Atlantic Healthcare
Collaboration
for Innovation and Improvement
in Chronic Disease
Charter

March 12, 2012
1.0 Background and Context

1.1 The Atlantic provinces, like all regions of Canada, face persistent challenges creating integrated, cost-effective, patient-centred care. Chronic diseases, which are becoming more common as the population ages, are a particular area of concern for patients, providers and healthcare policy makers. Proper management of chronic disease can do a great deal both to reduce the suffering of patients and control healthcare costs. Such a major health issue, however, is best tackled collaboratively, so evidence and ideas reach everyone who needs them and effective and sustainable solutions can be shared across organizations, regions and provinces.

1.2 The Canadian Health Services Research Foundation (CHSRF) has developed a program called Collaboration for Innovation and Improvement. It’s designed to help partners work together in a specially tailored learning process focused on improving broader health system performance. Working collaboratively, partners improve their ability to analyze the issues they face and to develop the processes, tools, learning systems and leadership they need to create and implement evidence-driven policy and solutions.

1.3 CHSRF and regional health authorities from Newfoundland and Labrador, Prince Edward Island, New Brunswick and Nova Scotia have agreed to work together on a Collaboration for Innovation and Improvement for people living with chronic diseases in Atlantic Canada.

1.4 The partners in this Collaboration for Innovation and Improvement will develop cross-regional and cross-provincial teams to lead improvement projects for systems-level improvement over a three-year period. Over the same time, the partners will work to build networks for sharing and spreading knowledge and innovations throughout their organizations and health systems, in the Atlantic provinces and beyond.
2.0 Partners

2.1 CHSRF is an independent organization (funded through an agreement with the government of Canada) dedicated to accelerating healthcare improvement and transformation for Canadians. We collaborate with governments, policy-makers, and health system leaders to convert evidence and innovative practices into actionable policies, programs, tools and leadership development. In this collaboration, CHSRF will work with the regional health authorities from Newfoundland and Labrador, Prince Edward Island, New Brunswick and Nova Scotia (referred to in this document as the Atlantic regional health authorities (ARHAs)). They include:

- Horizon Health Network (New Brunswick)
- Vitalité Health Network (New Brunswick)
- Central Health (Newfoundland and Labrador)
- Eastern Health (Newfoundland and Labrador)
- Labrador-Grenfell Health (Newfoundland and Labrador)
- Western Health (Newfoundland and Labrador)
- Annapolis Valley Health (Nova Scotia)
- Cape Breton District Health Authority (Nova Scotia)
- Capital Health (Nova Scotia)
- Colchester East Hants Health Authority (Nova Scotia)
- Cumberland Health Authority (Nova Scotia)
- Guysborough Antigonish Strait Health Authority (Nova Scotia)
- IWK Health Centre (Nova Scotia)
- Pictou County Health Authority (Nova Scotia)
- South Shore Health (Nova Scotia)
- South West Health (Nova Scotia)
- Health PEI (Prince Edward Island)
2.2 The ARHAs and CHSRF are the signatories to this document, but the success of this collaboration depends on a broader joint effort, which will include the four provinces' health departments, as well as their provincial health-research funders, academic institutions and others.

3.0 Goals and Objectives

3.1 Our goal is to improve the health of people living with chronic diseases in Atlantic Canada.

3.2 Our objectives are:
   - To develop a patient- and family-centred approach to chronic disease management;
   - To promote the sustainability of the health system; and
   - To help build a network of organizational, regional and provincial teams, which will share evidence-informed, effective, sustainable and systems-level solutions and work together to develop and implement improvement projects.

3.3 Our activities will include:
   - Establishing a network of chief executives to work together to identify health priorities and set outcome and systems improvement targets for their regions;
   - Building capacity in organizations and across all the regions and provinces to research, develop, share and sustain evidence-informed and systems solutions;
   - Increasing the availability of timely, relevant and evidence-informed policy analysis to clarify issues and guide decisions and planning;
   - Creating and training teams to lead improvement projects to achieve those outcomes and targets;
   - Promoting development of local channels to keep the exchange of evidence, innovation and ideas going;
• Introducing integrated evaluation and monitoring plans to track progress and outcomes; and
• Using detailed case study analysis and other comparative learning strategies to empower approaches and outcomes that have impact.

4.0 Roles and Responsibilities

4.1 CHSRF and the ARHAs will form a joint executive committee, and communicate regularly during the term of this project to ensure the work outlined in this charter succeeds.

4.2 CHSRF will:
• Act as the administrative hub for the collaboration;
• Assess needs to identify organizational or system problems and opportunities and policy barriers that may be impeding work on them;
• Guide the design of improvement strategies by working with executives, policy-makers, front-line professionals and patients to find and interpret evidence, assess solutions and devise implementation plans;
• Support implementation teams as they undertake improvement projects;
• Provide teams with faculty, coaches and mentors, tailored education and opportunities to learn together and share knowledge to encourage success in improvement projects;
• Send staff on site visits to the implementation project teams to facilitate the evaluation research and shared learning of the improvement projects;
• Promote the development of channels for the exchange of evidence, innovation and ideas among the regions and provinces as well as across Canada and internationally;
• Adapt the Executive Training for Research Application (EXTRA) curriculum for this collaboration and deliver it to participants;
• Hold tailored workshops on evaluation and performance management;
• Manage marketing and branding of the collaboration;
• Provide core funding to areas such as: planning meetings, site visits, commissioned research, webinars and dissemination; and
• Support members of the executive committee as they negotiate with their provincial governments to share the cost of developing, managing and delivering programs, and funding for faculty, mentors and web infrastructure.

4.3 The ARIHas will contribute financial and in-kind resources, including:
• Provide core funding to areas such as: contract costs for advisors and faculty, commissioned research and evaluation of the improvement projects;
• The cost of backfilling clinical staff to free them to take part in collaboration activities such as improvement teams and education programs;
• Local, indirect expenses teams incur for things like travel or collecting data and getting it analyzed (especially for smaller organizations that lack in-house support) as well as costs associated with carrying out the work related to the improvement project itself; and
• Sharing the cost of using resources from other programs to support the collaboration, such as staff time or office space.

The regions may count, as part of their contribution, resources for activities that would have been done anyway, as long as they are directly involved in an improvement project or other aspect of the collaboration.

5.0 Governance

5.1 The collaboration will be led by an executive committee, consisting of CEOs from five regions (one each from Newfoundland and Labrador, Prince Edward Island and Nova Scotia and one each from New Brunswick's Francophone and Anglophone populations) as well as one or more representatives from CHSRF. Health ministry staff will be invited to attend meetings when needed.
5.2 The executive committee will set the direction for the collaboration by choosing priority areas for improvement. Over the longer term, it will be a forum for sharing information, assessing needs, responding to outcomes, evaluating success and adopting and spreading effective innovations.

5.3 The executive committee will advise on policy changes needed to enable improvement, provide advice on allocating resources, and oversee evaluation, communication strategies and other initiatives to ensure the success of the collaboration.

6.0 Acknowledgment

6.1 CHSRF and the ARHAs will be acknowledged in all communications regarding this collaboration.

7.0 Copyright and Intellectual Property

7.1 CHSRF and the ARHAs will jointly retain all rights to the intellectual property developed under this collaboration. CHSRF and the ARHAs agree to promote sharing of knowledge by making the papers, reports and other documentation resulting from the work available to the broader community in various formats, either jointly or individually.

7.2 CHSRF will ensure appropriate contracts for items 7.1 and 8.0 in this charter will be included in all agreements with the improvement project team organizations.
8.0 Confidentiality

8.1 Any confidential information received by any of the parties shall be retained in confidence and shall be used, disclosed and copied solely for the purposes of, and in accordance with, this charter. The receiving party shall use the same degree of care as it uses to protect its own confidential information of a similar nature, but no less than reasonable care, to prevent the unauthorized use, disclosure or publication of confidential information.

9.0 Duration

9.1 This project charter takes effect January 30, 2012 and finishes on June 30, 2015. The timeframe may be extended with the written mutual consent of CHSRF and the ARHAs.

10.0 Amendments

10.1 Any amendment to this project charter will be by written mutual consent of CHSRF and the ARHAs.

11.0 Termination

11.1 This charter may be terminated by CHSRF or the ARHAs on the condition that a minimum of three (3) months’ notice is provided in writing to the other parties. The parties will, however, use their best efforts to resolve any disputes prior to proceeding with termination.

11.2 Notwithstanding such termination, all parties will be jointly liable for the costs incurred for the project-related work undertaken prior to the termination date. In addition, the parties will continue to be recognized as co-funders of the completed
work. Any notice given under this agreement will be sufficient if it is in writing and if delivered personally or sent by courier or registered mail.

12.0 Survival

12.1 Clauses 6.0, 7.0 and 8.0 shall survive the termination or expiry of this agreement.
13.0 Signatories

Maureen O’Neil
President
For the Canadian Health Services Research Foundation

NEW BRUNSWICK:

Donald J. Peters
President and Chief Executive Officer
For the Horizon Health Network

NEWFOUNDLAND:

Karen McGrath
Chief Executive Officer
For Central Health

Vickie Kaminski
President and Chief Executive Officer
For Eastern Health

Eric Power
Chief Executive Officer (Acting)
For Labrador-Grenfell Health

Date

May 22, 2012

Date

27 March 2012

Date

April 9, 2012

Date

April 17, 2012

Date

April 30, 2012

Atlantic Healthcare Collaboration for Innovation and Improvement in Chronic Disease Charter – dated March 12, 2012
Susan Gillam  
President and Chief Executive Officer  
For Western Health

*NOVA SCOTIA:*

Janet Knox  
President and Chief Executive Officer  
For Annapolis Valley Health

John Malcolm  
Chief Executive Officer  
For Cape Breton District Health Authority

Chris Power  
President and Chief Executive Officer  
For Capital Health

Peter MacKinnon  
Chief Executive Officer  
For Colchester East Hants Health Authority

H. Bruce Quigley  
Chief Executive Officer  
For Cumberland Health Authority

April 4, 2012  
Date

April 13, 2012  
Date

April 19, 2012  
Date

April 20, 2012  
Date

April 25, 2012  
Date

Apr 30, 12  
Date
Liz Millett  
Acting Chief Executive Officer  
For Guysborough Antigonish Strait Health Authority  

Anne McGuire  
President and Chief Executive Officer  
For the IWK Health Centre  

Patrick Lee  
Chief Executive Officer  
For Pictou County Health Authority  

Alice Leverman  
Chief Executive Officer  
For South Shore Health  

Blaise MacNeil  
President and Chief Executive Officer  
For South West Health  

PRINCE EDWARD ISLAND:  

Keith Dewar  
Chief Executive Officer  
For Health Prince Edward Island  

March 21/12  
March 23/12  
March 27/12  
April 5/12  
April 17/2012  
April 23, 2012  

Date  
Date  
Date  
Date  
Date  
Date