QEII Foundation TRIC Grants funded in the November 1, 2013 Competition
Summary of Anticipated Impact

1. Evaluating interprofessional collaborative practice within the rehabilitation and supportive care portfolio at Capital Health (level 1) $3,000
   Dr. Christine Short and Mary Ellen Gurnham
   Impact: The focus of this project is to establish an evaluation framework and identify measures to evaluate interprofessional collaborative practice within the Rehabilitation and Supportive Care Portfolio at Capital Health. The overall research goal is to evaluate and quantify collaborative practice and its impact on client-centered care. The method outlined is to: 1) conduct a review of the literature and environmental scan to identify exemplar projects to inform the evaluation framework, 2) develop a research protocol; 3) source instruments that could be adapted for CDHA's use to measure and monitor collaboration, 4) identify indicators and outcomes, 5) identify a relevant target population, 6) engage stakeholders, and 7) recruit a research team. Interprofessional collaboration (IPC) is essential for quality care and has the potential to greatly improve patient care and patient reported outcomes. But there are not good methods to evaluate collaboration in practice. The evaluation framework will allow better measurement of IPC, an essential step if strategies to strengthen IPC are to be implemented.

2. The Impact of a web-based "frailty portal" in Family Practice for patients, caregivers and providers: identification, screening and appropriate care planning (level 1) $3,000
   Dr. Fred Burge and Lynn Edwards
   Impact: Frailty is a multi-system deterioration (e.g., mobility, cognition, endurance) that mostly, but not entirely, affects the geriatric population. Of the 400,000 people served by Capital Health, 30% of those over 65 years of age are at least moderately frail, and 8% are severely or very severely frail (this number would be in the thousands). Most frail persons live in the community; there is a need for primary health care to have more support to identify and manage care for people who are frail. This team is developing an online portal that will contain tools for identifying and managing care for this population. It is important to ensure continuity of care for patients who are frail and improve communication and methods for primary healthcare providers to understand, identify and manage patients who are frail in a safe way that does not cause duplication in care or other unnecessary costs. The planned research is complex, and implementing a tool in primary care and assessing all important outcomes is a complex project.

3. The highly tolerant opioid patient - will a new paradigm of care improve outcomes? (level 1) $3,000
   Dr. Alexander John Clark and Karen Mumford
   Impact: Pain management of highly opioid tolerant patients (HOT) is complex, often leads to poor intra and post operative pain management, delayed discharge, less patient satisfaction and higher complications. It is important to better understand the actual etiology, extent and impact of this group of patients in order to direct future care. The overall aim is to identify and proactively treat patients with HOT to improve patient outcomes and lessen associated costs. Approximately 17, 000 people in Nova Scotia are prescribed opioids on a regular basis, many of whom are highly opioid tolerant. In addition, many of these patients require surgery secondary to their pain condition or co-morbidities. If this population does experience higher length of stay (LOS) and greater complications following surgery, as expected, the findings of this study will provide rationale to create better care strategies for this population to decrease complications and hopefully decrease LOS.

4. Beyond talking the talk: Integration of health behaviour change interventions into primary care settings (level 1) $3,000

   Dr. Michael Vallis and Dr. Tara Sampalli

   Impact: The team plans to: 1) identify the barriers to uptake of the self-management support by conducting a literature survey (assessing cognitive - outcome expectations, efficacy expectations, social norms - and organizational factors - workload, competencies, administrative support and running several focus groups to seek the input of the various diabetes clinics at CDHA as they differ in location, populations served and workplace expectations. 2) consult with clinical colleagues and identify a sequence of initiatives within each tier that would allow the development and scaling of a comprehensive service; and 3) establish an evaluation framework. Behavior change has been associated with over a 50% reduction in risk of diabetes, more than twice that found with the drug metformin. However, the effective use of behavior change management is underutilized in this population. The successful completion of this project to improve access to behaviour change intervention (BCI) has the potential to significantly improve and enhance care for individuals with diabetes.

5. Improving chronic care delivery and functional health outcomes for individuals with multimorbidities in primary health care, Capital Health (level 1) $3,000

   Dr. Tara Sampalli and Lynn Edwards

   Impact: Individuals with complex diagnoses, multi-morbidities and chronic conditions are common in primary care practices. Enabling better care for this population requires system-level shifts from current models that tend to be focused on a single body part or system to an integrated and patient-centered approach. Recognizing that this is a growing population, as part of a quality initiative an existing service at Capital Health was restructured to meet the needs of patients with multi-morbidities (Integrated Chronic Care Service - ICCS). The ICCS care model in its current state is focused on treating the person versus the diagnosis; improving functional health and measuring outcomes that are grounded in the needs of the individual and their self-selected areas of improvement. The grant will result in an evidence-based framework for evaluating the ICCS. The longer term impact is to ensure person-centered, evidence-based, cost-effective delivery of care to patients with multi-morbidities. The proposal aligns with one of Capital Health's strategic priorities.

6. The effectiveness of an online portal for the delivery of care to home dialysis patients (level 3) $45,456.84

   Dr. Karthik Tennankore and Cynthia Stockman

   Impact: Home dialysis (peritoneal and hemodialysis) has several benefits to patients however there are opportunities for improvement, particularly in terms of quality of life and hospitalization rates. Use of secure, online communication portals has been valuable in the care of patients with other types of chronic diseases, but the utility of an electronic medical record and online portal communication system has not been tested on a cohort of home dialysis patients. The team hypothesizes that such a system will improve care and outcomes for home dialysis patients. They propose a pilot feasibility study with a cohort of home dialysis patients to determine if: 1) an online portal improves patient satisfaction with home dialysis care, 2) an online portal improves quality of life for home dialysis patients, 3) an online portal communication system reduces hospital admission and use of health services, and 4) an online portal improves patient self efficacy. The results of the study will be used to develop and seek funding for a multi-centre trial to rigorously evaluate the utility of an online portal communication system. The online portal is potentially a valuable resource to allow home dialysis

patients to remain in their home environment, improve their health outcomes and overall quality of life. If the portal achieves the stated aims, there will be a reduction in health service utilization by this patient population which will have an effect at the system level. The communication system selected for the portal (RelayHealth) is currently being piloted with Primary Health. This makes it a reasonable choice in that it provides a consistent system for different patient populations.

7. Expanding the INSPIRED COPD outreach program to the Emergency Department: Assessing feasibility, efficiencies, and outcomes (level 3) $99,834

Dr. Graeme Rocker and Paula Bond

Impact: Chronic Obstructive Pulmonary Disease (COPD) is the 4th most common cause of death in Canada. COPD is second only to chest pain for reasons to visit the ED at the QEII. Approximately 85% of cases with COPD that present in the ED are not admitted. Implementing the INSPIRED (Implementing a Novel and Supportive Outreach Program of Individualized Care for Patients and Families Living with Respiratory Disease) Program in the ED is expected to increase patient ability to self-manage their care related to COPD. **Rationale:** By accessing patients through the ED they should be reached earlier in their disease progression. This is expected to lead to process and outcome changes for both the patient and the health system. Outcomes are operationally defined with specific pre-set criteria for success (e.g., 40 – 60 % reduction in ED visits vs. previous rate measured over a comparable period; and over 90% of patients in the INSPIRED program will create an action plan). While evaluating this program implementation, the team will also ask about the role of learned helplessness in uptake of the program, and prevalence of helplessness among participants. This will contribute to our understanding of the patient experience, and inform how to tailor care for specific patient profiles. This project identifies high system resource users earlier in the disease trajectory and provides self-management education which improves patient care and reduces healthcare system utilization (GPs, Emergency Departments, hospital and ICU admissions/length of stay). It will also contribute understanding about the predictive value of COPD-related learned helplessness and how it might help identify patients who need a more comprehensive care pathway and allocate INSPIRED program resources wisely.