afhto association of family health teams of ontario

AFHTO 2014 Conference – *In Partnership with Patients: True Integration of Care*

Concurrent Session Stream Descriptions and Review Group Tips

1. Accountability and governance for patient-centred care

Description: How does the board know that their organization is patient-centred? Presentations in this stream will include examples and stories of boards who have successfully incorporated the patient voice into strategic planning; created structures such as patient and family advisory committees; and processes for including patient stories in quality improvement planning.

The review group has identified the following examples:

- Strengthening leadership skills
- Examples of patient-centeredness: Primary Care vs. other health care sectors
- Discussion on how groups of FHTs & physician groups work together to achieve patient-centeredness
- Addressing concerns about bringing patients into committees
- Examples of barriers to patient centeredness and how to overcome them

2. Engaging the patient in their care

Description: Patients and caregivers are increasingly looking to be engaged and consulted in their own care. Primary care is finding innovative ways to support patient decision-making about their care and support for self-care. Presentations in this stream will include topics such as education programs for patients and their families; patient involvement in care planning; tools and coaching for patients to manage their own care; and using patient feedback to achieve a seamless patient experience.

The review group has identified the following examples:

- Examples and discussion on how teams integrate patient feedback into practice (organizational readiness and ability to change)
- Emerging practice in social media and patient care improvement
- Education and engagement activities that foster health literacy in patients and engage caregivers

3. Responding to community needs

Description: Primary care organizations serve communities with diverse populations facing unique needs and barriers. Identifying needs and planning programs to improve population health and achieve greater equity requires engagement and collaboration with patients and other community partners. Presentations in this stream will include population-based approaches to program planning; methods for identifying community needs, potential partners, and funding for patient and population needs.

The review group has identified the following examples:

- Discussion on how teams are meeting and balancing the needs of rostered patients vs. community populations (finding/developing partnerships and resources)
- Examples of how teams are addressing social determinants of health in primary care
- Examples of successful community partnerships (e.g. Public Health, CCAC, LHIN, long-term care, palliative care, homeless shelters, food banks, fitness centre, etc.)
- Discussion on emerging practices in social media and patient care improvement/engagement

4. Team collaboration in patient-centred care

Description: Interprofessional comprehensive primary care is focused on a collaborative practice that improves on the patient's experience each time they interact with the organization - from making an appointment through their care episodes and follow-up reminders. Presentations in this stream will focus on interprofessional team collaboration and factors affecting how the team coordinates their work to meet patient needs (i.e. team development activities, conflict resolution, and flexibility in scope of work for team members).

The review group has identified the following examples:

- Integrating patient stories into presentations Patient stories – comparing a FHT patient experience to a non-FHT patient
- Examples of successful interprofessional primary care putting the patient at the centre
- Innovations in bringing primary care to the patient (e.g. Home visits, paramedicine in the home and/or community, etc.)

5. Integrating the community around the patient

Description: Organizations in the community increasingly work in partnership to meet the needs of the patient and their community. Health Links and other initiatives have provided opportunities to improve coordination and transitions in care. Presentations in this stream will demonstrate how the patient's journey and experience in the system has improved through successful coordination and/or integration of services across organizations.

The review group has identified the following examples:

- Improving transitions of care (e.g. coordinated care plans and information sharing amongst providers)
- Using technology to provide increased access to care
- Innovative uses of community resources/partnerships in a rural and/ urban setting
- Examples of successful community partnerships (e.g. Public Health, CCAC, LHIN, long-term care, palliative care, homeless shelters, food banks, fitness centre, etc.)

6. Using data to improve transitions of care and care coordination

Description: Primary care providers collect and share patient information to help patients move safely and efficiently through the health care system. Presentations in this stream will share experiences to increase our collective capacity for:

- Collecting more consistent data AND using the data we already have more safely and effectively (even if it isn't consistent);
- Making personal health records available to patients;
- Knowing when and what personal patient information could and should be shared between providers; and
- Getting the most out of existing technology, even while working to make it better.

The review group has identified the following examples:

- Examples of teams at the various stages of data collection (data entry, data collection and using data)
- Discussion or examples of teams that have found ways to use the data they have to improve care, with clear discussion on how to overcome barriers
- Discussion on how teams support change within the team to improve data processes/practices
- Examples of tools that can be used in any team to improve transitions and care coordination

7. Clinical innovations in comprehensive primary care

Description: Interprofessional comprehensive primary care is the foundation of a sustainable responsive health care system in Ontario. Primary care teams work with patients to develop clinical services that respond to the expectations and needs of their patient population. This theme is focused on the *comprehensive* aspect of primary care. Presentations in this stream will showcase programs and services that integrate the interprofessional team and focus on a continuum of care for patients on everything from health promotion, illness prevention through chronic disease management to palliative care.

The review group will be looking for abstracts that cover all aspects of team care and specifically show how teams are providing comprehensive care of the patient as a person, not only the disease. **The review group has identified the following examples:**

- Examples of how teams adjust to increased demands from Health Links initiatives
- Examples of team-based, primary care clinical innovations outside of Ontario