ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

A Collection of Referral and Consultation Process Improvement Projects

Prepared for

CMA: The Referral and Consultation Process –
Making the System Work for Better Patient Outcomes

Multi-Stakeholder Summit
December 5th, 2011

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Acknowledgements

The Arthritis Alliance of Canada National Musculoskeletal Models of Care Working Group

Purpose / Area of Focus:

No matter the perspective, musculoskeletal (MSK) conditions are costly; However, advancements in this area are limited. Increasing volumes and complexity have led to waste, thus, systematic solutions are needed. By eliminating silos, barriers, and waste, models of care focused on best referral methods can lead to appropriateness and efficiencies in care delivery. One of the challenges has been the existence of a broad variety of models of care (MoC), resulting in the need for criteria to define appropriate models that stakeholders will want to endorse and champion at the national level. The committee has recognized a number of leaders in MSK and MoC; under the auspices of The Arthritis Alliance of Canada, these leaders have been brought together to form a National Working Group to improve pan-Canadian co-operation and co-ordination for optimal MSK care delivery.

Timeline from start to implementation (or conclusion):

2011 to 2012

Stakeholders:

Arthritis Alliance of Canada, Canadian Orthopedic Association, Novokowsky Consulting Group, Ontario Rheumatology Association, Canadian Rheumatology Association, University of Calgary, Sunnybrook Health Sciences Centre, Patient Partners in Arthritis Program, Canadian Arthritis Network, The Arthritis Society, Arthritis Research Centre of Canada, Bone & Joint Canada, Ontario Medical Association, Canadian Institutes of Health Research, University of Toronto, and others.

Project Activities:

- To create further common understanding among the leaders and providers of MSK care, research and education of why we need MSK 'models of care' (including best referral methods), where the concepts fit in to health care delivery, and what that concept really means (all the things it embraces and includes).
- To establish a "strategic planning framework" through explicit validation methods.
- Based on the refined "strategic planning framework", decide how to go on to debate and define the specifics of "more detailed MoC" for all MSK disorders and how to potentially implement and evaluate them (over time) in all provinces.
- Validate, in a scientific manner, the use of the filters (i.e. consensus based standards) for prioritizing MoC for endorsement nationally.

Challenges:

Despite the increasing burden, advancements in care delivery have been limited. One of the challenges has been the existence of a broad variety of models of care (from micro to macro). Clarifying these gaps and providing new evidence on how to overcome these gaps from a broader chronic disease perspective, will provide our Working Group with useful information on developing consensus-based standards to advocate for appropriate referral MoC that can support health care planning and funding for chronic health care delivery.

Successes:

Formation of a Working Group has engaged leaders from across Canada with an interest in MSK conditions. Two national meetings have been held with Working Group members. The first meeting was successful in highlighting the value of defining appropriate Models of care. Additionally, through a number of break-out sessions and subsequent off-line discussions a minimum essential criteria for MoC

were identified. Most importantly, this meeting was successful in garnering the support of national leaders to establish a strategic framework for advocating MoC at the National Level. The second meeting set the ground work for validating, in a scientific manner, the use of the filters (i.e. consensus based standards) for prioritizing MoC for endorsement nationally.

Lessons Learned:

1. There is value in national leaders agreeing on how models should be evaluated and compared.
2. It is possible for a national consortium to define and prioritize best practices using some validated tools
3. Care pathways (including best referral methods) can be defined with evidence.

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Shared Care Strategy for Patients with Chronic Diseases: Partners in Care – Providence Health Care

Vancouver, BC

Purpose / Area of Focus:

Joint project between the Shared Care Committee, Providence Health Care (PHC) and in collaboration with Vancouver Coastal Health

Mission to improve care for patients with complex chronic conditions
- Simplify the patient and health care provider journey
- Improve health outcomes
- Reduce per capita health care costs
- Strengthen the relationships between primary care and specialists

Additional Partners in Care sites building on the PHC model include:
- Kootenay Boundary
- Salmon Arm
- Kelowna
- Penticton
- Victoria

Timeline from start to implementation (or conclusion):

April 2010 – April 2012

Stakeholders:

Family practitioners, specialists, patients, clinical and administrative leaders, office managers

Project Activities:

1. Development of a multispecialty telephone advice line for family practitioners. **R**apid **A**ccess to **C**onsultative **E**xpertise: **RACE.** RACE allows FPs to call one number, choose from a selection of specialty services and speak to the specialist usually within a few minutes. RACE addresses critical challenges faced between specialists and FPs and is viewed as a model that reduces costs by avoiding unnecessary ER visits and face-to-face consultation, streamlines patient care, supports FPs, and utilizes specialist services more appropriately.
2. Identification of key elements of a comprehensive referral form including implementation of a process for confirmation of receipt of referral. On receiving a referral in the specialty area, a fax back process was implemented to acknowledge receipt of the referral. Previously, FPs did not know if the fax was received and could wait several weeks or months before hearing from the specialty area regarding the specialty appointment.
3. Identification and trial of key elements and format of a consult. Copy provided to patient as requested.
4. Development and implementation of a process for bi-directional communication between specialist and FPs following a consult. Previously there was no process for communication between the specialist and the FP following the consult. Patients were often followed up in the specialty area post consult for assessment. With the shared care planning communication tool, FPs can communicate to the specialists any questions or concerns regarding the specialists recommendations and if further follow up is necessary.
5. Trial and implementation of a set of questions to assist the patient with self-management. Two sets of questions were trialed. The first set helps assess a patient's experience of their condition by asking about 4 dimensions: Feeling, Ideas, Function and Expectations. The other set of questions are 3 questions to assist patients in the development of goals and action plans related to their condition.

Challenges:

1. One size does not fit all
2. Ongoing engagement of physicians
3. Care to avoid replacing traditional referral/communication lines which are working well
4. Securing ongoing resources to support the services

Successes:

Several of the prototypes developed through this work have been scaled out regionally/provincially.
RACE Telephone Advice Line
- 11 specialty services currently participating
- 1100 calls over a 10 month period
- 75% of calls answered within 10 minutes
- Currently bringing on board provincial services
- "RACE in a Box" developed - all you need to know to start up a telephone advice line including a decision making tool for areas wanting to start up a telephone advice line

Acknowledgement of Referral
- Implemented in several PHC chronic disease clinics
- Implementation in several specialty private offices, Division of Cardiology, Division of Nephrology, Endocrinology offices
- Scaled out provincially and implemented in provincial programs - CHF

Shared Care Planning
- Implemented in several PHC chronic disease clinics
- Shared regionally/provincially

Self-management
- Feedback indicates that it is difficult to address the questions in a usual visit. If the questions can be given to a patient at one appointment by a nurse or FP, the patient can then think about them at home and discuss the questions on a follow up visit.

Lessons Learned:

1. Communication is key
2. Even when you think you have engaged well, continue to engage
3. Engage physician champions who can influence their colleagues and move the work forward
4. Take every opportunity to talk about the work, engage people in discussion and elicit feedback
5. Share everything possible
6. Utilize organizational leadership to leverage the work
7. Although we are working on tools and processes, progress to date is largely attributable to enhanced communication and interactions between family physicians and specialists

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Alberta Health Services (AHS) Closed Loop Referral Management Program

Calgary, AB

Purpose / Area of Focus:

AHS Closed Loop Referral Management will improve transitions from primary to specialty care in a seamless, transparent, efficient way. The program of work to realize this intention includes policy, service redesign, tools and technology. A closely related program of work is near real time wait time measurement and management for all scheduled services.

Timeline from start to implementation (or conclusion):

This provincial initiative to improve the referral process is in year 1 of a 3-4 year program of work that will include: service design, provincial referral standards by population, operational policy (standard response times etc), and automation using e-referral. However, improvement to the referral process is part of ongoing 'research and development' as a result of provincial wait time initiatives.

From 2007-2010 Alberta Health and Wellness invested in 12 wait time management initiatives including work in: Cardiac Access, Medical Access, Cancer Care (prostate, breast), Bone and Joint, Regional Flow etc. Irrespective of service area, geography or project there was a high level of congruence in the service models and findings across initiatives to improve access. We will build on the learnings and key successes from this work.

Stakeholders:

AHS Provincial Access team, AHS operations, clinical networks (cancer, surgery, bone and joint, mental health and addiction, seniors, chronic disease etc.), primary care, specialty care, nongovernment organizations, patients and families.

Project Activities:

The Closed Loop Referral Management Program will:
- Develop and maintain a complete provincial health service inventory
- Standardize the elements of referral and triage criteria across program areas such as cancer care, seniors care, surgical services, medical services, mental health and addiction, paediatric specialty services etc.
- Launch central access and triage (CAT) pooled intake processes
- Establish consistent operational policy regarding service response times, patient and provider communication
- Increase transparency of service availability, wait time, improve request tracking, and status reporting
- Improve demand management for health services

The referral process will be optimized through technology, or e-referral, and will result in improved responsiveness, coordination, and communication between primary care physicians and specialists.

Challenges:

- Magnitude of organizational change
- Competing organizational priorities
- Recent AHS structural changes
- Staffing/Human resource constraints
- Information technology solution in a mixed EMR/paper environment
- Engagement in design across primary and specialty care

Successes:

- Standardized wait time definitions complete across the patient journey
- Central Access and Triage Models have improved responsiveness by specialty groups, referral completeness, reduced number of intake points, referral management and patient flow
- Standardized information requirements improve communication
- Wait time targets established (urgent, semi-urgent, routine), monitored and managed for specific services eg Bone and Joint)
- Improved navigation through the use of program specific navigators (eg Cardiac access)
- Service model maturity helping to pave the way toward automation – proof of concept e-referral pilot

Lessons Learned:

- Primary care needs to be supported as the hub to improve access, efficiency and clinical care
- Design from a system's perspective to optimize part and whole; develop measures at different levels
- Practice standardization is a key enabler; strike a balance between provincial standards and local adoption. One size doesn't fit all.
- Geographic and population specific central intake and screening improves access and navigation.
- Optimized service delivery (eg operating rooms) in rural communities improves access closer to where people live, and reduces demand in urban centers.
- Engagement and collaboration at all phases of program design, implementation, and adoption
- Importance of collaborative leadership between physician and operations, on the ground project management support
- Automated, widely available and timely performance measures are required for improvement and sustainment
- Patient and family members need to be a part of the service design/improvement team

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Medical Access to Service (MAS) – Department of Medicine, Calgary, Alberta

Calgary, AB

Purpose / Area of Focus:

The Medical Access to Service (MAS) project was initiated with an overarching goal to work in a collaborative, integrated manner to improve medical access. Objectives included broadly engaging participants in the health system to collectively improve patient access to specialist medical services, and to improve service integration and communication between medical specialists, primary care physicians and their respective healthcare teams within Calgary , Alberta and the surrounding areas.

Timeline from start to implementation (or conclusion):

As a smaller pilot, the Rheumatology Central Access and Triage (CAT) was initiated in 2006 followed shortly afterwards by the Gastroenterology CAT formation. Using a Wait-times Management grant from Alberta Health and Wellness, the formal project started in 2007, involving key stakeholders to develop consensus and priorities for both the referral issues to be solved as well as a process for moving forward.

Stakeholders:

Key stakeholders included: Diverse medical specialists, primary care physicians, administrative and office support staff, patients, families, administrators, representation from the Alberta Medical Association.

Project Activities:

- The MAS project was launched after broad engagement with more than 200 different stakeholders. All agreed that the referral system was not working well and required substantial system redesign and improvement.
- Two Referral and Access Conferences were hosted in October 2006 and January 2007. The first conference focused on issue identification, the second on ideal design.
- Development of a standardized referral form to be accepted across specialty services.
- Development of central access and triage standards.
- Alberta AIM (Access Improvement Measures) Access and Efficiency Collaboratives were implemented in both specialty and primary care clinics and offices to redesign clinic process flow . These initiatives resulted in reduced wait times, both waiting for an appointment as well as during an appointment.
- An evaluation of the project in 2009 demonstrated that there was less time wasted, clinics were more often booked to capacity and patients were less likely to "fall through the cracks" because of missing or incomplete information. There was also a decrease in hospital admissions, emergency department visits and wait times.
- The Medical Access to Service Re-evaluation 2011 by Wait Times Management Initiative and Alberta Health and Wellness again demonstrated the benefits of the CAT model. This work has been one of the programs providing a foundation for the developing Provincial Closed Loop Referral System.

Challenges:

- Development of a Central Access and Triage (CAT) team requires physician champion(s) to make changes to business process, to develop a CAT team, develop referral criteria and triage guidelines and work with other MD colleagues to ensure the adoption of these guidelines and standards by all participating physicians within the specialty.
- The lack of common centralized electronic scheduler solution resulted in decreased efficiency and extra clerical work.

- Specialists booking own patients has created some inconsistencies. Some specialists within CAT-supported divisions still book their own patients which made it difficult for the CAT teams to triage and book appointments in a consistent and fair manner.
- Recruiting specialist professionals (RN's or other disciplines) into CAT roles and providing in-depth orientations can be challenging for sustaining operations during times of staff flux.

Successes:

- **A single point of entry -** A primary care physician does not have to send out multiple consultation requests in order for their patient to be seen by a specialist. A complete referral may be faxed to the specialty clinic's CAT team office to access all of the MD specialists within that specialty group or still request a referral to a specialist within the specialty group. There are currently 70 specialty clinics participating including Cardiac Care, the Department of Medicine, Clinical Neurosciences, Palliative Care and Cancer Care as well as specialty pediatric clinics from the Alberta Children's Hospital.
- **Improved information flow –** One of the CAT standards is that referring physician receives acknowledgement within 2 days of the clinic's receipt of the form and a letter within 7 days with appointment information. (No more "black hole" of referrals).
- **Standardized triage guidelines -** Triage guidelines provide detailed information regarding what is required for a complete referral to a specific specialty clinic.
- **Single referral form** - There is only one form is used to request a referral to all participating specialist teams. Primary care MD's no longer need to store a large variety of ever-changing referral forms.
- **Quality of referrals has improved over time** – the incoming referrals are more complete, containing essential information.
- **Referrals are being triaged according to standard and consistently applied urgency/priority guidelines.**

Lessons Learned:

1. Continuous measurement and reporting of referral data, wait times and patient demographics is essential to monitoring the success of Central Access and Triage.
2. Having a central electronic scheduling system is critically important.
3. Ensure funding allows for growth.
4. Fragmented physician participation creates confusion, dual standards, and inconsistent communication.
5. Keep primary care MDs / providers updated. Every effort must be made to ensure primary care MDs / providers are aware of how to access medical specialty clinics and receive updated information regularly.

Contact information:

Medical Access to Service Project and its associated Central Access and Triage booklet is found on the Department of Medicine website (www.departmentofmedicine.com/MAS/)

Any further questions or concerns please contact:

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Spine Pathway Project

Purpose / Area of Focus:

BACKGROUND:
- There are over 900 different spine conditions
- Many conditions – both sinister and benign, present in similar ways
- The result is that primary care providers refer many patients to surgeons who would be better served by early screening and medical intervention
- 80% of cases seen by a spine surgeon do not need surgical intervention
- It is possible for Primary Care Providers to accurately assess and treat spine patients without diagnostics, if they are trained to accurately assess using a history and physical exam

FOCUS:
- Develop an on-line course to train Primary Care Providers in the new system of assessment and management of low back injuries
- Establish Spine Centers to provide screening, treatment and navigation support to patients referred by primary care providers
- Develop educational materials for patients
- Develop a system to assess and offer management options to patients at risk for developing Chronic Pain

SEE THE TRAILER
www.spinepathwaysk.ca

Timeline from start to implementation (or conclusion):

Began work in 2009. Courses for primary care providers began 2010, Clinics opened in June 2011, Chronic Pain process is still in development.

Stakeholders:

Multi-Disciplinary Team – champions were spine surgeons

Project Activities:

- Development of New system of Assessment and Treatment
- Development of Physician training course
- Approval of course for CME credits
- Training 2,000 primary care providers (900 trained to date)
- Opening of the Clinics
- Development of new flow processes for diagnostics
- Development of Benchmarks, Dashboards and Clinical Studies
- On-Going:
  - Development of patient educational materials
  - Development of an assessment and screening program for Chronic Pain
  - Development of learning modules for Chronic Pain
  - Creating on-line modules of the Chronic Pain program

Challenges:

- Communicating to all primary care providers – and thus challenges with complete buy-in
- Very big change management project

Successes:

- 900 PCPs have completed the training with a 95% satisfaction rating for the course
- SPINE journal editorial in October 2011 featured the successes of the Saskatchewan Spine Pathway
- Wait times for consult have decreased and wait time for surgery has dropped significantly.

Lessons Learned:

1. Communication is key
2. Engage other partner organizations (such as CMA, SMA, professional bodies) early
3. Establish baselines
4. Celebrate successes with GREAT PATIENT STORIES

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Hip and Knee Pathway Project

Purpose / Area of Focus:

Regina, SK

BACKGROUND
- Patients waiting over 3 years for surgery
- Wait time to see an orthopedic surgeon - up to 18 months

FOCUS:
- Develop a system to streamline patient flow
- Develop multi-disciplinary screening clinics
- Provide surgical patients with education to assist them in preparing for surgery and readying their homes
- Provide navigation and support for non-surgical patients.

Timeline from start to implementation (or conclusion):

Began work in 2007. Clinics implemented in 2009. On-going work in developing culturally sensitive materials for the far north in Cree and Dene.

Stakeholders:

Multi-Disciplinary Team

Project Activities:

- Development of Centralized Assessment clinics
- Development patient education related to the surgical experience
- Development and implementation of shared decision making for patients considering surgery
- Create video support of the education material which includes key first nations languages.
- Development of new flow processes for diagnostics
- Development of Benchmarks, Dashboards and Clinical Studies
- On-Going
  o Improvements in provider engagement

Challenges:

- Communicating to all primary care providers – and thus challenges with complete buy-in
- Very big change management project

Successes:

- Wait time to MDC is 3 weeks
- Wait time for surgery is greatly reduced (few people waiting more than 6 months)
- Post PATHWAY quality of life demonstrates a 30% increase in self-reported function
- Reduced LOS
- Reduced OR hours per procedure
- Increases in volume of surgery

Lessons Learned:

1. Communication is key
2. Engage other partner organizations (such as CMA, SMA, professional bodies) early
3. Establish baselines
4. Celebrate successes with GREAT PATIENT STORIES

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Clinical Practice Redesign™

Purpose / Area of Focus:

Clinical Practice Redesign™ (CPR ™) provides an exciting new opportunity to Saskatchewan health-care providers to make real and meaningful clinical improvements for patients, while creating a better and more manageable quality of life for those providing care. It's about fundamentally changing "how" we work and communicate throughout the system to identify gaps and inefficiencies that may be affecting the patient and staff experience, as well as your clinic's bottom line.

It's about supporting clinicians and their teams as they learn to make clinic improvements by applying:
- Systems thinking,
- The voice of customer/patient and family centred care,
- Improvement methodologies (e.g., Quality improvement [QI] science, Lean, etc.), and
- Measurement and data.

Timeline from start to implementation (or conclusion):

The roots of the CPR™ initiative stem back to the 2009 "Patient First Review: For Patients' Sake", aimed at creating a health care system that is fair, coordinated, convenient, timely, communicative, and comprehensive. As a result, patient and family centred care initiatives are gaining momentum and becoming part of the way we provide care in Saskatchewan, much like the partners hope CPR™ will also become embedded into the way we practice.

Other recommendations within Patient First focussed on the need to communicate better at all levels (e.g., within practice, between practices, with acute, primary care, and other providers, and with patients) in order to provide better care and timelier access to services. In March 2010, the provincial government unveiled the Saskatchewan Surgical Initiative (SkSI), a plan to decrease surgical wait times. As part of SkSI, 11 strategic objectives were identified, which led to the development of 25 high priority provincial initiatives; the CPR™ initiative is one of these 25 and aligns with SkSI's "Sooner, Safer, Smarter" plan to accelerate success, under the "sooner" category. CPR™ is in its early days, but has dedicated funding for a minimum of three years (until March 2014).

Stakeholders:

CPR™ is a partnership between Saskatchewan Health Quality Council (HQC), Saskatchewan Medical Association (SMA), Government of Saskatchewan, regional health authorities, care providers, and patients.

Project Activities:

Regional health authorities, in partnership with HQC, have hired geographic coaches to help providers and their staff identify and test changes in their practices. Measurement is a critical part of the CPR™ initiative, but understanding what information to collect and how to use it can be challenging. That's where coaches can help. They work with practice improvement teams, helping them understand what data to collect, how to interpret it to make sure clinic improvements are producing desired results as well as sharing some simple quality improvement tools and methods clinics can use to identify improvements and sustain the great work already done.

To help providers understand the impacts of these changes, we've created a web-based tracking tool: www.TransformMyPractice.ca. The tracking tool helps clinics integrate measurement into their day-to-day processes. This allows clinics to effectively and easily understand their practice data and monitor the impact (e.g., measure supply, demand, and activity, third-next-available appointments, etc.). In addition, the CPR™ partnership continues to work closely with EMR vendors as EMRs are implemented throughout the province.

Challenges:

- Demonstrating to regional health authorities that this was not "another initiative" or "thing to do," but rather a critical step in transforming our provincial health care system, and a new way of working with providers within our system.
- CPR™ is not a technical solution that can be "done" for practices. It requires a fundamental mind shift in the way we deliver care; close attention needs to be paid to the adaptive change/change management required.
- Though the potential benefits of CPR™ are large, providers need to be willing to invest considerable time and energy into making CPR™ work. Given their current workload and demands on their time, this is not an easy ask.

Successes:

- Development of a user-friendly, web-based tracking tool (www.TransformMyPractice.ca)
- Coaches actively working with practices in 10 Regional Health Authorities across our province.
- Accreditation through both the Canadian Family Physicians of Canada (up to 25 Mainpro-C credits), and the Royal College of Physicians and Surgeons (Section 2- Personal Learning Project which merits two credits for every one hour).
- Links to current priorities in our health system, including Patient First Review, Saskatchewan Surgical Initiative, Patient and Family-Centered Care, Lean, Primary Health Care Transformation, and Saskatchewan Medical Association's EMR program.

Lessons Learned:

1. Ongoing and regular communication with all partners is critical!
2. Adaptive change will take longer but will be more successful and sustainable in the long term than other "bandaid" solutions.
3. Physicians/clinicians want a convenient, customized initiative that will allow them to focus their improvements on the areas that make the most sense for them.
4. Local coaching support appears to be vital for providing convenient, customized support for practices involved in making improvements.
5. Identifying and breaking down barriers within the system is essential in creating sustainable improvements across the province.

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Bridging General and Specialist Care Project (BGSC)

Purpose / Area of Focus:

A collaborative undertaking between Primary Care providers and Specialist for consultation and referrals (C&R), which consists of mutually agreed upon:
1. Scopes of practice
2. Consultation and referral criteria, specific questions and answers
3. C&R information requirements
4. Information requirements and criteria for transitioning the patient back to primary care
5. Supported by an IT System

Timeline from start to implementation (or conclusion):

Wave I: May – December 2008 (minus the summer!) 6 specialty areas included 8 care pathways
Wave II: January & February 2010 extended to 7 more areas

Stakeholders:

- Provincial Director, Patient Access
- Project Director / Project Manager
- IT Project Director & IT Project Manager
- Software Development Team
- Project Coordinators / SMEs
  - 4 PM staff, 1 admin
- Family Physicians, Specialists and Clinical Office Staff

Project Activities:

The Bridging General and Specialist Care pilot project was funded by Health Canada, and Manitoba Health and Healthy Living. Led by the Manitoba Provincial Director of Patient Access, and Manitoba Health Wait Times Task Force, the two year pilot project developed the following as primary project objectives:

1. Criteria for referral and timelines which will act as patient Wait Time Guarantees;
2. List of the specific information and tests that specialists require in order to decide upon a treatment plan during the first visit;
3. An IT system that will provide a foundation for communication between the primary care provider and specialist. This communication bridge is intended to facilitate the referral process when going to the specialist, as well as the communication between the specialist and primary care providers when the patient is sent back to the provider following consultation/treatment with the specialist;
4. An IT system that will immediately:
   a) confirm that a referral meets the criteria and is therefore accepted; or
   b) request additional pertinent information; or
   c) provide notification that the referral does not meet criteria, along with suggestions as to how to proceed;
5. Navigation/recourse strategy in the event that a patient is not seen for specialist consultation within the guaranteed time. [This involved developing a strategy for monitoring patient referrals through the system and intervening when patients could not be seen within the guaranteed timeline.]

Challenges:

- Lack of integration with other established computer systems (i.e., EMR, patient scheduling software, and clinic management software, imaging systems, etc).
- Technological glitches such as slow processing time, system freezing, etc.
- Too much clicking.
- Infrequency of opportunity to use the system with limited specialty areas included in the project scope.
- Change in the workplace environment including changes to established roles and responsibilities shared between office staff and physicians.
- Lack of enforcement to all service providers due to independent practices.
- Working within the target date was a challenge as we discovered they were ideal but not supported by service capacity in the system.

Successes:

- Specialist providers indicated that the quality of referrals received via the electronic system was much better than those received using traditional referral methods.
- Fostered communication between primary care providers and specialist via the message board
- Knowledge that referrals were received and when patients would be seen by a specialist.
- Navigation/redirection of referrals and the help desk support.
- Resource materials and support document imbedded in the care pathways

Lessons Learned:

1. Physician leadership was important in the clinical development and engagement of other clinicians.
2. Should have engaged office staff in the flow of referral process .
3. Systems need to be user friendly for all, especially the users who are not comfortable with technology/computer.
4. Collaboration of multidisciplinary clinicians to develop clinical referral pathways generated interest to continue with the development of more pathways.
5. Lack of integration and interface with other systems was a barrier in participation.

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Champlain BASE project: Building Access to Specialists through eConsultation

Ottawa, ON

Purpose / Area of Focus:

To develop, implement and evaluate an electronic consultation process between primary care providers (PCPs) and a range of specialists across the Champlain LHIN.

Timeline from start to implementation (or conclusion):

- Fall 2009: Initial meeting with PCP's, development of eConsult template and work-flow
- January 2010: Launch of phase 1 "proof of concept"
- January 2011: in-depth qualitative evaluation including PCP focus groups/interviews, specialist interviews
- May 2011: Phase 2 => improved forms and process, addition of delegates, expansion of PCPs and Specialties
- July 2011:Integration with EMR, proof-of-concept with 2 vendors initiated

Stakeholders:

- Family physicians
- Specialist physicians
- Winchester District Memorial Hospital (IT and Family Medicine)
- The Ottawa Hospital
- Elisabeth-Bruyere Research Institute
- Champlain LHIN
- Privacy officer
- CMPA
- EMR vendors
- eHealth Ontario

Project Activities:

1. Development of eConsultation form and process
   - Templates developed for eConsulation referral and specialist response – forms were kept simple, allowing the clinicians to choose what they feel necessary and pertinent
   - Consultation with CMPA and privacy experts
   - Decision made to use the Champlain Collaboration Space – an innovative and secure web-based portal readily available
2. Recruitment of primary care physicians and specialists
   - Physician leaders met with primary care providers and specialists to recruit participants
3. Launch of phase 1 "proof of concept" with 5 specialties and 17 PCP's (primarily rural communities)
4. Expansion of PCP and specialist participants – 41 specialists from 16 specialties, and 109 PCP's & delegates
5. Evaluation of phase 1 with in-depth interviews/focus groups of PCP's (users and non-users, specialists)
6. Launch of phase 2 with enhanced form and process to improve performance and incorporate Phase 1 feedback, integration into EMR

Challenges:

- Physician engagement and integration into office workflow
- IT challenges – secure access meant some users had difficulties initially with the authentication process, and the wide range of computers and browsers being used resulted in some compatibility issues that had to be worked around.
- Sustainable funding- no existing payment structure for e-consultations
- Organization of care delivery amongst specialists is low
- High level of support is needed for adoption of new technology into primary care

Successes:

- Successful collaboration across academic Dept of Family Medicine, Dept of Internal Medicine, community hospital and Champlain LHIN.
- Avoiding the use of a complex prescriptive form , and enabling the clinicians to freely communicate what they consider as relevant information about the case, turned out to be very effective – the number of cases where specialist request more information from the PCP, or where PCP requested more clarification/information from the specialist, were minimal.
- To date over 150 eConsultations completed across a broad range of specialties (28% dermatology, 13% cardiology, 12% endocrinology, 12% internal medicine, 10% neurology). Based on survey results, in 37% of the cases the need for a face to face consultation was avoided.
- Very high user satisfaction both on the PCP and specialist side. 62% of PCP's received good advice for a new course of action, 31% felt advice confirmed what they had planned and only 6% did not find the advice helpful. PCPs have rated the value of the service for them and their patients as Very Good or Excellent in >85% of the cases.
- One of the first successful applications of the new provincial eReferral specifications for the EMR integration component
- Service is operated and maintained with minimal cost/support and without the need for highly specialized technical support

Lessons Learned:

1. An eConsultation system can be established on existing off-the-shelf secure web-based platforms
2. The service is highly effective and holds great potential to improve access through avoidance of face to face consult
3. Web-based services have to be kept simple and fast for the physician community – user orientation/education is a MUST
4. Physician engagement requires high touch, on site contact, follow-up and patience
5. High level of satisfaction reported by physicians, and the Specialist community is particularly enthusiastic and supportive of this type of service as it reduces unnecessary referrals

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ZorgDomein (Care Domain) – Dutch Referral System

Purpose / Area of Focus:

Purpose:
1. Improve the efficiency and quality of consultations and referrals
2. Increase information and choice for patients and referrers
3. Increase appropriateness of referrals
4. Help to balance supply and demand for specialist services

Areas of Focus:
- Referrals between healthcare providers (FP, Specialists, Allied health professionals)
- Tele-consultation
- Requisitions for diagnostic imaging / lab / other investigations
- Referrals to LTC/nursing homes, mental healthcare, inter-hospital transfers

Timeline from start to implementation (or conclusion):

Deployment of the referral system in a new region is generally completed within 3-4 months. See project activities section below for details of the process that is undertaken.

The referral system has been in use, and continually refined, for over 12 years:
- Initially consisted of binders with referral pathways, and fax-based communication
- ZorgDomein provided Family Physicians with internet connections and EMR systems during the transition to electronic records in the Netherlands
- Currently the system is web-based, utilizes secure communications modalities including email, and with interfaces with all Family Physician EMRs and most hospital scheduling systems/Hospital EMRs

Stakeholders:

Primarily FPs, hospitals and specialists

Project Activities:

There is a very tightly defined implementation program to ensure that change management issues are addressed during the implementation of the referral system.

- A Steering Team is defined
  - Members include Specialist and Family Physician representatives, hospital/practice management and an IT project manager.
- Family physicians and office staff in the referral region are trained and registered on the system
- Specialists and office staff are trained
  - In new regions, at least 5 specialties participate in the program launch, and remaining specialties are launched in a second phase
- Specialists develop basic referral pathways for the services that they offer.
  - Referral pathways are developed for specific clinical indications.
  - They are developed during multidisciplinary meetings, starting with templates (consistent with clinical practice guidelines) and updated by the specialists as necessary.
  - Referral pathways include a description of the services that are provided, access time, indications and contra-indications, "red-flags", necessary clinical information, investigations, and additional advice for Family Physicians and patients
  - An emphasis is placed on productivity. A maximum of 5 meetings (of 1.5 hours each) are held for each specialist team to develop their pathways.
- Advanced referral pathways can be developed based on the interest of specialists
  - These incorporate best practices, such as Advanced Access scheduling and multi-disciplinary consultations.

- Referral pathways are registered in a directory of services
- Utilization of the referral system is closely monitored, referral pathways and information are regularly updated and feedback is provided to users

Challenges:

- 'Buy-in' of clinicians creating referral pathways
- Ensuring that use of the referral system saves time, money and increases the quality of referrals
- Obtaining enough "market share" that users can manage the majority of their referrals with the system
- Provide patients with more information and choice during the referral process
- Managing adherence with referral criteria and ensuring that all information within the system remains up to date

Successes:

- \> 60% of hospitals use the referral system and > 80% of Dutch FPs
- \> 1.3 million referrals in 2011 (40% of all referrals)
- \> 100,000 diagnostic requisitions
- 59% fewer patient visits to hospital
- Fewer no-shows for appointments
- Lower administrative costs
- Development and growth over 12 years
- Integrated with all EMRs in use in the Netherlands (approx. 10 different EMRs + hospital scheduling systems)
- ZorgDomein is a privately owned company. In the Netherlands, users pay for the service directly
- ZorgDomein was developed and implemented without government funding

Lessons Learned:

1. How to engage and involve clinicians during pathway design and implementation
2. How to engage and satisfy users beyond the early adopters
3. How to interface with EMRs and e-scheduling systems
4. When and how to launch in a new region (how to ensure that enough referral pathways are present at launch and that system usage is sustained)
5. How to find a balance between standardization and flexibility in referral pathways

Contact information:

The ZorgDomein referral system is being evaluated in several regions in Canada. The developers are interested in pursuing partnerships to share knowledge and solutions that will help to improve referrals in Canada.

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ZorgDomein
http://www.zorgdomein.nl/en_gb/
ZorgDomein is a Dutch company that has developed a referral system over the previous 12 years. The system was originally developed by a healthcare consultancy during their work with physicians and hospitals to increase the efficiency and quality of referrals.

Ambulatory Referral Management system (ARMs)

Purpose / Area of Focus:

Timely access to specialized paediatric healthcare is contingent upon a referral and triage system that supports effective prioritization, comprehensive patient health information and good communication between patients and providers, as well as between primary care providers and specialists. With this premise in mind, efforts to design, develop and implement ARMs have remained focused on the following objectives:

1. Standardize the process of submitting and managing referrals, as well as patient prioritization
2. Enhance operational efficiencies and improve access to specialized paediatric care
3. Decrease workload compared with manual processes and faxes
4. Reduce the number of inappropriate and incomplete patient referrals
5. Enhance communication between specialist, health care team, referring physician and patient regarding status of referral and documentation required to support an effective process
6. Facilitate management of wait times associated with referrals based on priority levels (specifically Wait 1, defined as the time from submission of referral to time when patient is seen by specialist)

Timeline from start to implementation (or conclusion):

Currently, there are 54 clinics and approximately 1500 internal and 3500 external users with online access to ARMs. The majority of clinical programs at SickKids now use ARMs to manage the 55,000 referrals received annually. Designed as a tool to help support clinicians in their practice, stakeholders were engaged throughout design, development, testing and launch of the system. Strategies (e.g. telephone follow-up; letters; surveys etc) continue to be deployed ensuring ongoing stakeholder engagement in further refining the system's capacity and enhancing satisfaction and uptake (particularly on-line referral) in the community.

Stakeholders:

Stakeholders have continuously driven system development and ongoing refinements. To this end, three established user groups meet bimonthly (Super User) or quarterly (Physician Super User and External Advisory) and members take an active role in providing feedback, testing and approving system enhancements as well as helping to prioritize future developments from a list of potential new and enhanced features that have been requested. This process of stakeholder engagement ensures that the ARMs development team focuses on features and functions that are of greatest value and benefit to all users for the benefit of the patient care process.

Project Activities:

The Ambulatory Referral Management (ARM) system is a web-based system developed entirely "in-house" at SickKids and which automates management of referrals to SickKids and enables calculation and reporting of wait times associated with initial access to specialty care (i.e. Wait 1 -- time from submission of referral to time patient is seen by a specialist). Since its launch (2007/08), there have been a total of thirteen new releases averaging two to three per year, representing new functions and/or modification and enhancements to system features. As a result, ARMS has evolved into a comprehensive and robust referral management tool, creating a number of benefits for patients, families, staff and providers internal and external to SickKids. Firstly, the system helps support a more efficient and effective referral and triage process enabling the patient and family to gain more timely and appropriate access to specialty care. Evidence shows out-of-window wait times and overall referral processing times are decreasing which serves to boost patient and family satisfaction and also mitigates the risk to health outcomes associated with long waits and avoidable delays.

For providers (and patients), the system enhances security and confidentiality of patient information and enables more consistent decision-making with respect to the plan of care. Many of the system features including the automated "fax-back" notification mechanism, the capacity to include additional patient specific documentation, on-line accessibility of information by staff, as well as the availability of customizable templates for patient and family correspondence have been pivotal in enhancing communication and keeping everyone informed as to the status of a patient's referral. As well, clinical programs have developed evidenced based or consensus driven referral guidelines and all new, external patient referrals are processed in a more consistent manner.

Challenges:

System Development
Further system development is required to expand functionality and support en even more comprehensive referral management (i.e. Emergency department to clinic referrals, inpatient to clinic referrals, and follow-up referrals).

Ongoing Process Improvement
Despite pockets of excellence and best practice, current access procedures and workflow processes across the organization require ongoing monitoring. While the ARM system is a tool designed to support better management of patient referrals and improved access to specialty care, it is not "the solution". Attention must be paid to review and redesign of ambulatory processes to enhance efficiency.

Focus on Measuring and Monitoring key ambulatory indicators
The ARMs system is interfaced with SickKids Decision Support System, which in turn provides clinic-based and organization-wide statistics for each step in the referral process, from the time the referral has been received to the time the patient is seen. In addition, a pilot is currently underway to measure specialist-specific times related to the triage process. Monitoring these reports allows each clinic to identify the points of inefficiency in the referral process and make improvements that ultimately drive referral processing times and wait times down.

Successes:

ARMs continues to evolve as a robust system and an effective tool that has met or exceeded its primary objectives in terms of improving paediatric referral management. The system has helped standardize the method of patient prioritization across the hospital through development and embedding of evidence and/or consensus-based referral and triage guidelines. This in turn facilitates a more consistent, transparent, fair, and objective approach to decision making as well as improved communication and collaboration between primary care and specialists.

ARMS has the capacity to measure and monitor key metrics associated with waiting (e.g. numbers of referrals, wait times, referral process audit information etc) which becomes critical in effective management of wait lists as well as identifying and implementing process improvements to support more timely access to paediatric specialty care. As well, since all external referrals are stored in the ARMs database, the risk of losing referrals and/or delaying processing of referrals due to lack of information has essentially been eliminated.

Lessons Learned:

The Ambulatory Referral Management system is a valuable referral tool for the Hospital and the provincial healthcare system. Users continue to embrace the system as a valuable tool for managing, tracking, and auditing referrals. They have suggested with improved technical interface and navigation, continued development of needed functionality the system would be even more robust, increase online usage, and promote greater access to care.

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Acknowledgments: (not all staff remain in the roles listed below)

OsteoArthritis Service Integration System (OASIS), Vancouver Coastal Health Authority

Vancouver, BC

Purpose / Area of Focus:

The purpose of OASIS is to provide a coordinated early access system that will ensure equity and fairness for patients waiting to be assessed and treated for osteoarthritis (OA) and to provide them with a inter-disciplinary assessment of their condition and the education and tools necessary to manage their condition non-operatively, as well as pre and post surgery, as the case may be.

Goals:
- Limit the development and progression of OA
- Slow onset of complications that can cause severe disability
- Reduce avoidable declines in health
- Reduce variations in care
- Improve access, patient flow, quality and efficiency of services
- Build capacity of system to meet escalating demands
- Build the continuum of care
- Make cost-effective use of system resources & expertise
- Link multiple arthritis initiatives

Timeline from start to implementation (or conclusion):

Project start: January 2006
Currently: OASIS is a permanent program within VCH.

Stakeholders:

- Clients and caregivers
- Primary Care Physicians (PCPs)
- Allied Health Professionals
- Orthopedic Surgeons
- Rheumatologist
- Community Organizations
- Education Partners

Project Activities:

- Regional Office and three clinics in community
- Outreach/travel clinics for access to remote and marginalized population
- Interdisciplinary assessments by PT, OT & RN working closely with PCP and Specialists
- Assessment & triage to conservative or surgical care stream
- "First Available Surgeon" and "coordination of care" options
- Individualized action plan based on client goals – includes referrals and recommendations
- Robust feedback loop to PCP and referring provider
- Group education sessions at clinics and in community – primary education about OA, exercise, pain management, nutrition, weight management and pole walking – Currently running sessions in Cantonese
- Surgical optimization for arthroplasty patients – telephone optimization, prehab and preop education
- Translated education materials – Punjabi, Farsi, Mandarin, Cantonese
- Website with searchable Listing of Community Services
- Robust program evaluation framework – 3 themes: access to information and services, client health outcomes and quality of life, and use of system resources and expertise
- Electronic System: scheduling, patient information, interdisciplinary clinical documentation, communication documentation, tasking functionality, follow-up system, interface with OR scheduling, scanning, auto faxing, program evaluation built in
- Started with hip and knee. Expanding to wrist/hand and foot/ankle. Future: Shoulder and elbow

- Multiple partnerships including: The Arthritis Society, Mary Pack Arthritis, Foot & Ankle Screening Triage (FAST), VCH Arthritis Departments, Community programs (e.g.: Healthiest Winner)
- Knowledge translation of program to Provincial, National and International health agencies

Challenges:

- Buy-in of system change
- Being inclusive when setting up processes (difficult to get everyone at the table)
- PCP concerned about losing control of their patients
- First available surgeon
- Understanding of program (tagged as purely surgical)
- Interdisciplinary vs. multidisciplinary
- Resources
- EMR development – including users in configuration
- Not creating silos. Align with other programs, departments and initiatives.

Successes:

- Over 26,000 client encounters to-date and continuing to grow
  - 10,500 individual assessments performed
  - 14,000 education visits
  - 1,500 information only encounters
- Over 36,000 outgoing referrals and recommendations to community resources
- Over70,000 educational documents downloaded from the OASIS website: http://oasis.vch.ca
- Expanded to wrist/hand and foot/ankle joints
- Enhanced access through outreach/travel clinics, translated materials and customized education
- Increased functionality of electronic system has streamlined processes and reduced workload (Fully functional EMR by 2012)
- Moved from multidisciplinary to interdisciplinary culture
- Knowledge transfer with other health agencies – provincial, national and international
- Partnerships both internal and external to VCH including: The Arthritis Society, Mary Pack Arthritis, Foot & Ankle Screening Triage (FAST), Complex Joint Clinic, VCH Arthritis Departments, health care providers along the continuum of care and community organizations.
- Over 600 services on Listing of Community Services

Lessons Learned:

1. Have the support of Senior Leadership.
2. Have a champion PCP and orthopedic surgeon.
3. Early and ongoing engagement of stakeholders is vital.
4. Time is required to be truly inclusive in creating an interdisciplinary program.
5. Stay focused on the client/patient, the program vision and goals.

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Rheumatology Central Access and Triage

Purpose / Area of Focus:

Calgary, AB

To Triage the Rheumatology referrals to Calgary Rheumatologists focusing on getting the RIGHT PATIENT to the RIGHT PLACE at the RIGHT TIME.

Timeline from start to implementation (or conclusion):

Calgary Triage went live April 2006 and is ongoing

Stakeholders:

- Rheumatologists
- Family Physicians/Referring Physicians
- Patients
- Alberta Health Services/Department of Medicine
- Calgary Foothills Primary Care Network

Project Activities:

- Project Goals:
    - Single point of access http://www.departmentofmedicine.com/MAS/index.html
    - Right patient - right provider - right time - right diagnosis
    - Improve communication
    - Improve access and wait times
    - Data management of patient information and scheduling
    - Eliminate duplication of appointments
- Over 28,000 referrals received to date
- Improved access with shorter wait times across all referral categories
- Regular updates to referring and family physician re status of referral, patients confirmed by specialists office
- Eight sub-specialty interdisciplinary clinics
- Maintained short wait times for more urgent patients however now getting longer for routine patients
- Opportunity identified for specialist linkage with Calgary Foothills Primary Care Network
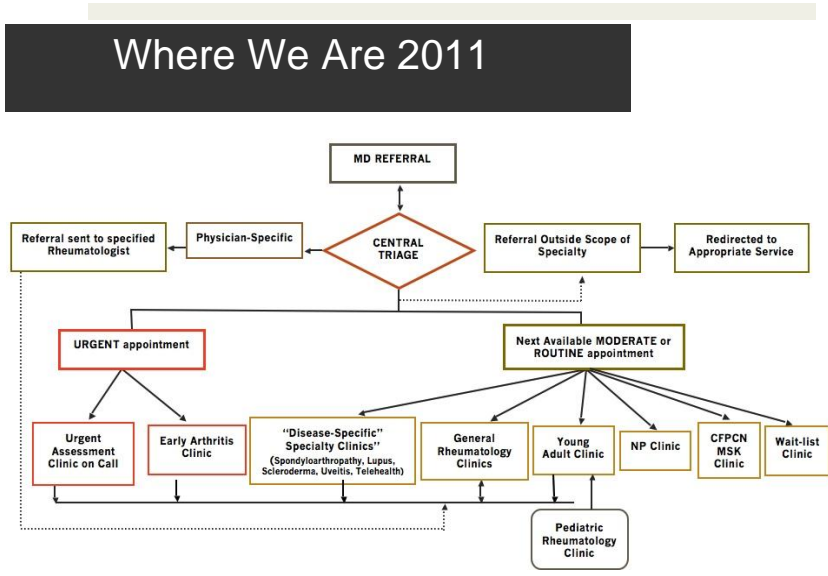
Challenges:

- Referral Quality
- Supply and Demand – number of referrals for number of available appointments
- Routine wait times longer – more urgent patients take priority
- Technology – EMR/Appointment scheduler

Successes:

- Streamlining of referral process/tracking of all referrals in database
- Decrease in shot-gun approach for referrals
- Prioritization of referrals to insure more urgent patients seen ASAP
- Improved communication to Referring Physicians re: receipt of referral, request for additional information, appointment booking time

Lessons Learned:

1. Specialists/Divisional buy in to program
2. Communication Loop
3. Planning essential
4. Database essential – best if connected to program wide EMR with scheduler for accurate tracking of appointments and wait times
5. Staff selection – specialty experience, clerical support, coverage

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RAAPID (Referral, Access, Advice, Placement, Information, and Destination)

Calgary and Edmonton, AB

Purpose / Area of Focus:

This project has the following aims:
1. To connect referring physicians, with acutely ill or injured patients, to the appropriate consultant physician in a timely manner.
   • This may be for advice only, or for transfer to a higher level of care.
2. To manage capacity and ensure that the right patient arrives at the right place at the right time.
3. To assist and manage repatriation, when patients no longer require an acute care facility.

Stakeholders:

This project has always been a venture of Alberta Health Services (AHS, but it began as two separate entities: centered in Calgary and Edmonton). It continues to involve all of the individual zones within AHS. Recently, it has come under one provincial administration, with the goal of drawing on the strengths of each individual entity.

As the process has evolved, RAAPID has teamed with STARS (Shock Trauma Air Rescue Society). STARS provides immediate access to referral physicians who have expertise in emergency care as well as transport medicine. STARS also services the rotor wing air ambulance service in Alberta.

Project Activities:

RAAPID remains a project in evolution with no defined end point. The activities are summarized in the purpose.

Challenges:

In all three areas, the biggest issue is capacity management.
• Alberta is in the process of adding capacity to the system, but a lack of resources, continues to put pressure on the system. RAAPID attempts to find the site with the most available capacity, and direct the patient to that spot. In certain cases, a patient must be stratified to a certain site, regardless of that site's capacity (for example, in Edmonton, all pediatric trauma must come to the Stollery/ University of Alberta Hospital Emergency Department).
• The perception of capacity at one's own site often leads to individual consultants being hesitant to accept a patient at his or her site. Recognizing that capacity is worse at another site usually leads to more a more collegial transfer, but still doesn't resolve the bigger issue (not enough resources).
• The issue of capacity management impacts repatriation as well. Often these patients are going from an acute care facility within the city to an rural acute care facility that may also be dealing with insufficient resources. This frequently sets up barriers to moving a patient closer to his or her community, and has the resultant problem of creating a barrier to decanting the urban acute care site.

Successes:

• This program has done a great deal to equalize the access to acute care across the province. It has made the resources of the urban centers more accessible to all our citizens.
• Its presence allows improved communication in the care of, and transfer of the acutely ill or injured patient.

Lessons Learned:

1. Communication is Key
2. Data is Power
3. Focus issues and conflicts on patient care

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Hip & Knee Arthroplasty Wait Times

Purpose / Area of Focus:

Edmonton, AB

To achieve the wait times for joint arthroplasty that have been recommended by Alberta Health & Wellness.

Timeline from start to implementation (or conclusion):

Started two years ago and attempting to achieve yearly targets.

Stakeholders:

Hospitals, central intake clinics, surgeons, and related providers.

Project Activities:

Alberta Health & Wellness has prescribed wait times for total hip and total knee arthroplasty. The wait times to be achieved over a five year period are 14 weeks from decision to surgery. A five year plan has been implemented across all Alberta. We have introduced a central intake model with next available surgeon to achieve a target each year which will gradually come to the prescribed 14 weeks.

Challenges:

Incenting physicians to take part in the central intake model. Working with providers at acute care sites to improve efficiency and reinvest resources in doing an increased number of cases. Coordinating the resources needed.

Successes:

We have a standardized continuum of care for total hip and total knee arthroplasty that has been accepted across the province. All 12 sites that do hip and knee arthroplasty are working from the same continuum of care. Implementation of this continuum of care has resulted in significant improvement including decreased length of stay, decreased readmission rates, and standardizing practice patterns.

Central intake clinics have been developed in most centers using the next available surgeon. Gradual acceptance by providers and administrators has been achieved .

Lessons Learned:

1. Working with key provider leadership is important prior to rolling out a continuum of care.
2. Understanding that you will always have a group of resisters and you will never get 100% support for everything.
3. Communicating to primary care must be done repeatedly and in a number of different ways.
4. Understanding how to incent providers is important.
5. Many times hospital administrators are more reluctant to change than physicians.

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Saskatchewan Surgical Initiative: Pooled Referral Project

Purpose / Area of Focus:

The purpose of this project is to demonstrate that pooling new referrals for same specialty surgeons can reduce or eliminate wait time variation for a first consult appointment.

This project will:
- Assist ten surgical practices to adopt pooled referrals,
- Use the ten practices as demonstration sites for other practices to examine,
- Document the development process of the demonstration sites to create a "How To Guide" as a learning tool for future practices to follow.

Pooling referrals should create the following improvements within the surgical practices:
- Standardize and quantify patient wait times
- Increased patient satisfaction
- Increased physician satisfaction (both specialist and referring GP)
- Increased understanding of demand and capacity for specialists and departments

Timeline from start to implementation (or conclusion):

Project launched June 2010.
First implementation scheduled for the fall 2011.
Expected projected completion is September 2012.

Stakeholders:

Ministry of Health
Surgeons – 7 surgery sections, 1 large practice
Saskatchewan Health Quality Council

Project Activities:

Pooled referral systems assign new patient referrals to the next available qualified specialist within a group instead of the traditional approach of referring a patient to a specific specialist. The benefit of this approach is that workload (patient demand) is distributed more evenly across all physicians within the group thereby reducing variability of wait times across the entire group. Patients and referring physicians continue to have the option of waiting for the specialist of their choice with the knowledge that the patient may wait longer.

The project began work with early adopters and then began to include groups recruited by the surgeon champion. Recruited practices representing a variety of practice configurations (Alternate Payment / Fee For Service, single office/multi-office, generalists/sub-specialization, EMR/no EMR).

A consultant was hired by the Ministry to:
- Facilitate a series of meetings with surgeons to establish a common understanding of pooled referrals, discuss the purpose of working together to build business rules for each group and to design a single intake/assignment process for new referrals. The design process includes introduction of several Clinical Practice Redesign concepts such as using a standardized intake form and measuring *time to third next available appointment*.
- Assist groups implement their new business processes.
- Develop a next available algorithm tool to assign new referrals to the next available specialist and to take specialist availability and sub-specialization into account.

- Develop a central fax intake line and tracking system for groups that are not co-located.
- Document the development process to function as a teaching tool for Health Quality Council and an implementation guide for other specialists wishing to adopt a pooled referral system. The How To Guide will help sustain and continue to distribute the knowledge gained from this project.

The Health Quality Council was engaged to:
- Evaluate the project,
- Introduce Clinical Practice Redesign tools with pooled practices,
- Once the demonstration sites have been established, take over introducing pooled referrals with new groups.

Challenges:

- Very little information in the literature to help advance pooled referral discussion,
- Surgeons expressed concerns regarding: impact on income, reputation, professional autonomy,
- Developing a central fax intake line for surgeons who are not co-located – who, cost, logistics, Health Information and Privacy Act,
- Surgeons wishing to maintain their preferred areas of practice,
- Data collection – everyone wants it, but no one wants to enter it,
- EMRs make it much easier to determine next available surgeon. Not all surgeons have an EMR.

Successes:

- Successful engagement of eight specialty sections to go forward with pooled referrals.
- The pooled referral meetings have facilitated interesting and progressive discussions regarding practice variation that go beyond standardizing wait times,
- Pooling referrals enables data collection for an entire surgical department and creates an opportunity to improve service delivery on a very large scale,
- Several groups have invited patients and GPs to provide them with feedback on their new processes,
- The creation of one standardized referral form for each group department,
- Most surgeons have expressed an interested in further Clinical Practice Redesign assistance .

Lessons Learned:

1. Having a surgeon champion adept in pooled referrals was a significant asset,
2. Transparency, from start to post implementation, is a must to maintain stakeholder confidence,
3. Trust among participating surgeons is important,
4. People will support what they create. Giving surgeons control and the resources needed to develop their own pooled referral system helped generate buy in and commitment. Also important to include each surgeon's MA.
5. People need to know what's in it for them. Needed to explain the benefits to the surgeons – more manageable workload, reduced stress, easier to recruit new surgeons.

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The Ontario College of Family Physicians' (OCFP) Collaborative Mental Healthcare Network

Toronto, ON

Purpose / Area of Focus:

Rapid access for family physicians to clinical assistance of psychiatrists, FP psychotherapists, psychologists and social workers. Groups of 10 family physicians (mentees) are assigned to team of experts in mental health and additions (a psychiatrist and a FP psychotherapists - mentors). When clinical issues arise, the individual FPs can email or phone his/her mentor and is able to access appropriate professional assistance enabling continuity of care in family practice within 24 hours. Formal small group CME/CPD sessions occur amongst the small groups and an annual conference provides further education for the Network members. Workshops developed by Network members are delivered throughout the province to support all FPs in the province, and increasingly across Canada, to develop knowledge and skills in the management of mental illnesses and addictions. Network materials are available on the OCFP website and on machealth.ca.

Timeline from start to implementation (or conclusion):

The program was initiated in 2000, with support from the MOHLTC in Ontario and has carried on ever since. The mentoring model is now expanded in other clinical areas such as addictions and chronic non cancer pain, women's health, children's health and other diseases-specific, such as Asthma and Diabetes. The mentors are provided with an honorarium for the time they spend in formal and informal educational sessions with individual FPs, with their small group and with other Network activities such as the conference. Family physicians do not get a fee but they and their patients are benefiting from the service. The Network consists of approximately 600 FPs and 60 other specialists and keeps growing year by year.

Stakeholders:

FPs members of the OCFP, psychiatrists, GP psychotherapists, psychologists, social workers/mental health workers interested in this model, MOHLTC, the OCFP

Project Activities:

See above

Challenges:

Initial concerns over medico legal liability which have been resolved by ensuring that the model is anchored in physician education of coaching and mentoring vs. the referral model of specialty care. The main challenge is the inability of the program to support wide-spread expansion of the model.

Successes:

The program was evaluated and demonstrated that family doctors are able to manage severe persistent mental disorders in their practices. The cost implications for the system in terms of decreased referral to specialists and fewer ED visits and inpatient admissions support the decision of the MOHLTC to provide permanent funding for the program. The mentees support colleagues in their own practices/communities and have become experts, coaches and mentors in their own right.

Lessons Learned:

1. With started small with a mindset of learning while doing and adjusting the program as we learned from one another what worked and what didn't. The program began with a small group of family physicians who identified psychiatrists who were well-known for working well in shared-care models and anchored the program in "family medicine friendly best practice guidelines".
2. Being an "expert" or a "great teacher" is not the same as being a good coach or mentor.
3. Even when a family doctor does not reach out to their mentor, knowing that they could if they needed is vitally important to them in managing these vulnerable patients.

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Academy of Medicine Ottawa - Psychiatric Referral Service

Ottawa, ON

Purpose / Area of Focus:

To facilitate the psychiatric referrals process between Family Physicians offices and Psychiatrists.

The Ottawa Psychiatry Referral Service was started in 2002 a pilot project. The service contacted all 130 psychiatrists in community based practice and asked them to accept at least one new patient a month through this service. A total of 70 psychiatrists have participated in the service. There are currently 33 psychiatrists actively participating in the service. Since 2002, 1,011 family physicians have used the service and a total of 7,157 of referral/consultations have been provided. There are currently 60-65 referrals per month.

In this process the family physician contacts the service with a referral request giving some clinical and demographic details. The service attempts to match this request to appropriate psychiatrists. The family physician is then given the name and contact information for two psychiatrists who could see the patient. The family physician then picks one of the psychiatrists and contacts that psychiatrist. The psychiatrist and family physician then work out the details of how the consultation/referral will be handled.

Timeline from start to implementation (or conclusion):

- September 2001 - Collect and compile data, install and set up database software
- October 2001 - Populate database, test and make necessary changes
- 1 December 2001 - Launch service. Marketing:
  - announce to members in September and December newsletters
  - announce to all physicians in Ottawa through annual letter re membership renewal
- April 2002 - Focus group test and feedback from members (mailing)
- May 2002 - Make any necessary changes to improve service and evaluate pilot project. Create project plan for electronic referral to all specialist groups for general practitioners
- September 2002 - Pilot complete – funding extension received to March 2003
- 26 March 2003 - One time funding payment received from Ministry of Health
- 1 November 2004 - One time funding payment received from Ministry of Health
- 15 April 2005 - Approval of Ongoing funding received

Stakeholders:

Psychiatrists, Family Physicians, Academy of Medicine Ottawa, Ontario Medical Association

Project Activities:

- Compile comprehensive list of community based psychiatrists
- Secure psychiatrists participation in the service
- Secure funding

Challenges:

- Initially: funding
- Ongoing:
  - Securing participation of psychiatrists
  - Ongoing participation of psychiatrists
  - Recruitment of new psychiatrists
  - Ensuring proper use of service by Family Physician's offices (ex. using psychiatrists provided for a particular patient for several patients, providing information requested at the end of the referrals process)

Successes:

- Increased access to Psychiatrists
- Ease administrative burden of FP offices
- Reduced wait times from initiation of referral to appointment with Psychiatrist

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Orthopedic Central Intake Project: Surgical Services Eastern Health

St. John's, NL

Purpose / Area of Focus:

The purpose of the project was to plan and implement a Central Intake Referral Model for the Orthopedic Service within Eastern Health. The previous model of referral and assessment was individual physician based, with no formal process for tracking wait times from family physician to surgeon visit. Improving access to surgical care was identified as one of the key priorities for Eastern Health.

Project Objectives were:

- Develop and implement a standardized orthopedic referral tool.
- Design an algorithm for an Orthopedic Centralized Intake process.
- Develop and implement processes to measure "Wait 1".
- Develop an interdisciplinary service delivery model for patient assessment for both surgical and non-surgical patients referred to the orthopedic service.

Timeline from start to implementation (or conclusion):

- The Central Intake project is currently in its second year of a three year plan.
- Project launched in September 2010 (Project Lead hired).
- Budget submission to Provincial Ministry of Health for new interdisciplinary patient assessment model: November 2010.
- Referral form implementation: April 2011.

Stakeholders:

- Department of Health and Community Services
- Executive Leadership – Eastern Health
- Surgeons – 7 orthopedic surgeons
- Family physicians – 316 physicians in the Eastern Regional Health Authority
- Clinical efficiency program
- Ambulatory Clinic groups, including appointment booking office staff, orthopedic clinic staff
- Diagnostic Imaging
- Decision Support/IT program
- Surgeons' office staff (private secretaries and Regional Health Authority staff)

Project Activities:

The central intake project invested significant effort in liaising and visiting other jurisdictions with established central intake clinic models to facilitate knowledge translation regarding the National Core Model of Care. National benchmarks established for total joint replacement surgery were used to develop definitions and processes for measuring Wait 1 and Wait 2.

The central intake office provides a coordinated, streamlined approach to receiving referrals. Allowing new patient referrals to be booked with the next available surgeon, instead of the traditional system of referring to a specific surgeon, can improve access and reduce wait time. Patients and physicians continue to have the opportunity to refer to a specific surgeon, with the understanding that the initial wait for consultation may be longer.

The patient referral form is inclusive for all orthopedics. The central intake process for receiving and screening new referrals provided clear definition of the demand (reason for referral) and the distribution of the demand across specific diagnosis and surgeon subspecialty.

The project lead developed an action plan to include:

- The formation of working groups to evaluate impact of a new referral system within existing structures, plan for implementation and manage change.
- Sessions with surgeons and family physicians to establish a shared understanding of central intake, design a single entry patient referral form and discuss group expectations and concerns related to introducing a new system.
- A communication strategy to establish key messaging for all stakeholders.

Challenges:

- Lack of IT support in an environment where multiple database systems have limited capacity to collect or measure outcomes related to the central intake process.
- Difficult to establish baseline measures for clinic volumes/wait times.
- Integrating a new referral system with a previously established process for booking that lacked standardization or formal policies to guide practice.
- Maintaining regular communication with physician providers and patients about the new process.

Successes:

- Established standardized wait time definitions across the patient continuum.
- Clearly defined the orthopedic demand for next available and surgeon specific requests across all subspecialties. Created opportunities for improved service delivery.
- Orthopedic Surgeon engagement in the Central intake process.
- Developed detailed algorithms to guide decision making.
- Standardized screening/triage criteria and prioritization guidelines for all orthopedic referrals.
- Improved accessibility for all priority orthopedic referrals and reduced Wait 1.
- Improved transparency for reporting timely data related to access and wait times.

Lessons Learned:

- Identify champions early.
- An established electronic database system is essential for managing data recording and reporting.
- Early engagement of people who have the most to lose and the most to gain.
- Allow time for adaptive change, it is essential for creating a system that is sustainable.
- Communicate consistently, through multiple mediums, with primary care physicians.
- Standardizing practice is key to eliminating inefficiencies.
- Selecting staff with the appropriate skillset and experience: clerical, allied health, nursing.

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Total Joint Assessment Clinic (TJAC)

Purpose / Area of Focus:

<div style="text-align:right">Ottawa, ON</div>

To decrease the wait time for assessment and treatment (surgical or nonsurgical) for patients with hip and knee arthritis.

Timeline from start to implementation (or conclusion):

Timeline to open was approximately 1 year. Proposals had to be written to receive funding from the Ontario Ministry of Health and Long Term Care. A literature review and visits to successful clinics were undertaken in order to establish the best model. Advertising to stakeholders was completed. Forms and model flow charts were developed. Training of the assessors with surgeons and with radiologists was completed.

Stakeholders:

Surgeons, Administration at all hospitals, LHIN staff, assessors, patients, family physicians, rheumatologists, Arthritis Society.

Project Activities:

Patients are assessed by either a physiotherapist or advanced practice nurse within 2 weeks of referral being received. Patients receive a 45 -60 minute assessment composed of medical history, joint history, physical exam and x-ray review and explanation. The patient becomes a partner in care as the options are discussed and decisions are made with the patient as to surgical or non-surgical treatments.

If the patient is non-surgical, advice and community resources are explained and a letter is sent to the referring physician outlining treatment options. If the patient is a surgical candidate, the surgical procedure, risks/benefits and hospital stay is explained to the patient. The patient can choose to consult with a specific surgeon or the first available surgeon. Patients then return to the clinic for a surgical consult (15 minutes) and the conversion rate to surgery is approximately 90%.

Challenges:

- Surgeon buy-in to the program – most are afraid that they will lose business with this type of model
- Referring physician change in referral patterns – most physicians are used to referring to a single specialist and the information is difficult to disseminate
- One assessment site uses a different mix of assessors

Successes:

- High patient satisfaction – survey completed twice and 95+% satisfaction with the assessment process
- High referring physician satisfaction – survey completed using survey monkey and family MD's were satisfied with the reports received and with the "one stop shop" where they only have to sent a referral to one site

Lessons Learned:

- Surgeon champion – this is a necessity in this type of project to obtain buy-in from other surgeons
- Advertising to patients is highly successful – patients will bring advertisement to family MD and ask to be referred to the clinic
- Speaking to family practice groups regarding the program promotes buy-in for the program
- Should have had all assessment sites using the same type of assessor and providing exactly the same service

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Regional Hip and Knee Replacement Program (RHKRP)

Purpose / Area of Focus:

The Total Joint Assessment Clinic (TJAC) at Queensway Carleton Hospital was so successful in reducing wait times (Wait 1 & 2) that the Champlain LHIN wished to apply the model to a regional approach to care. A Central Intake Centre was established to receive all referrals for potential hip and knee replacement patients within the LHIN. The referrals are checked for appropriateness and are sent to one of four assessment sites based on patient choice (language (French or English), specific hospital, specific surgeon or first available). Assessment centres all function in a similar fashion to TJAC at Queensway Carleton Hospital.

Timeline from start to implementation (or conclusion):

Timeline to open was approximately 3 months once the proposal for funding was approved by the MOHLTC. Steering committee was established and project manager appointed. Meetings held with surgeons to explain the model of care. Staff for the central intake office and the assessment centres needed to be hired and trained. Advertising to stakeholders was completed. Website was established. Partnership with The Arthritis Society was established to provide a conservative management program for our patients including a class (offered in person and by telehealth) and physiotherapy exercise prescription.

Stakeholders:

Surgeons, Administration at all hospitals, LHIN staff, assessors, patients, family physicians, rheumatologists, Arthritis Society

Project Activities:

See above

Challenges:

- Surgeon buy-in to the program – most are afraid that they will lose business with this type of model
- Referring physician change in referral patterns – most physicians are used to referring to a single specialist and the information is difficult to disseminate
- One assessment site uses a different mix of assessors

Successes:

- High patient satisfaction – survey completed twice and 95+% satisfaction with the assessment process
- High referring physician satisfaction – survey completed using survey monkey and family MD's were satisfied with the reports received and with the "one stop shop" where they only have to send a referral to one site

Lessons Learned:

- Surgeon champion – this is a necessity in this type of project to obtain buy-in from other surgeons
- Advertising to patients is highly successful – patients will bring advertisement to family MD and ask to be referred to the clinic
- Speaking to family practice groups regarding the program promotes buy-in for the program
- Should have had all assessment sites using the same type of assessor and providing exactly the same service

Contact information:

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Alberta Referral Directory

Purpose / Area of Focus:

- Primary Care Physicians expressed difficulty in identifying and contacting appropriate Medical Specialists for their patients.
- At the same time, Specialists reported frustration with referred patients that did not match their area of practice.
- Project goal was to develop a tool for Family Physicians and other healthcare providers to facilitate and improve the referral process to Specialists and specialty services
- The Alberta Referral Directory is a searchable, centralized, web-enabled tool allowing referral requesters (e.g. family physicians, referral coordinators, medical office assistants) to access referral information for Consultants practicing in the province of Alberta (including Family Physicians who accept consultations for areas of interest or expertise).

Timeline from start to implementation (or conclusion):

- Project funding received September 2008
- Directory Implementation March 2012

Stakeholders:

- Multiple stakeholders including family physicians, specialists, office managers, referral coordinators and Primary Care Network representatives were engaged to gather required functionality needs from which software requirements were developed.
- Design Working Groups consisting of Family Physicians, triage clinicians, clinic managers, and PCN referral coordinators provided input into the design. AHS Information Technology has been developing the product with ongoing business and clinical input.
- The Alberta Medical Association and the College of Physicians and Surgeons of Alberta were consulted during project feasibility and environmental scan for existing products and to assist with the communications plan.
- Alberta Health Services Information Technology executive leads, analysts and developers.

Project Activities:

- Dec 2007 - Project submission and request for grant funding
- Sept 2008 – Grant funding approval received
- Sept 2008 – April 2009 Project Initiation and Documentation
  - Project Steering Committee formed
  - Project feasibility completed, stakeholder identification & engagement started
  - Focus Groups established for requirements gathering
  - Software Specifications and Requirements document developed
  - Project charter developed and IT team established
  - Communication plan developed
- April 2009 – August 2011 Application Design and Development
  - Design Working Groups established to guide design and build
  - IT build and testing completed
  - Pre-implementation evaluation survey initiated
- September 2011 – Communication to specialists and data entry started
- March 2012 – Go live with directory

Challenges:

- Shifting sands of the organization and healthcare environment as Alberta Health Services formed in 2009.
- Changes in IT Team personnel supporting the project including architects, designers and developers.
- Engagement with specialists.
- Diversity of needs and or practice of specialists
- Managing expectations – "all things to all people"

Successes:

- Single source, online directory of consultants and referral information will ideally decrease the amount of time Primary Care Providers and consultants (or their staff) spend on making and receiving appropriate referrals.
- Higher percentage of patients referred to the consultant are appropriate, meaning the services the patient requires are the services that the consultant provides. This will reduce the staff time needed to take to inform the referral requester that the patient has not been referred to the appropriate consultant and needs to be referred to a different consultant
- Higher percentage of referral letters includes the information needed to triage the patient appropriately. This means staff does not need to contact the referral requester to get additional information or obtain it from other sources.
- Primary Care Providers, Consultants and their staff will not have to answer as many phone calls or faxes (e.g. about demographics, what services the consultant provides, "time to next available appointment", types of patients accepted, how to refer, referral requirements etc.) as the information is accessible online.

Lessons Learned:

1. Multi-pronged approach including one on one is required with specialists early in the process of stakeholder engagement, communication, product development and throughout the project.
2. Continuous scan of IT and referral environment to ensure product development is in alignment with where the referral process/system is going.
3. Clearly defined project scope from the outset helped to avoid project and scope creep.
4. Multiple touch points to view actual development and functionality is required to ensure product meets user requirements. Dedicated business analyst required to ensure clarity with business requirements and IT development.
5. Establish a Steering Committee comprised of key stakeholders to guide project in conjunction with establishment of specialist/physician champions in each specialty area to assist with communication.
6. Engage user interface designers early in development.
7. Ensure appropriate "home" and resources are established for ongoing operations post implementation.

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Enhancement of the Saskatchewan Specialist Directory

Purpose / Area of Focus:

The Specialist Directory is a Ministry of Health website that was first launched to Saskatchewan physicians in 2009 and following the release of the Patient First Review, the provincial government saw value in releasing the website to the public in 2010. The Specialist Directory is intended to improve the patient experience by providing detailed information about each of Saskatchewan's surgical practices and their associated wait times. Before being released to the public the website was redesigned to incorporate a patient focus however, the site still contained over 100 pages of unsearchable information that describes the practice of the province's 200 surgeons.

The goal of this project is to improve the functionality of the Specialist Directory so users - patients and referring physicians - can search the site based on their needs and preferences.
http://www.health.gov.sk.ca/specialists

Timeline from start to implementation (or conclusion):

Approximately 6 months.

Stakeholders:

Saskatchewan Senior Medical Officers; The Saskatchewan Medical Association; Saskatchewan Ministry of Health; Saskatchewan eHealth

Project Activities:

- The existing version of the Specialist Directory was derived from a combination of surgeon supplied information and wait time data in the province's Surgical Patient Registry. The website consisted of over 100 PDF pages of information to describe the practices of approximately 200 surgeons.
- The requirements used to guide this project were developed from focus group testing of the existing Specialist Directory with family physicians and surgical patients. Two focus groups were held with surgical patients, one urban group and one rural. Participants were solicited by telephone and then sent a link to the Specialist Directory with scripts to be used with the site prior to the focus group meeting. (e.g. find the orthopedic surgeon in your area with the shortest wait time).
- The Saskatchewan Medical Association supplied the names of family physicians willing to be interviewed by focus group researchers. Physicians were also provided a link to the Directory in advance of the interview and asked to use the site as if using it with a patient. Given the vast geographic dispersion of the physicians, their input was gathered through telephone interviews. All focus group feedback was summarized into a user requirements document for future implementation.
- An environmental scan of surgery websites revealed BC's Surgical Wait Times website which met many of the user requirements identified by Saskatchewan focus groups. The BC Ministry of Health agreed to share their website code with Saskatchewan. To assist in meeting the tight timelines, Saskatchewan also engaged BC's vendor (CGI Group Inc.) to implement Saskatchewan's specifications. The vendor was able to complete the website redesign, from engagement to completion, in eight weeks.
- Early versions of the new site were shared with select physicians and patients advisors for feedback during development phase. The Saskatchewan Medical Association and the Chair of the Senior Medical Officer Committee were invited to review and endorse the site prior to re-release to the public.
- The media launch included the Minister of Health, the president of the Saskatchewan Medical Association (a rural family physician) and a previous surgical patient. A larger media campaign targeted at the public and physicians is planned for early 2012.

Challenges:

- There was a strong desire to have this work completed by fall 2011 – 4 months away.
- This project was carried out over summer which required careful coordination of the project team's vacation schedules.
- Some surgical procedure groups were created in 2003 and required updating, rewording (e.g.. release carpal tunnel to carpal tunnel) or re-organizing (e.g.. ear, nose, mouth and throat to ear, nose and throat).
- Some surgeons don't provide their wait one data; some surgeons don't agree with their registry-generated wait two data; some surgeons don't see the value in providing this information to patients.

Successes:

- Two clicks of a computer mouse reveals every surgeon in the province who has performed > 5 of the selected procedure,
- The 2010 site received 1218 hits on release; the 2011 site received 2162 on release and about 500 onthe two days prior to the release. The site receives between 250 to 300 hits per week.
- Two ways to search data; use anatomical body graphic or by using search filters.
- Filters allow user to search by a procedure, a surgeon name, or a geographic area within the province.
- Eighty percent of data is now collected automatically from existing databases. (i.e.. Provider Registry and Surgical Patient Registry),
- Rural GP's are using the site to locate local surgical services. This will provide their patients with surgery closer to home and more often much sooner. On a larger scale this will reduce demand for surgery in larger urban centers,
- The new format has been very well received by physicians and the public. Surgeons have also taken note and are now contacting the Ministry to find out how to update their information.

Lessons Learned:

1. Early engagement with clinical stakeholders was essential. The Saskatchewan Medical Association and the Senior Medical Officers championed this project through their respective organizations. We continue to collaborate with these groups as improvements are made to the site to ensure their ongoing support.
2. Focus group testing adds significant value to website design at a relatively low cost. Focus group testing also revealed some interesting surprises that need to be addressed: e.g. "This is great information, what are patients supposed to do with it?",
3. Websites can also be used to **push** information to users. For example, a person searching for information about a popular surgeon will also receive the name and data for the surgeon with the shortest wait time for the selected procedure,
4. Working from an existing site and engaging an experienced vendor significantly reduced development time,
5. Keep web design simple, stay focused on the end users perspective.

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Catalogue of Specialized Services (CSS)

Purpose / Area of Focus:

- A web-based inventory of physicians and the specific specialized services they provide within their given service area (i.e. orthopedics – does feet, ankles, does not do shoulders) and links with other providers (Contact)
- Physician maintained on the web
- Implemented to:
  - Ensure patients are seen by the right physicians (one who delivers the service)
  - Maximize awareness of who is providing which services (not just traditional referral paths)
  - "We are tired of sending referrals to a specialist, only to get it back 6 months later with a note saying they don't provide that service or they don't provide it anymore"

Timeline from start to implementation (or conclusion):

- Compilation of data completed March to September 08
- Web development initiated September 08
- Web-version soft release December 16th 08, hard release Jan 12, 09

Stakeholders:

- Provincial Director, Patient Access
- Project Director/manager
- Software Development Team
  - 4 PM staff, 4 data entry
- Family Physicians, Specialists and Clinical Office Staff

Project Activities:

- A phone call to the specialist office followed up by a fax to verify the information which included (services provided, services not provided, facilities they work out of, address, phone number and fax number). This information was entered in a data base and then the software developer to build the system.
- Passwords and usernames provided to all MB physicians, RNEPs, midwives and RHAs
- Significant functionality updates and improvements since go live
- Continuing to do demos of CSS, teach users how to maximize usage
- Establishing partnerships in RHAs to increase clinician usage in uptake, updating and efficiency in usage
- Lots of FPs asking to be listed for specialized FP services or functional specialties (i.e. sports med, vasectomies, etc)

Challenges:

- Keeping it up to date (getting clinicians to keep their info up to date)
- Nomenclature & the details…
- Expanding participation (everyone wants to be in scope!)
- Sustainability

Successes:

- Clinicians expressing excitement about the product
- Numerous provinces requesting information, indicating intent to duplicate Catalogue
- Expanding participation (everyone wants to be in scope!)
- Helpful info on what services are being looked for

Lessons Learned:

- CSS is a "market research" tool
  o What FPs are searching for and how
  o If not found why (not easy to find or not available).
  o Allows to improve with feedback
- FPs and Specialists talk different languages
  o List only what makes them "special"
  o List more than they can handle

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Ottawa Physicians' Professional Directory

Purpose / Area of Focus:

To assist physicians to do their work: referrals, networking, and community resources

Timeline from start to implementation (or conclusion):

February – September 2005

Stakeholders:

Dr. Lee Donohue, Dawna Ramsay, Academy of Medicine Ottawa (developers, editors)
Ontario Medical Association
Ottawa Hospitals
College of Physicians and Surgeons of Ontario
Royal College of Physicians and Surgeons of Canada

Project Activities:

- Collected data of practising physicians in Ottawa, including specialty, sub-specialty, special interests and contact information (office and hospital addresses,)
- Collected data of community health care resources
- Developed database and user interface
- Requested permission for physicians to be listed in directory and to ensure data was accurate
- Created CD ROM and print directories
- Collected orders from physicians in Ottawa and periphery
- Delivered product to physicians
- Directory is updated annually and as of 2010 is available in a downloadable version. It now contains billing # (for physicians who have given permission), patient age group, languages spoken and GP focus practice designation.

Challenges:

Data collection and time to verify information (from multiple sources)

Successes:

- Comprehensive, which assists greatly with referrals
- Community resource listing helpful to patients
- 7 editions have been published

Lessons Learned:

1. Resource intensive
2. Keep the product simple to use (minimize support calls)
3. Understand how the product is used in practice

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Development of Surgeon Directory - In Development

Purpose / Area of Focus:

<div style="border:1px solid black; display:inline-block;">Halifax, NS</div>

Project: To develop a web-based catalogue of services provided by surgeons across Nova Scotia. This work will result in a profile of surgeons throughout the province, specifically identifying their area of specialization.

Purpose: To develop a guide that will help physicians ensure they are connecting their patient with the most appropriate surgeon to best meet their patients' needs and reduce misdirected referrals. The guide will provide meaningful, up to date physician-validated information on who does which surgical services in Nova Scotia. Doctors will be able to search the catalogue by surgical specialty and health district in order to make the referral process much more efficient and will improve quality of care for Nova Scotians.

Timeline from start to implementation (or conclusion):

Development of Catalogue Data & creation of surgeon profiles: December 2011 – January 2012
Validation of Surgeon Information: January – February 2012
Technical web development: February – March 2012
Go Live: April 2012

Stakeholders:

Partnership between Doctors Nova Scotia and the NS Department of Health and Wellness
Plan in development for consultation and validation with surgeon community.
Plan in development for engaging public and referring practitioners when surgeon directory is live.

Project Activities:

In development

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Wait time reporting for surgical consult (Wait 1) – In Development

Halifax, NS

Purpose / Area of Focus:

Project: Implement standardized provincial Wait 1 reporting for surgical services through the provincial Patient Access Registry. The intent is to publish District Health Authority (DHA) and facility level Wait 1 data on the public Wait Time Website, alongside the Wait 2 data that is currently reported.

Purpose: Improved knowledge of wait times for surgical services in the referring community, as well as for patients, care givers, and the public, to facilitate access to surgical services.

Timeline from start to implementation (or conclusion):

Development of Wait 1 data collection and report building: present – March 2012
Data auditing & stakeholder engagement: March – September
Go Live with Wait 1 data on public website: Fall 2012

Stakeholders:

Surgeon offices – submit booking forms for entry into OR information systems
District Health Authority Access Managers – reporting, decision support, and data quality

Project Activities:

In development

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