It's About Time: Rapid Implementation of a Hub-and-Spoke Care Delivery Model for Tertiary-Integrated Complex Care Services in a Northern Ontario Community

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Appendix B: Key Activities in Implementing the Timmins Community Complex Care Clinic

Key activities/deliverables	Tasks/areas to address	How these were addressed	Lessons learned
Memorandum of understanding	a) Achieving buy-in quickly from key stakeholders b) Having three organizations achieve consensus around a common MOU	Having champions within each organization, both administrative and medical/clinical, ensured the buy-in of organizations	Director/executive-level support is essential as well as medical director/leads
Project charter and management of the project	a) Team members have little time/no dedicated time to work on the Timmins clinic project b) Project scope and expectations of the Timmins clinic were unclear c) Attendance of all team members at meetings was a challenge	a) Fund a project coordinator/manager position to ensure the project was adequately supported b) Clarify project scope and deliverables through a project charter. We had all team members agree to the charter and the project plan and schedule. We set a target of five patients to be seen between June and December 2017 c) Established a fixed schedule of bi-weekly one-hour teleconferences	a) Dedicated funding to manage the project ensured that someone was responsible for the project and accountable to the steering committee. This also helped move things forward when team members were busy b) Clearly establish the performance expectations for the Timmins clinic. Rally team members around a common vision c) Set regular meetings. Do not expect all team members to be present every time

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Establishing a common vision for the Timmins clinic	a) Because of distance between stakeholders, most meetings needed to be done by teleconference, so establishing a common vision was challenging b) Many different visions (this was both a barrier and a strength). Different stakeholders brought different perspectives: community versus hospital, system versus front-line, province versus Ottawa versus Timmins, family versus provider c) Obtaining buy-in/engagement for the Timmins clinic from community paediatricians was challenging	a) The project manager worked with individual team members to gather their thoughts regarding the vision for the Timmins clinic. Input from all team members were compiled into one document b) During the one in-person meeting, two discussion groups were formed that each had diverse representation c) CT CTC and TaDH already had good working relationships with community paediatrician d) Leadership from the chief of paediatrics in Timmins to remind other physicians of the importance of the Timmins clinic	a) Telehealth/video-conference could greatly facilitate this type of meeting b) The family perspective is challenging to get but vitally important, consider having more than one family representative, if possible c) Physician champion (Dr. Smith) in the local community is imperative to get buy-in from other physicians. Also require stronger physician engagement (in writing if possible) from physicians who will be practicing in the Timmins clinic d) Be transparent about the difficulties in engaging physicians, the Timmins team members worked very hard to engage with community paediatricians once the concern was raised
Clinical flow	a) Team members did not agree on the clinical flow (i.e., from the moment of referral to actual service delivery)	b) The project manager had one-on-one conversations with team members to map out the clinical flow from their perspective and combined all the individual maps into one. From there, the team collectively agreed on the best clinical flow c) The team used existing resources to inform the creation of the clinical flow map (Report of the Paediatric Complex Care Coordination Expert Panel, 2008, p. 48, was especially useful)	a) Having a common vision was a determining factor in having a successful clinical flow map; also using evidence to support (existing reports and literature) b) Patient voice was very important c) Provincial perspective was also important because it allowed the sharing of innovative practices

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Information-sharing and information flow table	a) Provider organizations were using different methods to share information and communicate. No common system was in place (i.e., some organizations were using the provincial electronic children's health network eCHN, some were not; some organizations shared documents through OneMail, some did not) b) CHEO-OCTC was not sharing information in the optimal way	a) CT CTC Executive Director received access to eCHN and OneMail for the CT CTC staff to ensure staff had access to the most up to date information and could share information securely b) Timmins Chief of Paediatrics received access to OneMail for his practice in Timmins c) Dr. Smith convinced CHEO-OCTC to send their information from their patient EMR to eCHN (this was not being done consistently). Dr. Smith raised awareness to CHEO-OCTC leadership that the community paediatricians in rural/remote locations were not receiving enough information about their patients' stay at CHEO. This prompted CHEO-OCTC to act. Dr. Major, Chantal, Hugo and François were also instrumental in pushing this forward within CHEO	a) Leadership from ED and medical chief was essential, it also set the example for other organizations b) Having pressure from both internal and external stakeholders was important to make CHEO-OCTC commit to putting their information on eCHN. The timing of the request was also opportune because CHEO-OCTC had the capabilities to complete the request and had dedicated IT staff. The Privacy Officer at CHEO was also supportive of the request
Board meeting presentations Press conference and communication plan	a) Coordination of the press conference across multiple sites was challenging	a) Expertise from seasoned communications team and collaboration with CT CTC in Timmins was very helpful (in-kind contribution from CHEO-OCTC, PCMCH, CT CTC)	a) Use in-kind support where possible
Delivery of service	a) Community physician in Timmins was not present at the meetings and therefore had a limited understanding of the functioning of the clinic and the delivery of services	a) Community paediatrician's team (i.e., administrative assistant) were extremely helpful in ensuring that information was passed along to the community physicians b) NP was very flexible and willing to accommodate physicians' needs during Timmins complex care clinics (i.e., shorter intake visits, follow-up visits). Also, NP led the first intake visits with Dr. Smith	a) Demonstrate to providers how the clinic will add value for them b) Local champion essential in "lending credibility" of NP to local hospital staff to encourage optimal attendance to education sessions. Two sessions provided to Timmins: 1–2-hour session specific to tracheostomies and gastrostomies; 3-hour Grand Rounds specific to Trach, g-tube and central line assessment and emergencies c) At the initial stage of establishing clinic, it is important to clarify roles and responsibilities of team members (NP & MD), ensure understanding of the medical road map, medical care plan standard and various processes involved in providing complex care