Innovations for Evaluation: Summary of Themes and Lessons Learned

*a part of the* Health Services and Policy Research Support Network

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Key Lessons Learned

The Innovations for Evaluation were undertaken to capture innovative approaches to health human resources deployment that were taking place in the health system. Of the five projects funded, four examined collaborative care delivery models, which were implemented in response to a trend toward increasing numbers of patients/residents who are frail and elderly with chronic illness and complex health needs. One evaluation focused on the integration of nurse practitioners into the British Columbia (BC) health system.

Of critical importance are lessons learned from the evaluation of these health human resources innovations that support further integration of innovative practices focused on health system improvement.

Reformation of Teams
The reformation of teams associated with the implementation of collaborative care delivery models is a major change initiative that impacts individuals and overall team functioning due to staff mix changes, loss of team members and shifting responsibilities. Supportive leadership, continuing education and mentorship along with transition support through employee assistance programs are strategies recommended to address the considerable impacts on staff.

Leadership
Strong leadership provides the foundation for effective collaborative practice teams. Aspects of strong collaborative leadership highlighted in the evaluations include the capacity to build trust among team members, provide mentorship, facilitate open communications and effective decision making, and the establishment of an environment that enables collaborative team functioning. When strong leadership is in place, teams are more resilient to the impacts of change.

Teamwork
Role clarity and consistent staff that support continuity of care are seen to be key enablers of effective collaborative practice teams. Well-functioning collaborative practice teams share a common sense of purpose and commitment to the model of care they are delivering.

Communication
Formal communication that is clear, consistent and delivered regularly helps teams work well collaboratively. Open communication among team members is integral to effective problem solving that aligns with the shared common purpose of collaborative care.

Competing Programs
Competing program implementation during implementation of collaborative care delivery models makes it difficult to clearly ascertain whether practice change goals were achieved. It is important for leaders to identify and mitigate the impacts of multiple initiatives when implementing a care model change.
**Education and Training**

Effective modes of training for collaborative teams include learning that is more hands-on such as structured learning collaboratives that bring teams together to disseminate learnings and share results of Plan-Do-Act cycles.

There is the need to build core competencies in effective collaboration among the various health practitioners. Hiring professionals with these competencies and building skills internally will help ensure the future success of team-based inter-professional collaborative care.

**Quality of Care**

At residential care facilities, quality of life assessment may be more effective than traditional quality of care assessment (RAI-MDS) methods to understanding all aspects of quality of care. Care relationships are a vital factor to creating a sense of well-being, or quality of life for residents, and these relational aspects can also be a factor in staff job satisfaction.

New practice models do not always achieve improvements in quality of care, mainly due to the complexity involved in implementing the practice change and the various challenges this presents.

**Value of Nurse Practitioners (NPs) to the BC Healthcare System**

NPs are well represented across the province in diverse settings with different patient populations. NPs are accepted by co-workers, are effective collaborators and provide increased access to care that is patient-centred, comprehensive, consistent and convenient.
Introduction

Health Services and Policy Research Support Network (HSPRSN)

In 2003 and 2004, the BC Ministry of Health Services (currently the BC Ministry of Health) provided grants totaling $16 million to the Michael Smith Foundation for Health Research (MSFHR) for an initiative to fund and build capacity for health services and policy research focusing on health system evaluation, redesign and innovation. A Health Services and Policy Research Support Network (HSPRSN) was launched, with a steering council representing health authorities, universities and the ministry.

Five programs have been offered through HSPRN: Health Authority Capacity Building, Investigative Teams, Operating Grants, the Partnership Program and the Health Human Resources Program.

A report that summarized the collective impact of programs undertaken by HSPRSN was completed in 2013. At that time, one Health Human Resources Program was not complete, the Innovations for Evaluation Program. This report summarizes the key themes and lessons learned across the five funded evaluations of health human resources innovations implemented in the provincial health system. This summary is a companion piece to the five evaluation reports, which include more detailed findings and insights into health human resources innovations and their impacts on the health system and populations they serve.

Health Human Resources Focus

In September 2008, the HSPRSN Steering Council recommended and MSFHR’s Board of Directors approved funding to address health human resources research in three priority areas:

- Ways to better employ existing providers
- New models of staffing
- New models of practice

In 2009, MSFHR completed two scoping exercises. Findings revealed that while many innovative approaches to health human resources deployment take place in the health system, very few are documented or evaluated. As a result, the many pockets of excellence and progress remain unknown except to those who were directly involved.

Health Human Resources (HHR) Program: Innovations for Evaluation

The HHR Research Program – Innovations for Evaluation was developed in response to the findings of the scoping exercises. The aim of the program was to identify and provide funding to evaluate HHR-related innovations that were pending, in early stages of implementation or were being expanded from one BC health authority into other BC health authorities. The four areas of focus included:
1. The shift of acute care from the hospital to community settings
2. Interdisciplinary teams and inter-professional collaboration, including Integrated Health Networks
3. Use of Lean methodologies
4. Applied health-related technology/telehealth

Health authorities and the BC Ministry of Health were requested to submit suggestions for innovations suitable for evaluation. Five proposals were approved for funding from March 1, 2011 to February 28, 2014. No cost extensions were granted to the majority of the projects to complete their research and the HHR Innovations for Evaluation Program formally ended in early 2015. The following are brief descriptions of the five evaluation projects. More detailed descriptions can be found in Appendix A.

**Ministry of Health/University of Victoria: Evaluation of the Integration of Nurse Practitioners (NP) into the BC Healthcare System**

This study evaluated a practice innovation — the integration of NPs into the BC healthcare system, and established a framework for a sustainable ongoing evaluation of the impact of NP practice on those whom they serve and the health care system.

**Vancouver Coastal Health: Evaluation of Collaborative Practice Project (CP)**

The purpose of this evaluation was to assess and compare the implementation of CP in three residential long term care facilities within Vancouver Coastal Health. The evaluation included several areas of focus: a) clinical outcomes, b) health human resources (staffing), c) productivity, d) nursing staff engagement, e) consistency of collaborative approaches to care, and f) impact on clinician roles.

**Island Health: Evaluation of Care Delivery Model Redesign (CDMR)**

Island Health established the CDMR initiative in 2009 in response to observational studies in 15 inpatient units on Vancouver Island, and later with the other health authorities across BC to gather quantitative evidence that would inform changes to current care models and processes. The aim of the CDMR Program was to make changes that would result in patient-centred care delivery, reflect inter-professional practice, and be based on data and evidence.

**Island Health: Evaluation of the Enhanced Seniors Team (EST) Initiative**

The objective of this evaluation was evaluate the impact of the EST on the quality of patient care for frail and/or at-risk older adults; understand the extent to which EST can positively influence acute care practices; and identify the core elements necessary for successful replication in hospitals that differ in size, setting and staffing.

**Fraser Health/University of Victoria: Evaluation of the Residential Program Care Delivery Model (CDM)**

A team of researchers from the University of Victoria and Fraser Health aimed to answer the following research question:
Does the implementation of Residential Care Delivery Model, i.e. changing the nursing staff mix, changing the funding methodology, and changing the direct care hours, affect the quality of care delivered and received in residential care facilities operated by Fraser Health?

**Summary of Themes and Lessons Learned**

Of the five evaluation studies funded, four focused on interdisciplinary teams and inter-professional collaboration. One of these four studies also examined the shift of acute care from the hospital to community settings. This report identifies and summarizes several cross cutting themes and lessons learned that are evident across these four studies.

The thematic analysis was conducted through a comprehensive review of the four evaluation reports. Key themes and lessons learned in each report were identified and a comparative analysis was conducted to distinguish the cross cutting themes across the reports. Further analysis was conducted to show how different settings and structures within the health authorities led to more specific or additional findings.

The evaluation of the integration of NPs into the BC healthcare system stands apart from the other studies and a summary of common themes in this study is reported separately.

**Inter-professional Collaborative Care Delivery – Cross Cutting Themes**

In BC and across Canada, strategies to leverage health human resources to provide high quality, cost effective, patient-centred care include the implementation of innovative health care delivery models such as inter-professional collaborative care. The evaluations summarized in this report of collaborative care delivery models all state that the models were implemented in response to a trend toward increasing numbers of patients/residents who are frail and elderly with chronic illness and complex health needs. Prior studies examining collaborative care models reveal that complex health needs are better served through combination of skills and disciplines; no single discipline can address all of these issues.¹

Team-based collaborative care combines health provider skills, qualifications and disciplines to better match staff resources to patient/resident care needs. At its best, team-based collaborative care supports shared decision-making and respect for the unique competencies of each member who together contribute to patient-centred care goals and high quality care.

The evaluation of collaborative care delivery models revealed successes and challenges as well as lessons learned that will inform the effectiveness of collaborative care delivery models going forward.

**Reformation of Teams**

Two of the collaborative care models examined in Vancouver Coastal Health and Fraser Health revealed similar challenges, specifically related to the reformation of teams during the implementation

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¹ Evaluation of the Enhanced Seniors’ Team Service at Nanaimo Regional General Hospital.
of collaborative models involving nurses at residential care facilities. The reformation of teams impacted both individuals and team functioning overall due to role and staff mix changes, loss of team members and shifting responsibilities.

A key goal of collaborative team-based care is to optimize the scope of practice of team members and make the best use of their skills and knowledge. However, the reformation of teams, which involved the loss of some team members and the addition of others with different skills, personalities and varying levels of work experience, proved to be challenging. Team members were deeply impacted by losing coworkers and working with new individuals and felt unprepared and overwhelmed by team changes.

The change in staff mix among nursing teams included a decrease in registered nurses (RN), and hours. However, findings of these two studies highlighted that when the staff mix changes, so do the expertise and clinical skills on a team. RNs found themselves working with licensed practical nurses (LPN), which was a new experience. In some teams, many of the LPNs were new graduates and taking on the tasks previously performed by RNs was difficult, particularly when support from RNs was not readily available. RNs experienced added pressure as their role shifted to taking on more leadership for care planning and educating those who were less experienced.

Nursing team members were provided with comprehensive education and orientation related to their roles on the team. Yet, some did not fully understand collaborative practice and its goals to improve delivery and quality of care and found it hard to adapt to a different way of working.

Overall, the findings of these evaluations revealed that the formation of new teams is a major change initiative that takes considerable time and management support. The difficulties encountered due to staff mix changes point to the need for supportive leadership, continuing education and mentorship to assist those with less experience in developing new skills. The reformation of teams particularly affected team members who lost long-time colleagues and friends. Transition support from family assistance programs and change management resources were cited as strategies to address impacts on staff.

Strong, Consistent Leadership

All of the evaluations highlighted the need for strong leadership as the foundation of effective collaborative practice teams. In this context, aspects of strong collaborative leadership cited in the evaluations included the ability to build trust, provide mentorship, facilitate open communication and effective decision-making, and the establishment of a climate for team-based collaborative care. Leaders with strength in change management were more effective in building teams that were more engaged and empowered with a common sense of purpose. Findings showed that when strong leadership was in place, teams were more resilient to the impacts of change.

Major change initiatives like the introduction of new care delivery models were seen to benefit from consistent leadership from start-up through implementation. As noted earlier, the change to collaborative care delivery takes several years. Some studies noted that leaders that were involved at the outset had moved into other roles; this presented challenges in keeping the purpose of the new
Another study found that the change in post-implementation leadership from a single leader to multiple leaders affected team continuity and cohesion.

The most frequently cited gap in leaders’ knowledge was change management expertise. More support for operations leaders was called for including continuing education, mentorship and coaching in how to lead major change initiatives.

### Teamwork, Role Clarity and Consistent Staff

The way staff work together within collaborative practice teams was an area of interest across the evaluations. At some sites, the introduction of collaborative practice teams was very challenging due to gaps in role clarity and lack of consistent staff, as well as unforeseen events that impacted team functioning. Well-functioning teams were seen to share a common sense of purpose and commitment to the model of care delivery. Sites where investments in team building activities took place resulted in more trust where staff felt valued and supported. In these cases, teams were higher functioning and more adaptable and resilient to change.

Role clarity and consistent staff that support continuity of care were found to be key enablers of effective collaborative practice teams. Effective teams understand their roles and others on the team and the importance of each person’s contribution to delivering quality care. Roles were not always clear, particularly in the nursing collaborative care teams. There was some confusion relating to the scope of practice of RNs and LPNs, despite orientations. Suggestions to improve role clarity include involving team members early on and having them co-create job descriptions in partnership with team members. Formal and informal communication also played a major role in conveying clarity of responsibilities.

High team functioning was integral to the success of the specialized, inter-professional EST team evaluated at Nanaimo General Hospital. A key enabler of team success was the sense of unified purpose and strong shared values among the team. The team was fully committed to an inter-professional model of care as the optimal delivery method for the frail, elderly patients that came into the hospital with complex health needs. The EST also benefited from effective start-up leadership, investment of resources, and a systematic development process.

Consistent staff and shift rotations support continuity of care, an important factor in residential care facilities. The study of Fraser Health’s care delivery model highlighted that in addition to staff changes implemented with the model, Single Certification, a Collective Agreement change occurred at the same time. This made it possible for staff to bid into positions anywhere within the health authority, when previously they were permitted to apply for positions within a more limited geographic area. As a result, team members were bumped from positions and staff team continuity was difficult to maintain.

The EST experienced frequent vacancies, mainly due to uncertainty of the team’s future, which made it difficult to fill positions and retain staff. While the EST had many successes, staffing challenges made it difficult for the team to service a full caseload.
Clear, Consistent Communications

Communications, both formal and informal figured more prominently in some studies than others with varying impacts. Activities ranged from formal communication plans and tactics to communications that took place during shift reports and shift routines. Clarity and consistency were cited as key aspects of effective formal communication that helped teams work well collaboratively. Interestingly, observations of informal communication among team members showed a high degree of comfort, and willingness to share information.

An observation of the EST Program was that high quality collaborative care requires clear, consistent, regular communication at different levels: intra-program (within the team), inter-program (between programs) and between health care professionals and patients and their families. Strong internal communication among the EST was seen as a key enabler to providing quality, patient-centred care supporting continuity of care and a unified approach. Communications with other programs and personnel proved to be more challenging due to time constraints.

Open, clear communication among team members was cited in one study as integral to effective problem solving that stayed true to the common purpose of quality, collaborative care. This was especially important when getting to the right decision or solution was difficult due to differing values or perceptions on a team.

Communication that took place during the beginning and end of shifts was useful to delivering formal information on resident care needs, as well as fostering interdependence and cooperation among team members. Team members observed in residential care teams communicated with ease and were comfortable sharing stories and jokes. Communication was also observed during shift routines where team members continually shared information in the course of their work in hallways, storage areas and at the bedside.

Competing Program Implementations

All four studies reported on other organizational initiatives occurring at the same time as the implementation of collaborative care delivery models. Because the impacts of the model could not be entirely isolated from other initiatives occurring at the same time, it was hard to clearly demonstrate that the goals of implementing a collaborative care model were achieved.

Competing program implementation also caused confusion and stress for staff, patients/residents and families. One example is the Inter-service confusion that occurred between the EST and other similar, multiple specialty in-hospital geriatric services. Another is the Collective Agreement change that took place during the implementation of the care delivery model at Fraser Health affecting team continuity and cohesion. This suggests the importance of identifying and the mitigating the impact of multiple initiatives when introducing a care model change. Leadership training to help address confounding factors when implementing major change initiatives was recommended.

Education and Training

Education and training provided to collaborative care team members varied across the innovations that were evaluated. Some modes of training were more effective, particularly learning that was more
hands on. For example, Island Health used structured learning collaboratives as a way to bring teams together, disseminate learnings and share results of Plan-Do-Act cycles. These methods were effective in helping team members learn, contextualize and implement practice changes on clinical teams. Education was provided throughout their collaborative care delivery model implementation.

At Vancouver Coastal Health, a 14 week educator-supported program was developed that included comprehensive training based on learning needs. Transition support was also provided during the first six months of implementation. Despite the training and orientation provided, implementing staff found it difficult to transition the learning into practice. More transition support and continued education were recommended for major changes of this kind.

Collaborative care delivery recognizes patient needs are better served by disciplines working together for a common purpose rather than in isolation. The EST study emphasized the “pressing” need to build core competencies in effective collaboration among the various professional practitioners. The need to hire professionals with collaborative competencies and to develop these skills with existing staff is highlighted as key to the future success of team based inter-professional care.

Quality of Care
Two of the evaluations showed improvements in the quality of care and patient outcomes as a result of collaborative care delivery, but improvements in quality of care were not evident in the other two evaluations, mainly due to the complexity of the practice change and the various challenges this presented.

The Fraser Health study revealed improved quality of care in some areas, as a result of collaborative care delivery implementation. However, this study also revealed limitations to the traditional quality of care assessment methods. During the three-year period of the evaluation, the Residential Assessment Instrument-Minimum Data Set (RAI-MDS) showed little change despite an increase in direct care hours. Although large amounts of data were collected and analyzed to measure quality of care, the research team concluded that quantitative assessment data alone was not sufficient to understand all the aspects of quality care. Findings revealed that care relationships were a vital factor to creating a sense of well-being, or quality of life for residents, and it also highlighted that these relational aspects led to greater job satisfaction for staff.

The evaluation of the EST shows that this level of specialized geriatric expertise enables accurate assessments of older patients’ conditions and better transitional care for them. Study findings revealed that access to EST services contributed to improved patient outcomes including helping to prevent cognitive and functional decline and more likelihood of discharging patients home with community supports than a control group. Administrative data showed that EST patients had shorter hospital stays overall and a greater number were discharged back home than non-EST patients.

Island Health found that the CDMR implementation was so complex that it was challenging to determine if their aim to improve quality, patient-centred care was achieved. However, through the project they strengthened leadership, management and accountability structures to support the ongoing development of new practice changes.
At Vancouver Coastal Health, collaborative team members were significantly impacted by staff-mix changes. Staff felt that much of their attention was focused on adjusting to and working with new team members and disciplines, which also included a reduction in RNs. As a result, residents’ care needs and family members’ involvement may have received less attention during the adoption of the new model.

**Summary of Key Themes: Integration of Nurse Practitioners (NP) into the BC Healthcare System**

This study was undertaken to understand the value of adding NPs to the BC healthcare system. NPs have been practicing in North America for 50 years and were introduced into BC in 2005. There has been extensive study of this role with significant evidence that demonstrates their value. However, there is a lack of research that is specific to BC. Overall, the study showed that the integration of NPs into the healthcare system led to several positive outcomes. NPs were well represented in both rural and urban settings where they mainly provided community-based, direct care. In these settings, NPs provided increased access to healthcare that was comprehensive, consistent and in locations convenient for patients. They were also seen to be extremely effective collaborating with their co-workers who in turn were supportive of NP role integration. Patients were highly satisfied with the care provided by NPs and accepted them as their primary care provider. With the help and guidance from NPs, several patients made changes to self-manage their chronic health conditions, thus lessening the burden on the health care system.

**Comprehensive, Consistent and Convenient Care**

Findings of this study indicated that NPs were spending most of their time in direct care activities including assessing, diagnosing and managing acute and chronic illnesses and mental illnesses. NPs were practicing in both urban and rural and remote community-based settings where they served a diverse patient population. A higher concentration of patients were 60 years old with complex health conditions and social issues including First Nations people in remote settings, homeless, frail seniors, and new immigrants. In more recent years, there has been an increase of NPs being hired into smaller, rural and remote settings to meet these needs.

The addition of NPs to the healthcare system increased access to care that was comprehensive and consistent and in locations that were convenient. NPs were seen by patients and co-workers as the providers of consistent care, particularly in rural communities where there was frequent turnover of physicians. Since they were familiar with patients in their communities, NPs were able to provide the type of constant care that locum physicians were unable to deliver during physician vacancies. NPs also became involved in community outreach activities such as making home visits, developing specialized programs, advocating for marginalized people, and providing care in homeless shelters.
Effective Interdisciplinary Collaboration

Collaborative environments promote trust and respect where each team member contributes their knowledge and expertise to allow for shared decision making. In this study, co-workers commented that their collaboration and consultation with NPs on their teams was extremely effective and that NPs’ competency, approachability and communications skills contributed to their trust in them. Comments from patients indicate that NPs collaborated with other health professionals such as pharmacists and specialist physicians to meet their healthcare needs. Findings also revealed that environments that were supportive and embraced new practices fostered effective collaboration between co-workers and NPs.

Patient-Centred Care

Findings in this study showed that NPs provided patient-centred care that looked at the whole person and not just one health issue. Patients noted that they took time to listen, explain and answer questions and their input was valued. NPs also functioned as teachers and educators to help patients make changes to manage and improve their health issues. The quality of care that patients received from NPs resulted in fewer visits.

Barriers to Integration of NPs

At the time of the study, barriers to successful integration of NPs prevail and included: some administrators and physicians were not adequately knowledgeable of the NP role and were unsupportive; legislation continues to restrict NP practice; and, a model for sustained funding has not been secured.

Conclusion

The Innovations for Evaluation were undertaken to capture innovative approaches to health human resources deployment that were taking place in the health system. Of the five projects funded, four evaluated collaborative care delivery models, which were implemented in response to the increasing numbers of patients/residents who are frail and elderly with chronic illness and complex health needs. Evidence shows that combining the expertise of different health professionals facilitates high quality, patient-centred care, particularly for patients with complex health conditions.

The reformation of teams associated with these models, impacted both individuals and team functioning due to staff mix changes and shifting responsibilities. Strong leadership, communication, and role clarity were cited as factors that can make transition to new models of care more effective.

The evaluation of the integration of nurse practitioners clearly demonstrated the value of adding NPs to the BC health system. NPs are seen as effective collaborators on healthcare teams; they increase access to care and provide consistent care that is patient-centred.

Overall, the findings from the five evaluations provide valuable information for practice and policy leaders in the development and further integration of innovative practices focused on health system improvement.
Appendix A: Evaluation of Innovations Project Descriptions

Ministry of Health/University of Victoria: Evaluation of the Integration of Nurse Practitioners (NP) into the BC Healthcare System.

This study evaluated a practice innovation — the integration of NPs into the BC healthcare system, and established a framework for a sustainable ongoing evaluation of the impact of NP practice on those whom they serve and the health care system. The study supported the Ministry of Health’s strategic focus on primary and community care, clinical care management and patient safety, inter-professional practice and optimization of health human resources. The study addressed the following broad questions:

1. What changes result for patients, and what are the implications for the health care system when NPs become part of the care process?
2. What is the impact of adding an NP on the functioning of collaborative health care teams?
3. What are the practice settings and scope of practice of NPs working in BC?

Vancouver Coastal Health: Evaluation of Collaborative Practice Project (CP)

Within Vancouver Coastal Health, CP is understood to be an innovative and inclusive program that engages key stakeholders in the process of matching staffing resources to patient/resident needs. This proactive model allows care providers and management to quickly respond to increasing patient acuity and the rapidly changing labour force within an environment of limited financial resources.

The purpose of this evaluation was to assess and compare the implementation of CP in three residential long term care facilities. The evaluation included several areas of focus: a) clinical outcomes, b) health human resources (staffing), c) productivity, d) nursing staff engagement, e) consistency of collaborative approaches to care, and f) impact on clinician roles.

There were two research activities associated with this purpose:

- Objective 1: To examine staff and organizational outcomes of CP.
- Objective 2: To determine the extent to which there is a consistent and collaborative approach to care.

Island Health: Evaluation of Care Delivery Model Redesign (CDMR)

In 2008, Island Health undertook a series of observational studies on 15 inpatient units on Vancouver Island, and later with other health authorities across BC. The intent of these observational studies was to learn exactly how the health authority was providing patient care, so that quantitative evidence could be used to inform the changes that were required in current care models and processes.

Island Health established the Care Delivery Model Redesign initiative in 2009, to respond directly to these observational studies. The goal for the Care Delivery Model Redesign Program was to make changes that would result in care delivery that is responsive to the care needs and experience of patients, reflects inter-professional practice, and is based on data and evidence.
The three core objectives for care delivery change were to:

- Improve patient care by responding better to the care needs and experiences of patients, residents and clients.
- Optimize the scope, role and functions of all care team members, to make the best use of health human resources.
- Develop high-performing teams to provide a higher standard.

**Island Health: Evaluation of the Enhanced Seniors Team (EST) Initiative**

The Enhanced Seniors Team is an initiative under the Care Continuum Transformation Project (CCT) that Island Health launched at Nanaimo Regional General Hospital. The EST focuses on improving care for frail, at-risk older adults being seen in the emergency department (ED). The aim of the EST is to initiate early, goal-directed care planning and evidence-based interventions to prevent cognitive and functional losses associated with acute illness among hospitalized older patients. The team collaborates with the medical and surgical unit teams to achieve patient goals, decrease hospital length of stay and improve transition to home.

The objective of this evaluation was to evaluate the impact of the EST on the quality of patient care for frail and/or at-risk older adults; understand the extent to which EST can positively influence acute care practices; and identify the core elements necessary for successful replication in hospitals that differ in size, setting and staffing.

**Fraser Health/University of Victoria: Evaluation of the Residential Program Care Delivery Model (CDM)**

CDM was launched in Fraser Health in July 2010, with plans to implement the model across all residential care beds in the health authority. The model consists of three inter-related aspects: staff mix, funding methodology and direct care hours. CDM sets a goal of reaching 3.0 direct care hours per resident per day across Fraser Health by targeting residents, their families and staff in residential care programs in Fraser Health operated facilities. A team of researchers from the University of Victoria and Fraser Health aimed to answer the following research question:

Does the implementation of Residential Care Delivery Model, i.e. changing the nursing staff mix, changing the funding methodology, and changing the direct care hours, affect the quality of care delivered and received in residential care facilities operated by Fraser Health?

The overall aim of the CDM was to encourage a broader range of staff and skills to support a more socially-informed model of care that provides more direct assistance to residents to complete their basic activities of daily living. Implementation of the direct care level began in January 2011 using a phased approach and by 2012 all Fraser Health residential care facilities had implemented the model.