsequent interaction between the two providers. Face-to-face interaction and co-location facilitate access for the patient, increase consultation capacity, and enhance mutual learning by providers.

In another model, the Ontario College of Family Physicians introduced a collaborative mental health care mentoring program. A psychiatrist or general practitioner psychotherapist mentor is paired with a few family doctors and is available for guidance upon request via email or telephone (OCFP, 2011).

Evaluation of these initiatives has shown that they are perceived positively by patients and providers alike, improve access to care, and enhance system capacity. These types of collaborative models of care are now expanding into other clinical care areas (Kates, 2011).

Intraprofessional Collaboration

Some provinces are also improving the referral-consultation process, making certain that a referral by a family physician to a specialist includes the necessary clinical elements, is addressed to the appropriate specialist, and is prioritized appropriately using recent data. By the same token, providing feedback and guidance to the referring provider makes the process more efficient and effective.

Manitoba’s Bridging General and Specialist Care project is an innovation in the referral-consultation process. It consists of a directory of all specialists (including their scope of work) and an electronic system that refers patients to the specialist who can see them the soonest.

Timely access should not happen at the expense of other dimensions of care; it should be part of a strategy to deliver high-quality care.
In British Columbia, the Partners in Care Program gives interested family doctors expedited access to a range of specialists by phone, in order to streamline the patient journey and avoid unnecessary visits to the emergency department or a specialist.

**Interprofessional Care**

The medical complexity of many patients and the need for holistic community care has stimulated greater interprofessional collaboration within family practice. For example, in British Columbia, the Practice Support Program enables the medical office assistant – equipped with the Mental Health First Aid course and other tools – to take an active and engaged role in care.

According to the 2010 National Physician survey, 21.4 per cent of Canadian family physician respondents report being in an interprofessional practice (CFPC, 2010). Similarly, family practice nurses or nurse practitioners, working collaboratively with family physicians in a family health team are making inroads to enhance self-management through various programs.

**Group Visits**

Group visits have been implemented in some Canadian provinces, and these offer flexibility in terms of provider remuneration. For group visits, patients with a similar condition are seen together in one room; a range of providers also give attention to each participant and conduct group activities. The best evidence to date regarding the benefits of group visits comes from literature on the management of patients with diabetes mellitus. Studies show that those who participated in group visits were more likely to receive preventive interventions, have their urine checked for microalbuminuria, participate in patient education, and have helpful one-on-one counselling (Wagner, 2001). Furthermore, they showed a greater reduction in cardiovascular risk factors (Kirsh, 2007; Edelman, 2010). Early evaluation results for this model are positive, but further research is required; system supports to address legal and funding issues are also necessary.

**Electronic Communication and Health Information Technology**

Haggerty et al. found that being available to patients by telephone helped improve accessibility and continuity (2008). And yet, patients often call doctors’ offices only to get an answering machine, or an automated message.

Several reports also remind us that Canada has lagged behind in the implementation of electronic medical records (EMRs). A 2010 Commonwealth Fund Report indicates that Canada placed last in an evaluation of patients’ electronic communications with their most responsible provider. The 2010 National Physician Survey showed that 18.4 per cent of Canadian family physicians had web sites; of those, 13.1 per cent allow booking appointments online. Non-website electronic appointment/scheduling tools are used by 51.9 per cent of Canada’s family physicians (CFPC, 2010). EMRs have the potential to support effective collaborative care, and to improve access to appointments, advice, and care.

**The Right Panel Size**

In order to provide timely access to quality care, it is important for a practice to have an appropriate panel size (i.e., the
number of patients it can manage). The right panel size is one in which there is a good match between the demand and supply of services in a given practice. There is evidence that too large a practice results in less access to care (Campbell, 1996; Wilkin, 1984; Hudon, 2004), worsened continuity (Murray, 2007), lower-quality disease management (Russell, 2009), and a decrease in the comprehensiveness of care (e.g., a reduction in home visits) (Butler, 1987). There is also greater potential for the duplication of services and an increase in the number of inappropriate referrals.

Multiple factors must be taken into consideration when determining panel size. These include provider remuneration, the associates’ scope of practice, the case mix of the patient population, the community served, and the physician’s characteristics. Human resources support and office infrastructure will also affect an office’s productivity level.

Conclusion

Access is an important indicator of quality care. Timely access should not happen at the expense of other dimensions of care; it should be part of a strategy to deliver high-quality care. As new models of care evolve, it will be important for us to be innovative and flexible if we are to continue providing the kind of care that Canadians have a right to expect from us. This means care at the right time, in the right place, from the right provider, while at the same time maintaining a close link between patients and their main provider. This requires paying attention to access-related issues and to the many elements that relate to the organization of family practice/primary care.

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REFERENCES


Teleradiology to Solve Wait Times
From January 2009 until July 2011 PEI’s CT wait times diminished from 22 weeks to three weeks or less. MRI wait times decreased from 33 weeks to eight weeks for cases prioritized as routine, elective, or non-urgent. How did this incredible change occur?

In 2006 Prince Edward Island committed to Canada's National Wait Times Initiative (NWTI) (Health Canada, 2004). This initiative provided federal funding to the provinces to improve access to health care in five major areas, including diagnostic imaging [specifically, Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)]. In joining the NWTI, the province agreed to report its wait times to the Canadian Institute for Health Information for web publication.

Growing Discontent

Diagnostic Imaging Services on PEI operate from two acute care and five community hospitals; two CT scanners and one MRI scanner serve approximately 140,000 people province-wide.

In recent years, a growing dissatisfaction with the imaging wait times on PEI emerged. A physician/nurse practitioner referral satisfaction survey conducted in May of 2010 indicated dissatisfaction with wait times for CT and MRI appointments and report times. Diagnostic Imaging also received many direct complaints from patients and referring physicians/nurse practitioners with respect to the length of time required to access imaging services.

Diagnostic Imaging therefore established a committee, and using the LEAN methodology workflow analysis, identified several key issues contributing to excessive wait times (Graban, 2009). These included scheduling practices, issues around equipment and human resources, and radiologist staffing.

Scheduling Practices

Prior to the use of a provincial diagnostic imaging model, each of the seven hospitals scheduled its own patients for diagnostic imaging exams through the Radiology Information System (RIS). This lack of a comprehensive provincial model resulted in discrepancies among the various hospitals’ wait times and in time passing before requests were entered in the RIS. Reorganizing the scheduling practice to a provincial model meant that patients were offered the first available appointment, regardless of their location. Equipment and human resources began to be used more effectively.

Importantly, scheduling templates were also improved to better reflect patients’ acuity levels. The scheduling process was evaluated and adjusted to ensure that each requisition was entered in the RIS system as soon as it arrived, so that the data being used to prioritize patients was consistent and accurate. The process for prioritizing requisitions was standardized as a quality improvement measure.

Equipment and Human Resources

The existing technical staffing model was inadequate, inefficient, and provided limited hours of operation and access for CTs and MRIs; as a result, expensive equipment was underutilized. Appointment times were often inconvenient for patients as non-emergency CT and MRI services were only provided between 8am and 4pm Monday through Friday.

After joining the NWTI, the MRI wait time was helped by the addition of a general/MRI technologist, a focused clerical staff person for MRI, and extended hours. The NWTI provided additional technologist resources for CT scanning and as a result, the service extended its operating hours and the number of appointments it could offer to patients.

An upgrade to the hardware and software of the MRI scanner also increased throughput. Furthermore, the MRI staff adjusted protocols, scanning parameters, and exam schedules to decrease the length of exams and the time required for room preparation. These factors decreased the length of time for performing exams by 25 to 30 per cent.

Radiologist Staffing

Despite these changes, a chronic shortage of radiologists still limited Diagnostic Imaging’s ability to significantly increase the number of exams that were read/interpreted; keeping wait
times for reports at reasonable levels was a constant challenge. Although locum radiologists were hired as often as possible and provided good interim help, a long-term solution (i.e., consistent coverage) was necessary. There was also a shortage of radiologists who could interpret breast screening exams, and although breast screening was not a part of the NWTI, wait times for appointments were more than 12 months and needed to be addressed.

Teleradiology

The committee established priorities based on the three key issues noted previously, and the primary initiative that resulted was a teleradiology project, which addressed staffing shortages. An agreement between the PEI Department of Health and a radiology group in the Capital Health region of Halifax, Nova Scotia has radiologists in Halifax providing temporary radiology services to PEI; the Halifax-based group needed to obtain licensing on PEI for this project.

*Note: Breast screening images were not part of the teleradiology agreement. A separate agreement with a radiologist from Ontario who was also licensed on PEI, provided on-site breast screening reports every three to four weeks for a period of two years. Though not part of the NWTI, this supported the reduction of breast screening wait times from 12 months to within three weeks.
In addition to the commitment of their daily workload, the Halifax-based radiologists interpreted a pre-defined number of studies each day for PEI and committed to a predetermined turnaround time for reports. Their work included interpreting general X-ray, CT, MRI, and nuclear medicine images.* Physicians from PEI were given access to the radiologists in NS who had prepared their patients’ reports if consultation was required.

The imaging performed on PEI was sent via a secure link to an on-site server in NS. Once the reports were transcribed, verified, and signed, they were returned to PEI for distribution. Images were deleted from the NS server once reports were completed; this ensured the security of patients’ data and images. Furthermore, radiologists from NS had to be given permission to access the information from PEI.

This partnership enabled hospitals on PEI to increase the number of scans they performed and offered additional support to PEI’s radiologists while recruitment efforts continued. This project has had a positive impact on wait times for appointments as well as wait times for X-ray reports.

**Lessons Learned**

In the course of these initiatives, our team of radiologists on PEI learned that:

1) There are usually many factors that contribute to a single problem. The time and attention that goes into determining what these issues are is time well spent. If five factors are contributing to a problem, and only one is addressed, the problem will remain. By determining exactly what was contributing to wait times, we were able to achieve dramatic results.

2) It is crucial to track data about your initiatives so you know whether your interventions are working.

3) It is imperative to remain flexible when initiating an improvement process; evaluation and changes were required at several stages of our process.

4) Finally – but perhaps most importantly – improvement initiatives require a number of dedicated professionals to provide their expertise in order to achieve decreased wait times, efficiency in the use of resources, and improved satisfaction for key stakeholders (e.g., patient, referring physician).

**Results**

A decrease in wait times for CT has been achieved and sustained since April 2009. A CT appointment can be requested and granted within a few days at sites that offer CT services. Staff satisfaction at these sites has increased as their workday is less compressed and workflow has improved.

MRI wait times gradually improved and have now leveled off at approximately eight weeks. This success requires constant monitoring to ensure that wait times do not climb as other pressures are exerted on the system. Q

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**REFERENCES**


Innovative Technology Links
Communities of Practice
In rural Ontario, it is difficult for health care professionals to meet and collaborate with members of their surrounding communities of practice. Too often, the best attempt at reaching health care team members consists of circulating paper memos or posting them on bulletin boards. Attending meetings can be challenging and often takes time away from the delivery of patient care.

With this in mind, in 2006, information management staff at the Winchester District Memorial Hospital (WDMH) considered how technology might help solve the problem. In particular, they aimed to increase effective communication and collaboration among the many health care professionals providing care for local patients. Over 100 organizations/providers were identified as members of the WDMH’s surrounding community of care. These included local medical clinics, physicians’ offices, community care and mental health agencies, and other hospitals, all of whom had a direct or indirect role in providing care for patients.

Creating LHINworks

To begin, the WDMH ensured that any technological investment it made was aligned with and could be used in future regional and provincial initiatives such as Infoway and eHealth Ontario.

In 2007, the WDMH chose and implemented Microsoft SharePoint as its collaboration and documentation platform. The Champlain Local Health Integration Network (LHIN) took notice of the steps WDMH was taking and asked the WDMH to host an administrative, e-form-based, funding application within SharePoint. The WDMH agreed and the LHIN was pleased with the result.

In 2009, the WDMH and the Champlain LHIN pushed this technology one step further and decided to collaborate to streamline and enhance communication among primary care physicians throughout the Champlain health care community. This ‘Extranet’ project, completed in August 2009, is known as the Champlain LHINworks, and it is being used as a model in other communities of practice throughout the LHIN.

Meeting the Need

Champlain LHIN hospitals and their community partners are separate enterprises that do not have the luxury of systems that integrate neatly together. In fact, fully integrated business solutions are not even on the horizon. The expanded LHIN Extranet, as led by the WDMH, therefore eliminates a great deal of inefficiency and allows the LHIN to maximize productivity by putting shared applications and tools online. This, in turn, enables support staff in physicians’ offices and hospitals to manage clinics more effectively.

This well-structured Extranet is helping to overcome many obstacles by facilitating access to essential information and documents, and allowing colleagues to work together asynchronously when needed (i.e., communicating at different times over a period of time). It provides tools that support virtual work communities where health professionals can “meet,” share relevant information and documentation, and engage in discussions as necessary to support the collective work of the team. These virtual work teams enhance both administrative and clinical functions.

The Results

The LHINworks technology is now shared by and licensed to health care providers within the region and the province. It reaches 2500+ registered users representing 350+ organizations, and these numbers grow every day.

The technology is used for collaboration, sharing, and development; health care providers and their organizations’ information management teams are building and implementing electronic workflow and e-form applications to meet their business and clinical process needs across organizations and care providers. The Extranet now hosts 500+ sites and numerous other efforts are underway that will expand the LHINworks’ impact.
The WDMH created the following online initiatives and tools in recent years:

2009
- First targeted application — eScheduling
- Pandemic planning
- Privacy Impact Analysis (PIA) Tool
- Self-Registration Tool
- Committee, board, and project websites

2010
- eConsult — pilot launch
- Regional Non-urgent Transportation Go-live (Rural South)
- Automated administrative tools and wiki
- Regional non-urgent transportation system
- Concurrent Disorder Screening Tool
- Further committee, board, and project websites

2011
- Patient tracking
- Enhanced eConsult service integrated into physicians’ electronic medical records
- Specialized Geriatric Services Network
- Lync services (real-time communication linked to the OCCAC, Cancer Care Ontario, and Sick Kids)
- Geriatrics emergency medicine eForms and workflow sheets
- Further committee, board, and project websites
- An electronic system to centrally track all children and youth referred for mental health services at two key hospitals (Royal Ottawa Mental Health Centre and the Children’s Hospital of Eastern Ontario)
- GAIN-SS concurrent disorder short screener application
- The WDMH is transferring knowledge about its successes to other jurisdictions through presentations, conference submissions, and one-on-one mentoring support.

The Impact
The eConsult program is now being used by numerous specialties, including Cardiology, Dermatology, Diabetes Education, Endocrinology, ENT & Head/Neck Surgery, General Pediatrics, General Surgery, Internal Medicine, Nephrology, OB/GYN, Pediatric Hematology/Oncology, and Thrombosis.

Figure 1 shows the impact of the Extranet’s eConsult program on family physicians’ decision making regarding referrals. Use of the eConsult program has decreased unnecessary referrals by an astounding 41%, and brought about necessary referrals in 6% of cases in which one was not originally contemplated. Here is what some users said about the Extranet initiatives:

Improved Access
The e-Consult allows me to “…clarify the urgency with which a patient should be seen and cut down on any other forms of communication that might take longer.”
“The timeliness of the responses has been excellent. I feel I am walking the halls of a tertiary care hospital and stopping consultants at my whim.”

Better Integration
The e-Consult allows me to “…communicate to the patient to bring their medication or to find out a bit about their family history [before specialists visit].”
“I was absolutely satisfied with the type of information, the clarity of it, and especially the timeliness of it.”

Avoiding Unnecessary Visits
“It’s a big advantage…especially for the older folks, not having…to go through the trip down to Ottawa.”
“…almost a filtering system to reassure family doctors and at the same time not burden ourselves as specialists with too many consultations that perhaps are not necessary.”

Summary
Staff members at the Winchester District Memorial Hospital are proud to lead a cutting-edge technological hospital in Ontario.
The opportunity to leverage this technology as part of the hospital’s new build in 2006 has had a significant impact. Five years later, the WDMH has been able to address significant communication challenges and develop a regional solution that supports knowledge exchange and collaboration across eastern Ontario.

In particular, the WDMH’s leading role in the development of the Champlain LHIN’s Extranet — LHINworks — has resulted in improved continuity of patient care. This successful innovation is now being shared and applied on a larger provincial scale.

Sean O’Brien is a recognized technology leader who began his IT career over 21 years ago at the Civic Hospital in Ottawa, Ontario. In 1998, he managed the IS/IT department for the Ottawa Regional Cancer Centre. Almost 8 years later, he accepted the role of CTO and IT consultant for a new Hospital being built in Winchester, Ontario. Sean received the “Who’s Who in Healthcare” award in 2007.
As 2011 comes to a close, I am delighted with the authors’ accomplishments and contributions to improving the quality of health care in the past year. They have shared valuable lessons with us about primary, mental, and community health services, and they have helped us enter into more productive knowledge exchange conversations with our peers.

As many of you may know, the first cycle of Qmentum was completed in December 2010, and this presented an opportune time for us to evaluate the entire program. This past October, Evaluating Qmentum: Results and Program Enhancements was released and is available on the Accreditation Canada surveyor and client portals and on our website at www.accreditation.ca/accreditation-programs/qmentum and www.accreditation.ca/programmes-d-agrements/qmentum. The report includes key findings and how the results will be used to enhance the accreditation program from this point forward.

The evaluation process reinforced the need for us to continue to respond effectively to organizational and jurisdictional priorities while maintaining program integrity. It also pointed to the need for greater efforts to coordinate the pan-Canadian quality agenda. The benefits of a national measurement and performance system (complementary to Accreditation Canada measures) and broader-level strategies, developed and implemented in full cooperation with the provinces and territories, would be immense.

Also note that Accreditation Canada recently revised its accreditation decision levels in an effort to provide clear accreditation-related terminology to the public and clients. It is important that patients and their families understand what it means when a health care provider has attained a particular accreditation decision.

The change in accreditation decision levels was made after extensive consultation with stakeholders, including client organizations across various sectors and regions. Based on this thorough review, the number of levels has been changed from three to four.

Until now, Qmentum client organizations have received one of three decisions: Non-accreditation, Accreditation with Condition, or Accreditation. Beginning in January 2012, the four decision levels will be: Not Accredited, Accredited, Accredited with Commendation, and Accredited with Exemplary Standing.

The change in decision levels is retroactive to organizations that had on-site surveys in 2011. Starting in January 2012, these organizations will be notified of their new decision level. Organizations that were accredited in 2011 will retain their accredited status under the new approach. It is important to note that it is not possible for accredited organizations to become Not Accredited as a result of this change. For organizations that earned “Accreditation with Condition” in 2011, the original on-site results and any conditions that were issued still stand.

In closing, I remind you that the Recognizing Excellence in Health Care conference will take place in Ottawa from 3-4 February 2012 and will consist of knowledge exchange opportunities, the sharing of best practices, and keynote speakers. It is tailored primarily to clients as well as Accreditation Canada surveyors. I encourage you to attend this event to share and learn about innovative approaches and exemplary practices in quality improvement.

I extend my best holiday wishes to all of the authors and readers; may everyone enjoy a joyous and healthy 2012!

With warm regards,

[Signature]

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