The background features a light blue outline of the United States map. Overlaid on the map are numerous concentric circles of varying sizes, some overlapping each other, creating a ripple effect. In the top right corner, the word "ARTIC" is written in a bold, blue, sans-serif font. Below it, the tagline "Accelerating the spread of proven health care" is written in a smaller, blue, sans-serif font.

ARTIC

Accelerating the spread of proven health care

The ARTIC Program

Reflecting on five years of spread and scale

Foreword

In Ontario, we know that there are innovative ways of providing care that are more effective than those currently in use. However, adopting these initiatives – both for clinical teams and at the organizational level – is difficult, and adopting them at scale across the system can be even more challenging. It requires dedication to change and sustained, focused effort at all levels, from front-line providers to executive leadership.

The ARTIC Program was created to support this focus on spread and implementation of evidence-based approaches to care. Active in its current iteration since 2014, it has funded eight projects to spread proven interventions across Ontario. In this document, we summarize the ARTIC program: what it is; how it started; its emphasis on an evidence-based implementation approach to the projects it supported; its impacts on care, patients and their families; and our collective learnings on how interventions can best be spread to improve care on a large scale.

One learning that is particularly important to us is the value of strong partnerships and collaborations. The ARTIC Program itself is a partnership between Health Quality Ontario (soon to become part of Ontario Health) and the Council of Academic Hospitals of Ontario. Each organization brought their own valuable perspectives to the table. The Council of Academic Hospitals of Ontario brought

their learnings from the initial iteration of the ARTIC Program that focused on moving research evidence into action across Ontario's academic hospitals. Joining with Health Quality Ontario presented the opportunity to extend the program into all care settings of the health system under the banner of improving integrated care, which aligned with Health Quality Ontario's mandate and focus on improving quality and system priorities. The close collaboration between the Council of Academic Hospitals of Ontario, Health Quality Ontario, and the many other stakeholders involved, greatly contributed to the success of the ARTIC Program.

We'd also like to acknowledge the clinical teams and leaders in the field that ultimately led and supported others to adopt new models of care. Their experience, know-how, and trusted advice is one of the key ingredients that made ARTIC successful.

People often refer to Ontario and/or Canada as “the land of pilot projects”. We can proudly say that the efforts of the ARTIC Program have taken us well beyond that to accelerate the spread of initiatives that have improved outcomes for patients. As we undertake the transformation currently underway in Ontario, we hope that you find the reflections described in this report useful to ensuring we continue this important work – to more rapidly spread innovations that improve care.



Lee Fairclough

Vice President, Quality Improvement,
Health Quality Ontario



Anthony Dale

President & CEO, Ontario Hospital
Association

**Health Quality
Ontario**

Let's make our health system healthier

CAHO

Council of Academic Hospitals of Ontario

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Introduction

In health care, we are fortunate to have many new innovations available to improve care. Too often though, evidence-based interventions or change ideas that improve quality of care are successfully implemented in only one organization, yet are never spread to other organizations.

Many of these interventions address problems that are common across the health care system and could improve care at the system level if implemented on a wide scale. However, effective spread of interventions is challenging and requires a significant investment of time, knowledge, expertise, and resources.

The Adopting Research to Improve Care (ARTIC) Program has accelerated the spread and implementation of evidence-based interventions that improve integration of care across Ontario since 2014, building on prior experience focused on the hospital sector. During this time, a total of eight ARTIC projects have been funded and their chosen evidence-based interventions implemented in numerous spread sites across the province. Most of these interventions have been sustained to date, and have improved care for hundreds of thousands of patients in Ontario.

Over the past five years, people involved in the ARTIC Program have gained unique insights into the process of spreading evidence-based interventions at the provincial level. This knowledge is particularly relevant during the current period of transformation for the Ontario health care system. This document was created to provide a written record of the insights gained over five years of spread through the ARTIC Program.



The ARTIC Program

The ARTIC program was originally developed by the Council of Academic Hospitals of Ontario (CAHO) in 2010 to spread evidence-based initiatives among their 23 member hospitals. In 2014, Health Quality Ontario partnered with CAHO to lead a renewed ARTIC Program (affectionately called ARTIC 2.0), expanding beyond academic hospitals and across sectors of the health care system to focus on improving the integration of care.

Project selection

Project selection occurred on an annual basis, initiated by the release of a Call for Proposals outlining the priority areas of focus for the round of application. Projects were selected through a rigorous process based on factors including the strength of the evidence supporting the intervention, the strength of the implementation plan (also rooted in implementation science), the relevance of the intervention to current priorities, and the lead project team's demonstrated expertise in leading spread and forming successful partnerships.

The ARTIC Program provided funding for a set period of time (typically two years) to support implementation of the evidence-based intervention. Funding could be used by both the lead project team and the sites where spread was occurring. After the initial funding period, the interventions have been sustained without the need for additional funding.

ARTIC program structure

The ARTIC program was structured to utilize experts' collective knowledge about implementation science to select appropriate projects for spread and provide guidance on program implementation, enabling the teams who were actively implementing changes to be successful.

ARTIC Operational Committee

The Operational Committee provided operational program oversight, led the selection of the ARTIC projects, routinely received status reports from the project teams and ARTIC program staff, and supported the dissemination and uptake of ARTIC findings. It was composed of clinical and administrative leaders from across the health care system, implementation experts, evaluation experts, and patient representatives. A critical role was to ensure an appropriate degree of fidelity to the model of care across sites.

ARTIC program staff

The ARTIC program staff were from Health Quality Ontario and CAHO and worked closely with the Governing Council, Operational Committee, lead project team, and participating organizations. These staff members supported the implementation of the project and ensured that information and knowledge-sharing occurred efficiently and effectively. Critically, the ARTIC program staff also brought to light key lessons learned between projects to help newer teams be more successful.

ARTIC Governing Council

The ARTIC Governing Council provided strategic oversight and final project selection and funding approvals. It included the CEO of Health Quality Ontario, the Executive Director of CAHO, and Assistant Deputy Ministers at the Ministry of Health. This council also ensured the strategic value for Ontario, and relative alignment to system priorities.

ARTIC Lead Project Teams and Spread Sites

The ARTIC Lead Project Team was the successful proponent from each Call for Proposals. This team led the implementation of the intervention across participating organizations (spread sites) by providing expertise, education/training, implementation materials, coaching, and establishing a community of practice. The teams developed and managed project timelines, deliverables and budget, and were accountable to the ARTIC Operational Committee actively

working through the ARTIC program staff. Typically, teams were led by clinicians who may have championed the intervention within their organization. The concept of strong leadership in the field is central to the ARTIC program, as teams that have implemented similar models of care bring the clinical expertise and knowledge to guide others.

Project evaluation and reporting

ARTIC projects were continually evaluated against a common framework, both at the project selection phase and during the implementation period. Elements in the evaluation framework include measures of quality, reach, and impact. The evaluation framework is presented in *Appendix A*. Regular status updates were provided by the ARTIC Project Teams to the ARTIC program staff and Operational Committee.

ARTIC Projects

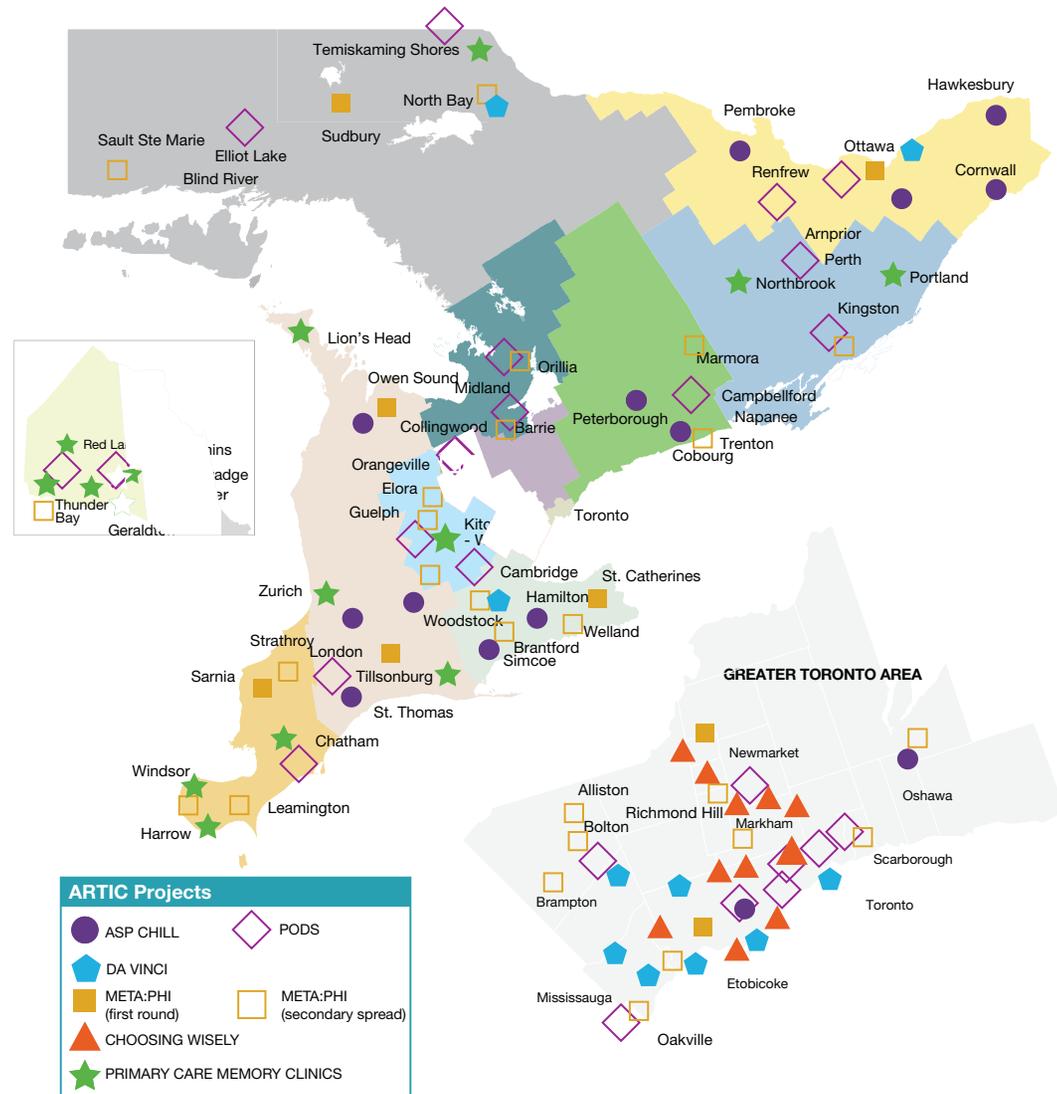
Eight ARTIC projects have been funded since the partnership between Health Quality Ontario and CAHO started in 2014. These projects have addressed diverse problems in the health care system and have fundamentally changed the health care system in Ontario.

Collectively, >292,000 patients across Ontario were affected by these projects during the project evaluation periods alone. Once implemented, the interventions were largely sustained at participating organizations, and many have spread further; therefore, the number of patients affected is now much higher. *Figure 1* shows the distribution for all eight ARTIC projects (lead teams and spread sites).

ARTIC project summaries

This section presents a brief summary of each ARTIC project's aim and approach to implementation. Additional details about project leads, spread sites, funding and terms are presented in *Appendix B*.

FIGURE 1 Spread of ARTIC projects in Ontario





ASP ARTIC CHILL

ASP ARTIC CHILL implemented antimicrobial stewardship programs (ASPs) in the intensive care units of community hospitals.

A hub-and-spoke model was used, in which academic hospitals partnered with community hospitals to help them implement ASPs in their intensive care units. Implementation supports included a Train-the-Trainer day for hub sites; a full-day, in-person education session for both hub and spoke sites; community of practice teleconferences; and the use of data from Ontario's Critical Care Information System. This project resulted in the establishment of sustainable ASPs at all participating sites.

Depression and Alcoholism: Validation of an Integrated Care Initiative (DA VINCI)

DA VINCI implemented an integrated care pathway for the treatment of both major depressive disorder and alcohol dependence in a variety of health care settings.

The project team used interviews, process mapping exercises, and facilitated sessions with front-line clinical teams to develop customized plans to embed the DA VINCI protocol in each site. These plans included education, coaching, process reengineering, implementation of proper screening and confirmation of diagnosis, and the utilization of treatment interventions. This project resulted in i) the establishment of a highly effective integrated care pathway

for major depressive disorder and alcohol use disorder, and ii) introduced measurement-based assessment for mental health and addictions treatment.

Choosing Wisely

The Choosing Wisely project implemented Choosing Wisely recommendations (to enable health care providers to 'choose wisely' and avoid tests, procedures and treatments which are commonly used, yet are not supported by evidence and could expose patients to harm) among Joint Centres for Transformative Healthcare Innovation hospitals and their affiliated primary care sites.

Participating sites worked together to focus on three primary areas of activity enabling the implementation of Choosing Wisely recommendations: shared governance and idea sharing; local leadership, engagement and implementation; and evaluation and sustainability. This project is estimated to have prevented >500,000 unnecessary tests ([learn more](#)).

Primary Care Collaborative Memory Clinics (PCCMC)

The PCCMC project established accessible, comprehensive, interprofessional PCCMCs to support patients with memory problems and their family members in remote and rural communities.

Implementation centred on an accredited, five-day multi-disciplinary training program (the Centre for Family Medicine Memory Clinic Training Program) designed to establish fully operational, self-sustaining interprofessional teams embedded within primary care practice and to address the challenges family physicians face in caring for patients with memory problems. These clinics reached a patient population of 28,000 in rural, remote and underserviced areas, achieving high patient and caregiver satisfaction, with 96% of patients and caregivers indicating that they would recommend the clinics to others ([learn more](#)).

Patient-Oriented Discharge Summaries (PODS)

PODS has improved patients' experience with discharge, confidence in ability to self-manage, and transitions in care through providing patient-oriented discharge summaries.

UHN OpenLab led a supportive and open community of practice among hospitals committed to implementing PODS. Hospitals received education on the PODS guidelines and were supported through the process of implementation. Shared resources were created and disseminated. Over 83,000 patients were discharged with PODS during the implementation period ([learn more](#)).

Rapid Access Clinics for Musculoskeletal Care

Rapid Access Clinics for musculoskeletal care help people with musculoskeletal conditions, including hip and knee arthritis and low back pain, access the right treatment faster.

The ARTIC program staff acted as the lead team and worked closely with provincial clinical leads, advanced practice providers, and staff from the LHINs and the Ministry of Health and Long-Term Care. Project managers in each region worked with in-hospital leads and other community-based providers. Rapid Access Clinics are now operating in every region of the province, and >41,000 patients with hip and knee arthritis were treated at Rapid Access Clinics in 2018/19 ([learn more](#)).

Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration (META:PHI)

META:PHI has improved addiction treatment by implementing evidence-based addiction practices into different health care settings, creating an integrated care pathway between these settings, and providing addiction medicine training and support to health care providers in these settings.

Implementation included a strong emphasis on peer learning, including through workshops, rounds, and training for staff. A toolkit featuring addiction treatment protocols and clinical summaries was distributed. Finally, Rapid Access Addiction Medicine (RAAM) clinics were established to provide low-barrier access for patients seeking treatment for substance use disorders. More than 50 RAAM clinics have now been established, and the community of practice led by the META:PHI team continues to be active in connecting clinicians who provide evidence-based care to patients with addictions and mental health ([learn more](#)).

Key enablers to success among ARTIC projects

Each of the ARTIC project teams encountered unique successes and challenges as they worked to implement initiatives at sites across Ontario. Over the course of the ARTIC Program, the members of the ARTIC program staff and Operational Committee learned from each of these successes and challenges, and made use of this knowledge when guiding subsequent projects.

Initially, the ARTIC Program was guided by a set of key enablers, which were adjusted over the course of the program based on learning from experience. Broadly, these enablers are: strategic selection of evidence-based projects, executive champions and governance, implementation supports, and evaluation. These are discussed in more detail below.

Strategic selection of evidence-based projects

Choose an evidence-based intervention and approach to implementation

Both the intervention and the approach to implementation should be rooted in sound evidence. The chosen intervention should be a mature model to warrant further spread. In addition, the implementation method should be tailored to the intervention and the intended mechanism of change. For example, we know that changing physician practice requires more than simply providing education. META:PHI included both educational resources and clinical leadership and a strong community of practice.

ARTIC Reflections Workshop

In June 2019, the ARTIC Program held a workshop to summarize and discuss learnings from the program. Attendees included members of the ARTIC Operational Committee, members of the ARTIC program staff from Health Quality Ontario and CAHO, ARTIC project leads, and representatives from the Ministry of Health.

During this meeting, attendees were asked to reflect on and discuss key enablers to successful spread and scale. The enablers you see mentioned here were highlighted during this discussion.

Link the project to priorities

The more successful spread initiatives are linked to organizational and provincial priorities. This helps to create a sustainable project that can get wide organizational support.

“ We benefited from the changing zeitgeist within the system to have a bigger focus on patient experience and patient engagement. All of this has happened in the last few years, and we kind of rode that wave to provide a solution that patients had been asking for.

– Tai Huynh, Creative Director, UHN OpenLab; Project Lead, PODS

Ensure long-term sustainability during project selection

Selecting projects with an eye for long-term sustainability from the outset helps ensure the success of the spread. Projects that are more likely to be sustained will not require added work on behalf of health care providers after the initial implementation period (i.e., they are “in place of” rather than “additive”), and will not require additional funding beyond implementation. Sustainable projects should also have a positive return on investment, whether financial or otherwise.

Assess readiness for spread

The project selection process included an assessment of the readiness of the project team as well as the spread sites for spreading and adopting the intervention. Factors that should be considered during a readiness assessment include organizational commitment from senior leadership, capacity for change, and organizational culture.

Partner with patients

ARTIC interventions are ultimately intended to improve care for patients, and working with patients makes for better solutions. The expectation that patients be involved was integrated into the ARTIC selection process. Patient representatives were members of and had an active role in the Operational Committee as well.

Plan to embed the project in systems that enable care

Embedding the project in existing infrastructure or processes can help to maximize sustainability and fidelity. For example, spread sites could include the ARTIC project in the organization’s Quality Improvement Plan or corporate scorecard to ensure commitment to the project, awareness of the project throughout the organization, and support of senior leadership, and cementing changes in order sets can help to ensure that the changes are sustained.

“*The Choosing Wisely initiative became the focus of participating sites’ Quality Improvement Plans during the period of the project. This embedded it in accountability structures, requiring endorsement at the level of the Board of Directors of the family health teams. Having the work embedded in these accountability structures was key.*

– Kimberly Wintemute, Medical Director, North York Family Health Team; Project Lead, Choosing Wisely

Champions and governance

Choose a project team led by credible leaders in the field

Strong leadership within the project team is essential, both on the local level and on the provincial level. Leaders who are passionate and respected in their fields and who have in-depth clinical knowledge can help to influence others involved in adopting the intervention. In addition, dedicated and skilled project teams are integral to the success of the implementation.

“*The project leads provincially and at spread sites include people who have done this before and know how to help others implement these changes. The credibility and know-how of these leaders is fundamental to the ARTIC program model.*

– Lee Fairclough, Vice President, Quality Improvement, Health Quality Ontario; Co-Chair, ARTIC Operational Committee

Champion the role of local senior leaders, the ARTIC program staff and the ARTIC Operational Committee

The local senior leaders, ARTIC program staff and ARTIC Operational Committee provided oversight, support and guidance to the ARTIC projects. They helped to remove barriers and shared their collective wisdom gained through their experience with previous ARTIC

projects. These leaders came from multiple sectors and had different roles, and could therefore provide insights from multiple viewpoints. Collectively, they provided invaluable mentorship, advice and advocacy to ARTIC project teams.

Implementation supports

Follow a structured implementation plan with defined milestones

Having a plan in place to complete implementation during the funding period (while support from the ARTIC program staff was available) was essential to keep project teams on track. This ensured that attention was focused on implementation during this period.

Build a community of practice

A good community of practice built early in the spread process created a space to share ideas, problems, and figure out solutions together. Through a community of practice, team members had the opportunity to ask questions and easily resolve them. Members of the community shared practical tools – for example, job descriptions or assessment tools – as well as tips on how they can be implemented. Many communities of practice lasted well after scaling up – for example, the META:PHI team is still active in their community of practice (currently with >400 members), creating educational materials, providing clinical support for challenging cases, advice and mentorship, and networking.

Common education and training

Development of common, shareable education tools (such as META:PHI's pocket guide to management of alcohol use disorders, opioid prescribing, and opioid use disorders in primary care) and training programs (such as the PCCMCs' five-day training) helped to facilitate spread and ensured fidelity to the core components of the intervention.

Get buy-in via customization, balanced with fidelity to the model

Interventions spread best when they were tailored to local contexts. Local customization of interventions allowed communities to co-design solutions for themselves and helped them understand how the intervention could address their needs. However, this customization must be balanced with fidelity to the model given that this has been proven to impact outcomes.

Evaluation

Follow a strong evaluation framework with ongoing measurement

It is critical to have a strong evaluation framework and plan for tracking achievement. Reliable data allowed the teams to see where things were working and where they are not, and helped them to adjust when needed. Elements in the evaluation framework include measures of quality, reach, and impact, and helped demonstrate the ultimate impact of the project.

The ripple effect: Wide-ranging impacts of the ARTIC Program

The ARTIC Program has had positive impacts on health care organizations and the overall health care system beyond the direct benefit to patients, caregivers, and providers. Here are some ways in which ARTIC influenced the health care system beyond the specific projects that were funded.

Instilling a quality improvement mindset among participants

Some spread sites reported that the ARTIC implementation process led them to other quality improvement opportunities. In general, this may reflect a shift in the organizational culture toward a mindset of continuous quality improvement.

Improved care integration

Implementation of ARTIC projects has built relationships and improved collaboration among acute care, primary care, and community care organizations and provided the infrastructure for collaboration on post-ARTIC initiatives.

Further spread beyond ARTIC

The success of ARTIC projects enhanced credibility and strengthened the evidence base for other opportunities for funding (e.g., CIHR grants, funding from the Ministry of Health and Long-Term Care), encouraging further spread after the ARTIC funding period. Some teams that applied but were not selected for ARTIC funding also later received other grants.

Several of these applicants noted that the process of developing the ARTIC application itself led to valuable partnerships that helped with their later success.

“ This initiative continues to spread. A week does not go by without a new hospital contacting us to join our community of practice and get information about PODS.

– Shoshana Hahn-Goldberg, Scientist, UHN OpenLab; Project Lead, PODS

Application of ARTIC expertise to areas outside the core program functions

The expertise of the ARTIC Operational Committee and ARTIC program staff has been used in ways that expand beyond the core program goals. For example, the implementation of the MSK project was led by the ARTIC team at the request of the Ministry of Health and Long-Term Care, and ARTIC expertise was also leveraged for a provincial evaluation of the PCCMCs.

Conclusion

For the past five years, the ARTIC program has successfully led the spread of evidence-based innovation across Ontario, impacting more than 292,000 patients. These interventions continue to be sustained at participating organizations and spread further across the province, and have resulted in improved care for patients in Ontario to this day.

Over this time, those involved in the ARTIC program have learned what it takes to spread and scale evidence-based interventions on a provincial level. This has resulted in an established model for leading spread and recognition of the key enablers of this type of work, as presented in this document. This collected knowledge will be helpful as we enter an era of immense system transformation.

We strongly encourage those who will be involved in implementing health care system transformation to integrate the ARTIC model and key enablers into their approach to spread and implementation at a provincial level.

Acknowledgements

We would like to acknowledge and thank the many dedicated individuals who contributed to the ARTIC Program between 2014 and 2019:

The ARTIC Operational Committee

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The ARTIC Project Team and Contributors

The ARTIC Project Team Leads include: Saima Awan, Marcia Correale, Jeff Gollish, Shoshana Hahn-Goldberg, Kate Hardy, Tai Huynh, Mel Kahan, Linda Lee, Tracy MacArthur, Donna McRitchie, Andrew Morris, Yoshiko Nakamachi, Raja Rampersaud, Susan Robarts, Andriy Samokhvalov, Deepak Sharma, Rachel Solomon, Lily Whitham, and Kimberly Wintemute.

We also thank each one of the dedicated individuals who participated in the ARTIC Project Teams as well as those involved in implementing the initiatives at sites throughout the province.

Appendices

Appendix A: ARTIC Evaluation Framework

Category	Domain	Measures (examples & core)	Data Source / Responsibility	Level of Measurement			Expected Term
				Project	Program	System	
Implementation Success	Adoption	Core: Full Implementation of the intervention	Survey & interviews (Project Team/ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
		Core: Partial Implementation of the intervention	Survey & interviews (Project Team/ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
Quality Dimensions / Outcomes	Timely/ Access	e.g. time from referral to appt, time to spec post discharge	Source varies: project level records, admin databases, PCP EMRs (Project Team)	Yes	Yes	Yes	Short, Medium, Long
	Equitable	e.g. reduced variation, standard followed		Yes	Yes	Yes	Short, Medium, Long
	Effective	e.g. reduced opioid related deaths, ED usage, BDI, PACS		Yes	Yes	Yes	Short, Medium, Long
	Patient Centred	Core: Patient Satisfaction / Patient Experience		Yes	Yes	Yes	Short, Medium, Long
	Safe	e.g. reduced SSI, Nosoc infection, falls		Yes	Yes	Yes	Short, Medium, Long
	Efficient	e.g. antimicrobial use, reduced ED usage, admissions		Yes	Yes	Yes	Short, Medium, Long
Integration	Service Planning	e.g. shared QIPs, regional COEs	(Project Team/ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
		Length of Stay (LOS)	(Project Team/ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
		Wait time / time to service	(Project Team/ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long

Category	Domain	Measures (examples & core)	Data Source / Responsibility	Level of Measurement			Expected Term
				Project	Program	System	
Integration - continued	Service Planning - continued	Readmissions	(Project Team/ ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
	Care Coordination	“e.g. # of care plans created & shared demonstrated active use of care plans”	(Project Team/ ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
Value/ Cost / Savings	Cost savings and/or avoidance	Core: Value: Outcomes related to investment/cost	Varies by Project (Project Team/ ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
Spread / Reach	Patient Population	“i. count of pts reached ii. % of population (outcome of spread)”	Project records, surveys (Project Team)	Yes	Yes	Yes	Short, Medium, Long
	Organization / Provider Participation	“Core: i. # of organizations / providers participating” “ii. # trained iii. time to uptake”	Project records, aggregation, extrapolation (Project Team/ ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
Sustainability	Provider Satisfaction	Core: Staff / Provider Satisfaction	Survey & interviews (ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long
	NHS Dimensions	“e.g. i) Senior & Clinical Leadership engaged & supportive ii) Staff buy-in iii) Infrastructure in place to sustain iv) Provider outcomes to be included to assess sustainability”		Yes	Yes	Yes	Short, Medium, Long
	Knowledge Transfer	“Core: i) COP Participation ii) Satisfaction with /Value derived from CoP”	Project reported & survey (Project Team/ARTIC Team)	Yes	Yes	Yes	Short, Medium, Long

Category	Domain	Measures (examples & core)	Data Source / Responsibility	Level of Measurement			Expected Term
				<i>Project</i>	<i>Program</i>	<i>System</i>	
Capacity (Implementation)	Organizational Capacity	e.g. leading other change projects, in own organization	Survey & interviews (ARTIC Team)	Yes	Yes	Yes	Medium, Long
	System Capacity	e.g. leading other change projects - multi-organization		Yes	Yes	Yes	Medium, Long
ARTIC Approach	Evaluation	Measures to be determined - will include description of a clear causal pathway - the methodology of how ARTIC works, and then assess those elements	Mixed methods approach including surveys and interviews with participating orgs to assess each component, as well as assessment of overall program. (ARTIC Team)	Yes	Yes	No	Medium
	Champions / Governance			Yes	Yes	No	Medium
	Implementation Support			Yes	Yes	No	Medium
	Education / Training			Yes	Yes	No	Medium
	Selection			Yes	Yes	No	Medium

Appendix B: Summary of ARTIC projects

Project	Aim	Lead	Spread Sites	Funds	Term (Years)	Impact
ASP ARTIC CHILL	Antimicrobial stewardship at provincial standard for community hospitals	Morris, Nakamachi, Mount Sinai Hospital/ University Health Network	10 sites in 4 regions	\$200K	1.5 years 2014–2016	Sustainable antimicrobial stewardship programs at all partner sites
DA VINCI	Concurrent major depression and alcohol abuse integrated care pathway leading to improved outcomes for both	Samokhvalov, Awan, Centre for Addiction and Mental Health	8 sites in 6 regions	\$822K	2 years 2015–2017	Highly effective integrated care pathway for major depressive disorder and alcohol use disorder
META:PHI	Integrated care pathway/rapid access addiction medicine (RAAM) clinics offer effective treatment for opioid and alcohol addiction	Kahan, Hardy, Women's College Hospital	7 sites in 6 regions	\$855K	2 years 2015–2017	>2100 patients and activation of growing network of RAAMs (Learn more about META:PHI's impact)
Primary Care Collaborative Memory Clinics (PCCMCs)	Accessible, comprehensive, inter-professional primary memory care supports patients and family members in their community	Lee, Centre for Family Medicine Family Health Team	17 sites in 6 regions	\$500K	2 years 2015–2017	28,000 patient population, 96% satisfaction (Learn more about PCCMCs' impact)
Choosing Wisely	Appropriate use of tests and procedures for better care, patient involvement in decision making	McRitchie, Sharma, Wintemute, North York General Hospital	11 sites in 2 regions	\$500K	2 years 2016–2018	>500,000 unnecessary tests prevented (Learn more about Choosing Wisely's impact)
PODS	Improve patient experience with discharge, confidence in ability to self-manage and improve transitions	Huyhn, Hahn-Goldberg, University Health Network Open Lab	27 sites in 14 regions	\$987K	2 years 2016–2018	>83,000 patients discharged with PODS (projected), growing site list (Learn more about PODS' impact)
Rapid Access Clinics for Musculoskeletal Conditions	To help people with musculoskeletal conditions, including hip and knee arthritis and low back pain, access the right treatment faster	Gollish, Robarts (Sunnybrook), Rampersaud, Correale (University Health Network)	>50 sites in 14 regions	\$2M	2.5 years 2017–2019	>41,000 hip and knee patients in 2018/19 (Learn more about Rapid Access Clinics for Musculoskeletal Conditions)
META:PHI (secondary spread)	Supporting newly funded RAAM clinics to universally offer evidence-based care and cohesively work with other system stakeholders	Kahan, Hardy, Women's College Hospital	46 sites in 13 regions	\$550K	1 year 2018–2019	Growth to >50 clinics, 420 community of practice members (Learn more about META:PHI's impact)

Health Quality Ontario
130 Bloor Street West
10th Floor
Toronto, ON M5S 1N5

Telephone: 416-323-6868
Toll-free: 1-866-623-6868
Email: info@hqontario.ca
www.hqontario.ca

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