Conference Abstracts

BREAKOUT SESSION #1:10:30 am – 12:00 noon

TOPIC: WELLNESS/INR

ORAL 1a:

TITLE: Wellness Workshops to Prevent and Manage Chronic Illness: A Family Health Team Approach
PRESENTER (S): Michaela Devries-Aboud, PhD, CK; Sylvia Scott, MSc RN; Heidi Smith, BSc RD; Jo-Anne Costello, CDE MScN, NP; Sarah Gordon, BScN RN; Gwen Laughton, MSc RD
FHT/ORG: Guelph FHT

ABSTRACT: The movement towards preventing chronic illness before it starts continues to be a challenge to both primary care and patients. The Guelph Family Health Team (FHT) has a series of Wellness Workshops designed to help prevent and manage chronic illness. Patients participating in one or more of the Wellness Workshops increased their overall health knowledge ($p<0.03$), their confidence in their ability to set self-management goals ($p<0.02$), their level of happiness with the amount they know about physical activity ($p=0.003$) and healthy eating ($p<0.005$) and indicated an intention to adopt healthy lifestyle habits ($p<0.04$). Additionally, feedback has indicated that patients find the workshops very valuable and the interactive group nature helps them realize that they are not alone in their struggles. Challenges continue to include effective strategies to increase referral to classes and attendance. Future direction includes evaluating behaviour change sustainability over the long term.

ORAL 1b:

TITLE: The Credit Valley Family Health Team "WALK TO WELLNESS" Program
PRESENTER (S): Heather Hadden, BSc Phm
FHT/ORG: Credit Valley FHT

ABSTRACT: The Credit Valley Family Health team works with many patients who have chronic disease states. These include but are not limited to Diabetes, COPD, Asthma, Hypertension, Obesity, Arthritis and Osteoporosis. Many of these patients do not lead an active lifestyle and do not meet the Canadian recommended requirements for daily activity. It was felt that having a weekly walking group would help to educate and motivate these patients to increase their daily activity. The "Walk to Wellness" program started with a selected group of patients with Diabetes. Our goals were not only to provide a 2-hour orientation on active lifestyle and then a weekly 1-hour activity session but also to help motivate the patient to do expand on their own. Goals included weight loss, decrease in BMI, decrease in waist circumference and also changes in FBS, HBA1C, Triglycerides, Cholesterol, LDL, HDL, and cholesterol ratio. To date the program has opened up to patients with COPD, Asthma, Obesity, Arthritis, Osteoporosis, CVD and addictions.

ORAL 1c:

TITLE: Point of Care INR: Successful Outcomes from an RPN Lead Clinic

PRESENTER (S): Katharine De Caire RN (EC), MN; Jennifer Scott, RPN; Mary Park, RPN; Joan Morris, RPN; Brian Hemens, RPh BScPhm; Shelly House RPh BScPhm
FHT/ORG: McMaster FHT, Stonechurch Family Health Centre

ABSTRACT: Monitoring the international normalized ratio (INR) is a key component of using Warfarin therapy effectively and safely. Traditionally, measuring an INR has involved routine visits to laboratories for venipuncture. Point-of-care testing is an effective alternative. By putting patient, practitioners and test results in the same place at the same time, they facilitate timely and proper patient evaluation and education and leads to improved patient satisfaction. Multiple studies have shown that a systematic approach to anticoagulation management, focused at the point-of-care, may increase the time patients are in range and reduce the risk of adverse events. In this presentation, we will highlight our RPN lead INR clinic and our experience with the development and ongoing logistics associated with a FHT-based point-of-care INR testing program. Our evaluation focuses on time in therapeutic range, patient satisfaction, and costs

TOPIC: SENIORS

ORAL 2a:

TITLE: Planned Senior's Health Days - An Interdisciplinary Approach to Geriatric Screening and Management in a Busy Clinic Setting

PRESENTER (S): Cherie Robinson, RPh; Christine Fitchett, RN (EC); Joanne Sugden, RN; Kathy Croucher, RPN; Eva West, RD; Karen Quemby, MA
FHT/ORG: Cottage Country FHT

ABSTRACT: Acknowledging the increasing demographic of the over 65yr population living at home at high risk (i.e. > 5 meds, Hx of falls/falls risk, frequent office and emergency department visits, frequent hospital admissions, depression, delirium, dementia and/or cognitive impairment), our Planned Senior's Health Days provide comprehensive screening, treatment and support to these patients and their caregivers. Outcomes include reduced drug related problems, decreased falls, improved cognitive screening and management, with the overall goal of keeping seniors in their home longer and as healthy as possible. Additional benefits include enhanced interdisciplinary team effectiveness and community collaboration, reducing silo approaches to care. The Planned Senior's Health Days provide an opportunity for seniors to be assessed by various health care providers, including a Nurse, Nurse Practitioner, Pharmacist, Social Worker, Health Educator and Dietician, in one two hour morning visit focusing on prevention and chronic disease management. A Round Robin discussion with the allied health professionals, physician and community partners (e.g. CCAC, Alzheimer's Society) is held in the afternoon. The patient is seen within 2 weeks in a follow-up appointment with the physician to address the flagged concerns and recommendations. At six months, follow-up patient assessments and outcome measurements are completed. This unique geriatric program offered by our FHT, using a multidisciplinary team approach, requires no supplementary funding and can be implemented in most primary care settings.

ORAL 2b:

TITLE: Practitioner Experience of an Interprofessional Integrated Primary Care-Based Programs For Seniors

PRESENTER (S): Dr. Ainsley Moore, MSc, MD CCFP; Joy White, RN-EC, MSN; Kalpana Nair, MSc, PhD; Maria Chacon, MD
FHT/ORG: McMaster FHT & Department of Family Medicine, McMaster University

ABSTRACT: Background: Multidisciplinary, integrated primary care-based programs involving multiple practitioners are recommended for frail seniors with complex concurrent conditions. This study sought to understand the perceptions and experiences of family physicians and nurses whose patients had been seen through a multidisciplinary, integrated primary care-based program for seniors, the Seniors Collaborative Care

Program (SCCP). Methods: This study used a qualitative descriptive approach and took place at Stonechurch Family Health Centre (SFHC) in Hamilton, Ontario. Purposive sampling was used and each participant took part in a semi-structured, individual interview. Analysis involved a content analysis approach. Results & Conclusions: Five family physicians and 4 nurses working at SFHC took part. Main themes centred on need for clear communication and role clarity. Access to the SCCP Program was also a predominant theme, suggesting that availability of specialized geriatric services in primary care is an important step towards increasing knowledge and skills of primary care clinicians.

ORAL 2c:

TITLE: Summerville Arthritis Program: An Innovative Approach to Local Partnerships for Osteoarthritis Care
PRESENTER (S): Lucy Bonanno, Executive Director; Nadya Zukowski, Health Promotion Specialist; Jackie Elias, Clinical Pharmacist
FHT/ORG: Summerville FHT

ABSTRACT: The Summerville Arthritis Program is a collaborative approach to community Osteoarthritis care. Our interdisciplinary team partnered with The Arthritis Society and Pfizer to map out the delivery of a comprehensive yet flexible program. The program guides the patient through in-house services including a group education session, one-on-one counseling, a joint injection clinic, the 'Maximize Your Health' Stanford Chronic Disease Self-Management Program, and local community resources. It includes a communication pathway between the FHT and The Arthritis Society ensuring better communication between organizations and more comprehensive patient care. The program was piloted winter 2011, with many lessons learned and is now available FHT-wide.

TOPIC: MENTAL HEALTH

ORAL 3a:

TITLE: Mental Health Process Mapping: A Direction for Improved Patient Care
PRESENTER (S): Dr. Ken Burgess, MD, CCFP
FHT/ORG: Hamilton FHT

ABSTRACT: Crown Point Lower established a multi-disciplinary Quality Improvement team to reorganize mental health services within the clinic to better serve their patient population. Throughout the year the team established a process for front line staff to assist MH patients when they call the practice in a crisis; to ensure that all practice staff are trained in screening patients with MH issues; to educate all providers on patient self-management and the resources to support this practice. A tracking system was created for all mental health patients and a process for maintaining that system was created. The use of a process map enables practice staff to ensure consistency of patient flow through the streamlined process within the clinic. This presentation will outline how this team is now better able to utilize both assessment tools and the newly created resources to serve their high need Mental Health Patient population.

ORAL 3b:

TITLE: Central Intake Triage: A Practical Approach to Enhanced Mental Health Care
PRESENTER (S): Dr. Kathleen Brooks, M.D., FRCP (C); Mary Jane McDowell, MSW
FHT/ORG: Prince Edward FHT

ABSTRACT: Within the services offered by the Prince Edward Family Team nowhere is critical decision making more important than at the point of entry to our mental health system. At a time when demand for mental health services exceeds available resources, the importance of effective triage at the front door takes on increased importance. Mental health agencies can sometimes be reluctant to divert scarce clinical staff, especially the more experienced, in order to perform the role of coordination, intake and triage. The PEFHT views mental health intake as a critical decision point in serving our patients with mental health issues and as such our first hire to the

program was a social worker who assumed the title of mental health program coordinator. Experienced and effective coordination and triage provides for a cohesive, accessible and equitable use of a limited resource.

ORAL 3c:

TITLE: The Power of Groups: A review of the integration of Group Therapy targeting depression and anxiety, in the primary care setting of a multiple site Family Health Team Practice. Exploration of group development, delivery and outcomes. Challenges, successes and future steps.
PRESENTER (S): Donna Klinck, Social Worker; Dr. Pamela Cooper, Psychologist
FHT/ORG: The Ottawa Hospital & Bruyere Academic FHT

ABSTRACT: The purpose of this workshop is to explore the use of therapy delivered by a shared mental health care team in a group format, within 2 large urban FHTeams. We hope to present the learning, challenges and successes of incorporating this method of service delivery to a large client group. The workshop will provide an overview of the progressive development of the Ottawa group program, including statistical outcome measures, for example use of OQ-45, PHQ-9 and other evaluation tools. Content/structure and format of the weekly therapy sessions will be included for sharing and feedback.

TOPIC: CHANGE & PATIENT EMPOWERMENT

ORAL 4a:

TITLE: iPrep (Illness Prevention and Rehabilitation Program) - Pilot Program
PRESENTER (S): Dr. Lori Teeple
FHT/ORG: Bluewater Area FHT

ABSTRACT: To assist participants to transform their lifestyle into one of healthy eating and exercise so as to achieve and maintain a healthier body weight and waist circumference to prevent or remit disease such as diabetes, hypertension, cardiovascular and cerebrovascular events. Target Group: Patients with BMI > 25 and Waist Circumference WC>102 cm (men) and WC> 88 cm (women). Program Objectives: 1. To help six women achieve a weight loss of 10% of their body mass in 12 months through a combination of education, mentoring and coaching utilizing advanced internet technology and weekly/bi-weekly visits. 2. The program will be evaluated on an annual basis by determining the number of females who have completed the 12 month program and reduced their weight and waist circumference, creating a healthier body and rehabilitating disease such as diabetes, hypertension and lipid disorders. The program will give the females encouragement to continue with their ongoing lifestyle changes. Each participant will be asked to complete and evaluation upon the completion of program. Evaluation: The iPrep program was started January 2011 and after six (6) months all participants have seen positive results and are encouraged about their lifestyle changes. The program is looking to expand the number of participants and include men.

ORAL 4b:

TITLE: The Barrie Situation: Is this the natural evolution of a Family Health Team?
PRESENTER (S): Dr. Brent Elsey, Medical Director
FHT/ORG: Barrie & Community FHT

ABSTRACT: The Barrie and Community Family Health Team has been going through fundamental changes on many levels. The factors and principles that have driven this evolution are the following: 1) Change has been clinically driven _ Patient oriented _ Evidence based best practice _ Provider “user friendly” 2) Inclusive _ Maximum inclusion in all processes of elements or sectors involved 3) Non-Mandatory _ Opportunity to opt-in or out based on individual or group need 4) Communication/Communication/Communication 5) The FHT is perfectly situated to be the hub for health care in our Community _ The interface between public/private sectors _ Link to providers _ Link to patients _ Connection to other health care sectors/providers _ Link to Academia _ Link to research opportunities 6) Quality Improvement Opportunities _ In processes _ In knowledge/skill levels _ Continuity/ communication. To demonstrate the actual steps of this evolution, the presentation will highlight the

following areas: a) IT Project b) Diabetes Program c) Prenatal/Well-child Program. The presentation will close with the vision of where this FHT evolution will continue.

ORAL 4c:

TITLE: Realizing Patient Goals: Aim for nothing and you'll hit it every time!
PRESENTER (S): Andrea Petroff, BA Honours. Psych, M.I.R. (Masters of Industrial Relations), Executive Director; Claudia Mariano, NP-PHC, MSc, CDE, Primary Health Care Nurse Practitioner
FHT/ORG: West Durham FHT

ABSTRACT: Our commitment to our patients, our community, and to ourselves, to provide the best possible care for chronically ill patients, meant that we needed to take a cold, hard look at how we currently manage versus how we need to be managing this vulnerable patient population. Focusing first on patients with diabetes; we took a strategic approach to establishing FHT procedures and policies that can be easily applied in managing other chronic illness.

These are the tactics we employed:

- Developed outcome and monitoring goals for all Type Two diabetic patients >18yrs
- EMR review of baseline patient statistics measured against goals set
- In-depth analysis of current resources, practice design, interprofessional collaboration and office efficiencies to identify gaps that jeopardized our goals
- Prioritized actions to address areas of concern and assigned personnel to lead change for improvement

TOPIC: DEVELOPING IP PRACTICES

ORAL 5a:

TITLE: Inter-Professional Education in a Family Team: Learning.....To Work Together.
PRESENTER (S): Dr. Doug Oliver, Family Physician; Ms. Andrea Liss, MSW
FHT/ORG: McMaster FHT

ABSTRACT: Family health teams (FHT's) provide an excellent platform from which to explore the potential benefits of various Inter-professional education (IPE) learning models. At McMaster Family Practice (part of the McMaster FHT), we have been holding monthly IPE rounds since 2007. Our model for IPE has lead to a series of successful educational sessions, presented by various combinations of our IP team. Topics have included "Care-giver burden in Dementia Care", "The Obesity Epidemic" and "Dealing with Poverty in Primary Care". Each monthly IPE Rounds is an opportunity to work together with professionals from different disciplines and to facilitate a case-based discussion with the entire IP clinical team. This session will focus on a description of the IPE Rounds at the McMaster FHT, ideas for getting started, potential pitfalls and strategies for evaluating the success of your own experience.

ORAL 5b:

TITLE: Creating a Culture of Quality Improvement - A Collaborative Interprofessional Model
PRESENTER (S): Dr. Lesley Adcock, Quality Lead; Dr. Jeff Bloom, Physician & Chief; Dr. P Ellison, Director, University of Toronto, DFCM Quality Program; Dr. D Toubassi, Residency Program Director; Lara DeSousa, Executive Director; Anna Gallinaro, Research Assistant
FHT/ORG: Toronto Western FHT

ABSTRACT: In order to create a culture of continuous quality improvement within our family health team we have developed a model for collaborative, interprofessional small team based projects. Project team members are provided with education in basic quality improvement language and concepts while simultaneously developing and conducting quality improvement projects of their choice. Through the linking of quality improvement activities to daily clinical practice, team members learn the skills necessary to apply knowledge to actual clinical practice in order to optimize the efficiency and effectiveness of care for our patient population. Combining education,

research and professional development for all family health team members facilitates the creation of empowered teams. The success of the projects fosters enthusiasm for and trust in the process of continuous quality improvement. We now promote and integrate quality measures into all aspects of program development and evaluation within our family health team.

ORAL 5c:

TITLE: Dietitians on Academic Family Health Teams: Providing Nutrition Expertise to Patients, Providers and Resident Learners
PRESENTER (S): Michele MacDonald Werstuck, RD., MSc., CDE.;Glenda Pauw, RD., CDE.
FHT/ORG: McMaster FHT & Department of Family Medicine, McMaster University

ABSTRACT: Whether it's answering infant feeding questions or promoting heart healthy eating, nutrition issues arise frequently in primary care. It's essential that family medicine residents are familiar with the nutrition therapies to treat and prevent disease and feel comfortable providing dietary advice to their patients, knowing when to refer to a Registered Dietitian (RD) for nutrition counseling, if necessary. RD's are nutrition experts, uniquely trained to support the nutritional health of populations through evidence-based treatment, disease prevention and health promotion services. On academic family health teams (FHT's), RD's are responsible for providing nutrition counseling for patients, supporting the nutrition work of other team members and offering nutrition learning opportunities for residents to develop essential competencies in pediatric and growth assessment, pre and post natal nutrition, care of the elderly, and chronic disease management.

TOPIC: UNDERSTANDING FHT NEEDS AND PERFORMANCE

ORAL 6a:

TITLE: The experience of physicians working in this model: Results of the AFHTO-OMA physician survey
PRESENTER (S): Dr. John McDonald, President, AFHTO and Lead Physician, PrimaCare FHT; Dr. Stewart Kennedy, President, Ontario Medical Association and Physician, Harbourview FHT
FHT/ORG: AFHTO/OMA

ABSTRACT: AFHTO and the OMA are collaborating on a survey of physicians working in FHTs. Its purpose is to inform both associations on the experience of physicians working in this model, and gain insight into their needs, ideas, issues and concerns. The results will be released in this joint OMA/AFHTO presentation and discussion.

ORAL 6b:

TITLE: Laying the foundation for performance measurement for quality improvement
PRESENTER (S): Patricia Sullivan-Taylor and Brenda Tipper; TBD/ a PHC VRS user/ benefactor
FHT/ORG: Canadian Institute for Health Information

ABSTRACT: This session will explore how CIHI is working with its stakeholders to lay the foundation for performance measurement for quality improvement - through the development of pan-Canadian PHC indicators, standard survey questions and tools and EMR content standards. Presenters will demonstrate how these tools are being applied in practice through the PHC Voluntary Reporting System (PHC VRS), highlighting data findings on areas of interest that contribute to our understanding of FHT needs and performance.

TOPIC: PAIN/PT/OT

ORAL 7a:

TITLE: Feasibility and Effectiveness of Interprofessional Chronic Pain Management Group in FHT: A Pilot Randomized Controlled Trial
PRESENTER (S): Dale Guenter MD; Martha Bauer OT; Miriam Wolfson MSW; Lisa McCarthy PharmD; Lana Bullock MD; Ricardo Angeles MD, MPH, MHPEd; Maria Chacon MD
FHT/ORG: McMaster FHT & Department of Family Medicine, McMaster University

ABSTRACT: Aim: Assess feasibility of a chronic pain program in FHT, and impact on quality of life, health utilization and medication use. Methodology: Pilot RCT. McMaster Family Health clinic patients >18 years with musculoskeletal pain >6 months and no previous participation in pain groups were identified by family physicians, recruited to participate, and randomly assigned to Early or Delayed (6 months later) intervention groups. Participants were invited to 2-hour group sessions once weekly for 8 weeks, led my an interprofessional team. Quality of life, pain medication use, health care utilization were assessed before, immediately and 6 months after intervention. Results & conclusions: 200 patients were identified by clinicians, 63 agreed to participate. Mean age was 54.8 years (SD=13.9); 62.3% were female. SF-36 Bodily Pain scores significantly improved. Qualitative interviews indicated the program was helpful in assisting patients cope with chronic pain. Recruiting and maintaining patients in the groups proved challenging.

ORAL 7b:

TITLE: Self Management for Chronic Pain Patients: Will they come? Will they Benefit?
PRESENTER (S): Shellie Buckley, RN
FHT/ORG: Stratford FHT

ABSTRACT: Self management is a fairly new, vogue term used in healthcare but does it really work for patients with chronic pain? The data collected at the Stratford Family Health Team over the past two years shows chronic pain patients will attend six week group sessions and will benefit not only at the time but continue to demonstrate positive effects weeks and months later. Following the standardized model of the Stanford Chronic Pain Self Management Program patients are supported and guided through a six week structured program. Each week patients learn and develop skills or tools to help them be competent and successful self managers. A collection of real patient case studies will be reviewed to demonstrate the benefit of self management for the patient with chronic pain.

ORAL 7c:

TITLE: Effectiveness of Physiotherapy and Occupational Therapy for Patients with Chronic Illnesses in Family Health Teams
PRESENTER (S): Lori Letts; Julie Richardson
FHT/ORG: School of Rehabilitation Science, McMaster University

ABSTRACT: This presentation will share findings from two research projects that evaluated the contributions rehabilitation professionals make with patients with chronic diseases in primary care. The first study was a randomized trial with patients seen by physiotherapy and occupational therapy for individualized assessment, intervention, group self-management, and web-based supports to self-manage their conditions and functioning. Intervention group participants had significantly fewer planned hospital days, and were significantly more satisfied with rehabilitation services. The second study was a before-after design with case-matched controls, using a population based approach to rehabilitation self-management and organizational capacity-building. Participants in the intervention group had significant improvements in physical activity and strength; and improved self-efficacy that was not maintained. Team members reported benefits from the capacity building intervention. Together, these two studies call attention to the importance of self-management, physical functioning, and meeting rehabilitation needs of patients with chronic illnesses seen by Family Health Teams.

TOPIC: IP TEAM / GENETICS

WORKSHOP A1:

TITLE: The Interprofessional Team Case Conference: Putting Together Pieces of the Collaborative Practice Puzzle
PRESENTER (S): Difat Jakubovicz, MSc, MD, CCFP, FCFP; Ian Waters MSW RSW; Azadeh Moaveni, MD CCFP, Gita Lakhanpal, MES, OT Reg (Ont)
FHT/ORG: Toronto Western Hospital

ABSTRACT:

Learning Objectives

Participants will be able to:

a) Understand key components of an Interprofessional Team Case Conference (IPCC)
b) Appreciate how IPCCs can help health care professionals become a patient centered collaborative practice team
c) Discuss opportunities and challenges when planning an IPCC

Rationale/Background:

Family Health Teams face numerous challenges in becoming effective interprofessional teams. The Toronto Western Hospital (TWH) Academic Family Health Team (AFHT) pioneered the Interprofessional Team Case Conference (IPCC) as a way to share expertise among health professionals in order to improve patient care. TWH then shared their expertise with St. Joseph's Health Centre (SJHC) Urban FHT, who developed a site-specific model. Successes and challenges of developing and maintaining IPCCs will be discussed and suggestions provided for how one can implement a similar model in their own practice.

The IPCC focuses on improving patient care by developing: a) an understanding of the various roles and scopes of practice of various health care professionals, b) the ability to effectively communicate with other team members, c) respect for each profession's contribution to patient care and d) a reflective process to maximize the quality and effectiveness of patient care.
This will be an interactive presentation.

WORKSHOP A2:

TITLE: The use of Genetics and Personalized Medicine in Health Promotion and Chronic Disease Management – What the Family Health Team Needs to Know
PRESENTER (S): Sean Blaine, BSc MD CCFP, Lead Physician; Jill Davies, MSc., CCGC, Genetic Counsellor, Program Director, Medcan Clinic
FHT/ORG: STAR FHT

ABSTRACT: Genomic information is growing at an exponential rate and can be used as a tool in clinical decision making. It is now technically and economically feasible to consider the application and utilization of genomic sequence data in clinical care. Identifying individuals at increased risk for rare hereditary diseases as well as common diseases can lead to improved clinical outcomes through health promotion and early detection. This requires a proactive multidisciplinary approach combining new technologies with family history information, clinical data and patient education around risk reduction and disease prevention. New technologies can also identify specific genetic variants in enzymes of drug metabolism which have an impact on the selection and dosing of medication. In this way, pharmacogenomic (PGx) testing allows physicians to optimize drug selection and dosing based on a patient's unique genetic makeup. The application of PGx in clinical practice is expected to improve health outcomes by decreasing medical costs and increasing patient compliance with medication regimens.

TOPIC: DIABETES

WORKSHOP B1:

TITLE: Motivational Interviewing; putting it into practice Or "Do as you say, not as I say"
PRESENTER (S): Jessica Janssens, Registered Dietitian
FHT/ORG: Stratford Family Health Team

ABSTRACT: For Registered Dietitians and other health care professionals, facilitating positive lifestyle and behavioral change is a major part of one's job, especially when it comes to chronic disease management. While it can be rewarding, it often proves to be quite challenging at times. One way to facilitate behavior change that seems to be slowly emerging in not only the literature but in workshops and conferences is "motivational

interviewing" (MI). There are many formats one can take to learn more about MI, however it can often appear difficult to turn the theory of MI into application. This workshop is designed to share some practical tried and tested methods of how one can implement specific motivational interviewing strategies to not only provide a more rewarding experience for their patients, but make their own job appear less challenging.

WORKSHOP B2:

TITLE: Group Diabetes Visits: An Effective Team Approach adds Fun and Improves Outcomes
PRESENTER (S): Dr. Kenneth Hook; Janice McCutchen, RN (EC); Adrienne Vermeer, RD; Marc Michaud, BSc Pharm; Dr. Afrooz Derakhshan, Family Physician
FHT/ORG: STAR FHT

ABSTRACT: The STAR Family Health Team has developed an interdisciplinary approach to our management of patients with diabetes. Our patient outcomes have been improved and at the same time the professional team is excited and having fun with our strategy. We offer patients individual appointments, multidisciplinary clinic appointments, and the opportunity to attend an interdisciplinary group medical visit. The role of our population manager has been enhanced the success of our diabetes program. Data from our electronic record illustrates our improved patient outcomes. This workshop will feature a presentation of the STAR FHT team, followed by small group discussions around barriers and solutions for effective interdisciplinary care for patients with diabetes. This will be followed by a general discussion to allow each of the participants to share what we have learned with the entire group. Participants are invited to share their experiences with multidisciplinary care of patients with diabetes.

TOPIC: WELL BABY

WORKSHOP C1:

TITLE: Where You Need to Go for All You Need to Know About the Enhanced 18-month Well-Baby Visit
PRESENTER (S): Dr. Jean Clinton; Dr. Jean Mullens
FHT/ORG: McMaster University, Offord Centre for Child Studies & Hamilton FHT

ABSTRACT: The Province of Ontario has implemented an enhanced 18-month well-baby visit to shift the focus from a well-baby check-up to a pivotal assessment of development. Standardized tools (the Rourke Baby Record-Ontario and Nipissing District Developmental Screen (NDDS)) are recommended to facilitate health care professionals to have a broader discussion with parents on child development, parenting, literacy, and connecting to local community services. An educational webportal (www.18monthvisit.ca) has been developed to provide education and support for the visit. The webportal includes downloadable versions of the recommended tools, key resources, learning modules, blogs, discussion forums and more.

WORKSHOP C2:

TITLE: Implementing the Baby Friendly Initiative in a Family Health Team
PRESENTER (S): Kim Lichty, RN IBCLC; Sarah Kolk, MD CCFP
FHT/ORG: Two Rivers FHT

ABSTRACT: While it is encouraging that 9 out of 10 new mothers in Ontario initiate breastfeeding, only 1 in 4 continue to breastfeed exclusively for six months.
The Baby Friendly Initiative is an effective strategy that focuses on the implementation of evidence-based best practice throughout the continuum of care. The Initiative is designed to promote health and prevent disease by increasing initiation, exclusivity and duration of breastfeeding. Whereas the designation of Baby Friendly is currently restricted to Hospitals and Community Health Centers, the application of this Initiative in a Family Health Team (FHT) is unique and innovative. In order to successfully integrate baby friendly practices that support successful breastfeeding, Family Health Teams need to be in alignment with Hospitals and Community Health Centers. By implementing BFI in the 200 FHT's across our province we can make significant change in breastfeeding rates.

BREAKOUT SESSION #2: 1:30 – 3:00 PM

TOPIC: INTEGRATING TEAMS: NP's PA's & OT's

ORAL 8a:

TITLE: The Glue that Holds Us Together: NPs as Team Experts
PRESENTER (S): Jan Baxter, RNEC; Betty Delcome, RNEC; Cathy Risdon, MD
FHT/ORG: McMaster FHT

ABSTRACT: Setting: Academic FHT "Teamlet" with 2 NPs, 7 MDs (3.8 FTE), 24 Fam Med residents. Approx 6500 patients. Open Access, EMR=Oscar
Challenges: Continuity, Team Coordination, Interprofessional Communication, Coverage, Chronic Disease Management Strategies to Highlight: Team Room Design, NPs role with learners, Shared care of all MD patients with NPs, EMR, Team Meetings Challenges to Explore: Who owns patients, Asking for help, Saying no, Negotiating with Docs

This presentation will briefly highlight an NP-directed team with high morale and excellent coordination, despite the challenge of working with more than 30 bodies in a large teaching practice.

ORAL 8b:

TITLE: Integrating the Physician Assistant into the Family Health Team: A McMaster FHT Experience
PRESENTER (S): Anne Childs, McMaster FHT Coordinator; Erika Brown, Physician Assistant; Veronica Nguyen, Assistant
FHT/ORG: McMaster FHT

ABSTRACT: Physician assistants (PA) are independent health professionals who work under the supervision of a physician. Despite a lengthy presence in the Canadian Forces, Canada is only currently introducing the PA role into the healthcare system. A pilot project has been initiated to demonstrate the benefits of PAs within family health teams. The McMaster Family Health Team and the Department of Family Medicine (DFM) have participated in this Physician Assistant Demonstration Project. This experience has identified several steps which are necessary for the successful integration of PAs into the FHT model. This presentation details the McMaster FHT experience and provides an educational template for the introduction of PAs into other FHTs. The development of unique hiring criteria and medical directives were important steps in the integration of the PA into the FHT. Future goals to include address ongoing inter-professional team participation and the extension of the PA role into education and research.

ORAL 8c:

TITLE: Occupational Therapy in Family Health Teams: An Innovative Opportunity for Health Promotion and Chronic Disease Management
PRESENTER (S): Laura Turner, OT, Project Coordinator; Shellie Buckley, RN, Project Coordinator
FHT/ORG: Stratford FHT

ABSTRACT: Working in primary care on a Family Health Team is a new and emerging practice area for occupational therapists. Sharing common values of health promotion and wellness, occupational therapists and FHTs utilize varied models of service delivery to best address patient needs. A collaborative team effort is required to ensure that occupational therapy is a good fit with established teams, effectively meets the needs of rostered patients and does not duplicate existing community services. The objectives of this presentation are to share our experience providing OT in a FHT, including steps taken to design and implement a successful pilot project, the development of referral criteria for OT, an overview of patients who received therapy, examples of the

interventions provided and a summary of the outcome measures and results used to demonstrate the value of this project. Plans to expand the role of occupational therapy will be included in this discussion.

TOPIC: PATIENT-CENTRED/LUNG HEALTH

ORAL 9a:

TITLE: Patient Centred Access: A Pilot to Meet the Needs of the Full Spectrum of Primary Care Patients
PRESENTER (S): Margaret Tromp MD, CCFP, FCFP, FRRMS; Karen Brooks, RN, BScN, CRE
FHT/ORG: Prince Edward FHT

ABSTRACT: Patients who have primary care providers often perceive that they are unable to get timely appointments. Open Access is proposed as a response to this, but does not meet the needs of patients with chronic disease or those requesting health maintenance visits (well baby, prenatal, periodic health review). We are piloting Patient Centred Access, as described by Leonard et al (Ann Int Med 2003). We offer same day appointments to those with acute problems. We encourage those with chronic health issues to book follow up appointments in advance and they are seen jointly by the chronic disease nurse educator and the physician. The nurse educator also does lifestyle and preventive counselling for all patients. We also offer telephone appointments for those who do not need to be seen in person, usually to follow up tests or treatments. We are introducing web based medication refills and conveyance of normal test results

ORAL 9b:

TITLE: A Business Model for FHTs: People First
PRESENTER (S): Margaret Alden, Executive Director
FHT/ORG: Maple FHT

ABSTRACT: Family Health Teams are young organizations that must be able to quickly marshal their internal processes to successfully meet the expectations of stakeholder communities and demonstrate their ability to make a positive difference to the healthcare system. Drawing from popular business philosophies, Maple has designed and is implementing a model that is helping to systematize their approach to healthcare management. Based on a guiding philosophy that people come first, Maple has established a framework to align all aspects of their organization to meet expectations and to operationalize delivery of consistent, standardized, high quality care. The main features of the model are: - accommodates different practice styles while achieving universal operating outcomes - incorporates team-wide continuous quality improvement - embodies learning organization principles This novel systems approach provides a framework for working together, where people feel valued and engaged, towards the common goal of better patient care.

ORAL 9c:

TITLE: Improving Lung Health and Reducing Health Care Costs: A Comprehensive Patient Care Model: for Managing COPD and Asthma
PRESENTER (S): Andrea Stevens Lavigne, MBA, Vice-President, Provincial Programs; Carole Madeley, RRT, CRE, MASc, Director, Respiratory Health Programs
FHT/ORG: Ontario Lung Association

ABSTRACT: Research from the Ontario Lung Association has demonstrated that a comprehensive patient care model for primary care, which utilizes evidenced-based tools for health care providers and patient education, can not only improve lung health but also save health care costs. The Primary Care Asthma Program (PCAP) model was proven to be effective in improving patient outcomes and reducing expensive healthcare resources. A Comprehensive Patient Care Model suggests adapting the successful asthma management model (PCAP) for COPD patients, and making the model available to all patients with asthma or COPD throughout Ontario. The direct economic impact of other interventions, such as smoking cessation models, will also be illustrated, over 10 years and 30 years into the future.

TOPIC: IT

ORAL 10a:

TITLE: Family Health Teams in the Intelligent Community.
PRESENTER (S): Tim Iredale, Stratford Family Health Team; Paul West, Rhyzome Networks
FHT/ORG: Stratford FHT

ABSTRACT: The Stratford FHT is located in a city that is one of the Top 7 Intelligent Communities of 2011. The Stratford FHT has partnered with Rhyzome Networks to improve its IT infrastructure which has resulted in better access to our EMR and improved FHT collaboration. Rhyzome Networks offers 60 kms of fiber optics which supports a city wide mesh WiFi. This improved IT infrastructure has provided consistent and redundant connectivity and capacity for IP based voice and data communications between offices. The Stratford FHT receives results electronically into our EMR within minutes of them being posted at our local Hospital as a result of this intrastructure. Physicians can access our EMR securely from a WiFi enabled device anywhere within the City of Stratford. The next step is a patient portal made available through the city wide WiFi to any Stratford FHT patient regardless of economics.

ORAL 10b:

TITLE: Preparing for Electronic Labs: Defining Processes and Accountabilities for Shared Practice Management
PRESENTER (S): Katharine De Caire, RN (EC), MN; Katalin Ivanyi, MD, CCFP, FCFP
FHT/ORG: McMaster FHT, Stonechurch Site

ABSTRACT: Laboratory information systems are an important component of an electronic health record. The ability to electronically access laboratory test information assists health care providers to make faster, better patient care decisions, enables timely access to information, provides better coordination of care and improves workflow Shared care is the basis of a Family Health Team. In a shared care environment a team's Physicians and Nurses are both accountable for managing patient lab results and these accountabilities need to be clearly defined, communicated, and documented. In 2011 Stonechurch Family Health Centre began to prepare for the implementation of electronic labs. Our team recognized that managing test results effectively is vital to quality patient care and a failure to follow up on test results can lead to patient harm. In this presentation we will highlight our team's paper-based process for results management, discuss our journey to prepare for electronic labs and present our final plan.

ORAL 10c:

TITLE: An innovative solution of Information Technology beyond your EMR
PRESENTER (S): Dr. Sanjeev Goel, Lead Physician; Jaipaul Massey-Singh, CEO
FHT/ORG: Wise Elephant FHT

ABSTRACT: The Wise Elephant FHT has built a unique online collaborative space that facilitates care collaboration and coordination within FHT and between organizations. This space also pulls data from our EMR at regular intervals to allow us to measure our performance on various Health Quality indicators. We invite fellow FHT organizations to join our collaborative project and thus improve patient care.

TOPIC: MENTAL HEALTH

ORAL 11a:

TITLE: Building a Psychiatric Primary Care Program in Primary Care
PRESENTER (S): Jacqueline Guigue-Glaspell, MSW RSW
FHT/ORG: Guelph FHT

ABSTRACT: The Guelph Family Health Team shares our success in implementing Psychiatric services. We have created for our membership a full scope service which supports mild to moderate psychiatic care patient needs,

generally within a 4-6 week period from time of referral. Service supports the patient and care team throughout treatment. A variety of specialists have been recruited to ensure full scope of care is supported including adults, children and families and seniors. Services are provided by a team that spans comprehensive specialty areas of the DSM including concurrent disorders. The presentation will review our experiences from planning to implementation. Specific focus will be placed on recruitment, creating an effective service delivery model and evaluation processes. We will share strategies learned regarding developing a service that delivers accessible and collaborative patient care deliverables.

ORAL 11b:

TITLE: Reducing Depression Symptoms & Instilling Hope: The Benefits of the Rise Up! A Self Care Depression Group
PRESENTER (S): Kimberly Vaughan, MSW RSW; Elizabeth Smith, RN (EC), MN PHC Nurse Practitioner
FHT/ORG: Thames Valley FHT- Old South Site

ABSTRACT: Adapted from the Antidepressant Skills Workbook (Dan Bilsker PhD/Randy Paterson PhD), this program for individuals with mild/moderate depression is short, structured, and focused on getting activated. An antidepressant toolkit encourages SMART goals and small steps towards success. Participants complete the PHQ-9 and Herth Hope Index at the beginning of the first session and at the end of the fourth session to provide pre- and post-test evaluation of the program's effectiveness. In the pilot project of this program, participants post-test PHQ-9 scores averaged 2-3 points less than pre-test scores and post-test HHI scores averaged 4-6 points higher than pre-test scores indicating an decrease in depressive symptoms and an increase in hopefulness. Feedback provided by participants was overwhelmingly positive emphasizing benefits of the materials provided and the group format. Facilitated by a social worker and nurse practitioner, the success of this intervention also highlights the impact of interdisciplinary collaboration of FHT's.

ORAL 11c:

TITLE: Utilizing the PHQ-9 in the Management of Depression in the Primary Care Setting
PRESENTER (S): Dr. Douglas Green, Psychiatrist
FHT/ORG: The Ottawa Hospital, Shared Care Mental Health Team

ABSTRACT: Although depression is prevalent in primary care settings its diagnosis is frequently missed. The PHQ-9 is a widely accepted and utilized tool for assessing depression which has been shown to have good specificity and sensitivity for detecting depressive disorders. In addition to assisting with screening it can be used to establish a diagnosis of major depression. It also provides a depression score, which can assist with the assessment of depression severity and which can allow for monitoring of treatment response. As well, this score allows for improved communication between health care providers about diagnosis and illness severity, which in turn can promote greater opportunity for collaboration. In this presentation participants will be introduced to the PHQ-9 and will be taught how to use it. In addition the challenges and lessons learned in the ongoing implementation of a depression rating scale into a primary care setting will be discussed.

TOPIC: CARDIOVASCULAR & RESPIRATORY DISEASE PROGRAMS

ORAL12a:

TITLE: From a Basic Hypertension Clinic to a Complex CV Risk Clinic - Successes and Challenges
PRESENTER (S): Shellie Buckley, RN; Jenny Carter, RN
FHT/ORG: Stratford FHT

ABSTRACT: Two years ago a basic hypertension clinic was designed and launched as a pilot, with two physician partners at the Stratford Family Health Team. Now, in 2011, we have a complex CV risk program that services over 3000 patients. Gradually, over the past 2 years we have partnered with several doctors and their office staff, we have been through the QIIP learning community for HTN, have added more equipment and grown to welcome another RN. Progress has been slow at times; data extraction and organization is sometimes painful. We are now

past the point of basic BP checks and offer patients tools to prevent CV events, screening for hypertension and hyperlipidemia, management of blood pressure and cholesterol plus ongoing monitoring and support. We are continually looking for new ideas and strategies to reach and benefit our patients. The outcome data remains positive as do the patient comment

ORAL 12b:

TITLE: Chronic Respiratory Disease Management in the Community - (a snapshot of the Stratford Family Health Team Respiratory Clinic)
PRESENTER (S): Maria Savelle, RN, Certified Respiratory Educator, Nurse Educator
FHT/ORG: Stratford FHT

ABSTRACT: The Stratford Family Health Team Respiratory Clinic began as a pilot project in June 2009 after it was identified there was a need to assess and provide education regarding patient self-management of chronic respiratory conditions (COPD and Asthma). After a successful trial period, the SFHT Respiratory Clinic opened to all patients rostered with the 13 physicians of the Stratford Family Health Team. A specially trained registered nurse (COPDTrec, AsthmaTREC, SpiroTREC, TEACH trained) accepts referrals from physicians and Allied staff. Office spirometry is performed, and three champion physicians interpret the results to diagnose COPD and/or asthma. Pharmological management is decided between the Nurse Educator and the responsible physician. Follow up education regarding self-management of their respiratory condition is then provided either one-on-one, or in a group education session by the Nurse Educator. Follow up visits are arranged to ensure compliance with respiratory medications, assessing control/management of symptoms, and further patient teaching is provided to aid the patient in optimum self-management (Action Plans, Diary of symptoms, identifying need for reassessment in times of increased symptoms, etc.) If the patient is smoking, smoking cessation counseling is offered by the Nurse Educator as part of the follow up visit regime. The SFHT was a part of the QIIP COPD Learning Community, and was able to identify a number of patients appropriate for spirometry testing by way of screening with the Canadian Lung Health Test - a number of patients were newly diagnosed with lung conditions earlier, due to this screening process, and a number accepted smoking cessation counselling as a result of their screening and spirometry testing procedures. The Stratford Family Health Team Respiratory Clinic continues with the Nurse Educator assessing patients Monday to Friday, 8-4, where a constant flow of referrals for new patients continues in the busy clinic. The goal of the clinic is to identify respiratory conditions, ensure proper treatment according to current guidelines, teach patient self-management of respiratory conditions, in the hopes of reducing physician office and ER visits related to respiratory symptoms.

ORAL 12c:

TITLE: Pharmacists providing patient care in diverse settings: an overview of a pharmacist-led point-of-care anticoagulation management program
PRESENTER (S): Sherri Elms, Pharmacist; Dr. Karen Hall Barber
FHT/ORG: Queen's FHT

ABSTRACT: Our point-of-care, pharmacist-driven anticoagulation management program began in September 2009, based on the recommendations of a medical student research project and our FHT pharmacist. The program draws on the skills of our pharmacist, nursing team, resident physicians, and nurse practitioner team. Since the introduction of this program, time-in-therapeutic-range has increased from 68% to 72% and the percentage of patients drawn within 28 days has improved from 43% to 92%. Currently, almost 100% of our patients on anti-coagulation medications have been enrolled in this program and anecdotal feedback from providers and patients has been very strong. This session will focus on challenges and successes, as well as recommendations for other FHTs who are interested in this type of program.

TOPIC: PATIENT EMPOWERMENT/THE RN ROLE/ADOLESCENCE

ORAL 13a:
TITLE: Improving Access for the Adolescent Population: A drop-in model of collaborative care
PRESENTER (S): Janet Obre, RN (EC), BScN, PHCNP; Karen James-Abra, M.Ed.,RSW,R.M.F.T; Adrienne Vermeer BaSc, RD
FHT/ORG: STAR FHT

ABSTRACT: The "Teen Health Check In" Clinic was developed to increase accessibility to mental and physical health care for youth in our practice community. The goal of the clinic is to provide information and supports that promote prevention, early identification and intervention for common mental and physical health concerns in a format that fits for teens. The plan for achieving this involves offering weekly open access / drop in time for teens, no appointment is necessary and youth can meet with a nurse practitioner and / or a mental health counselor. This initiative was developed in collaboration with community partners that can be referred to from the clinic. In providing this clinic the gap between mental and physical health is closed thereby decreasing stigma associated with mental health concerns. This presentation will outline the development and progress of this initiative, specifically addressing need, planning, implementation and evaluation.

ORAL 13b:

TITLE: Advancing the RN role in Chronic Disease Management and Prevention in Primary Care
PRESENTER (S): Sylvia Scott, Clinical Manager
FHT/ORG: Guelph FHT

ABSTRACT: Health care systems continue to be challenged to respond effectively to the increasing impact of chronic diseases on population health and health care resources. Using the Ontario Chronic Disease Management and Prevention Model, Guelph Family Health Team (GFHT) responded by integrating advanced registered nurse roles in primary care practice team settings with a goal to improve care for individuals with and or at high risk for chronic conditions. This presentation will discuss a unique interdisciplinary and collaborative model led by RN as the case manager within programs or embedded in the practice team. Their role is provide a holistic approach to the patient/caregiver in order to prevent or manage chronic health conditions by engaging the patient to identify and prioritize their own physical and emotional well-being. The RN also works with the patient/caregiver by monitoring progress and barriers to achieving wellness goals and clinical outcomes. The overall goal is to build patient/caregiver and interdisciplinary team capacity. This is achieved through the RN's role by triaging in order to facilitate patient focused care, timely provider and community collaboration, patient education, and systems navigation across the entire health care spectrum. Outcomes measures include improved access to primary care, reduced number of emergency room visits and or hospital admissions, improved self-management and improved overall quality of life.

ORAL 13c:

TITLE: Self–Empowering patients to self-manage and direct their health care needs.
PRESENTER (S): Julie Brown, MSW, Clinical Program Specialist; Jacquie Guigue-Glaspell, MSW RSW, Mental Health/Psychiatry Lead
FHT/ORG: Guelph FHT

ABSTRACT: SELF is a brief but intense course centered on the use of a dynamic multi-disciplinary self-assessment tool. The self-evaluative process of the course guides patients to clearly identify areas of mental and/or physical health concerns, define personal care plans, while providing education regarding stress and change management. SELF promotes the patients' abilities to be the "driver of the bus" in primary care settings and life in general. From a clinical perspective, SELF takes collaborative care to a higher level; providing a foundation for undefined therapeutic settings & interventions (collaborative primary care) and answers the question "HOW do we work together"? The end result is a self-directed plan, engaged patients and optimal use of clinical resources.

TOPIC: TRANSITIONS BETWEEN PRIMARY CARE & HOSPITAL: REDUCING ER USE AND IMPROVING HOSPITAL DISCHARGE

ORAL 14a:

TITLE: Post-Hospital Discharge: Medication Discrepancies and Drug Therapy Problems in Primary Care
PRESENTER (S): Victoria Siu, BScPhm, PharmD (candidate 2013), Karen Cameron BScPhm, ACPR, CGP, Patricia Marr PharmD, Bassem Hamandi, BScPhm, MSc, Olavo Fernandas, PharmD, FCSHP, Sumeet Sodhi MD, MPH, CCFP, Christine Papoushek PharmD, Debbie Kwan BScPhm, MSc, FCSHP.
FHT/ORG: Toronto Western FHT

ABSTRACT: Background: Patients transitioning from hospital to home are at risk of medication related problems. Our objective was to describe the frequency and characteristics of post-hospital discharge medication discrepancies and drug therapy problems (DTP) in our clinic.

Method: Patients hospitalized for ≥ 48 hours were seen by a pharmacist and physician within 14 days of discharge. Medication discrepancies and DTPs were identified and classified. The clinical impact of discrepancies was assessed by an independent panel of clinicians.

Results: Twenty-three (77%) of 30 patients had ≥ 1 medication discrepancy. Of these, 14 (47%) patients had clinically significant discrepancies. Twenty-three patients had at least one DTP. Common reasons for DTPs were: poor information transfer (50%) and adverse drug reactions (34%).

Conclusion: Most patients experienced at least one medication discrepancy or DTP after discharge. Collaboration between family physicians and pharmacists in identifying and resolving discrepancies and DTPs has the potential to improve patient care.

ORAL 14b:

TITLE: Innovative Community Partnership Reduces ER Visits
PRESENTER (S): Katherine Campbell, BSc., MHS
FHT/ORG: Dryden Area FHT

ABSTRACT: An innovative program was developed to address senior community service needs providing the opportunity to reduce ER visits while focusing on supporting seniors in their home setting of choice. The Dryden Area FHT in partnership with Patricia Region Senior Services (PRSS) has developed a position that has evolved to assist in service integration through a Community Service Guide (CSG). The CSG attends hospital morning interdisciplinary meetings to discuss patient care within the site and visits with in-patients that may benefit from the FHT and PRSS programs. The CSG attends the ED and collects the referrals for the day which are then distributed for physician/NP follow-up. The CSG receives all referrals for the FHT and navigates the patient through the system. The seniors are then linked into the PRSS community programs for services as identified. In addition, the FHT has developed senior outreach clinics addressing caregiver burnout, education, medication reconciliation, treatment and chronic disease management/prevention.

ORAL 14c:

TITLE: Emergency Department Visits: Identification process and strategies to relocate demand to Primary Care
PRESENTER (S): Kirk Miller, Business Services Manager
FHT/ORG: Guelph FHT

ABSTRACT: Emergency departments see rostered patients for non-urgent care every day. Using acute care resources to process non-urgent visits is costly and impedes access for patients requiring urgent care. The WWLHIN has targeted a 10% reduction in CTAS 4 and 5 for hospitals in the region. The Guelph Family Health Team (GFHT) began a study of Guelph General Hospital (GGH) ED visits using a Learning community PDSA approach in March 2011. This presentation summarizes the methods for data collection, the process to present

data to physicians, the collaborative work between GFHT and GGH and the strategies to achieve ED visit reductions.

TOPIC: PRACTICE IMPROVEMENT

WORKSHOP D1:

TITLE: Health Coaching: Skills and strategies for engaging and sustaining patient self-management of chronic disease
PRESENTER (S): Durhane Wong-Rieger, PhD
FHT/ORG: Institute for Optimizing Health Outcomes

ABSTRACT: This workshop provides an introduction to Health Coaching for Patient Self-Management. Case studies and brief demonstrations/role plays will be used.

After participating in this program, participants will be able to:

1. Define the role of self-management in promoting treatment adherence and health behaviour change
2. Identify the knowledge and skills patients learn as self-managers
3. Know five-stage model of health coaching and concepts that support self-management
4. Know principles of motivational interviewing and stages of change
5. Identify the roles of healthcare professionals in facilitating patient self- management

WORKSHOP D2:

TITLE: Practical approaches to building communities of practice for knowledge translation in interdisciplinary clinical groups
PRESENTER (S): John Parboosingh, FRCSC
FHT/ORG: University of Calgary

ABSTRACT:
Objectives: At the completion of this interactive workshop, participants should be able to:

- Describe the elements of communities of practice (CoPs) and discuss how CoPs can become a knowledge translation strategy for interdisciplinary groups of health professionals;
- Identify components of generative conversation and how this type of conversation contributes to emergent learning and continuous practice improvement; and,
- List several facilitation techniques that can be used to build a community of practice among existing groups of health professionals to enhance their engagement in continuous improvement initiatives.

TOPIC: QUALITY IMPROVEMENT

WORKSHOP E1:

TITLE: Herding Cats: Developing a strategy for quality improvement and patient safety - and how to get everyone on board
PRESENTER (S): Dr. Karen Hall Barber, Physician Lead; Danyal Martin, Clinical Program Coordinator
FHT/ORG: Queen's FHT

ABSTRACT: In 2007-08, the Queen's FHT embarked on a series of workshops that brought together our entire team of clinicians, residents, and staff members to ask how we wanted to approach quality improvement within our organization. From this emerged key themes: standardization, collaboration, and proactive approaches to care. Since then, these themes have evolved to form the basis of our Quality Plan, which serves to provide a roadmap for our quality and patient safety initiatives. Based on the Institute of Medicine's domains of quality, the Quality Plan is focused on improving safety, timeliness, efficiency, patient-centeredness, effectiveness, and equity. This workshop will provide an overview of the development of the plan, challenges and recommendations, and tips for how to engage your team.

WORKSHOP E2:

TITLE: IT TAKES A TEAM: The Complex Medical Care Clinic in Action
PRESENTER (S): Dr. Pauline Pariser, Physician Lead; Dr. Nadiya Sunderji, Consulting Psychiatrist
FHT/ORG: Taddle Creek Family Health Team

ABSTRACT: The Complex Medical Care Clinic is a partnership between the Taddle Creek Family Health Team and the Centre for Innovation in Complex Care at UHN. The clinic proactively addresses patients with complex co-morbid disease in order to improve their quality of care. Our consulting internist and psychiatrist, as well as professionals representing six disciplines, meet with the patient to develop a coherent treatment plan. The intended outcomes include reduction in emergency room visits and hospital admissions, reduction of the burden of care for the primary care provider and modeling synergistic problem solving for all health care providers. We will present a 20minute film of a clinic in action. Discussion will focus on the benefits of this service for the patient and family as well as for members of the team and the challenges in setting up this initiative for a family health team.

TOPIC: PUBLIC HEALTH

WORKSHOP F1:

TITLE: Collaboration In Action– Family Health Team, Children's Aid and Public Health Working Together To Support Families
PRESENTER (S): Brenda Mills, Coordinator, Child & Youth Mental Health Initiative; Zsuzsi Trim (BScN, RN) Public Health Nurse, City of Hamilton
FHT/ORG: Hamilton Family Health Team

ABSTRACT: The Hamilton Family Health Team (HFHT) has embarked on two key partnerships to improve patient care. This presentation will discuss the unique relationships between the HFHT and the Children's Aids Societies, and the HFHT and Public Health Services. The first initiative involved the assignment of two child protection staff to work collaboratively with three family practices to increase knowledge and communication with a goal of early intervention and prevention strategies that are timely and less intrusive. The second initiative, the HFHT- Public Health relationship, started in 2009 with a focus on facilitating adaptation of the new 'Enhanced 18 Month Well Baby Visit' and has continued to expand since that time. This presentation will illustrate how the HFHTs partnerships have reduced barriers and increased capacity building, and will provide insight as to facilitating factors, challenges and key lessons learned from both exciting collaborations.

WORKSHOP F2:

TITLE: Public Health Family Health Team Partnerships
PRESENTER (S): Kieran Moore, MD, Associate Medical Officer of Health, KFLA Associate Professor of Family Medicine
FHT/ORG: Queen's, KFLA Public Health

ABSTRACT: Workshop will discuss integration of primary care with public health initiatives including but not limited to pandemic preparedness, smoking cessation, 18-month assessment and vaccination strategies

BREAKOUT SESSION #3: 3:15 – 4:00 PM

WORKSHOP G:

TITLE: Improving Patient Care through Group Medical Visits in Family Practice: Diabetes, Dyslipidemia, Osteoporosis and More: A Nurse, Dietitian Physician Collaboration
PRESENTER (S): Tara Currie R.N., BScN., CDE; Michele MacDonald-Werstuck RD., MSc., CDE
FHT/ORG: Hamilton FHT

ABSTRACT: Group medical visits may be more effective than traditional medical visits in providing care and support for patients in a Family healthcare setting. They provide patients with peer contacts with whom they may identify because of their shared medical condition, in turn assisting them to share questions, knowledge, and gain confidence. They stimulate involvement of patients in their care, which is associated with better health outcomes, as well as build confidence in own capability to manage their condition. Self-care management may reduce the need for other healthcare services. Learn how to improve patient access and outcomes through group medical visits with a Registered Dietitian, Registered Nurse and Family Physician. This interdisciplinary approach allows for patients to gain better knowledge about their condition and improve their self- management skills

WORKSHOP H:

TITLE: Using IT to Solve Process Problems
PRESENTER (S): Dave Sellers, Director of Operations; Dr. Mark Fraser, Lead Physician
FHT/ORG: West Carleton FHT

ABSTRACT: This presentation will describe how innovative approaches within the FHT IT infrastructure have been used to solve process issues and improve efficiencies and data quality. The quality of the data in your EMR has a direct impact on quality of care and your ability to identify care issues, promote self care and identify population care needs. The presenter will demonstrate approaches that have been used and the impact that they have made in the FHT using tools that you may already have and did not know it. This is a highly technical presentation; therefore you should have a good understanding of your current Information Technology Infrastructure and processes to glean the most from this presentation. This presentation is not specific to single vendors EMR.

WORKSHOP I:

TITLE: 'The Pork'n Beans' of CDM A Pilot Project: New Innovations and Best Practices in a FHT
PRESENTER (S): Karen Y. Brooks, RN, BScN, CRE, CDM Nurse Educator; Dr. Margaret Tromp, MD, CCFP, FCFP
FHT/ORG: Prince Edward FHT

ABSTRACT: "Left undiagnosed or untreated, chronic disease may also exact serious health and economic consequences from patients, families, and communities" (Every, 2007, p. 70). A FHT Family Physician and CDM Nurse Educator, have implemented aspects of The Edmonton Southside Primary Care Network Chronic Disease Model. This has brought the care of chronic disease back into the family physician's office, where FHT team members contribute, but work to improve care and coordination of service is achieved within. We have customized this approach within our family practice. Highlighted is the MOHLTC's seven themes of priorities for FHT's, correlated with practice management of several chronic diseases. Utilization of upstream approaches to patient preventatives and screening is addressed. A patient may see the CDM Nurse Educator, the Family Physician, or both, and spend time discussing disease management. "This team approach frees the physicians to see more patients, to concentrate on those who need them and to take satisfaction from knowing they are doing a good job" (Spooner, 2007, as cited in Every, 2007). You won't want to miss 'The Pork'n Beans' of CDM.

WORKSHOP J:

TITLE: Elder Mediation
PRESENTER (S): K. Lynn Dykeman, MSW, RSW; Joy White, Nurse Practitioner
FHT/ORG: McMaster FHT

ABSTRACT: Elder mediation uses the principals of mediation to resolve conflict between family members about the care of an elderly family member. Conflict between family members of elderly patients is common and impacts many variables including patient care, hospitalizations and utilization of community and FHT resources. When family meetings of all involved parties are held, consensus can often be achieved and a plan of care and support which is agreeable to all can often be the result. This innovative strategy has been increasing in popularity and has resulted in some very positive outcomes.

WORKSHOP K:

TITLE: Using Spirometry in Clinical Practice
PRESENTER (S): Angie Shaw, RRT,CRE Respiratory Educator; Amy Massie, RRT, CRE Respiratory Educator
FHT/ORG: New Vision FHT

ABSTRACT: This workshop will assist Family Health Team members in utilizing spirometry as a valuable tool in various clinical settings. Case studies will be presented, worked and reviewed. There will be a brief review of spirometry interpretation principles. Participants will then have the opportunity to practice interpretations, and consider recommendations based on the case presentations. Upon completion of the workshop participants will be better able to use spirometry results as a valuable tool in diagnosis and treatment of obstructive/restrictive lung conditions, and have an improved understanding of what recommendations to make based on results from spirometry testing.

WORKSHOP L:

TITLE: Turning the Place Upside Down: Exploring Successes and Challenges in Practice Changes in Family Health Teams
PRESENTER (S): Dale Guenter; Kati Ivanyi; Cathy Risdon
FHT/ORG: Department of Family Medicine, McMaster University & McMaster FHT

ABSTRACT:
Aim: Discuss methods and strategies for bringing about small or large changes in how an FHT does its work

Approach: The presenters are directors of clinics in an academic Family Health Team. We will summarize briefly some of our experiences and ideas about what works and what does not work in helping a large organization to participate effectively in organizational change. We will facilitate case discussions among group participants, of situations in their own work environments where practice change has happened or is anticipated.

Outcomes: Participants will leave with some ideas of actions they can take within their own settings to facilitate effective participation and engagement in organizational and practice change.

WORKSHOP M:

TITLE: Medical Directives: Clinical Pathways that Build Teams and Increase Access to Care
PRESENTER (S): Dr. Kimberly Wintemute, Medical Director; Dr. Jon Hunchuck, PharmD, Pharmacist
FHT/ORG: North York FHT

ABSTRACT: Maximizing access to care is an important primary care goal. Medical Directives are one tool for improving access. The workshop objectives will be: to become familiar with essential structural elements of medical directives; to identify clinical opportunities within your organization for the development of meaningful directives; to consider factors within your organization to assist with directive implementation; to write a sample

directive that can be brought back to your organization; to leave with a number of sample directives that could be polished for your FHT.

WORKSHOP N:

TITLE: Planned & Proactive Community Care: Diabetes
PRESENTER (S): Elisha Laughren, Health Promoter, Timmins FHT
FHT/ORG: Timmins FHT

ABSTRACT: Developing a detailed Diabetes Patient Algorithm (through Process Mapping + PDSAs) our team has identified patient flow success and challenges, the required diabetes clinic supply to meet the demand, and areas to improve collaboration within TFHT and with VON Diabetes Education Center.

WORKSHOP O:

TITLE: Oncology Nurse Navigator - Supporting the Journey
PRESENTER (S): Sarah Givens, RN CON(C), Oncology Nurse Navigator
FHT/ORG: North Perth FHT

ABSTRACT: The Oncology and Palliative Care Program for the North Perth Family Health Team is a nurse designed, implemented and led program that began in 2007. The Oncology Nurse Navigator (RN CON(C)) provides support to patients as required anywhere along the disease trajectory. Patients receive support during the pre-diagnosis and preventative care process to ensure appropriate tests are ordered and followed up in a timely fashion. When a cancer diagnosis is confirmed, emotional support along with assistance navigating the medical system is provided locally throughout treatment for patients and family. Patients are then transitioned to survivorship, a very important part of the healing process, or to palliative care. Whatever the transition, support is provided at the primary care level within our Family Health Team. The Oncology and Palliative Care Program is an innovative program that makes the best use of our resources and available community linkages.

WORKSHOP P:

TITLE: Occupational Therapy Role in Optimizing Practice in Primary Healthcare: team perspectives, clinical experiences and where to begin.
PRESENTER (S): Catherine Donnelly, OT Reg. (Ont.), Assistant Professor, Queens University; Lori Letts, OT Reg. (Ont.), Associate Dean Occupational Therapy, School of Rehabilitation Science, McMaster University; Colleen O'Neill, OT Reg. (Ont.), McMaster Family Practice; Candace Crawford, OT Reg. (Ont.), Wise Elephant FHT; Anne Childs, MHSc. (N), McMaster Family Practice Team Coordinator; Cathy Risdon, MD, McMaster Family Practice
FHT/ORG: McMaster Family Practice

ABSTRACT: With a core focus on enabling engagement in everyday living, occupational therapists (OT's) are uniquely positioned as valued interprofessional team members on FHT's. Since March 2010, occupational therapy positions have been supported. This workshop will review the ways OT's can support interprofessional FHT's in reducing risk of injury or illness, promote chronic disease self management, and implement early intervention strategies with the goal of optimizing physician and team resources. Two OT's, one in an academic and a non-academic setting will share their unique experiences including case studies that demonstrate the value of occupational therapy to their teams. Occupational therapy with clients through the lifespan and with varying conditions will be highlighted. Team members' perspectives will reflect the added value offered by occupational therapy. Additionally, an Executive Director will discuss helpful strategies to address challenges in applying for Ministry funding for this role.